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Socio-structural Determinants and Health Seeking Behaviour of the Mankirdia Tribe of Odisha: An Ethnographic Study (SDHSBMTO)

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ABSTRACT The paper attempts to study the role of the Mankirdia tribe's socio-structural determinants and its influence on their health-seeking behaviour. The extensive ethnographic method has been used to collect relevant and in-depth information from the study community. The paper conclusively finds that social structures have impacted the health-seeking behaviour of the community at large. It also finds the inter-connection among the larger structural elements of the tribal society, such as socio-political, and economic structures with health-seeking behaviour and the disease burden of the Mankirdia. It has suggested stringent policy measures for qualitatively improving the health status of Mankirdia tribe, and also existing social determinants or structural aspects needs to be strengthened. In addition, traditional healthcare practices need to be reinforced, especially an indigenous healer's knowledge with existing biomedical health services.

INTRODUCTION

Social structure is about patterns of relations (Martin and Lee 2011).The perception of social structure is one of the central ideas in social science. It denotes to social forces and pathways, which are external, relatively independent from and more than the summation of the individuals (Leyton 2014). In the most general sense, the idea of social structure is composed of patterns of institutionalised relationships, social institutions and social network that connect us and in the interaction that fill everyday lives (David and Orenstein 2007; Ashley 2019).

The relationship between social structure and health-seeking behaviour is closely connected, and it locates health in society with close integration with its institutions, norms, social categories, and processes (Mishra 2017). Siddique et al. (2016) have highlighted the significant role of social structure or socio-economic status of Fatkhichri of Chittagong rural people and its impact on their health-seeking behaviour. Major social determinants or social structures were mentioned that affected their decision-making choices, that is, socio-demography, education, knowledge and perception towards healthcare.

Health and disease are the two striking dimensions of an individual's behaviour. Every individual once faces an issue of disease in their lifetime. Many social determinants influence the health status of individuals, and these are social status, caste, and education. It can also influence the existing environment, local hospitals, the behaviour of the doctors, and access to technologies. Besides, the health-seeking behaviour is also attached to internal dynamics that is family health culture and geography. The choices of the local people are not confined to a certain medical system but rather believe in a plurality of health services (Nanjunda 2014).

Srinivas et al. (2019) have mentioned tribal populations known for their cultural uniqueness. Many affirmative policies have also been adopted for their socio-economic and health development but the result remains abysmal. Although their geographical inaccessibility is one of the factors of their backwardness, in addition, the study also explores many other social structures

or social determinants that are equally responsible for tribal people's poor health. Nanjunda (2019) in his study mentioned dynamic health culture and health-seeking behaviour among rural people.

The health problems and practices are closely connected with social-cultural economic and political factors. The study by Marrone (2007) has equally highlighted the poor tribal health resulted because of a lack of proper access and utilisation of health services. Major factors that have obstructed the health of indigenous communities in comparison to general include geographic area, communication and socioeconomic status (Marrone 2007). To facilitate this argument, Kolahdooz et al. (2015) study also outlined that Canadian indigenous people's health is disproportionately affected by four Sustainable Development Goals (SDGs). The main issues mentioned that is lack of proper understanding or link between income, social space, and health outcome.

In this study, an attempt has been made to study the social structure or social determinant of the Mankirdia tribe and their health-seeking behaviour. Mankirdia are a small semi-nomadic primitive tribal community of Odisha (one of the rudest and least known jungle tribes of earlier found in Chota Nagpur plateau (Roy 1925; Manna et al. 2013).

The motivating factors to conduct a study on this Particularly Vulnerable Tribal Group (PVTGs) are their unique socio-cultural history (monkey eating and rope making work) and semi-nomadic style of living. They are known for their traditional rope-making skills and monkey-eating habits across the state. Most of their life depends on local forest resources, while hunting the games is also another important occupation. Nowadays, they are gradually adopting new means of life and livelihood. These unique attributes of the Mankirdia tribe have created the background for the study. There is a paucity of research on this tribe in general and most specifically on their health issues. The above factors have inclined researchers to engage in extensive fieldwork on the Mankirdia tribe.

Objectives

The main objective of the present study is to study the role of the social structure in health-seeking behaviour, disease burden, and treatment mechanism. These social structures among the Mankirdia community are family, religious belief system, education, livelihood, political participation, land ownership and ethnic image.

