

ORIGINAL ARTICLE

Traditional Healthcare Practices and use of Local Medicine Among the Lodhas of Bhalia Ghati Village of Jhargram District, West Bengal, India

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ABSTRACT

This research explores the indigenous healthcare practices and ethno-medicinal knowledge of the Lodha community of Bhalia Ghati village in Nayagram block, Jhargram, West Bengal. As a Particularly Vulnerable Tribal Group (PVTG), the Lodhas have historically relied on forest-based knowledge systems, particularly in the face of limited access to modern healthcare facilities. Through a mixed-method approach including primary field interviews, door-to-door census survey, observation, case studies and secondary data from academic literature and government records, this study reveals the role of traditional healers (ojhas), herbal remedies and community rituals in treating ailments ranging from fevers and wounds to snake bites and childbirth complications.

Findings suggest that more than 70% of the population first consults a traditional healer before seeking clinical aid. The reliance on local medicinal plants such as tulsi, harjora, neem, and kalmegh is high. However, due to deforestation, migration of youth and cultural shifts, traditional knowledge is declining.

Case studies of elderly healers, women caregivers and community health outcomes are presented. The paper concludes by advocating for the documentation and preservation of tribal ethnomedicine alongside improved access to public health services under schemes like PM-JANMAN and Ayushman Bharat.

KEYWORDS

• Lodha community • PVTG • Healthcare • Ethnomedicine • Medicinal Plant

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INTRODUCTION

Traditional healthcare practices have long served as a cornerstone of community well-being among India's Indigenous and tribal populations. Among these, the Lodha tribe of West Bengal represents a distinctive group whose health-seeking behaviour is deeply intertwined with their ecological knowledge, cultural beliefs, and socio-economic marginality. Located in the Nayagram Block of Jhargram district, the village of Bhalia Ghati is home to several Lodha families who continue to rely on local medicine and traditional healers for most of their primary healthcare needs.

The reliance on herbal medicine, spiritual healing, and ritualistic practices is particularly pronounced among tribal groups living in remote and forest-fringe areas, where formal healthcare infrastructure is either absent or inaccessible. Researchers like Debnath (2019) and Bhowmick (2004) have emphasized that traditional medicinal knowledge among the Lodhas and other Particularly Vulnerable Tribal Groups (PVTGs) is passed down orally through generations and remains largely undocumented. These practices include the use of plant-based preparations for fever, dysentery, respiratory illnesses, skin infections, and reproductive health issues.

In the context of the Lodhas, whose history is marked by colonial criminalization and post-independence marginalization (Basu, 1987), traditional healthcare becomes not only a pragmatic choice but also a culturally embedded system of care. According to Sen and Roy (2017), for many Lodha households in Jhargram, the village "ojha" or herbalist is more trusted than government health workers, and rituals are often combined with medicinal herbs to treat both physical and spiritual ailments.

However, increasing exposure to formal healthcare through government initiatives like the National Rural Health Mission (NRHM), the introduction of ASHA workers, and mobile health clinics has begun to shift the healthcare landscape. Studies such as that by Murmu and Hansda (2020) show that while modern healthcare access is improving, the cost, language barrier, and distrust of biomedical systems still push many Lodha families back toward traditional routes of treatment.

The Lodhas of Jhargram are an Indigenous community with limited access to modern health infrastructure. In Bhalia Ghati village, where government facilities are scarce, traditional knowledge plays a central role in healthcare. This research article seeks to explore and document the healthcare practices among the Lodhas of Bhalia Ghati village through primary fieldwork and case studies. It aims to understand the interplay between traditional medicine, ecological knowledge and socio-cultural dynamics, while also critically examining how these practices coexist or conflict with modern public health efforts.

Objectives

The objectives of the present study are:

- i. To document traditional health practices among the Lodhas.
- ii. To assess the availability and usage of medicinal plants.
- iii. To know the traditional knowledge and modern healthcare systems of Lodhas.

METHODOLOGY

This study employed both primary and secondary data sources to investigate traditional healthcare practices and the use of local medicine among the Lodhas of Bhalia Ghati village, locally known as 'Nicher tola'. A multi-method qualitative approach was adopted to ensure a comprehensive understanding of the subject. Primary data were collected through various anthropological field techniques, including pre-structured interview schedules, participant and non-participant observation, household census surveys, in-depth interviews, and case studies. These tools were designed to explore the community's health-seeking behaviour, indigenous medical knowledge, and usage patterns of local medicinal resources. For secondary data, relevant sources such as the Census of India (2011), district-level health and administrative reports, ethno-botanical research journals, and records from Integrated Child Development Services (ICDS) and the National Rural Health Mission (NRHM) were consulted to contextualize the findings and validate primary observations. All collected data were systematically tabulated, classified, and interpreted using descriptive statistical methods to identify patterns, trends, and

thematic insights related to traditional health practices in the community.

