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Sexual Illnesses and Underutilization of Biomedicine Among Tribal Women of Rajasthan

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INTRODUCTION

Health is a worrying sector among tribals of Rajasthan. Widespread under nutrition, poor infrastructure, high morbidity and mortality rates characterize the population groups of Rajasthan. The sexually transmitted infections (STIs) are important causes of morbidity and mortality among women of reproductive age. STIs related complications result in spontaneous abortion, infertility, ectopic pregnancy and cervical cancer apart from long-term impairment of reproductive health and increased risk of HIV transmission from one person to another (Cameron et al., 1989; Wasserheit, 1992; Population Information Programme, 1993). Estimated sexually transmitted infections and related complications collectively rank second in importance in the world among diseases in women of reproductive age (World Bank, 1993).

The prevalence of sexually transmitted infections among tribals of Rajasthan is not clearly known. Available estimates show a wide variation of STIs occurrence. Large number of *sujak* (venereal disease) patients is found. *Sujak* is loosely a category of conditions affecting genitals and urinary tract. Common problems among adult females are leucorrhoea (*safed pani*), followed by swelling (*soojan)*, syphilis *(challe*), gonorrhoea (pus discharge) and chancroid (chancroid is a venereal infection causing ulceration of the lymph nodes in the groin). Carstairs equates *sujak* with urithritis (Carstairs 1975, 1985) but English speaking Rajasthani's usually translate *sujak* as venereal disease or gonorrhea.

Three main methods exist for the diagnosis of gynecological and STIs namely self-reported symptoms, clinical examination and laboratory tests. Some studies have reported a reasonable degree of consistency between self-reports and clinical or laboratory evidence of infection, provided the diagnostic criterion are clear (Zurayak et al., 1995). However, large number of studies has reported rather low levels of agreement between different types of diagnostic approaches (Filipi et al., 1997; Bhatia and Cleland, 2000). Several reasons have been put forward to explain these discrepancies. Studies have been reported where patients show no symptoms but have reproductive tract infection, including sexually transmitted infections (Mabey, 1996). Conversely, some people who report symptoms have no biomedical detectible pathology (Abdool, 1994). These discrepencies reflect the fact that women's perceptions of these diseases are rooted in cultural beliefs. In India, it has been suggested that the reporting of abnormal vaginal discharge may be more an expression of underlying psychosocial distress than evidence of infection (Patel and Oomman, 1999).

Reproductive Tract Infections (RTIs) have come into the limelight in the past few years since the HIV\ AIDS scare. It was decided in Cairo Conference in 1994 to include the concept of reproductive health while tackling the health problems of women in India. Reproductive health has been defined as" a state in which people have ability to reproduce and regulate their fertility; women are able to go through pregnancy and child birth safely; the well being; and couples are able to have sexual relations free of the fear of pregnancies and of contracting diseases". Government of India planned to implement the project of prevention of RTIs at a national level. However before starting the programme it was decided to check the magnitude of the problem and whether it was an issue to be dealt with at P.H.C level. Centre of Social Medicine and Community Health conducted a study on STD with data from Maulana Azad Medical College, New Delhi's STD department. The data demonstrated extremely high male-female ratio. Most men gave a history of extra-marital contact while the few women in whom STD could be demonstrated were either commercial sex workers or partners of these men (*Source:* Centre of Social Medicine and Community Health, 1998).

STD diagnosis and treatment has been given the third line of prevention in reproductive health package. The high association between STDs and HIV infection is well documented .STD clinics

are the most obvious source for detection of these infections. However, in areas where these are located, not many STD cases go there, and proportion of women is even less. This is not only because women by and large avail the medical services much less than men but also because STDs produce noticeable symptoms in very few women. Access of women to good general health services, including gynecological services, is the only means of detecting STDs in women. Treating STDs through special clinics can deal with infected males alone; women will benefit indirectly. Thus detection of cases in women can happen only when women come to the PHCs for their non-specific symptoms. This can benefit only if it promotes the idea of faithful and monogamous relationships among men. This is a complicated issue, which medical services alone cannot solve as it depends upon communication and education facilities in addition to wider socio-cultural processes

Collecting information about sexual diseases was rather difficult. Awareness regarding STIs causes and reasons among tribal women of Rajasthan is not much. During fieldwork doctor of health center pointed out that large number of tribal women suffers from leucorrhoea and burning sensation while urinating but they do not consider this as sexually related ailment. Even while registering the name of the disease all these are registered under the category 'Diseases of Urinary System' (urinary tract infection). Very few (men or women) are aware that STIs could be transmitted through engaging in sex with the infected person or indiscriminate sexual activities are responsible for the prevalence of sex diseases. They are totally ignorant about the fact that STIs could be transmitted through blood transfusion, infected equipment and from infected mother to new born. Educated women were better informed than illiterates. Tribals could recognise certain symptoms of STIs better than the transmission of disease. All knew the irritation of sex-organs as a symptom. The preventive measures were unheard of. Precautions during sexual inter-course, choosing faithful partners or use of condoms is not recognised as a way to offset these diseases. Sexual promiscuity is basic to the spread of venereal diseases (V.D) as all these are sexually transmitted. However tribals themselves blame other sources as cause of the disease. Their ignorance of cause of disease and misinformation about sexual illnesses act as widespread obstruction in combating V. D in traditional societies.