METHODOLOGY

The present study has used an ethnographic methodology. This was a one-year, intensive field based study. Several qualitative methods are used in this research, like a case study, focused group discussion (FGD), oral history, and interview schedule. Case studies were conducted for indigenous healers, patients and village heads for understanding the status of the influence of existing socio-structural determinants on indigenous health care practice and practitioners. Focused group discussions (FGD) were adopted for the study community to explore more about their viewpoints on social determinants like education, income and religious belief system in day-to-day life.

Study Area and Population

Mankirdia tribes mostly live in the northern regions (Mayurbhanj and Balasore) districts of the state of Odisha and fall into the category of a hunting and food gathering tribe. To continue their livelihood they have to maintain traditional occupational relations with the local farmer groups. They frequently change their dwelling places within a demarcated region and are thus recognized as a wandering tribal group. They are present in different states like Odisha, West Bengal, Assam, Madhya Pradesh and Maharashtra. In the state of Odisha, they are identified by diverse names such as Mankidi, Mankidia, Mankharkhia and Mankirdia, which have been so-called mainly because of their monkey hunting and eating character (Adhikary 2008).

They are primarily separated into two categories such as *Jaghi and Uthlu* (Ota and Mohanty 2015). The first group is known as the settled one and the second is nomadic. Few social scientists claimed that the native place of the Mankirdia tribe was the Chhota Nagpur Plateau of the Jharkhand and Bastar region of Chhattisgarh. The current study was carried out in two villages, namely Kendumundi and Dengam

of the Karanjia and Khunta block of the Mayurbhanj district. The over-all respondents were 365, out of which 187 are males and 178 are females. There are 175 married, 185 unmarried, four widows, and one separated person found in the study village.

RESULTS AND DISCUSSION

The health-seeking behaviour of Mankirdia has been immensely influenced by their social structure. Most significant socio-structural aspects are education, livelihood, earnings, spending, and culture, linguistic base, housing and household. The main occupation of the Mankirdia is rope making, and they use the *Siali* creeper for making varieties of rope-made products, which are used by the local peasant community for agricultural and domestic purposes (Patnaik 2015).

Sonowal's study explored the significance of various socio-economic factors on nutritional status of tribals of Maharashtra. He has categorically highlighted that because of shortage of sufficient amount of suitable job opportunities, land, forest resource and exposure to local non-tribals, it makes them more vulnerable towards poor nutritional status, while Dash in his study illustrated the same (Sonowal 2010; Dash 2014).

The occupational structure shows that Kendumundi Mankirdias largely depend on traditional rope making, followed by jungle-based occupation, driving establishment work and wage labourer. In the case of Dengam village, they depend more (46.9%) on rope-making work than driving work and 13.7 percent of the population depends on driving work. In Kendumundi village, the study shows only 14.1 percent engaged in rope-making work, while 10 percent in driving work and 1.6 percent work as daily wage labourers. It was also found that 41.6 percent were non-workers and 3 percent of the population were wage labourers (Table 1). Patnaik (2015) mentioned that the Mankirdia community face the problem of forest rights or habitat rights, which is to only refrain them from their traditional livelihood but disintegrated from their traditional skills of rope making and hunting activities. Besides, they were unable to collect the foodstuff from the forest, and restrictions from the forest department have brought food security issues for them, which may lead to starvation and acute malnutrition problem (Patnaik 2015). Mitra and Chakrabarti (2014) have also argued that the traditional occupational structure of the Mankirdia community has changed because of their close contact with neighbouring villages and peasant communities. The deforestation issue has reduced their dependency on forest collection and their dependence shifted towards agriculture and wage labour (Mitra and Chakrabarti 2014).

Somawar and Phulejhale (2015) have further highlighted the development of expenditure levels and the rise of food production was not able to bring any positive results for them. The socio-economic backwardness has brought poor health status, as infant child mortality, low birth weight, under-nutrition, and malnutrition are prevalent among their children.