Study Area and People

The present study was conducted in Bhalia Ghati village, located in the Nayagram Block of Jhargram District, West Bengal, India. The area is predominantly rural and forest-dependent, with agriculture and forest produce being the main sources of livelihood. Bhalia Ghati is a small tribal village inhabited mainly by Lodha families, alongside a few families from Scheduled Castes and other marginalized communities. The village is economically backwards, with limited access to proper roads, electricity, potable water and healthcare services. It falls under the jurisdiction of the Bhalia Ghati Gram Panchayat, and development interventions are primarily undertaken through block-level schemes under the Nayagram administrative structure.

The Lodhas are recognized as a Particularly Vulnerable Tribal Group (PVTG) by the Government of India due to their low literacy rates, economic backwardness, and dependence on traditional occupations. Historically, the Lodhas were classified as a 'criminal tribe' under the British colonial regime, which has led to generations of stigma and marginalization (Basu, 1987). Although they were "denotified" post-independence, many Lodha families continue to live in poverty, with limited access to formal education, employment, and healthcare services. Ethnographically, the Lodhas are known for their animistic belief systems, oral traditions, and ecological knowledge, particularly regarding medicinal plants and forest products. They rely heavily on *ojhas* (traditional healers) and use locally available herbs to treat common ailments such as fever, diarrhoea, skin diseases, respiratory infections and reproductive health issues (Bhowmick, 2004). Their medical practices are not only curative but also preventive, rooted in ritual and spiritual beliefs.

Socially, Lodha villages are typically organized into small, close-knit hamlets with extended family structures. Their economy is primarily based on seasonal wage labour, collection of forest products, and small-scale shifting cultivation, although recent government schemes have aimed to introduce alternative livelihood programs and promote healthcare awareness (Sen & Roy, 2017).

Despite various state and central development interventions such as the National Health Mission, ASHA initiatives, and tribal welfare programs there remains a significant disconnect between formal healthcare systems and indigenous medical practices. This makes it essential to document and understand the traditional healthcare methods still prevalent among the Lodhas, particularly in remote areas like Bhalia Ghati.

Demographic Profile and Traditional Healthcare System

Table 1: Age and Sex-Wise Distribution of Population of Bhalia Ghati Village

Age Group	Male		Female		Total	
	No	%	No	%	No	%
0 - 4	25	6.08	14	3.41	39	9.49
5 - 9	10	2.43	25	6.08	35	8.52
10 - 14	18	4.38	10	2.43	28	6.81
15 - 19	14	3.41	18	4.38	32	7.79
20 - 24	15	3.65	28	6.81	43	10.46
25 - 29	30	7.30	15	3.65	45	10.95
30 - 34	25	6.08	15	3.65	40	9.73
35 - 39	25	6.08	13	3.16	38	9.25
40 - 44	5	1.22	9	2.19	14	3.41
45 - 49	8	1.95	7	1.70	15	3.65
50 - 54	6	1.46	12	2.92	18	4.38
55 - 59	3	0.73	9	2.19	12	2.92
60 - 64	10	2.43	10	2.43	20	4.87
65 - 69	7	1.70	3	0.73	10	2.43
70 - 74	5	1.22	6	1.46	11	2.68
75 - 79	3	0.73	1	0.24	4	0.97
80 - 84	2	0.49	0	0.00	2	0.49
85 - 89	0	0.00	2	0.49	2	0.49
90 - 94+	1	0.24	2	0.49	3	0.73
Total	212	51.58	199	48.42	411	100.00

Source: Primary data collected by the researcher through household survey in Bhalia Ghati Village, during fieldwork.

Table 1 presents the age and sex-wise distribution of the population in Bhalia Ghati village, revealing demographic patterns that

are crucial for understanding the community's health, social structure, and dependency ratios. The table presents primary data collected directly by the author during fieldwork in Bhalia Ghati Village through a door-to-door household survey. The total population of the village stands at 411, with 212 males (51.58%) and 199 females (48.42%), indicating a marginally male-dominated sex ratio.

The age group 25–29 years constitutes the highest proportion of the population (10.95%), followed closely by 20–24 years (10.46%) and 30–34 years (9.73%), highlighting a predominantly young and working-age population. These cohorts are critical for the village's economic and reproductive activities. Children aged 0–4 years account for 9.49%, signifying a high fertility rate and the need

for robust child healthcare, nutrition, and immunization services. Interestingly, there is a sharp drop in population numbers beyond the age of 60, suggesting lower life expectancy, potentially due to poor access to healthcare, high disease burden, and socio-economic vulnerabilities. The elderly population (65 years and above) accounts for only 6.29% of the total, which also reflects limited geriatric care in the region.