Numerous studies have documented the extent and alarming situation of sexually transmitted diseases among tribals of Rajasthan (Carstairs, 1955; Dave, 1960; Naik, 1960; Malvi, 1980; Mann, 1980; Vyas, 1980; Meharada, 1985; Joshi, 1984, 1995). They attributed the present situation to the 'reservations of the tribals themselves, and partly to the constraints of those who carry out this (national and state level effort to fight this menace) programme'. Conversely, there is rising need of additional labor for management and eradication of sexually transmitted diseases. Biomedical institutions both government and private are already provided for but their facilities remain underutilized.

PRESENT STUDY

Present study is an attempt to analyze why the tribal women of Rajasthan, estimated 80 percent who suffer from STIs (little detail available on how many of these are minor) do not make use of government provided biomedical facilities. In case of other sicknesses these people are highly pragmatic in opting for type of treatment from the various systems accessible to them (Bhasin, 2002). Their choice is influenced by cultural and economic factors. Availability and accessibility are other deciding parameters. The data were collected from tribal groups namely Sahariyas, Minas, Bhils, Kathodis, Damors and Garasias inhabiting districts of Baran, Swai-Madhopur ,Udaipur, Dungurpur and Sirohi. A profile of the six tribal communities in southern Rajasthan highlights considerable heterogeneity. The districts of Udaipur, Dungarpur, and Sirohi are situated in the hilly region of Aravalli range. Small streams traverse these hills. The riverbeds are fertile with good rainfall. The Swai Madhopur and Baran districts are located in the southeastern plateau of Rajasthan with stony and high table land. Bare rocks with no vegetation characterize areas of Baran district. The rainfall is frequent in both the districts. In Udaipur district, Kotra and Jhadol tehsils (from where Bhil and Kathodi data were collected) are backward areas with few amenities, while theoretically available health and education facilities function only sporadically. The Swai Madhopur and Baran district from where data for Mina and Sahariya tribals were collected respectively are located in the

southeastern plateau of Rajasthan with stony and high table land. Amenities and services are largely available, as are a host of private health and education facilities. However tribal villages remain at the periphery and are devoid of these facilities. Owing to the nature of the socio-historical factors, these tribal groups occupy distinct and unequal position with regard to their access to material resources, knowledge base and social conditions exiting in society. The ecological conditions in the area dictate many aspects of traditional life; especially settlement pattern and disease pattern.The tribals possess poor assets, meager resources and petty means of livelihood. Small, hilly fragmented infertile landholdings devoid of irrigation facilities are the basic assets. The forests, which were the main source of their food, fodder and fuel are rapidly depleting .The social field of Rajasthan can be said to be split vertically, horizontally and diagonally into caste, religious and national categories. The tribals in Rajasthan are typical examples of the chasm identified by government between the exploitative social system and insensitive administrative machinery marginalizing them on their own land by promoting disinterest in developmental activities and alienation are graduating them to the vicious circle of poverty. Of these tribes the Minas are slightly better off and relatively more developed due to their exposure to modern life. The Sahariyas, Bhils, Kathodis ,Damors and Garasias remain largely under exposed .

The tribal villages under study tend to be poorly connected by roads, have severe water supply problems and are often reduced to depending on rain and river water. In the rain-fed region, agriculture does not offer a reliable and adequate source of income, is constrained by the uncertainty of water supply, and is chiefly geared to subsistence production with the main crops being wheat, maize and millet. A large number of men are employed in non-agriculture occupations, particularly labour.

The tribals have retained their deep-rooted animistic faith and totemic concepts with a high level of superstition in spite of proximity or contact with Hindus. Though having absorbed several traits of neighbouring religions, even the deities, gods and goddesses, the sphere of tribal religion has been least affected and has maintained its identity. Among tribals religion provides ethical guidelines for living, for interpreting natural events including disease, misfortunes and disasters. Traditional societies understand that their survival depends on relating correctly to their physical and spiritual environment. They know how to balance both the material and spiritual, to enjoy their lives without losing respect for their living connection with the environment. Disturbing this equilibrium is considered the cause of many ailments. The findings of the study show that the greater the extent of traditionalism in tribal society the wider is the tendency of utilizing the indigenous therapeutic practices. However, the belief in supernatural causes exists alongside the belief in natural causes as in case of general health problems and reproductive health problems, tribal start with home remedies and herbs. They are familiar with some conditions, which point to the cause, and so the treatment. Tribals are fastidious about the etiology of the disease as this is important for therapeutic measures. Diagnosis is necessary before selecting the right treatment. The diseases that follow a particular route of treatment have been described as" fixed-strategy diseases"(Beals, 1980).

