

SOCIO ECONOMIC PROFILE AND HEALTH CARE PRACTICES AMONG THE ORAONS OF HATIDوبا VILLAGE, SILIGURI, DARJELLING

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Abstract

The Oraons (Kurukh) constitute one of the major Scheduled Tribe communities of eastern India, yet continue to experience persistent socio-economic and health-related disadvantages. The present study examines the socio-economic profile and health care practices of the Oraon community residing in Hatidoba village, located in the Siliguri subdivision of Darjeeling district, West Bengal. Employing a qualitative and descriptive anthropological approach, the study is based on primary data collected through household surveys, participant observation, interviews, group discussions, and case studies, supplemented by secondary sources. The findings reveal a demographically young population characterized by high fertility, early female marriage, fluctuating sex ratios, and a relatively small elderly population. Educational attainment remains low, with more than half of the population illiterate and a pronounced gender gap disadvantaging women. Occupational patterns show heavy dependence on agriculture and tea garden labour, indicating economic insecurity and limited livelihood diversification, especially for females. Health care practices among the Oraons reflect a pluralistic system in which traditional healing, home remedies, and ritual practices coexist with modern biomedical services. Traditional healers often serve as the first point of care, while institutional health services are primarily sought during complications. Maternal and child health indicators remain concerning, although gradual improvements are evident due to the role of ASHA workers and government schemes such as Janani Suraksha Yojana. The study underscores the need for culturally sensitive, integrated interventions focusing on female education, health awareness, and improved accessibility of primary health services to achieve sustainable development among the Oraons of the Terai region.

Keywords: *Oraon tribe, Socio-economic profile, Health care practices, Tribal health, West Bengal.*

Introduction

India is a country considered by immense ethnic and cultural diversity, with Scheduled Tribes (STs) constituting one of the most socio-economically marginalized groups. Among the recognized tribal communities, the Oraons—also known as Kurukh—hold a significant place in the eastern and central parts of India. Traditionally residing in Jharkhand, Chhattisgarh, Odisha and West Bengal, the Oraons have gradually migrated to various regions in search of better livelihood opportunities (Xaxa, 2004). One such population has established itself in Hatidoba, a tribal-dominated village located in the outskirts of Siliguri, West Bengal. Understanding the socio-economic profile and health care practices of indigenous communities like the Oraons is crucial to ensure inclusive and culturally sensitive development.

The socio-economic conditions of tribal communities in India are generally marked by low income, illiteracy, underemployment, poor housing, and limited access to health services (Munshi, 2016). Despite various state and central government welfare schemes aimed at uplifting tribal groups, a significant disparity still persists in health outcomes, education, and income levels between tribal and non-tribal populations (Planning Commission, 2011; Ministry of Tribal Affairs, 2021).

The Oraons of Hatidoba are mostly engaged in informal labor sectors such as tea garden work, construction, small-scale agriculture, and daily wage labor. These occupations are often unstable and poorly paid, which directly impacts their socio-economic mobility and access to resources (Sarkar & Das, 2019). A majority of households in this community also lack formal education, which further restricts their ability to seek alternative employment opportunities or access government facilities effectively. Educational attainment among Oraon women is particularly low, contributing to the reinforcement of traditional gender roles and limiting their participation in household decision-making, especially concerning health and child welfare (Patra, 2020).

Health care practices among the Oraons are shaped by a complex interplay of tradition, economic constraint, accessibility, and awareness. Traditional belief systems still hold a strong influence, and many families continue to rely on local healers, herbalists, or "Ojhas" for primary health needs (Chaudhuri, 1986). Although government health care services have expanded their outreach to tribal areas through initiatives like the National Rural Health Mission (NRHM), utilization remains low due to factors such as language barriers, fear of discrimination, lack of culturally appropriate services, and physical inaccessibility (Mohindra et al., 2010).

Poor sanitation, lack of safe drinking water, and inadequate nutrition compound the health challenges faced by the Oraons in Hatidoba. Common illnesses reported among the community include respiratory infections, diarrheal diseases, anemia, skin problems, and reproductive health issues. Child

and maternal health indicators are particularly concerning, with high incidences of low birth weight, child malnutrition, and limited antenatal care (NFHS-5, 2021). Furthermore, there is a significant gap in awareness regarding immunization, contraception, and disease prevention, particularly among women and the elderly (Das & Biswas, 2022).