Education Status and Health among Mankirdia

The educational achievement of the Mankirdia in the studied village is very low. It has been mentioned that 78.9 percent were illiterate and the rest were literate among them. This group comprises primary education (12.3%), with matriculation (0.3%) and Anganwadi pre-school

Table 1: Occupational Structure of Mankirdia

Primary occupation	*Kendumundi village*	*Dengam village*	*Total*
Jungle based occupation	29.7%	04.6%	13.4%
Rope making	14.1%	46.9%	36.8%
Driving work	10.0%	13.7%	04.7%
Establishment work	0.8%	08.4%	0.5%
Wage labourer	01.6%	05.8%	03.0%
No work	43.8%	20.6%	41.6%
Total	100%	100%	100%

Source: Turuk KK, Patra AK, Sarangi S (2021: 61)

completion (8.9%) among them. Education acts as a medium of transformation and development. However, it has not brought any drastic transformation among them. The educational status of Mankirdia is almost the same in the study villages. But the Kendumundi village shows some variation and some sort of improvement in education. In the case of Dengam village, it is slightly higher than Kendumundi village. The total literate numbers were forty-seven out of that 27 have completed primary education, and one person had completed matriculation, and 19 were enrolled in an Anganwadi centre. The total illiterates in the study villages were 79.9 percent.

The findings of the study mentioned that only 1.3 percent were literate and the rest come under the illiterate category. It was pointed out that 0.6 percent of people completed high school. It has also been mentioned that poor education status affects their health behaviour because children's education is closely linked with their state of health. Due to regular sickness, their children skip classes, which brings poor results (Maharana and Nayak 2017). There is a direct connection between education and the health status of the Mankirdia tribe. Education and economic status are correlated and similarly influence each other, for instance, those families have improved their economic condition, and also improved in education and health care as well. Many of the young generation of Mankirdia and a few of the older people have also mentioned that because of illiteracy, their progress has been blocked. Nanjunda has mentioned the important role of changing the economic, political, cultural and demographic profile of the rural population and its impact on illness ideology and perception, health seeking behaviour, and culturally bound attitude on onset of disease and use of different systems of medicine. In this study they have tried to link rural population understanding health and adoption of various systems of health care services, besides the role of changing socio-economics conditions of the individuals that also impact choices of various health care systems (Nanjunda 2019). Besides this field based data about education, there are some earlier studies, which have also mentioned the pathetic education condition of the Mankirdia community. Because of this, their health is not developed satisfactorily (Das 2011; Manna et al. 2013; Ota and Mohanty 2015; Sethi and Mohanty 2015).

Family and Health Seeking Behaviour

Family plays an important role in the overall well-being of the individual and society. An individual gets strength from their family to fight a crisis or transitional situation (Mishra et al. 2018). Lindstrom et al. (2019) have also mentioned the importance of the family's role in adolescent health advice and treatment. In another study, it was mentioned that the health-seeking behaviour of caregivers of febrile children is determined by the head of the family, education, occupational status and income. The Mankirdia family is a small social unit that performs production and distribution, which works for daily subsistence (Adhikary 2008). It is a parental family group that consists of a husband, wife and unmarried children. It comes to the limelight that the nomadic or simple tribe possesses an elementary level of the family. The family structure of this nomadic tribe is not only based on one objective of the production-consumption activities rather work as a kin group. Murdock has outlined four fundamental social functions of the family like sexual guidelines, multiplication, financial collaboration, and socialisation/instruction. These are significant characteristics of a family for individuals and communities (Murdock 1949).

The evidence shows that a nuclear family is predominantly found in the study villages (94%) and only 3 percent prefer to join a family. Apart from these, 2.7 percent live in single families and 0.3 percent in a separated type family. The family composition shows the importance of a small family (Ota and Mohanty 2015). The most common size is three to five-member families. Besides, some families have exceeded five to eight members. They neither go for a very small family nor adopt large families, rather they prefer a middle size family with three to five members. It was evident that they never isolate their old parents even if they are separated from their children. Indeed, this is a reality, as the family performs multiple activities to survive the fellow members and provide all the comfort to the family members. Social caring is of paramount importance for Mankirdia rather than an economic one (Patra 2021).

The family's role in health care is immensely important for Mankirdia. Family members are the pillar of their strength in adverse conditions, be it social suffering, environmental suffering, or

physical suffering. The social suffering indicates the discriminatory behaviour that Mankirdia face in day-to-day life (the physical or racial identity of Mankirdia and traditional food practice). Physical injury generally happens during hunting or forest based collection. Every member of the family cooperates and coordinates with each other and shares their emotions and helps each other to overcome the situation.

