

## Negotiating Illness and Care: An Ethnographic Study of Morbidity and Healing Practices among the Mankirdia Tribes of Odisha

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### INTRODUCTION

Indigenous people constitute 370 million individuals across the globe inhabiting every region of the world (Sarivaara et.al, 2013). They represent diverse communities and their distinct socio-cultural and economic structures, maintained through customary laws and traditional institutions have set them apart from the mainstream population (Cobo, 1986). The Working Group on Indigenous Populations (2006) conceptualizes indigenous people as groups who due to the processes of colonization and the modern state formation have become differentiated from the dominant sections of population. These communities reproduce their autonomous social, economic and cultural institutions despite varied legal positions. India for an instance, harbouring over 104 million tribal population exhibits a rich tapestry of distinct health beliefs and practices (Sahu et al., 2024). Despite forming such a significant chunk of India's population, the indigenous communities continue facing disparities in accessibility to healthcare systems with higher Under-5 mortality (57.2), malaria related deaths, underweight, pulmonary tuberculosis (703/100,000) and prevalence of anemic women (65% in 15-49 age group) (Bang, 2018). It is therefore imperative to enquire into the workings of healthcare systems in the tribal communities.

The cultural frameworks of indigenous people have profoundly influenced their approaches to health and well-being (Rowkith & Bhagwan, 2020). These communities integrate traditional healing practices with their religious and spiritual beliefs and socio-economic realities (Kumar & Jain, 2023). The intricate dynamics between health seeking behaviors and belief systems necessitate a nuanced understanding of the workings of healing practices among indigenous communities, which denote a stark departure from conventional biomedical notions of medicine (Sahoo & Pradhan, 2021).

The indigenous understanding of health extends beyond the biomedical paradigm encompassing both collective and individual dimensions. Congruent with WHO's multidimensional approach in conceptualization of health, tribal health integrates four dimensions of life: *spiritual, intellectual, physical and emotional* (Stanley & Stanley, 2003). These dimensions form a continuum that shape the broader conception of well-being. In tribal societies, health is not understood in isolation but in relation to the magico-religious fabric of existence. According to Singh (2021) health is influenced by a complexity of social, economic and political factors and health behavior by their culture. Therefore, understanding of tribal culture is imperative in understanding the concept of tribal health. In tribal societies, health is understood in functional terms where ill-health is considered as inability of an individual to perform his normal or routine work in society. This functional understanding of health often manifests in neglect of acute disorders like cold, cough, headache as they do not hinder performing of daily activities. Interpretation of illness is a culturally informed process in tribal societies (Singh, 2021). Forrest Clements in 'Primitive Concept of Disease' has identified broadly five categories of causation of disease based on worldwide prevalence. They are *i. Sorcery, ii. breach of taboo, iii. intrusion by disease objects, iv. intrusion by spirits and v. loss of spirit*. Sachidananda sees the field of tribal health as a cultural concept as well as a part of social structure and organization that is adaptive and receptive to changes in the wider society. Supernatural agencies are believed to be the major reasons behind disease in tribal societies. Broadly, four types of supernatural powers have been ascribed to by tribal societies:

1. Protective spirits who always protect them.
2. Benevolent spirits worshipped at familial and community levels regularly else they bring death and destruction.
3. Malevolent spirits, the evil spirits who control smallpox, fever, etc.
4. Ancestral spirits who always protect them.

Ill health in tribal communities can be attributed to two categories: *known and supernatural*. Tribal groups like Savaras, Bogatha, Konda Dora, Valmiki, Koya, Kond, Reddi believe in the effect of prayers and rituals giving healing powers to medicinal herbs while attributing diseases to deviant acts of self and others towards elders, nature and divine rules. According to Jain and Agarwal (2002) Bhils in Jaipur, Rajasthan attribute diseases to act of deities and spirits and they believe that by appeasing them, the disease could be healed. Likewise, the study by Sunita Devi (2003) among the Meities of Manipur reveal the persistence of the concept of deities and their effect on human health despite literacy. In Rajasthan, sexually transmitted infections are locally called as 'Sujak' which is attributed to the evil effects of matron, a spirit that evolves whenever a pregnant woman dies. While women prefer modern healthcare practitioners for different forms of illnesses, the treatment for sexually transmitted disorders are often treated with traditional healers (Bhasin, 2017). The findings have been corroborated by Jagga (1996) who found the belief in spirits and deities widely prevalent among the tribal population in West Godavari district of Andhra Pradesh.