Migration is another crucial factor influencing the socio-economic and health status of the Oraons. Many young members of the community, especially men, migrate seasonally to nearby urban centers or tea gardens, which results in disrupted family structures and a dependence on remittances. This temporary migration also affects health-seeking behavior, as migrant laborers often lack access to continued or preventive care in unfamiliar environments (Narayana & Rao, 2014).

Gender also plays a significant role in shaping both socio-economic participation and health care decisions within the Oraon community. Women are often overburdened with both economic and domestic responsibilities, including care for children and the elderly, and yet have little autonomy in making decisions about their own health or that of their children. Studies have shown that patriarchal structures, even within tribal settings traditionally seen as egalitarian, can limit women's access to health care and education (Bhattacharya, 2011).

Despite these challenges, the Oraon community exhibits a strong sense of kinship and social cohesion, which supports informal safety nets during illness, food shortages, or economic crises. Community-based strategies such as collective farming, mutual labor exchange, and traditional healing practices provide a form of resilience against institutional neglect (Roy, 2018). However, these informal systems are increasingly under stress due to modernization, economic pressures, and changing aspirations among the younger generation.

The present study aims to provide a holistic understanding of the socio-economic conditions and health care practices among the Oraons of Village Hatidoba, situated in the Darjeeling district, within the Terai region of northern West Bengal. The selection of this location is crucial, as the area lies at the intersection of tribal tradition and urban expansion, providing a unique lens to observe how traditional communities adapt to and are influenced by external socio-economic forces.

Review of Literature

Tribal populations in India, including the Oraons, often experience poor health outcomes due to poverty, limited access to medical facilities, malnutrition, and reliance on traditional medicine (Nayak, 2006). In West Bengal, especially in the tea garden and adjoining tribal areas like Siliguri, the health care infrastructure is often inadequate in terms of both quality and quantity (Bhattacharya & Sarkar, 2015).

A survey by the Ministry of Tribal Affairs (2021) reported that more than 60% of tribal households in West Bengal still depend on traditional healers for initial treatment. The Oraon community's reliance on indigenous knowledge systems for health care reflects a deep-seated worldview where illness is both a physical and spiritual experience.

Moreover, studies show that Oraon women in rural Bengal have limited access to maternal health services, with many home births still attended by untrained traditional birth attendants (Das & Bhattacharjee, 2019). Nutrition is another concern, with protein and micronutrient deficiency being widespread, leading to higher infant and maternal mortality rates.

Despite these challenges, community health workers like ASHAs (Accredited Social Health Activists) are playing a key role in bridging the gap between traditional beliefs and modern medicine. In Hatidoba, several ASHAs have successfully educated women on immunization and antenatal care, slowly transforming health-seeking behavior among the younger Oraon generation.

Objectives of the present study

- To assess the socio-economic profile of Oraon households with reference to marital status, education, occupation, and related demographic characteristics.
- To examine health care practices among the Oraon community, including choice of treatment modalities, maternal and child health care, awareness and utilization of government health schemes, supported by selected case studies.

Methodology of the Study

This was a qualitative and descriptive field-based study employing multiple anthropological data collection techniques. A combination of primary and secondary sources was used to collect relevant information. The research emphasized a holistic approach to understanding the socio-cultural and health-related aspects of the Oraon community. The study aimed to document the socio-economic conditions and healthcare practices of the community. All individuals in the village who were willing to participate were included in the study. The age of the child was recorded according to information given by parents and/or elderly members of a given household. The data were collected going door to door with prepared questionnaire. The data were collected and cross-checked for getting correct information. Most of the data were collected through observation, interview, group discussion and case studies method.

Study Area and Population

The present study was conducted among the Oraon tribal community residing in Hatidoba village under the Burgange Gram Panchayat in the Siliguri subdivision of Darjeeling district, West Bengal. The studied village is basically a multiethnic village. The village mainly consists highest concentration of Oraon community. Few houses of Santal community were lived there.

The Oraons from a community of settled agriculturist who are presently distributed over the large tract of estern India. Racially, they belong to the Dravidian stock of southern India and according to their tradition, it is claimed that their ancestors migrated from Konkan in the west coast to northern India, and there from ultimately came to their present habitat at Chotonagpur plateau in Bihar. Later on, the exaction and atrocities of money lenders and Zamindars, the loss of land, an increase in population, the need for hard cash, the persuasion of labour contractors and many other social reasons have driven a large number of the Oraons to districts of Bihar, West Bengal, Orissa and Madhya pradesh. The present-day distribution of the Oraons still reveals their most concentration in the plateau of Chotonagpur.