Paraphernalia Position of the Mankirdia

The possession of paraphernalia of the Mankirdia is one of the important factors of their health-seeking behaviour. This comprises various indispensable amenities and assets of the Mankirdia, which includes energy facilities, kitchenette, drinking water and latrine. A total of 63 percent of them live in a leaf hut while 37 percent live in a semi-*pucca* house. They lack basic household facilities like housing, drinking water and a toilet. The majority of them live in leaf huts and a few of them live in semi-*pucca* houses. The temporary leaf hut is called *Kumbha* or *Tanda* (Ota and Mohanty 2015). Nadal mentioned that government-provided housing facilities are not easily accepted by them because of their cultural and religious beliefs. They make the necessary changes in the modern house and then stay there. It is also mentioned that many of them keep their old-style leaf hut as a symbolic model and a few of them use it for an ancestral deity (Nadal 2015).

They use three types of kitchens that include outside, inside and kitchen in the outlying. It was found that a maximum 77 percent of them use the outside kitchen, while 12 percent use the outlying kitchen and only 11 percent use the kitchen inside the house.

In case of electricity facilities, it is observed that 48 percent of households including two villages use electricity facilities. In the study villages, with regard to drinking water facility, most of them at 77 percent practise pool and rivulet water for regular purposes, and the rest 23 percent use tube well water. They regularly practice river water for drinking because it is accessible during the year, and many times they suffer from water-borne diseases like diarrhoea and dysentery, which may be due to poor water quality. In the case of the toilet, most of them are habituated to open defecation. Presently the government has constructed toilets but only 38 percent of them use toilet facilities.

In case of their material possession, mobile phone, cycle, television and motorcycles were rarely found among Mankirdia. For instance, 60 percent of them use a cycle as the major source of transport, 5 percent of them use television radio for their entertainment, while only 3 percent of them use a motorbike. It was found that 6 percent of households in the study villages were getting benefits or depending on the Public Distribution System (PDS). In addition, 50 percent of them have claimed possession of health coverage and health system services, however they never get any benefit from these cards.

Interconnection Between Social Welfare Schemes and Health-seeking Behaviour

The social welfare schemes include old age pension, ration card, job card, and health insurance/schemes. It was found that 61 percent of households in the study villages were getting benefits from the Public Distribution System (PDS), through Below Poverty Line (BPL). In the case of old-age benefits, only 25 percent of them are getting such facilities. Out of this, 18 percent belong to Dengam, and the remaining 7 percent from Kendumundi village. In addition, 54 percent have claimed health insurance and health scheme facilities, but they never get any benefit from this card. More particularly health care insurance is not bringing any positive impact on tertiary health care for them. The government health care facilities are not properly reaching them, which is one of the important causes of their higher rate of disease burden.

Religious Belief System and Health Seeking Behaviour

Mankirdia are polytheists (Nayak and Das 2014). They worship the elements of nature. They believe that God and spirits who create trouble, illness and death are regarded as malevolent and others who bring progress and prosperity to society are benevolent. Every sphere of their life has been strongly influenced by religion, health, food habits, politics, occupational, marriage and social control. The religious belief

system of Mankirdia more often influences their health behaviour. There are specialised Gods and Goddesses for specific areas like Sing *Bonga* for hunting activity and *Burhi Mai* for good health. Subsequently, they have a strong belief in the religious world as well as supernatural forces.

According to their belief system, everything is controlled by religious forces, as it maintains the cosmos for the betterment of the whole earth. They believe that they are the small creation of *Sing Bonga* who blesses them to maintain a good life and protect them from future misfortune. Consequently, they have to perform various sacrifices to their respective deities. Presently they are practising three religious principles such as traditional nature worshipers, Hindus, and Christianity. The existing religious structure of Mankirda shows dynamics in the belief system.

Earlier they were habituated to drinking alcohol and losing their hard earned money on this. According to Lenka Mankirdia of Kendumundi village, earlier they wasted a maximum of their income on the ritual feast, sacrifices and drinking. The early religious life was more conservative and focused on strict adherence to the religious principle. Along with several sacrifices and rituals which were a costly affair for them. As a result, they remained poor and unhealthy. Their health condition was affected by excessive alcohol drinking and the absence of proper medical facilities (Ota and Mohanty 2015). Although their village headman Brahma was there, he was unaware of the outer world. Hence he was unable to bring desirable change for the community. It was very essential for them to overcome the social system, which damaged more than brought happiness for them. It does not mean that earlier religious belief was bad, but it lacked strict disciplinary ethics, which created a problem for them.