METHODS

The fieldwork for the study was conducted between1997-1998. The ethnographic data were collected through a range of methods, including personal narrations, household surveys, conversations, observation and interviews with the help of schedules in the villages selected from five districts. The present report forms part of a much larger study, "Human Settlements, Human Activities And Health Among Tribals of Rajasthan" which covered 46 villages, 15 in Baran district, 12 villages in Swai Madhopur, 13 villages in Udaipur, 3 villages in Dungarpur and 3 villages in Sirohi district. For demographic analysis 900 families have been studied, out of which 200 families each are from Bhil, Mina and Garasia and 100 families each from Sahariya, Kathodi and Damor tribals. The data comprises women aged 15-59 in the reproductive age group. Their educational levels, exposure to media and occupation of their husbands was also taken in to account. The occupation of husband is an important criterion, as husbands who go for labor activities are exposed to outside hazards. Consequently their wives are at greater risk of contacting STIs. Status of women as unmarried,

married, divorcee and widow were also reported though among these people it is not a significant factor because of laxity in sexual relations. The risk remains same for unmarried, married, divorcee or a widow. Women were asked about symptoms, the number, systems and chronological order of treatments they had taken. Afterwards, the methods they described were grouped in to four categories:-(1) traditional home remedies; (2) herbal; (3) spiritual; and (4) biomedicine. Biomedical treatment included government sponsored centers as well as the private practioners. Folk-healers, herbal as well as cultural *(Bhopas)* specialists were interviewed. Specialists in medicinal plants were asked for detailed information on its uses, preparation, and application. Likewise ritual healers were observed while treating a patient. This is a cultural construct of sickness and medicine among tribal lay people and folk healers and it will be a fruitful guide to the meanings which *sujak* has for those who are experiencing and treating it. Lambert (1992) has discussed popular therapeutic rituals that are "structured by what might be termed the local ethnography of certain kind of sickness". Health among these tribals is related to the habitat, settlements and amenities available. Other factors affecting the health of the tribals are historical, socio-cultural, economic and developmental. As STIS are directly associated with medical and socio-economic factors, the focus of the study stay put on socio-economic factors and medical facilities available to counteract this menace. The socio-economic factors include education, laxity in customs, broken homes, labor activities, prostitution, migration and poverty. The extension of biomedical facilities in tribal areas alone does not guarantee the utilization of the same. How do tribals respond to the efforts made by the government or how do they tackle these sex related problems is the vital question. The tribals' knowledge of the three dimensions (transmission, symptoms and prevention) of STIs is imperative. Ethnographic documentation of indigenous therapeutic beliefs and measures among tribals is useful either as a basis for scheming more effective health programmes or to improve communication between health workers and patients for better compliance.

PROFILE OF TRIBAL WOMEN IN THE STUDY AREA

During the course of study 1087 women of six tribal groups in the age group 15-59, which constitute 24.8 percent of the sample, were contacted. It was found that numbers of females were suffering from some kind of infection that they were not able to identify. Some of them could recognize certain symptoms of STIs like irritation of sex-organs, yellowish-white secretion and swelling of the thigh and uterus but their knowledge of transmission of disease was poor. Likewise prevention measures were unknown. Great deal of laxity prevails in the sexual relations. Pre-marital, extra-marital and transitional unions though not appreciated but are tolerated by society. Marriage among tribals is not a religious sacrament and is comparatively free. Divorce and widow remarriage is customary. Early marriage has traditionally been the norm in tribal culture, nearly 53.3 per cent females were married by the age of 14 years; the age at marriage among Minas and Sahariya is very low.

Marriage customs among tribals allow them to have economic compensation in exchange of spouse. If relations between a unmarried girl and a boy are noticed, the boy is obliged to marry her or pay compensation to her father or brother. Similarly, if relations between a man and a married woman are found out, the man is supposed to pay compensation to the husband. If a man abducts an unmarried girl, he is expected to marry her or recompenses her father. In case a married woman runs away with a man, he has to pay penalty to the husband the amount of which exceeds the original bride price. The incidence of STIs is high among societies where sexual rules are not stringent and there is laxity in social behaviour. In practice, of course, patterns of behaviour, gender roles and relations are more fluid than suggested by overview given above. Furthermore, despite broad commonalities, tribal women are not a homogeneous group. As the level of awareness about the transmission, symptoms, consequences and prevention of sexual diseases is of low order among tribals, women suffer more than men. The problem of STIs is also connected to the level of education and socio-economic characteristics of the respective population. Education by and large augments the ability to know more and form a supportive framework. The tribal women of Rajasthan have been very unfortunate, as majority of them never went to school. Alternative means of communication like community-based health forums to reach these women to improve their knowledge of sexual