Gender-wise, certain age groups, such as 5–9 years and 20–24 years, show higher female representation, while males dominate in others, such as 25–29 years and 30–34 years. This fluctuation may be influenced by migration, occupational patterns, or differential mortality rates.

Table 2: Occupational Status of the Population of Bhalia Ghati Village

Occupation Category	Male		Female		Total	
	No	%	No	%	No	%
Daily Wage Labour	128	31.14	7	1.70	135	32.85
Pastoralism	1	0.24	2	0.49	2	0.49
Forest Product Collection	12	2.92	8	1.95	20	4.87
Government Job	0	0.00	4	0.97	4	0.97
Under Age for Occupation	50	12.17	49	11.92	102	24.82
Small-Scale Business	6	1.46	0	0.00	6	1.46
Traditional Healing and Spiritual Services (Ojha)	6	1.46	0	0.00	6	1.46
Domestic Worker	0	0.00	126	30.66	126	30.66
Migrant Labour (Seasonal Migration)	10	2.43	1	0.24	4	0.97
Self Help Group	0	0.00	1	0.24	1	0.24
Total	212	51.58	199	48.42	411	100.00

Source: Primary data collected by the researcher through household survey in Bhalia Ghati Village, during fieldwork.

Table 2 outlines the occupational distribution of the population in Bhalia Ghati village and highlights distinct patterns of gendered division of labour, economic dependence, and livelihood vulnerability. Out of the total population of 411, 212 are male (51.58%) and 199 are female (48.42%). However, significant gender disparities emerge in occupational roles.

The most common occupation is daily wage labour, accounting for 32.85% of the total population, with a stark gender difference: 128 males (31.14%) compared to only 7 females (1.70%). This indicates that men

predominantly engage in wage-based manual labour, possibly in construction, agriculture, or local infrastructure work. Such reliance on daily labour reflects economic precarity and dependence on irregular income sources.

In contrast, the second-largest employment category is domestic work, which is entirely female-dominated, with 126 women (30.66%) engaged in household labour, either within their own homes or as informal workers in others'. This suggests a traditional gender role structure, where women are either unpaid caregivers or underpaid domestic labourers.

A notable proportion (24.82%) of the population is classified as underage for occupation, including 50 males (12.17%) and 49 females (11.92%), indicating a relatively young demographic and the future need for educational and vocational planning.

Other occupations, such as forest product collection (4.87%) and seasonal migration (0.97%), show that some villagers supplement income through natural resource-based livelihoods and out-migration to states like Odisha or Jharkhand. Interestingly, government employment is minimal (0.97%), and only among women, suggesting extremely limited access to formal employment and state-supported livelihoods.

Small-scale businesses (1.46%), traditional healing (1.46%), and participation in Self Help

Groups (0.24%) remain marginal, indicating that entrepreneurship and community-based economic empowerment initiatives are still underdeveloped. The presence of 6 male *ojhas* (traditional healers) also highlights the continuing relevance of indigenous health practitioners, albeit as a niche role.

Traditional Healthcare System

The Lodha tribe, classified as a Particularly Vulnerable Tribal Group (PVTG), is primarily concentrated in the forest-peripheral areas of Jhargram district in West Bengal. Among their various settlements, Bhalia Ghati village offers a representative picture of how indigenous health beliefs and practices continue to shape the community's approach to well-being and disease management.

Table 3: Local Medicinal Plants used by the Lodhas

Sl.no.	Local Name	Botanical Name	Used for	Part Used	Mode of Preparation
1.	Tulsi	Ocimum sanctum	Cough, cold, fever	Leaves	Decoction with honey
2.	Harjora	Cissusquadrangularis	Bone fracture healing	Stem	Paste for bandaging
3.	Neem	Azadirachtaindica	Skin disease, worm	Leaves, bark	Bathing water, paste
4.	Kalmegh	Andrographispaniculata	Liver problems, jaundice	Leaves	Juice, infusion
5.	Arjun	Terminaliaarjuna	Heart health	Bark	Powder with milk
6.	Bhuin- nim	Phyllanthusniruri	Kidney stones, urination	Whole plant	Infusion

Source: Primary data collected by the researcher through interview methods, during fieldwork.