Data Validation and Ethics

Data were cross-verified through multiple sources to ensure reliability. Ethical considerations were maintained by obtaining informed consent from all participants and ensuring confidentiality of the information collected.

Results

Table No.1: Age-sex composition of the population of Hatidoba village

Age Group	Male	%	Female	%	Total	%
0-4	16	55.17	13	44.83	29	12.55
5-10	20	54.05	17	45.94	37	16.01
11-14	16	55.17	13	44.83	29	12.55
15-19	12	60	8	40	20	8.65
20-24	6	31.57	13	68.42	19	8.22
25-29	15	55.55	12	44.45	27	11.68
30-34	7	36.84	12	63.15	19	8.22
35-39	12	75	4	25	16	6.92
40-44	2	22.22	7	77.78	9	3.89
45-49	6	85.71	1	14.28	7	3.02
50-54	2	50	2	50	4	1.73

55-59	3	42.85	4	57.14	7	3.03
60-64	2	66.66	1	33.34	3	1.29
65-69	0	00	2	100	2	0.86
70+	3	100	0	00	3	1.29
Total	122	52.81	109	47.18	231	88.51
%	46.74	52.81	41.76	47.18	88.51	88.5

Table 1 presents the age–sex composition of the village population comprising 231 individuals, with males (52.81%) slightly outnumbering females (47.18%), indicating a modest male predominance. The population structure is distinctly young, as children and adolescents below 15 years constitute 41.11% of the total population, reflecting high fertility and recent population growth.

The 0–14 years age groups show a consistent male surplus, while sex ratios fluctuate considerably across adult age groups. Females outnumber males in several reproductive and middle-age cohorts, particularly in the 20–24, 30–34, and 40–44 years age groups, possibly reflecting male out-migration for employment, differential mortality, or marital mobility. In contrast, pronounced male dominance is observed in the 35–39 and 45–49 years age groups.

The proportion of the elderly population (≥ 60 years) is relatively low, accounting for 4.73%, suggesting lower life expectancy and limited population ageing. Female predominance in the 65–69 years age group aligns with generally higher female survival at older ages.

Overall, the age–sex distribution indicates a demographically young, expanding population with irregular sex ratios across age groups, shaped by fertility patterns, migration, and differential survival, characteristic of many rural and tribal populations in India.

Table No.2: Marital Status of Male and Female of Oraon community

Age Group	Married				Unmarried				Widower/Widow				Total	Under Age				Total
	Male	%	Female	%	Male	%	Female	%	Male	%	Female	%		Male	%	Female	%	
0–4	0	0	0	0	0	0	0	0	0	0	0	0	0	16	16.84	13	13.68	29
5–9	0	0	0	0	0	0	0	0	0	0	0	0	0	20	21.05	17	17.89	37
10–14	0	0	0	0	0	0	0	0	0	0	0	0	0	16	16.84	13	13.68	29
15–19	3	2.21	2	1.47	9	6.62	6	4.41	0	0	0	0	20	0	0.00	0	0.00	20
20–24	4	2.94	12	8.82	12	8.82	0	0.00	0	0	1	0.74	29	0	0.00	0	0.00	29
25–29	14	10.29	12	8.82	1	0.74	0	0.00	0	0	0	0.00	27	0	0.00	0	0.00	27
30–34	6	4.41	10	7.35	1	0.74	1	0.74	0	0	1	0.74	19	0	0.00	0	0.00	19

35-39	12	8.82	5	3.68	0	0	0	0.00	0	0	0	0.00	17	0	0.00	0	0.00	17
40-44	3	2.21	5	3.68	0	0	0	0.00	0	0	1	0.74	9	0	0.00	0	0.00	9
45-49	6	4.41	2	1.47	0	0	0	0.00	0	0	0	0.00	8	0	0.00	0	0.00	8
50-54	1	0.74	0	0.00	0	0	0	0.00	1	0.74	0	0.00	2	0	0.00	0	0.00	2
55-59	1	0.74	0	0.00	0	0	0	0.00	1	0.74	1	0.74	3	0	0.00	0	0.00	3
60-64	0	0.00	0	0.00	0	0	0	0.00	1	0.74	0	0.00	1	0	0.00	0	0.00	1
65-69	0	0.00	0	0.00	0	0	0	0.00	0	0.00	1	0.74	1	0	0.00	0	0.00	1
70+	0	0.00	0	0.00	0	0	0	0.00	0	0.00	0	0.00	0	0	0.00	0	0.00	0
Total	50	36.76	48	35.29	23	16.9	7	5.15	3	2.21	5	3.68	136	52	54.74	43	45.26	231

Table 2 illustrates the age- and sex-wise distribution of marital status among the Oraon community (n = 231). Of the total population, 136 individuals are of marriageable age, while 95 individuals (41.13%) fall under the under-age category, indicating they are below the socially and legally accepted age of marriage.