Against this backdrop of cultural beliefs, practices influencing the health systems of tribal communities, the present study attempts to focus on Mankirdia tribe, a particularly vulnerable tribal group (PVTG) and how religious and cultural beliefs among the Mankirdia tribe influence their approach to health seeking behavior and healing practices.

### The Mankirdia Tribe: Socio-Demographic Profile

The Mankirdia constitute a semi nomadic section of the Birhor tribe traditionally known for their hunting and food-gathering practices (Roy, 1925; Chaudhuri, 2004; Sinha, 1973; Ota & Mohanty, 2015). They are denoted to as "Mankirdia" based on their customary practice of trapping and consuming monkeys and rope making skills. Although found in different states like Odisha, Bengal, Assam, Madhya Pradesh, and Maharashtra, their largest concentration is found in Odisha's Mayurbhanj district where they are classified among the hunting and food-gathering communities. Within Odisha, they are known by different local names such as Mankidi, Mankidia, Mankharkhia, and Mankirdia, all reflecting their association with monkey hunting and consumption (Adhikari, 2008).

Ethnographically, the Mankirdias are a Particularly Vulnerable Tribal Group (PVTGs) of India whose preoccupation has been that of hunting of monkeys and consumption of monkey meat. They are known to move in small bands and live in temporary dome shaped leaf huts called 'Kumbhas'. They speak a form of Munda language and some of them are also conversant in Odia.

Physiologically, the Mankirdias are marked by short stature, dark complexion, long head, broad flat nose, thick lips, wavy hair and bow-shaped legs. They demonstrate an archaic mode of existence. Though originally hailing from the Chotanagpur Plateau, in due course of time, they have migrated to different parts of Odisha settling around hill tracts and forested regions.

Thus, Mankirdia tribes traditionally, are not settled agriculturalists but semi-nomadic hunter-gatherers by nature, relying on forest resources for subsistence (Ota & Mohanty, 2015). Their economic activities like hunting, food gathering and collection of forest produce reflect a close relationship with their environment (Goswami, 2013). Mobility within confined regions reflect their adaptive strategies to forest ecosystems.

## Methodology

This research aims at an assessment of morbidity patterns among the Mankirdia tribe, the social and cultural capital that influences health seeking behaviour as well as the different typologies of treatment availed by the community members during periods of illnesses. Additionally, the paper delves into the epistemological construction of illness among the Mankirdia community supplemented with case studies.

This study used a qualitative research design in capturing the health beliefs and practices of the Mankirdia tribe. A combination of in-depth interviews, focus group discussion (FGDs), oral history, informal conversations and participant observation were used for data collection. Primary data was generated through fieldwork and transcriptions of interviews and discussions while secondary data was obtained from policy literature on tribal health and indigenous medical systems.

In this case, the number of participants in each FGD were twelve. In-depth interviews were conducted with members of the Mankirdia community, including spiritual leaders, elders, and knowledgeable practitioners, to document the social and cultural foundations of their indigenous health knowledge. All interviews were audio-recorded and transcribed verbatim. A series of Focused Group Discussions (FGD) were held with groups of community leaders. Three FGDs were held, comprising of 8-12 participants to elicit their perspectives on health seeking behavior and traditional healing practices. Besides, participant observations were also carried out to cross verify information obtained through interviews and FGDs. Detailed field notes were maintained throughout the study.