Table 3 presents a selection of six medicinal plants commonly used by the Lodha tribe of Bhalia Ghati village, highlighting their deep ethnobotanical knowledge and reliance on forest resources for primary healthcare. The listed plants serve a wide range of health functions, from treating common ailments like cough and fever to addressing chronic issues such as liver disorders and kidney stones. This table illustrates how the Lodha community utilizes specific plant parts in targeted preparations, reflecting a well-developed system of indigenous pharmacology. The diversity in application from decoctions and pastes to infusions demonstrates not only plant knowledge but also skill in preparation techniques. These practices are based on centuries of oral tradition and ecological familiarity, underscoring the importance of documenting and conserving tribal ethnomedicinal knowledge before it is lost to

deforestation, modernization, and cultural erosion.

Table 4: Health Beliefs and Practices of Lodhas

Belief/Practice	Prevalence (% among 25 HHs)
Belief in Evil Eye/Spirit Possession	80
Preference for Ojha Over Doctor	72
Belief that Hospital Medicines are "Hot"	60
Use of an Herbal Bath After Childbirth	90

Source: Primary data collected by the researcher through interview methods, during fieldwork.

In Table 4, the data on health beliefs and practices among 25 tribal households in Bhalia Ghati village reveal a strong adherence to traditional and culturally rooted healthcare perceptions. A significant 80% of households expressed a belief in the influence of the evil eye or spirit possession as a cause of illness.

This high prevalence indicates that spiritual or supernatural explanations continue to play a dominant role in health-seeking behaviour and disease understanding within the community. Consequently, biomedical interventions may be delayed or rejected if spiritual causes are believed to be involved.

Further emphasizing reliance on traditional systems, 72% of households reported a preference for ojhas (traditional healers) over biomedical doctors. This preference suggests that ojhas are not only more accessible but are also trusted for their understanding of local illness concepts, spiritual healing rituals, and community integration.

Interestingly, 60% of respondents held the belief that hospital medicines are “hot”, meaning they may be too strong or cause bodily imbalance an idea tied to traditional humoral or Ayurvedic concepts. Such beliefs may influence treatment compliance, especially in the case of antibiotics or allopathic drugs, which are perceived as harsh on the body.

Lastly, a remarkable 90% of households reported the use of herbal baths after childbirth, reflecting the widespread practice of postnatal care through indigenous knowledge. This practice is typically aimed at promoting maternal recovery, cleansing, and warding off evil spirits, and is deeply embedded in traditional postpartum rituals.

Belief System and Health Perception among the Lodha Community

The Lodha tribe perceives health and illness through a dual framework that includes both natural and supernatural explanations. While some illnesses such as digestive problems or fever are attributed to physical causes like dietary imbalances or seasonal changes, a significant portion of health-related suffering is believed to arise from supernatural forces. Common causes include the evil eye, spirit possession, or the curse of ancestors, which are often addressed through ritual healing and spiritual intervention by local ojhas. Violations of social or cultural taboos, such as entering sacred groves during menstruation or childbirth, are also considered potential causes of illness. Additionally, illnesses are sometimes interpreted as signs of displeasure from village deities, such as Thakurani, Jahera Era, or Gram Devta, who are central to the community's religious and cosmological worldview. These

beliefs guide health-seeking behaviour and influence treatment choices, often prioritizing ritual appeasement and traditional healing over biomedical care (Field Survey, 2025). Understanding this culturally embedded belief system is essential for developing effective, respectful, and integrated healthcare strategies within tribal populations.

Traditional Healers and Health Practitioners in the Lodha Community

The Lodha community continues to depend heavily on indigenous healthcare providers who offer both physical and spiritual healing based on traditional knowledge systems. Among them, the Ojha is the most prominent figure and often the first point of contact during illness. Ojhas use a combination of herbal medicine, chants, and rituals to treat a wide range of ailments, from fever and injuries to spirit possession and infertility. In cases where illnesses are perceived to be caused by supernatural forces, the Gunia or Baiga is consulted. These spiritual healers specialize in conducting rituals to expel malevolent spirits or appease offended deities, playing a vital role in maintaining spiritual balance within the community. Another essential group of healers are the local herbalists, known as *Bonoushudhi Janeni*. These are usually elderly men and women with deep knowledge of forest-based medicinal plants, acquired through experience and oral tradition. They provide remedies for common illnesses using locally sourced herbs and are respected for their ecological wisdom. Together, these traditional practitioners form a culturally embedded and accessible healthcare system that addresses both the physical and metaphysical dimensions of illness (Field Survey, 2025).