illness have not been considered at length. The crude female literacy rate among the six tribal groups under study is among Sahariyas = 4.2; Minas = 8.4; Bhils = 4.8; Kathodis = 13.2; Damors = 10.5; Garasias = 0. The studies of Malvi (1980) and Vyas (1980) have reported high incidence of STIs among the tribals of Rajasthan. Promiscuity plus liberal attitude towards pre-marital and extra-marital sex has been accounted responsible for this. In regions where mines and industrial units are located and tribals work as labourers, there is high interaction of tribal women with non-tribals. The tribal habitations that are located near the National Highway # 8 are more prone to these hazards as truck drivers halt along these. The tribals of Rajasthan inhabit the area, which may be included in the 'poverty square' of India, measured according to four indicators, infant mortality, female literacy, number below poverty line and per capita net domestic product (Bhasin, 2003; Unpublished Report) . The tribals in the study area are landless labourers, tenants and small landholders who fulfill their subsistence requirements of fuel and fodder from the Common Property Resources (CPR). There are no big landlords except among Minas. In the study area meager 10 per cent Minas own more than 51 Bighas of land. With no permanent irrigation facilities, the tribals do not depend on agriculture alone. They practice mixed economy wherein they undertake gathering, collecting, subsidiary agriculture and labour activities. The tribal households mix these resources and activities across a given year according to seasonal fluctuations. However, about 51 percent males' and 25 percent females in the study area claim wage labour as their primary occupation

INDIGENOUS DISEASE THEORY

'Humoral' and 'predictive' or 'prophetic, dimensions constitute characterization of two forms of cultural logic that orient tribal folk therapeutics. It is believed by tribals of Rajasthan that sickness is caused by social offences against dead or living or celestial world and natural forces cause minor ailments like cuts, bruises and burns. Similarly tribals classify some diseases like colds, fevers and other respiratory infections as illnesses of cold (*sardi ki bimariyan)*; and problems like boils, ulcers, piles, genitor-urinary disorders are believed to be the illnesses of heat (*garmi ki bimariyan).* These illnesses are supposed to be caused by excessive internal cold or heat in the body respectively. This heat or cold does not correspond to body temperature but rather to internal humoral state. Treatment of such illnesses is always accompanied by dietary modifications. Tribals differentiate between food having hot (*garam*) and cold (*thanda)* traits. *Tendu, Mahua, Bajra* and jaggery produce heat in the body whereas gram, wheat, milk of goat and cow and *Beri* has a cooling effect. In case of illnesses caused by cold, foodstuffs producing 'hot'effect are increased in diet and foodstuffs having 'cold'effect are prohibited and opposite scheme are followed in case of illnesses caused by internal heat. In case of diseases like pox (*bari mata, choti mata, acparo), miyadi bukhar* (time bound diseases), *motijhara* (typhoid) etc. tribals are not bothered about etiology of the ailment but of development and consequence of it.

In case of STIs the tribals have altogether a different stance. Even though *sujak* is considered an illness of body heat, there are three different sources from which *sujak* may be contacted and none of it is remotely connected with sexual behaviour. These are namely: (i) if *sakkar* or *gur* is eaten together with the *bajri roti* (millet bread) instantly followed by drinking cold water;(ii) if a person passes urine at a wet fence where someone inflicted with *sujak* has urinated before; and (iii) *sujak* may be contacted from a infected person. It is believed by tribals that *matrons* (the females who die during pregnancy or delivery become *matron*) cause female troubles.Garasia believe that bleeding from vital organs, is caused by a *veer* (malingnant spirit) named *Rangito*. To placate this *veer*, a goat is sacrificed and liquor, coconut and seven types of grains are offered. It is believed that breast diseases among the lactating mothers are caused by *Duedhio veer*. Milk of single coloured goat or breast milk is offered to mollify this *veer.* The tribals are greatly afraid of these diseases that according to them run down to the seven generations. Carstairs (1955) during his stay in Rajasthani village came across many 'apparently robust' looking men who requested him for injection to make them strong. In the course of time it became clear to doctor that what such people really wanted was some medicine that could contain 'the condition of spoiled and leaking semen'. Carstairs further mentions "this preoccupation was quite independent of the recognition of venereal disease

and the fear of having contracted it. Gonorrhea was specifically mentioned as being only one of many ways in which spoiled semen might leave the body" (ibid: 124). The villagers according to their education were aware of nature and functions of the semen; factors conducive to the increase of semen. Dietary restrictions and adherence to right behaviour was most important . "Any violation of the many strict rules of behaviour which concerns the orthodox Hindu is regarded as detrimental to his store of semen, and thus to his store of semen, and thus to his mental and physical well-being" (ibid: 25). Lambert (1992) gives example of' "spermatorrhea *(dath*—also *garmi ki bimari,* more generally used to denote venereal disease), said by the local *vaidya* to arise from the heat engendered by excessive sexual activity or, according to a village midwife, by contact with a polluting (hot) menstruating woman" while relating the indigenous etiology or cause of the condition. The folk etiology attributes transmission of venereal diseases to innocent sources. Tribals use charms, amulets, perform rituals to please annoyed deities, sacrifice animals and also allows free discussion of subject quite openly in the community and medical counter measures can be taken unimpeded by shame and secrecy. The folk etiology of sexually transmitted diseases is in consonance with the socio-cultural conditions of the area. Here popular medical notions make it possible to maintain a convenient morality in matter of sexuality. These local medical notions help in maintaining clandestine extramarital sexual outlets and officially acclaimed standards of pre-marital chastity and marital social loyalties. Stability of ethical norms and cultures as such is hence reinforced. So far as AIDs and HIV are concerned, tribals are least knowledgeable.