After conversion to Christianity, they have changed in their life and various habits. The shift from a polytheism belief to Christianity brings positive transformation among them (including health behaviour). It was observed from the Kendumundi village that most of them have changed their earlier religious status to Christianity. Those households have adopted Christianity, and they have improved their income-generating capacity and developed general awareness about new lifestyles and adopted new occupations like wage labour, Raj Mistri work and driving work. It helped them to overcome the circle of poverty. Overall understanding of the changing worldview was very little, which also restricted them to think beyond their philosophy or logic. Many times it acted as the cause of their backwardness and poor health (Turuk et al. 2021).

At present time younger generations of their community are more inclined towards Christianity. But they never engage in any conflict between these two religious groups. The basic difference between the two study villages was their level of awareness, assimilative process, educational achievement, and the role of religious belief in their lifestyle.

These were major causes that play a significant role in changing social space for them. In the present time, they have left the practices of alcohol drinking habits, which improve their social status in the locality. For which they were humiliated earlier. These changing social practices are possible in the above study villages because of a Christian Pastor's involvement in their day-to-day life. They perform a vital part in their progress and act as a major agent of change.

Ethnic Identity in Health Seeking Behaviour of Mankirdia

Social identity originates from the conviction that a group holds, and can help people to imbibe meaning in social situations that realises their origin and relationship. The identity comes through ethnicity and race discourse (Karlsen and Nazroo 2002; Bradby 2003; Ghosh 2003; Kumar 2005). The first one indicates the cultural tradition of Mankirdia and the second highlights the physical attributes. The identity of Mankirdia comes with their physical appearance and cultural practices like rope making and monkey-eating habits. The food habit (eating monkey flesh) is a derogative tag for them. This kind of food practices was not supported by local non-tribals, and as a result, they face social discrimination in various facets of their life.

They face many issues like cultural differences, gender subordination, and class asymmetries, particularly in the field of health. The cultural frames of Mankirdia more often create different levels of understanding about the diseases, which increase the gap between patient and health care professionals. Due to this, they

have been discriminated against based on their social identity, which creates a negative attitude towards health professionals. Espinosa et al. (2018) has also highlighted the role of ethnicity, gender subordination and spirituality, and their impact on health behaviour. In the case of the Mankirdia community some of their old social practices bring suffering or discriminations for them.

Case Study on Social Suffering of Mankirdia

Subas Mankirdia, aged 45 years, lives in Kendumundi village. He is one of the pastors of the Kendumundi village church. He recalls a sad memory, from March 2008, when he went to the local shop to bring an electric bulb. After paying the price of INR 25, he bought a new bulb. When he checked it in his house, the bulb didn't light up. Again, he went back to the shopkeeper and said that he wanted a new bulb as it was not lighting up. Then suddenly the owner of the shop shouted to Subas and said, "You, Mankirdia! Don't you know how to light up a bulb? And blame me that it is not lighting. It is not the fault of a bulb, but you have a problem, you have a habit of living in darkness and Dibri, so how can you light up an electric bulb?" In this way, he criticised the whole community.

Here, one can understand that their social suffering is more painful than their physical. Every day they are facing such type of stereotyping behaviour from other communities. It also matters in the case of the hospital. This is one of the instances of racial discrimination, but most of the time, people target them because of their stigmatised social practices and position in the locality. Besides, a certain attribute of Mankirdia brings defame to their racial identity. In this way, they face discrimination in their day-to-day life. They do not get normal behaviour from others in the community, which creates mental trauma and agony in their daily life. Somehow they felt that their low social status undermined their equal existence in society. For instance, if they go outside for wage work, they are not given proper wages and respect, and rather face exploitation. Besides, they also face exploitation and harassment from the health care professionals while taking treatment. Either they are not given appropriate treatment or are deliberately exploited by writing unnecessary prescriptions of medicine.

Mankirdia Understanding of Health

The concept of health receives different interpretations from various perspectives or domains of discourse. Health is a precondition for human well-being and development and is an essential aspect of Mankirdia. It is influenced by so many factors or the determinants of the society like beliefs, traditions, customs and other practices that are closely related to the health and well-being of the individual. It can be positioned as more than the biomedical field of the individual. In other words, one can approach a state of mental, social and economic wellbeing and not merely absence of disease (WHO and OECD 2016).