## Data Collection and Analysis

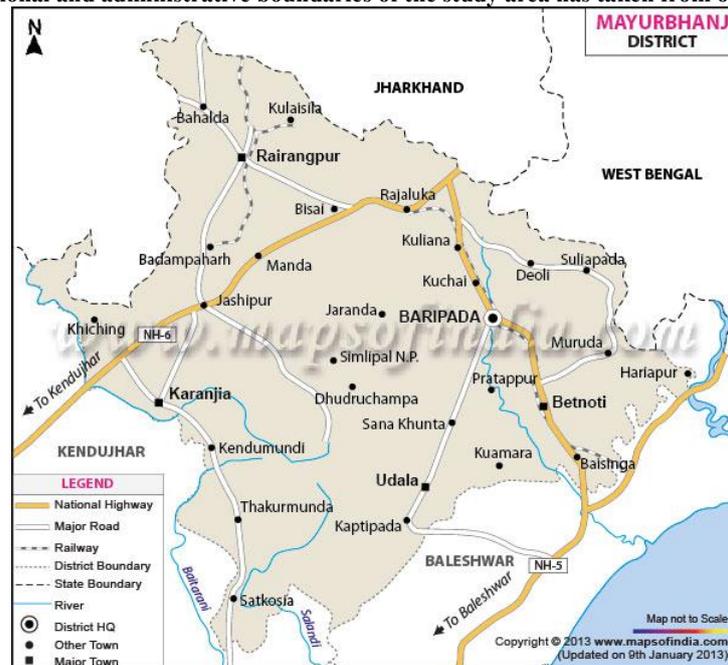
The first step in the analysis involved data cleaning and management. The qualitative data were organized in a thematic manner drawing from field observation, case study, key interview, case history, phenomenological interview, in-depth-interview and FGD. Then, the data were transcribed from Odia language to English. Subsequently the data were interpreted to have some understanding into the wide-ranging ideas and perspectives of the community studied. Additional emphasis was given on codification and identification of quotes from the field. Utmost care was ensured to organize the codes into ideas. In addition, this process helped to generalize the findings into themes and forms. Ultimately, these results were construed in relation to existing theories, other research findings, and researchers' personal reflection.

## Ethical Consideration

Informed consensus at different levels were obtained for this research including confidentiality of evidence given by contributors; and avoidance of conceivable maltreatment to participants as a result of participating in the study. The first level of approval was obtained from Institutional Ethical Review Board, of Jawaharlal Nehru University. The second level of approval was added from various district level administrative offices. Besides, finally, each individual participant was asked for his or her informed consent.

## Geographical Area of the Study

Figure 1 shows the regional and administrative boundaries of the study area has taken from online mapsindia website.



## Results and Discussion

### Patterns of Morbidity

The health seeking behavior of the Mankirdia community is closely intertwined with their belief systems, cultural practices and the ecological context. Cultural beliefs significantly impact the etiology of diseases and the processes of treatment (Brahma and Mudgal, 2020). The morbidity pattern across the community reveals that a majority (26%) suffer from fever, followed by back pain contributing 17% of the disease burden. Meanwhile, cold and cough account for 10% of disease burden while 5% reported abdominal discomfort. Malaria remains one of the most prevalent communicable diseases, affecting 5% of the population. Only 3% reported suffering from diarrhoea, tuberculosis, or ulcer diseases. Besides, jaundice, hypertension and paralysis make up 4% of the total disease burden while fractures and acidity related complications comprise 3% and 1% reported suffering from skin-based disorders. This has further been corroborated by existing literature that highlights major health issues faced by the Mankirdia community such as high rates of chronic energy deficiency, stillbirths, unhygienic and primitive birth practices, high maternal and child mortality, upper respiratory tract infections, inadequate vaccination, and delayed diagnosis as key factors contributing to their poor health status (Nayak and Das, 2014; Goswami, 2015). Furthermore, other researches have highlighted a strong correlation between illiteracy, socio-economic marginalization and ineffectiveness of government policies which directly impact on the overall health and well-being of the Mankirdia tribe (Somawar & Phulejhale, 2015; Goswami, 2015). These challenges are not merely biomedical but rooted in socio-economic and the cultural context of the tribe. This form of structural marginalization reinforces the tribe's dependence on traditional medicine and indigenous healers that delay timely medical intervention.