HEALTH CARE SYSTEM

The health care among tribals is pluralistic. Four systems of treatment are available to tribals: herbal; ritual care; biomedicine and Ayurvedic beside home remedies. The State government has introduced biomedicine and Ayurvedic system of treatment. There are government-sponsored Primary Health Centers (PHCs), private medical practitioners practicing biomedicine as well as Ayurvedic medicine (herbal and mineral tradition of Indian Medicine). The traditional healers who cater to the needs of tribal are: -specialists in home remedies; ritual care practitioners *(bhopas*); herbalists *(jaangar/jaankar)*; *nabj or nadu* (pulse) specialists; grain diviner(*devala);* priests *(khoont);* and midwives.

These healers are not full-time specialists, as they are not completely engaged in the pursuits of supernatural goals like priests. They do not charge anything in cash or kind. It is misnomer to call them specialists but they are the ones who possess supernatural or herbal knowledge out-of-the-way to common people.

TREATMENT STRATEGIES

Since health care is a constant choice of individuals, their perception of available alternatives and their motivation to seek cure is important. Subsequent to failure of home remedies the services of other therapists are sought only after the diagnosis has been made.. Sickness is a fundamental assault on person and society, is a matter of deepest concern; affecting the life and death. It can induce deep emotional arousal. The strategy of a person while choosing a therapy for a family member or kin depends on local interpretation of the symptoms, causes, therapies and personal experience and preference.

The tribal response to health problems reveal a multiple and simultaneous usage of home remedies and multiple therapy. The therapies include spiritual action, religious rituals, exorcism, herbal remedies and diet to prevent future sickness. Various practitioners whose services are sought after are herbalists, spiritists or supernatural healers and public health practitioners (Ayurvedic as well as biomedical practitioners).

The medical traditions among tribals maintain their individual character though these are in constant contact with each other. Each medical system is not only a product of particular historical setting and cultural tool; it has also its own cognitive categories. Human beings caught in sickness event are less concerned with the subject of mishmash of healing therapies but are simply concerned with recovery and relief. For this, division between 'rational 'and 'non-rational 'methods of diagnosis and treating sickness is eliminated. The distinction between 'science 'and 'faith'; and 'magic' and 'religion' disintegrate. Systems of contemplation and explication, like astrology and Sufism, which principally are not medicinal, are approached for therapeutic

purposes, on the premise that religion is to be resorted in case of suffering, and illness is a kind of suffering, the mitigation of which can be sought through prayers, touch, invocation of spirits, sacrifice; libation, appeasing the adverse planetary configuration and wearing talisman and charms on body. Tribals also believe in visiting shrines or temples or *dargah* (muslim shrine) that are abundant in Rajasthan. One of the most important functions, apart from worship is to offer healing rituals that cure psychic and socio-psychic problems. In a hierarchy of resort, the shrine or temple would rank as a kind of last.

During fieldwork doctor of health center informed that large numbers of tribal women suffer from leucorrhoea, burning sensation while urinating and anaemia. As in case of other sicknesses, the same route is followed, based on referrals and advice from relatives, neighbours and practitioners. This seems to be related with extreme anxiety over the apparent mounting seriousness of an illness. When a person is sick, he or his family members are primarily interested in getting his health restored, for which they readily combine different therapies regardless of their ontological, epistemic, ethical and aesthetic foundation. Medical pluralism is the outcome of this orientation where achievement of health is main objective and the person is restored to health totally, rather than just the symptoms of a disease. When one therapy fails to restore health, the patient goes to another therapist in search of relief and even if this one also does not work, he will go to another therapist, the choice being entirely his or his family members. In fact it is customary among tribals to discuss disease symptoms among relatives and friends and then decide the course of action.

Self or home treatment is usually the first step in medical care, consisting primarily of concoctions of herbs, barks of trees, flowers, roots, leaves, seeds etc. and change in diet. Traditional medical knowledge is coded in to household cooking practices, home remedies, ill health prevention and health maintenance beliefs and routines. Many of these are commonly known. Some of this materia medica grows wild in the area, some are cultivated in the home gardens and others are bought in the market. Herbs are assigned a hot, cool or cold quality and are incorporated into the local hot-cold classification system relevant to illness causation and treatment. The treatments are known to elders in the house or neighbourhood or are suggested by folk therapist. Treatment is generally a family based process, and the advice of family members or other important members of a community have a main influence on health behavior and the form of treatment that is sought. Herbal and home remedies used by tribals in case of reproductive health and STIs are:

Cases of gonorrhea are usually treated locally with an extract of *neem* leaves, fried in one kilogram of ghee, strained and taken daily till symptoms disappear.

Tribals take one seed of *chanbol(Abrus precatirius*)orally for infection.

The whole plant of *Baam (Bacopa monnieri)* is crushed and taken orally. In case of bleeding root of *Geengsi (Grewia flavescens*) is powdered finely and taken with milk.