Among adults, married individuals constitute the largest group, comprising 36.76% of males and 35.29% of females, reflecting a largely universal marriage system with minimal gender disparity. However, unmarried status is more prevalent among males (16.9%) than females (5.15%), suggesting earlier marriage among women. Marriage begins in the 15–19 years age group, though unmarried individuals still predominate, indicating a transitional phase rather than widespread child marriage.

The 20–29 years age groups represent the principal marital transition period, particularly for females, while male marriage peaks slightly later. Widowhood is relatively low but higher among females (3.68%) than males (2.21%), especially in older age groups, reflecting gender differences in mortality and remarriage practices.

Overall, the marital pattern indicates early female marriage, delayed male marriage, low permanent celibacy, and a young population structure, characteristic of a traditional tribal society.

Table No.3: Literacy rate of Male and Female of Oraon community

Educational Category	Male	%	Female	%	Total	%
Illiterate	55	45.08	66	60.55	121	52.38
ICDS	5	4.10	1	60.55	6	2.60
I-IV	43	35.25	33	60.55	76	32.90
V-VIII	10	8.20	6	60.55	16	6.93
Secondary	8	6.56	3	60.55	11	4.76

Higher secondary	0	0.00	0	60.55	0	0.00
Graduate	1	0.82	0	60.55	1	0.43
Total	122	100.00	109	60.55	231	100.00

Table 3 depicts the educational attainment and literacy status of male and female members of the Oraon community (n = 231). Overall, the data reveal a low level of educational attainment, with more than half of the population (52.38%) classified as illiterate. Illiteracy is markedly higher among females (n = 66) than males (n = 55), indicating a pronounced gender disparity in access to education.

Primary-level education (Classes I–IV) constitutes the largest literate category, accounting for 32.90% of the total population, suggesting that schooling is initiated but discontinued at early stages for a substantial proportion of individuals. Participation declines sharply beyond the primary level, with only 6.93% attaining middle school (V–VIII) and 4.76% reaching secondary education. Educational attainment beyond secondary level is negligible, with only one male graduate (0.43%) and no individuals attaining higher secondary education.

The ICDS category represents a small proportion (2.60%), reflecting limited early childhood educational exposure. Overall, the pattern demonstrates poor educational continuity, early dropout, and persistent female disadvantage, underscoring the need for targeted interventions to improve literacy, especially among women, and to enhance retention beyond the primary level within the Oraon community.

Table No.4: Occupational status of the Oraon community

Occupation	Male	%	Female	%	Total	%
Agriculture	33.00	34.74	8.00	8.42	41.00	43.16
Agricultural labour	0.00	0.00	2.00	2.11	2.00	2.11
Sharecropper	6.00	6.32	0.00	0.00	6.00	6.32
Day labour	2.00	2.11	0.00	0.00	2.00	2.11
Tea garden labour	14.00	14.74	25.00	26.32	39.00	41.05
Service	3.00	3.16	0.00	0.00	3.00	3.16

Driving	1.00	1.05	0.00	0.00	1.00	1.05
Mason	1.00	1.05	0.00	0.00	1.00	1.05
Total	60.00	63.16	35.00	36.84	95.00	100.00

Table 4 presents the occupational distribution of 95 economically active members of the Oraon community, revealing a livelihood pattern dominated by primary sector and wage-based employment. Agriculture and tea garden labour together account for 84.21% of total employment, underscoring the community's strong dependence on land- and plantation-based livelihoods.

Agriculture is the most prominent occupation overall (43.16%), with a pronounced male predominance (34.74% males vs. 8.42% females), indicating gendered control over land-based activities. In contrast, tea garden labour constitutes the principal occupation for women, engaging 26.32% of females compared to 14.74% of males, reflecting the feminization of plantation labour and limited occupational mobility for women.