The disease causation and treatment of Mankirdia is a complex and dynamic process. The study focused on live experiences and their understanding of disease symptoms, and explores other factors as well. The dichotomy of the severity of diseases and the role of a healthcare professional (healers and modern practitioners) more often health-seeking behaviour does not follow horizontal but many times go with a vertical line. They define health as "*Bulu Haram*", which means the person is in good health and ill health is known as "*Kharap Haram*". It is influenced by the large socio-religious and supernatural realm of the community. Further, it is influenced by the different spirit worlds and natural forces. Hence, their health behaviour influences internal and external factors, as they also believe in natural events, which are not controlled by man. They have faith in the natural incidents and their hidden power, which can cause or bring many illnesses for them. Consequently, they have great respect for physical forces around their dwelling places. The concept of good health is termed as "*Buluharam*". A person is considered healthy if they can perform expected work. The physical manifestation of the Mankirdia indicates their health as good or bad. They give importance to a person's physical strength to understand their health seeking behaviour. According to them, health indicates the absence of any disease, which is also attributed as a symbol of good health. Thus they give

priority to their physical strength to understand the concept of good health. Broadly, the concept of health and illness differ according to gender owing to their physical structure and gender-related roles in society. They attribute different causes and seek different types of remedies for the diseased person. They take time to understand diseases and their severity, and so, the manifestation on the body is difficult to understand among them. Many of them do their daily work without any compliance from the disease inflicted body. They do not take common diseases like fever, cold, and cough seriously. But to respond to their bodily pain and its working pattern, they take some home remedies to cure diseases. The health condition influences both the external and the social environment. It affects the normal routine work of the person. The individual suffers from role handicap due to ill-health, which means the normal social responsibilities are getting disrupted by the illness.

Illness is defined by Parsons (1951) as a state of disorder in the customary working of the whole human individual, including both the state of the organism as a biotic system, and of their individual and collective adjustment. It is thus defined partly biologically and partly socially. The improvement of health is not necessarily on biomedicine factors rather on changes to an improvement in food security or diet, housing and other broader social and economic changes to ensure people's health (Barry and Yuill 2012).

Illness or disease is considered as an annoying event in their community. They do not easily disclose their suffering before others, and their idea is to know the origin and causes of the disease. They opine that illness and diseases are unnatural and make their presumptions from this proposition. They are habituated to a lifetime exposure of many privations since childhood, and they have been trained to accept hardship and able to bear up for a longer time against the disease. As long as they are able to perform their daily routine work without hindrance, they do not care, although it is necessary to make any attempt to cure. They are confident about illness and more or less careless, until they consider it to be serious.

Diseases Profile of the Mankirdia

The health-seeking behaviour of the Mankirdia is closely related to two things, like belief structure and surrounding environment. Their culture influences the ethno-medicinal practices, the whole process of disease causations and treatment process (Brahma and Mudgal 2020). The ailment contour of the study communities displays that the majority of them (26%) grieve from fervour followed by vertebral pain, which contributes to 17 percent of the aggregate ailment load of the people. Cold and cough account for 10 percent and a few of them (5%) also agonize from abdominal discomfort. Malaria is one of the foremost contagious ailments that extremely upset their health, which accounts for 5 percent of the total disease burden. Only 3 percent of them suffer from diarrhoea, tuberculosis, and ulcer disease. Moreover, the incidence of jaundice, blood pressure and paralysis contribute to four percent of the disease burden in the study village. Apart from this, body fractures and acidity-related health complications also contributed to 3 percent of the study villages and a few (1%) of them suffer from skin disease.

There is some existing literature, which has mentioned the major health issues of Mankirdia. These are higher rate of chronic energy deficiency specifically in women, high incidence of stillbirth, unhygienic, primitive parturition practices, high maternal mortality, child mortality, upper respiratory tract infection, inadequate vaccination, lack of early diagnosis and prevention were mainly responsible for their poor health status (Nayak and Das 2014; Goswami 2015). In addition to this, few other studies have also highlighted the correlation between illiteracy with socio-economic backwardness of the Mankirdia tribe and impartiality of government policy, which directly affect their health and wellbeing (Somawar and Phulejhale 2015 ; Goswami 2015).