### Determinants of Health Seeking Behavior among the Mankirdias

The duration of treatment among the Mankirdia tribe varies from a few days to several weeks, depending on the resources available and the nature of illnesses. The study found that a majority (42%) recover within one week, while 28% reported a treatment period of one to two weeks. Around 17% required two to three weeks, and 13% needed three to four weeks to recover. Village-wise differences were also observed — most respondents in Kendumundi village reported recovery within two to three weeks, whereas those in Dengam village required about a week longer

to heal. Besides, the social structure of the Mankirdia community also influences their health seeking behavior. Individuals belonging to poorer sections have limited access to healthcare facilities. Lower literacy levels further hinder awareness about preventive healthcare leading to social discrimination and exploitation by local middlemen. Besides, language barriers obstruct communication with health service providers reinforcing their dependence on traditional treatment methods. However, it is notable that despite economic hardships, the Mankirdias display strong social bonding and collective solidarity. As observed by Turuk et al. (2021), extended family systems among the tribe ensures no tribal member suffers in isolation. For the Mankirdia, health is an integral part of everyday social life and is not a separate medical concern. Certain diseases have a familial and hereditary origin making the family as a source of illness and center for healing (Loveland-Cherry & Carol, 2006). Poor access to institutional care compels the tribes to rely on indigenous medicine as their primary source of treatment. Several studies confirm the positive correlation between social determinants and tribal health outcomes (Dhargupta et al., 2009; Das & Mohpal, 2016; Lal, 2021). Chandrakant and Sindhu (2015) found that socio-economic status significantly influences the emotional and physical well-being of tribal populations. This has also been corroborated by Sarkar and Singha (2019) in their studies on the Santhal community of West Bengal who outlined that economic stability and cultural cohesion promote better health outcomes. Meanwhile, it has also been observed that the political structure of the tribal community also influences the health seeking behavior of tribals. It was found that individuals who participated in village level political processes had better access to healthcare opportunities owing to more awareness of governmental schemes and higher capability of mobilizing healthcare resources. Respondents noted that political participation enhanced their confidence and knowledge about multiple sources of healthcare. Family organization also plays a pivotal role. Both nuclear and joint family systems coexist among the Mankirdia, but members of joint families experience greater emotional security and better support during illness. However, individuals who live in isolation experience vulnerability and psychological distress (Raj & Nayak, 2018). This has also been observed among the tribal communities in Central India where unawareness of maternal, neonatal care practices manifests in hypothermia, sepsis and infections, resulting in high maternal and child mortality (Sharma, 2010).

Likewise, delayed health seeking behavior among tribal groups especially TB, exacerbates gendered disparities in access to healthcare systems (Thomas, 2021). Finally, the availability of material assets like televisions, mobile phones, bikes along with basic amenities like sanitation, energy, drinking water, health protection shape the health seeking behavior of the community. These assets improve awareness and connectivity and also attitudes towards modern healthcare, marking a shift from traditional exclusivity to plural medical practices.

### **Perceptions of Health, Illness, and Healing among the Mankirdia**

The disease causation and treatment practices among Mankirdia community are complex and dynamic. The distinction between severity of the disease and the role of healthcare professionals does not follow a horizontal continuum but reflects a hierarchical pattern of existence.