Other occupations—such as sharecropping (6.32%), day labour (2.11%), service (3.16%), and skilled work including driving and masonry (each 1.05%)—are marginal and largely male-dominated. Female participation outside agriculture and tea plantation work remains minimal, highlighting restricted access to diversified and skilled employment.

Overall, the occupational profile indicates economic vulnerability, gender-based occupational segregation, and limited livelihood diversification, characteristic of many tribal communities in eastern India, emphasizing the need for skill development and employment diversification initiatives.

Case Studies on Health Care Practices of the Oraon Community

Name of the informant: Lakhia Oraon

Sex: F

Age: 48

Occupation: Agricultural labour

Lakhia Oraon, a middle-aged woman residing in Hatidoba village, provided insights into the health practices followed by her and her community. She reported that for minor illnesses such as cold, cough, body pain, and stomach upset, the Oraons primarily rely on home remedies and traditional healers known

as Ojha or Dhami. For instance, turmeric milk is used for colds and fevers, neem leaves are used for skin infections, and hot fermented rice beer (handia) is consumed to generate body heat during seasonal changes.

When her husband suffered from a prolonged fever with body rashes, they first consulted the Dhami, who performed a healing ritual involving chanting and offering animal sacrifice (a chicken) to appease local spirits believed to cause illness. However, when there was no improvement, they were advised by a local youth (who works in a nearby town) to visit the Primary Health Centre (PHC) in Matigara Block. They walked over 3 km to reach the PHC, where the patient was diagnosed with typhoid and given antibiotics.

She also narrated that pregnant women in her village rarely visit hospitals during early pregnancy. Most deliveries happen at home with the help of elderly women or traditional birth attendants (Dais). Only in case of complications, families seek help from Siliguri Subdivisional Hospital. Institutional deliveries are slowly increasing due to ASHA workers encouraging hospital visits and government incentives like Janani Suraksha Yojana (JSY).

Lakhia acknowledged the gradual change in perception due to mobile health camps, school awareness programs, and interaction with non-governmental organizations (NGOs). Still, trust in traditional healers remains strong, especially among the elderly.

Name of the informant: Rupa Oraon

Sex: F

Age: 35

Occupation: House wife

Rupa Oraon, a mother of four children and a resident of Hatidoba village, shares her experiences with health care practices within her household and community. She recounts that in most health situations—whether for children or elders—the first line of treatment involves home remedies passed down through generations. For fever, a decoction made from tulsi, black pepper, and ginger is prepared. For stomach pain, dried mango seed powder is used. Minor injuries are often treated with turmeric and mustard oil paste.

Rupa notes that although she has visited the Naxalbari Rural Hospital for vaccinations and during her last pregnancy, she still prefers consulting the local *Ojha* (traditional healer) for ailments like jaundice, skin infections, or what the community perceives as "evil eye" afflictions. During a bout of

illness in her youngest child—marked by high fever and restlessness—she first visited the Ojha, who performed a ritual using a chicken feather, rice grains, and chants. Only when the child's condition worsened did they approach a modern doctor.

She highlights that access to quality health care is still not timely for many, due to long travel distances, cost of medicines, and lack of health awareness among older women. Rupa herself walked five kilometers while nine months pregnant to reach the PHC. There was no ambulance service available at the time, and her family could not afford private transport. She delivered her child at home with the help of her mother-in-law and an untrained local birth attendant.

Nevertheless, change is happening slowly. Rupa says that the ASHA workers have been visiting regularly to educate women about government schemes like JananiSurakshaYojana and to encourage institutional deliveries. She now ensures her children are vaccinated on time and maintains a record of their immunization cards. According to her, the younger generation is more open to using government health services, although trust in traditional practices still remains strong, especially among the elderly.

Case study on Child birth

Name of the informant: Nirmila Oraon

Age: 26

Sex: F

Nirmila Oraon realized she was pregnant when her menstruation stopped and shared the news first with her husband, then with the elderly women in her household. She lacked biological understanding of pregnancy and believed childbirth to be a divine gift. Two months into her pregnancy, she and her husband visited a doctor at Naxalbari Hospital. She did not consult any traditional healer or priest.

During her pregnancy, Nirmila continued regular household chores without restrictions. She consumed a variety of foods like small fish, chicken, fruits (especially papaya for lactation), but avoided all intoxicants. She followed several taboos, such as avoiding funerals, religious worships, and venturing alone at night. She also kept a piece of iron tin to ward off evil spirits.