Health Expenditure

It has been estimated that a maximum (33%) spend less than INR 2,000 for their action of diverse illnesses, out of which 11 percent of them spend INR 2,000 to 3,000. Besides, a very few, at 6 percent, spend INR 3,000 to 4,000 and 5 percent spend INR 4,000 to 5,000 in health care. It was established that 44 percent of the Mankirdia did not use a single rupee on therapeutic problems and they believe that supernatural entities are present in their health. Thus their reliance on the aboriginal process of therapeutic is compara-

tively greater in contrast to other health care services. The relative representation of the study villages displays that the domestic disbursement of Kendumundi village is greater than that of Dengam in health care.

Source of Treatment

It was found that most of (37%) the Mankirdia community depend on the traditional treatment method. The reason has been mentioned by them as the existing government health service system has not sufficiently addressed their health care needs. The second source of treatment is mixed medical services like government, private and traditional, and the third one is the government source, which contributes 10 percent of the total treatment process. The fourth one was the private source of treatment, which contributes 6 percent of the total expenditure. The comparative sources of treatment status show that customary and public medical sources were maximum in Dengam village, and the mixed and private sources were highest in Kendumundi village. The mixed treatment source contributed a total of 26 percent. Besides, few of them were not taking any of the treatment mechanisms, which contributed to 21 percent. This category of people was highest in Dengam village in comparison to Kendumundi.

Duration of Treatment

The treatment duration of Mankirdia (minimum to maximum). It was observed that a maximum of them (42%) take one week to cure of disease followed by (28%) one to two weeks to cure their disease burden. Besides, few of them (17%) also take two to three weeks and 13 percent need three to four weeks to cure the disease. It was found that most of them in Kendumundi village take two to three weeks, whereas in Dengam village people take only one week more to be healed from disease.

Social structure has an unswerving effect on the health-seeking performance of the individual demonstrated to be accurate in the study community. The community members those who practised indigenous livelihood belonging to the poverty-stricken group, have less availability to contemporary health care. Another imperative societal organisation that influences their health-seeking behaviour is edification, as due to higher level of illiteracy, they could not accept innovative occupations, health awareness and face social discernment and mistreatment by the local middle man. In addition to this, the language barrier of the Mankirdia community which also hampers their access to better health care facilities.

They are poor, but social bonding is very high among them. This is the strength and source of care, which helps the diseased person to get well quickly. Because of this, single and separated families are not ideally helpful in the crisis and suffering of the individual (Turuk et al. 2021). So they try to cure the diseased person as early as possible. Mankirdia people do not consider health issues as a separate entity but connected with their daily life. There are certain diseases increased because of their family genes. Family acts as both source of illness and a centre for health and well-being (Loveland-Cherry and Carol 2006). They have no money to invest in modern health care and take regular check-ups of the diseased person. So they try to cure the sick person with proper family care and their medicinal approach.

Some of the reports from recent literature have mentioned the effect of positive correlation societal determinants on health status of tribal people (Dhargupta et al. 2009; Das and Mohpal 2016; Lal 2021). Chandrakant and Sindhu (2015) have conducted a study on the socio-economic status and its impact on the emotional intelligence of tribals. The study has mentioned a positive correlation between health and socio-economic conditions of tribal people. Besides, the study of Sarkar and Singha (2019) on the Santal tribal of West Bengal has categorically highlighted the positive relation between health and social economic and cultural aspects of the society. The significant point illustrated by them is that health care assets and investment directly depend on tribal economic conditions (Sarkar and Singha 2019).

The third-social structure of Mankirdia is political participation, which is also an important determinant of health-seeking behaviour. It was found that in the study village those who participate in village-level political events, become aware of the political happenings of their locality, get extra advantage of taking govern-

ment benefits, and develop better interpersonal communication with their immediate neighbour, which helped them to channelise their health issues. Some of them have mentioned that after they participated in political activities, their awareness has developed, helping them to choose multiple sources of health care facilities, which was not possible earlier. Health is very much closely connected with societal elements cultural, financial, didactic, societal, and administrative. The health position of a humanity is closely connected to its value system, moral and traditional traditions, and social, economic and political organisation a function, not only of medical care but also of the overall integrated development of society (Nayak and Das 2014).