Health in their language is defined as “*Bulu Haram*”, signifying good health of a person while illness is referred as “*Kharap Haram*”. Their conception of health and illness is influenced by socio-religious beliefs and the supernatural realm. As they attribute major illnesses to spiritual forces and natural phenomena lying beyond human control, they maintain a deep sense of reverence for the natural and physical forces surrounding their dwellings. For the Mankirdia, good health or ‘*Buluharam*’ is essentially associated with the ability to perform work effectively. Physical appearance and activity levels are considered visible indicators of one’s health status. During the fieldwork, when the researcher asked ‘*Brahma Mankirdia*’ an experienced healer from Dengam village about his understanding of health, he offered a metaphysical comparison stating that ‘*the health of a person is like health of a house*’.

He says “*our body is just like a house. Unlike house our body has several small rooms, windows, front and back stage. Like we wake up in the morning, we clean our bedroom, veranda, and arrange the room in order. In the same way, we need to keep clean our body to remain healthy. For that we do many things, for instance, we have many rooms in our body, it means we have several important parts of the body, that need to keep clean to work properly. Accordingly, we consider our body like our house, so we keep it clean*”.

*In this way, they start their day with personal as well as their environmental cleanness. Brahma also added that, when someone fails to keep cleaning his or her body then person become ill. Consequently, they keep clean their body to stay healthy. Brahma Mankirdia (Healer) Said, our Harmo (body) is like a house, which protects us from heat, cold, rain and attack of the wild animal; if we don't maintain the house, it becomes damage. Likewise, we consider our body as a house. We protect our Harmo (Body) from various Rua Kanam (disease) if we don't care properly, it also damage. They comprehend the manifestations of an infected individual through, pulse rate, the shade of the urine, the shade of the eye, and so on.*

Excessive alcohol consumption becomes a major source of illness among the Mankirdias, not only affecting their health but also in its manifestation of adverse social and familial consequences, contributing to other diseases. Physical strength for the Mankirdia community constitutes a primary indicator of good health, equating health with bodily strength and work capacity. Thus, their conceptualization of good health is rooted in physical capability rather than preventive or diagnostic awareness.

### **Interpretation of Illness among the Mankirdias**

The experience and perception of pain among the Mankirdia community is complex. The tribal members take time to assess their diseases and recognize the severity of their symptoms. Despite signs of illnesses, many tribal members continue eking out their daily activities. Ailments like fever, cough and cold are considered as not serious and treated through home-based remedies. They approach traditional healers for treatment only when these methods fail. Healers diagnose illnesses primarily by observing bodily symptoms and the duration of the disease, relying on experiential knowledge rather than biomedical parameters. The notion of what constitutes a ‘sound health’ is still not defined in the community. Even minor ailments like scabies, headaches and skin infections that disrupt normal routine might not be classified by these communities as signs of ‘illnesses. Hence, the World Health Organization’s notion of health as the absence of disease doesn’t align with the perception of the Mankirdia tribal community. This divergence represents a culturally embedded notion of health. Thus, for them, good health denotes physical and mental activeness- to work, eat and engage in social life. Events like inability to work, loss of appetite, feelings of lethargy are considered as signs of being diseased. Among the Mankirdia, poor health is considered as a social event that disrupts normal work routines and social responsibilities, resulting in Thomas (1986) formulation of the concept of “*role handicap*”. Illness thus affects individual and communal functioning. Besides, community members are not known to be vocal about their disease with others, rather they first attempt at comprehending the origin and cause of the disease and try developing tolerance towards illness until it becomes severe. Therefore, health concerns are not immediately prioritized and medical attention is sought only when the illness restricts daily activities.

### **Sources of Treatment among the Mankirdias**

Field studies reveal a pluralistic pattern of consumption of healthcare blending traditional, home-based remedies and modern healthcare systems. The study found that the majority (37%) of the Mankirdia depend primarily on traditional healing practices as their main source of treatment. A second group, comprising 26%, make use of mixed medical services, combining government, private, and traditional systems. Home remedies account for 21% of treatments, with noticeable variation between the two study villages — 30.6% in Dengam and 15.6% in Kendumundi. Government health services contribute 10%, while private healthcare is the least preferred, with only 6% relying on it.