For treating menstrual disorders and prolonged bleeding they also use charm (*totka*) comprising different items arranged on a cow dung cake. The healer encircles this charm over the patient's head and places the charm at the crossroads at an appointed time. This charm acts as a means of transferring disease.

In case of burning during urination roots of a plant *Argyreia strigosa* are taken orally for 2-3 days.

For infection tribals take a fistful of seeds of *Jungli-Tulsi (Ocimum canium*) orally with milk.

For abortion 200 grams of roots of *Thuar (Euphorbia neriifolia)* are boiled in a liter water and this decoction is taken orally.

For inflammations juice of leaves of *Doodhii (Pergularia daemia)* is taken orally.

Stem barks of *Amb (Mangifera indica), Jamun (Syzgium cumini*) and root bark of *Jhadbor (Ziziphus nummularia*) are taken orally for abortion.

In addition to these common procedures tribal women use charms to transfer the disease, wear black thread in the lower portions of their legs as protection against magic. In case the symptoms persist they go to ritual therapist for diagnosis and therapy. Apart from these there are 'specialists' or' famed people' who possess divine knowledge or healing power for particular ailment or give medication, which is an accomplishment or approved by deities themselves. This type of therapy in which curative and symbolic aspects are interlinked has a separate and independent existence. A person of any caste or ethnic group from any strata of society can hold acquisition of

this type of knowledge. In the study area there were one or two accomplished people who could provide help in specific ailments. However detailed information regarding STIs could not be gathered, as females were shy in discussing symptoms.

BIOMEDICAL FACILITIES IN THE STUDY AREA

At the time of formation of Rajasthan, barring a few big towns, medical facilities were conspicuous only by their absence. The expansion of health services and facilities has taken place mostly after its formation. The health services in post-independence period have resulted in the establishment of government hospitals, dispensaries, Primary Health Centers and Sub-Centers. In addition to these biomedical institutions, Ayurvedic and Unani hospitals and dispensaries were also started. The primary health centers are meant for serving rural areas and are more in numbers than hospitals and dispensaries. The government attempts to provide reproductive health services that emphasize maternal and child health and family planning. For this purpose, it has established an extensive network of reproductive health services that reaches even remote areas. Female field workers, work at the grassroots level. In the study area, out of 46 villages, only 2 villages can boast of primary health centers, 7 villages contain the facility of sub-centers, 3 villages have Ayurvedic dispensaries, and one village has a Unani health center.

PERSISTENCE OR CONTINUATION OF TRADITIONAL PRACTICES

For appraising underutilization of the biomedical services provided through government agencies in the tribal areas, availability and acceptability are two important factors. As already mentioned that all the villages in the study area were not provided with health centers. Difficult geographical terrain and the far-flung sparsely distributed human habitations add to the problem of access to the health services. Although the tribal population is aware of the existence of PHCs, relatively few people actually use the services. A review of above- mentioned services reveal that the facilities offered at these centers remain underutilized. The users comprise mostly clients who live close to a PHC or reproductive health center and come from educated sections of the society. Further, the majority of the recipients of these services do not have clear idea about the services provided by these centers. Most consider these centers as family planning centers. It is right that these centers do provide MCH (maternal and child health) and clinical contraceptive services. However other medical services are also provided for. Some tribals feel that these centers are mainly for childcare and the treatment of the minor ailments of the women. It is most likely that the tribal women who knew about the type of services provided by these centers will use the facility than those who are ignorant about it. The tribals who want to benefit from these services have to face many hardships. Tribals have to walk long distances to avail these services. It was found during the study that these health centers were poorly provided for. Absence of doctors and non-availability of medicines typify the PHCs. In Bhil, Garasia and Damor settlements as huts are scattered, these remain cut off for days together during monsoon (the time for major illnesses) by fast flowing streams. The muddy drinking water causes diarrhoea and other water-borne diseases. During this period, areas are cut off and health workers are not able to arrive at settlements and patients themselves cannot reach the health center. So the tribals have to depend on traditional therapies. It was observed that in tribal areas where both the facilities (biomedical and traditional) were accessible, the tribals did not hesitate to make use of bio-medicine. Nevertheless alongside they also performed traditional rituals. Biomedicine as provided by PHCs is generally criticized for failing to respond to the wider emotional and spiritual needs of the patients. It is like a commodity delivered by health profess-ionals and their assistants. Community members do not participate in its planning, implementation and evaluation.