Joint family is one of the significant societal aspects that performs basic household assignments for Mankirdia community. The preference towards family structure (nuclear and joint families) remain equal weightage for them. People face many societal sufferings (insecurity and depression) those who live in separated or single family rather than joint one. The study by Raj and Nayak (2018) on Oran tribal adolescent girls have argued that existing basic structural issues like inaccessible geographical area, inadequate medical facilities and unique socio-cultural settings create vulnerability among the Orans in terms of health. Besides, the study also has highlighted the significant role of their traditional healers and cultural practice of the community, and act as major facilitator of health. Another study on newborn care among the central India tribal people have mentioned that because of their unawareness about the medically approved care that is clinically acceptable maternal and newborn care practices for delivery, cord cutting care, bathing of mother and skin massage are uncommon. As a result they suffer many life threatening diseases like hypothermia, sepsis and other infections. Moreover, the study has mentioned the prevalence of malnourishment among tribal women and children (Sharma 2010).

In contradiction to this study, Thomas (2021) in his study has argued that because of delayed health-seeking behaviour among tribal people those presumptive tuberculosis symptoms further aggravates their health complication. Authors have found the differences across gender about symptoms that prompt care-seeking in this population. The study suggests the need for gender sensitive interventions with the health system strengthening are urgently required to facilitate early diagnosis and treatment among this population (Thomas 2021).

The material assets (television, transistor, itinerant and motorbike) and possession of basic amenities (latrines, drinking water, accommodations, energy and health protection) of the Mankirdia people have also impacted their health-seeking behaviour.

CONCLUSION

The present study has highlighted the impact of societal factors on health-seeking behaviour of the Mankirdia. The societal elements has dissimilar consequences on studied villages. The study villages gets mixed benefits from existing societal aspects. This is because of acceptance towards to the transformation practices of the Mankirdia people in the study village. Mankirdia people maintain a direct communication with non-tribals and other dominant communities as result of that their way of life has changed in greater extent. It was observed that many times they assimilate behavioural pattern of neighbouring non-tribals. These are the part of the change along with the structural variables of the society. All the existing societal factors income, educational status, medical care facilities, and other structural element (household, societal identity, and linguistic identity) have influenced their health-seeking behaviour and overall health status. The ailment contour of the Mankirdia people illustrates that all the contagious illnesses were only perceived among the Dengam village. The working structure, earnings and spending aspects of the Mankirdia of Kendumundi village were better than Dengam village, which represented as a detrimental cause in selecting substitute health facilities. For this reason, the private and mixed medical services were higher in the Kendumundi village, while traditional and government service was more in Dengam village.

The overall scenario of the study village proved that the social structure of Mankirdia community has a direct impact on health status and health-seeking behaviour. In addition, the Kendumundi village has taken the more positive benefit or existing structural elements have

positively improved their health status than of Dengam village.

Many existing literature have mentioned the positive correlation between socio-economic determinants and its impact on health-seeking behaviour of tribal people. The socio-structural determinants of the Mankirdia community have immensely influenced their health-seeking behaviour. But it varies according to their level of adoption of the modernisation process and interpersonal relations with non-tribal people in the regions. Major socio-structural determinants of Mankirdia's are occupational structure, education, income, expenditure, health expenditure, family, social identity and language accessibility to medical care. The disease profile of the study villages further strengthened this argument. Besides, the socio-economic conditions play a major role in deciding health care services in the study villages. It was found that the village having better income generating capacity had more opportunities to select various health care facilities. For this reason, the better income village has opted for more private and mixed medical services while traditional and government health services predominated in less socio-economic developed villages. The societal elements of the Mankirdia community have an unswerving influence on health-seeking behaviour.

RECOMMENDATIONS

In order to improve the health status of Mankirdia tribe qualitatively, the existing social determinants or structural aspects need to be strengthened, and their traditional health care practices needs to be reinforced with existing biomedical health services at primary health care level. In addition, the indigenous healer's knowledge has to be properly utilised for larger context with proper scientific validation. Moreover, the tribal development programmes/schemes of the government like Integrated Child Development Service, Public Distribution System and provision of the Panchayat Extension Scheduled Areas (ICDS, PDS PESA) needs to be changed according to the needs of the Mankirdia community. Apart from these, the indigenous healer's knowledge has to be properly connected with primary health centres. Mankirdia communities require dynamic health service in their regions to address various health hazards.

LIMITATIONS

The generalisation of this paper is not applicable for other tribal groups of Odisha. Although it covers many structural aspects of the Mankirdia and its impact on their health seeking behaviour, it needs further study on macro structural aspects of the society, and its interrelation with health seeking behaviour of the tribal group.

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