A comparative perspective across the two villages Dengam and Kendamundi revealed that Dengam village because of its homogeneous social structure marked by social cohesion, and deep-rooted religious beliefs validate a higher symbolic relationship with the forest ecosystem reinforcing their reliance on indigenous methods and traditional forms of treatment. In contrast, the tribals of Kendumundi village exhibit a heterogeneous social character and increased interaction with outsiders and non-tribals has led to adoption of external lifestyles, hence they display a diversified health seeking behavior that integrates government, private healthcare services with traditional and home-based remedies.

Thus, treatment choices among the Mankirdia are not merely determined by disease type, but by a complex interplay of culture, economy, environment, and social change.

### **Disease Causation Theory**

In simple and traditional societies, the values, beliefs, ideas and customs are closely interwoven with the perception of disease and health. Illness in the Mankirdia community is a social state affecting one's ability to discharge everyday responsibilities.

The Mankirdia term for disease is '*Harma*' and a person is not considered ill unless he or she becomes incapable of performing routine tasks. The causes of the disease can be broadly attributed to three domains:

1. Naturalistic cause
2. Personalistic causes
3. Man-made causes

### **Naturalistic Causes**

Naturalistic explanation attribute diseases to natural and physical forces like heat, cold, humidity or wind. Diseases like dysentery, diarrhoea, cough, fever, itching, scabies, and headache are considered outcomes of these imbalances in the natural environment (Clarke, 2007; Clements, 1932). The community believes that exposure to polluted environment disturbs bodily equilibrium that manifests in ailments. For an instance, cold and cough arise from bad air or cold winds due to seasonal transitions. Likewise, acute ailments like common cold, fever are attributed to humidity and temperature.

### **Personalistic Causes**

Personalistic explanations attribute illnesses to supernatural agents like ghosts, spirits, sorcery and witchcraft. Illnesses are interpreted as a result of intervention by malevolent forces in the human body. In this case, the healer acts as a spiritual as well as therapeutic guide: identification of the harm and restoring balance through ritualistic practices. The acts of treatment involve appeasement of supernatural spirits and symbolic purification.

### **Man-made Causes**

Man-made causes include ailments that arise from the intentional malevolent human actions like jealousy, sorcery believed to be performed by others. Illnesses are attributed to the malevolent acts of individuals who use sorcery and black magic. Treatment in such cases require anti sorcery rituals conducted by a healer who acts as a mediator between humans and the supernatural realm. Thus, the causation of disease among the Mankirdia community highlights a pluralistic healthcare framework where natural, man-made and personalistic factors intersect aligning with earlier anthropological observations of indigenous healthcare systems. In the following section, a group of selected case studies are highlighted that throw light on the procedures of treatment adopted by Mankirdia community during episodes of illnesses and disease.

### **Case Studies**

#### **Case Study: I**

Sunaram Mankirdia, aged 36, resides in Dengam village and has been suffering from a chronic skin ailment for over a year. During this period, he sought treatment from a local private practitioner on several occasions; however, these interventions failed to provide sustained relief. According to Sunaram, irregular bodily care combined with strenuous domestic and occupational labour aggravated the condition. Despite repeated consultations, the biomedical treatment neither alleviated symptoms nor addressed the perceived cause of illness. When interviewed, the local traditional healer attributed Sunaram's condition to prolonged physical exhaustion and imbalance within the body, compounded by inadequate access to institutional healthcare facilities. In the absence of reliable medical services, the Mankirdia largely depend on indigenous healing systems. Sunaram similarly relies on the treatment provided by the local healer and the village Ojha, reflecting a broader pattern of health-seeking behaviour within the community. Though the traditional medicines offer limited physical improvement, they provide psychological reassurance and cultural legitimacy. The perceived ineffectiveness of modern medicine frequently leads patients to revert to indigenous practices, which align more closely with their belief systems and lived realities. The treatment for skin-related ailments involves simple but culturally embedded practices. Neem-infused water and garlic are used for cleansing scabies, while turmeric paste is applied to affected areas. Additionally, an herbal paste prepared from Kulitrama Daru and Bana Tulsi leaves is commonly used. The affected areas are cleaned daily with hot water, particularly in cases involving boils or pus formation. These practices demonstrate the community's reliance on ecological knowledge and accessible resources in managing chronic illnesses.