The traditional health care practices are ‘patient-centered’ and holistic views of many factors meet more effectively the needs of the patients. Patients’ views about the meaning of health, treatments, the role of emotions and healer-patient communications are important. Wide variety of emotional and spiritual factors have impact on tribal health, and that fundamental change is required in the way health care is organized and provided to take full account of this. These days’ tribals do not totally rely on ritual healers; however they opt for herbal

remedies as well. Compared to allopathic medicines, herbal remedies are cheaper and are easily available in the vicinity. These herbal remedies are free from side effects many tribals suffer from after taking the allopathic medicines. As in case of malaria, tribals believe that herbal infusions are trustworthy cure than quinine, which creates many other problems. Malaria is understood as 'coldness entering the body',' the chill disease',' three days disease', 'and three fevers in two days' 'dumpling in belly'. The discernment in each name for the complex illness of malaria, the varying times schedule of chill and fever and the short space and the long, even the swollen spleen in the last stages, which could be described as 'dumpling'. The cause of disease is well known. In tribal areas of Rajasthan medicinal plants are an important resource for restoring health. In case of severe illness, ritual healing is vital alongside other therapies. Ritual and empiric therapies are integrated. Phytotherapeutic treatment may be recommended for the sickness diagnosed by religious technician-*Devala* or grain diviner. In such cases, patients are asked to look for suitable plants and use these in precise way. If the family does not find exact plant, it can be procured from the professional herbalist on payment.

Within the concept of medical pluralism (existence of more than one medical systems) the focus remains on medical traditions as bounded systems rather than as social institutions. This article describes the way tribal women cope with STIs. It was found that knowledge among tribal women regarding sexually transmitted diseases was very poor. Although raising awareness about the transmission, prevention and cure of STIs has received increased attention in other parts of India; the women in tribal Rajasthan seemed to have limited access to information about these. As already mentioned that tribals have their own explanation about the causes of these diseases and have their own therapeutic measures. If they know symptoms, they suffer silently but do not want to consult any male curer for gynecological problem. Usually they take herbal medications. As these consultations are not accompanied by checkup, these infections remain uncured. Then they pay visit to the *Bhopa*, a medium also referred as *sayana, gothia or* godle, who act as a vehicle of the deity through possession. Diagnosis and propitiation remedies are suggested. Common procedure employed for such illnesses is *jhara* for driving the spirits away. In case where *Jhara(*the ritual sweeping away of illness) is required, the patient is asked to sit in front of *Bhopa* who burns incense and moves leaves and twigs of some special plants in front of the patient accompanied by chanting of some *mantra*. Generally the leaves and twigs of Neem (*Azadirachta indica*) are moved from head downwards. The visits to *Bhopa* for ritual healing enables the tribals to relate their ritual needs to supernatural powers and to ask for help and forgiveness. In addition they also keep charms (*totka*) on the crossroads with the belief that this charm would act as a vehicle of transfer of disease. The charms are kept on the crossings with the belief (i) that it will inflict harm to the person passing by or touching it accidentally; (ii) to appease an evil spirit or deity, the believed cause of sufferance; and (iii) to leave suffering there. Various types of charms may be used for treating different ailments.The charms consists of sweets, lighted dough lamps, Vermillion, *moong daal* grains and lemon, but other variations like coconut, *chanmol* seeds and flesh etc. are also common.

As traditional medical systems have survived in this area for such a long time, its therapeutic value and what is retainable of traditional systems and how these can be upgraded through education, licensing and incorporation in to state health planning becomes important. The state health programmes are well intended but lack anthropological consultation. As a consequence herbal and ritual therapies practiced in this area are not granted due importance. The cultural importance of ritual cure and role of medicinal plants (their healing properties, their symbolic values and easy accessibility in the surrounding area) in the traditional therapeutic system is of immense worth. It was observed from the ethnographic data that there are number of diseases where oral application of herbal preparations are a frequent part of the treatment. However the data also shows that at certain point the tribals see the limits of herbal form of treatment. Any ailment that is associated with severe, long lasting pain and other odd symptoms requires contact to and help by supernatural. The tribals relate their ritual needs to supernatural powers and ask for assistance and clemency. However it was seen that even *Bhopas* were unable to suggest correct remedies in case of sexually related diseases. It was found that if at

all they were prepared to go to a PHC even as a last resort, the government medical institutions are not located in the rough, difficult terrain in the forest where most of the tribals reside. Sometimes it almost takes a whole day to reach the health center. As these centers have regular working hours, and are closed by the time the patient arrive there. If coincidentally the center is even now not closed it is difficult to find the staff. If inadvertently they are working, there is no doctor. If there is a doctor, there are no medicines. If at all they visit the doctor and start medication they do not finish the complete course. They start with the medicine and as soon as there is slight improvement, they stop taking medicine. In cases where the health centers are not in the vicinity, only ANM visits the area. The ANM approaches them and gives them iron pills and antibiotics for 15 days. The visits of ANM are not regular. He visits the particular area after an interval of 2-3 months and starts afresh and the problem continues. The tribals prefer to visit private practitioners (qualified or unqualified) as they are available all the 24 hours. The health centers provide services for limited hours of the day. Then there are holidays or doctors are otherwise busy in the managerial work as that too is the part of the duty. Even the diagnosing process is totally different from what tribal are used to. The diagnosis has two types of consequences, conceptual and physiological. The process of healing is deeply embedded in culture. In the traditional system on visiting *Bhopa* or *Jaangar* they do not have to spell their symptoms. The healer would do the needful. Spiritist would tell about the annoyed spirit and its remedy to counteract. Herbalist would read the pulse and prescribe the medication. The doctors in the centers inquire about symptoms and get irritated on no reply. In raised voice they repeat their queries and frighten them (patients) away. As doctors are mostly from outside the tribal areas, the language is another barrier, which restricts the utilization of health facilities.