At the third month of pregnancy, she stopped working in the tea garden, and by the fourth month, ceased sexual relations with her husband. When labor began in the tenth month, a traditional midwife (Dhaimaa) and her mother-in-law assisted the delivery in a secluded mud-walled room. No male, including her husband, was allowed to enter.

Labor was assessed using a traditional mustard oil method. During delivery, she was kept upright and encouraged to walk, eventually delivering in a squatting position. The baby was born at 7 p.m., and Nirmila fainted briefly afterward. Once conscious, she was given milk, and the placenta was buried inside the room following customary rituals. The umbilical cord was cut using a freshly prepared bamboo knife, and ashes were applied to the stump for healing.

The newborn was bathed with warm or cold water depending on the season and placed on a straw bed. Nirmila was given full rest, avoiding any work or contact with water sources like wells. A fire was kept burning in the room for seven days to maintain warmth, and an earthen lamp was lit continuously during this period.

Food was offered only a few hours after delivery, consisting of milk, fish, eggs, fruits, and doctor-prescribed tonics. On the 7th to 9th day, after the umbilical cord stump fell off, the village barber shaved the child's head and pared the mother's nails in a symbolic purification ceremony. Nirmila then took a ritual bath, marking the end of the confinement period.

Discussion

The present study reveals a multidimensional view of the Oraon community in Hatidoba village, highlighting the interplay of tradition, economic hardship, social structure, and evolving health behaviours. The findings of the study shows that the Oraon community of Hatidoba village exhibits a demographically young population structure, characterized by a high proportion of children and adolescents, moderate sex-ratio fluctuations across age groups, and a relatively small elderly population. Such patterns are typical of tribal populations in India and reflect high fertility, early marriage, and limited longevity, shaped by socio-economic vulnerability and health disparities (Xaxa, 2004; Planning Commission, 2011).

Marriage among the Oraons remains nearly universal, with earlier marriage among females and delayed marriage among males, reinforcing gendered life-course transitions. Similar trends have been reported among other tribal groups, where marriage functions as a central institution for social integration and economic security (Patra, 2020). Female-dominated widowhood in older age groups further reflects gendered mortality patterns and remarriage norms (Bhattacharya, 2011).

Educational attainment is notably low, with over half of the population illiterate and a sharp decline beyond primary schooling, especially among women. This mirrors broader tribal educational disadvantages documented in eastern India, where poverty, early marriage, and domestic responsibilities

restrict female educational continuity (Munshi, 2016; Ministry of Tribal Affairs, 2021). Limited education, in turn, constrains occupational diversification and awareness of health services.

Occupational data demonstrate a heavy dependence on agriculture and tea garden labour, with pronounced gender segmentation. Women's concentration in plantation labour reflects economic necessity rather than choice, reinforcing income insecurity and health risks (Sarkar & Das, 2019). The marginal presence of skilled or service-sector employment highlights limited upward mobility.

Health care practices among the Oraons reveal a pluralistic system, where traditional healing, home remedies, and ritual practices coexist with biomedical services. Case studies illustrate that traditional healers often serve as the first point of care, especially for culturally defined illnesses, while modern health facilities are approached mainly during complications. Similar health-seeking patterns among tribal communities have been attributed to cultural belief systems, accessibility barriers, and mistrust of institutional health care (Chaudhuri, 1986; Mohindra et al., 2010). Encouragingly, ASHA workers and government schemes such as JSY are gradually improving institutional delivery and immunization uptake among younger women (NFHS-5, 2021).

Conclusion

The present study provides a comprehensive understanding of the socio-economic conditions and health care practices of the Oraon community in Hatidoba village, revealing persistent structural vulnerabilities alongside emerging transitions. The community is characterized by a young population, early female marriage, low educational attainment—particularly among women—and heavy reliance on insecure, labor-intensive livelihoods.

Health care practices remain deeply embedded in traditional belief systems, with modern medical services used selectively and often belatedly. While traditional practices offer cultural coherence and community support, they also contribute to delayed treatment, especially in maternal and child health contexts. Nonetheless, increasing engagement with government health schemes and the active role of frontline health workers indicate a gradual shift toward institutional care, particularly among younger generations.

For meaningful improvement in health and socio-economic outcomes, integrated, culturally sensitive interventions are essential. These should prioritize female education, livelihood diversification, health awareness, and improved accessibility of primary health services. Strengthening trust between tribal

communities and formal institutions, while respecting indigenous knowledge systems, is crucial for achieving sustainable and inclusive development among the Oraons of the Terai region.

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