#### **Case Study: II**

Manoj Mankirdia, aged 32, is a resident of Kendumundi village and lives with his wife and three children. His livelihood depends primarily on driving and the collection of forest produce. Though not highly educated, Nari is a well-known figure in the locality and acts as an informal intermediary between government officials, NGOs, and the Mankirdia community. Owing to his extensive social networks, he maintains regular contact with staff of the Hill-Kharia Mankirdia Development Agency in Karanjia block. Nari sustained a fracture in his left foot during his driving work. Initially, he relied on home remedies such as *Seka* (hot fomentation) and rest; however, the lack of improvement severely affected his family's livelihood, as he is the sole earning member. He subsequently consulted private practitioners and later sought treatment at the sub-divisional hospital in Karanjia. Despite undergoing X-ray examinations and prolonged medication for nearly one and a half months, his condition showed little improvement. According to Nari, the doctor's indifferent attitude and lack of clear communication regarding the treatment process heightened his sense of uncertainty and dependence, compelling him to passively comply with medical advice. Disillusioned with biomedical practices, Nari turned to indigenous healing practices. He stated that for minor ailments the community usually consults traditional healers first and approaches hospitals only when symptoms worsen. Following continued pain, Nari visited an herbal healer in Jashipur block, Mayurbhanj. The healer diagnosed the injury as being aggravated by malevolent spiritual forces and initiated treatment using medicinal leaves such as *Hatma Banda* and *Naga Fani*. An herbal paste was applied to the fractured area, supported with bamboo splints, and replaced daily for seven days. Additionally, *Mantura* water was administered, and the root of *Arjuna Daru* was worn as a protective amulet. Nari reported complete recovery following the traditional treatment, reinforcing his trust in indigenous healing systems. This case showcases the layered health trajectory of tribals beginning with domestic remedies to hospital systems and then a revert back to indigenous healers. The persistence of traditional healing underscores the cultural logic of health, where illness is interpreted through both biomedical inefficacy and supernatural causation, leading to the reaffirmation of indigenous medical knowledge and social trust within the community.

### **Conclusion**

This study offered a multi-faceted and comprehensive investigation into the traditional medical practices of the indigenous and tribal communities integrating multiple methodological tools like ethnographic observations, semi-structured interviews with traditional healers followed by a review of ethno-medical and tribal literature that contextualizes the interrelationship between cultural beliefs and health outcomes. This allowed for a robust understanding of the indigenous epistemologies of health and disease alongside the practical applications of traditional remedies within their ecological contexts. This paper reestablishes the fact that the complex system of tribal health beliefs leads to multiplicity of healthcare practices in management of health. In tribal communities, the social construction of illness determines the curative action. Illness is not limited to only the biological realm but extends into the social realm of the individual and family. Tribal communities offer a shared explanation situated

within the context of their socio-cultural milieu. The healthcare practices in tribal communities take into consideration environmental factors as well as usage of taboos, ritualism and propitiation of supernatural powers. Broadly, the indigenous methods of treatment can be categorized as: preventive and curative. In preventive aspect, tribal members perform rituals, use charms and amulets while in curative aspect, the help of specialists, priests and healers is sought (Misra, 2004). This paper has highlighted how the social structure of the Mankirdia community acts as a source of constraint and resilience in shaping the health seeking behavior. While dependence on traditional sources of medicine continue, contact with non-tribal communities, urbanization, modernity has led to a gradual shift towards pluralistic medical practices. Yet, significantly, the cultural beliefs, customs, rituals continue predominantly shaping the healthcare milieu of the Mankirdia tribal community.

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