The conceptual explanation of sickness, diagnosis and treatment are important in understanding the management of sickness. The theoretical sides of traditional medicine, medical system, the religious background, particularly the belief in the fear of evil spirits, healing performed according to spiritual rites explain the persistence of indigenous system. The patient, his/her family and sometimes the entire village participate in the curative ritual. In contrast, in the health center the patient or his family is not included in the treatment and is provided with prescription. All these factors affect the working of the health center and medical facilities remain underutilized. As majority of the tribal female were illiterate, they were resigned to the fate and believed that these problems cannot be cured, as even *Bhopa*s are unable to cure these. However, evidence from other country settings show that the net effect of education in raising the knowledge of the three dimensions (transmission, symptoms and prevention) of STIs was significant (Hadi and Praveen, 2003; Khan et al., 1997). The study of Hadi and Praveen (2003) from Bangladesh has included NGO forum participation along with the education to see the net effect of these parameters on the three dimensions of STIs. As expected, the role of education in improving the knowledge of sexual illnesses was significant. Although the role of education was more prominent than the forum participation when the effects of media exposure and other socio-demographic factors were controlled. Age was also strongly associated with level of knowledge of sexual illnesses. Stone et al., (2003) in their study among unmarried Nepalese show that schools play an important role in informing young people about sexual health matters. Although this research, on which further work is required, leaves number of questions unanswered. As Nepal has incorporated sex and sexuality education in to his national curriculum, tribals in Rajasthan also need this type of education, which will help them in understanding the transmission, symptoms and prevention of *sujak*. Nepal's education policies over the last thirty years, have vastly increased school attendance and raised the educational status of both males and females. Given the relatively short period of time that the programme has been running, the results presented by Stone and others clearly show the potential that school have in generating understanding about sexual diseases and reproductive health matters.

Although terrain, difficult travel, lack of infrastructure, irregular attendance by the paramedics, ineffective treatment, inadequate supply of drugs and unsatisfactory behaviour of the members of the staff have been attributed to the underutilization of these centers, but patient's awareness of disease, its transmission, prevention and ways and means to fight it have been little mentioned. If tribal women themselves are not

aware of the cause or the nature of the disease or from where curative help can be sought for, increasing the efficiency of the health centers (better services with good staff and continued supply of drugs) would remain unproductive, and will not ensure the complete utilization. As tribal women are ignorant about the services available at these centers there is added need for information, education and communication related services focusing on clients' needs. Field workers and paramedics at the health centers ought to instruct tribals about the accessibility of and need for utilizing the services they offer.

It is well established by studies that maternal health services have a crucial role to play in improving the women's reproductive health and consequently the family and community health (WHO, 1989; Bhatia and Cleland, 1995; Magadi et al., 2000) The utilization of health delivery services is influenced by number of factors such as availability, quality and cost. However, it cannot be said that where there is good supply of services, demand is created in and of itself. It may happen that availability of health services may not encourage all women to avail the services; some women are more likely to use health services than the others. Availability of the maternal health services is not the only explanation for using these; other factors such as social structure and status of women are crucial for underutilization of these facilities. The deterioration in child female- male ratio in the group 0-6 is a serious challenge to the basic right of survival and protection of the girl child in the State. Use of modern technology for sex selective abortions, limited access to health and nutrition care for the girl child and their early age of marriage- continue to act as barriers to growth and development of women and girl children in Rajasthan. The average Maternal Mortality Rate (MMR) for Rajasthan for the year 1992-93 was550 deaths per 100,000 live births as against national average of 420 deaths (UNICEF, 1995).

The general health services have a major role to play in detecting and treating STDs cases. Diagnoses of STDs in women entail efficient general health services. Effective medical services, which evoke confidence and trust, are essential pre- requisites for this. No health services can gain credibility among its clients if it provides RH care but does not treat other common conditions such as fevers and diarrheas.

Adopting a public health approach to reproductive health care and STIS, within the context of Primary Health Care. Reproductive health needs are a subset of women's broader health needs, and needs to be approached as such. There is no other way one can improve upon women's reproductive health and alleviation of STIs in isolation from her overall welfare. It would be better to rely on holistic and integrated rather than on technical solutions.

KEYWORDS Gynecology. Reproductive Health. Morbidity. Mortality. Gender

ABSTRACT The general health services have a major role to play in detecting and treating STDs cases. Diagnoses of STDs in women entail efficient general health services. Effective medical services, which evoke confidence and trust, are essential pre-requisites for this. No health services can gain credibility among its clients if it provides RH care but does not treat other common conditions such as fevers and diarrheas. Adopting a public health approach to reproductive health care and STIS, within the context of Primary Health Care. Reproductive health needs are a subset of women's broader health needs, and needs to be approached as such. There is no other way one can improve upon women's reproductive health and alleviation of STIs in isolation from her overall welfare. It would be better to rely on holistic and integrated rather than on technical solutions

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