Medicinal Plants and Remedies among the Lodhas

The Lodha community holds a rich repository of ethnobotanical knowledge, traditionally transmitted through oral tradition across generations. Their healing practices involve the use of locally available plants, prepared in various forms such as pastes, decoctions, and poultices, often combined with indigenous substances like mustard oil or cow urine to enhance therapeutic effects. Among the commonly used plants, Harjora (*Cissus quadrangularis*) is applied for treating bone fractures due to its reputed bone-healing

properties. Tulsi (*Ocimum sanctum*) is widely used for managing coughs and colds, while Neem (*Azadirachta indica*) is employed in the treatment of skin disorders and fevers, valued for its antibacterial and cooling properties. Ashwagandha (*Withania somnifera*) is consumed to combat general weakness and promote vitality. Turmeric (*Curcuma longa*), known for its strong antiseptic qualities, is applied to wounds and infections to aid healing. These plant-based remedies reflect the community's close relationship with their forest environment and their reliance on nature for primary healthcare needs (Field Survey, 2025). Preserving this traditional plant knowledge is crucial not only for cultural heritage but also for sustainable community health practices.

Some Commonly Used Plants:

Local Name	Botanical Name	Use
Harjora	<i>Cissus quadrangularis</i>	Bone fracture treatment
Tulsi	<i>Ocimum sanctum</i>	Cough and cold
Neem	<i>Azadirachta indica</i>	Skin diseases, fever
Ashwagandha	<i>Withania somnifera</i>	General weakness
Turmeric	<i>Curcuma longa</i>	Wound healing, anti-infection

Source: Primary data collected by the researcher through interview methods, during fieldwork.

Maternal and Child Healthcare Practices among the Lodhas

In the Lodha community, maternal and child healthcare is predominantly managed within the household through traditional knowledge systems. Pregnancy and childbirth are typically overseen by traditional birth attendants, or Dais, who provide delivery support based on inherited experience rather than formal medical training. Postnatal care is culturally significant and includes a range of indigenous practices aimed at ensuring the mother's recovery and the newborn's protection. Mothers are given herbal baths, their abdomens are wrapped tightly with cloth to support uterine contraction, and they follow strict dietary restrictions to restore bodily balance. Newborns are believed to be particularly vulnerable to supernatural harm, and are thus protected from the "evil eye" through the tying of black threads around the wrist or ankle and the application of ash marks

on the forehead or cheeks. These culturally embedded practices reflect a holistic approach to maternal and child well-being that integrates physical care with spiritual protection (Field Survey, 2025). Understanding these traditions is essential for designing culturally responsive maternal health interventions in tribal areas.

Health-Seeking Behaviour among the Lodhas

While traditional healing practices continue to dominate health-seeking behaviour among the Lodha community, the gradual influence of government healthcare interventions is becoming evident. Community members still primarily consult Ojhas and other indigenous healers for common illnesses and spiritual afflictions; however, awareness of formal health services is slowly increasing due to the efforts of ASHA workers, local health sub-centres, and immunization drives. ASHA workers, in particular, have played a crucial role in sensitizing women about antenatal care, institutional deliveries, and child immunization. Despite persistent cultural barriers and mistrust of allopathic medicine, some families now opt for a combination of traditional and biomedical approaches, especially in emergencies or for services like vaccinations and maternal care (Field Survey, 2025). This evolving health-seeking behaviour indicates a slow but important transition towards integrated healthcare access, where traditional beliefs coexist with formal health infrastructure.

Community Attitudes Towards Modern Medicine

Among the Lodha community, attitudes toward modern medicine are marked by a mix of scepticism and cautious acceptance. Many Lodhas express distrust toward government health facilities, primarily due to a lack of cultural sensitivity, where health workers often fail to understand or respect indigenous beliefs and languages. Additionally, there is a widespread perception of delays in treatment and the ineffectiveness of hospital care, which contrasts sharply with the immediate, ritual-based responses offered by traditional healers. Cost and distance also serve as practical barriers, especially in remote villages where transportation to Block Health Centres is limited or unaffordable. Despite these reservations, modern healthcare is not entirely rejected. In situations of medical emergency

such as snakebites, prolonged fevers, or severe injuries some families do seek help from Block Health Centres or health camps organized by NGOs, often as a last resort when traditional methods fail (Field Survey, 2025). This selective engagement with modern medicine highlights the need for more culturally competent, accessible, and responsive healthcare systems tailored to tribal communities.

Role of Ojhas (Traditional Healers) and Household Remedies

Traditional healers, locally known as *Ojhas*, play a vital role in tribal healthcare systems by combining herbal knowledge with spiritual practices. Their healing methods often include chants, herbal pastes, and spiritual divination to address both physical and supernatural causes of illness. *Ojhas* are commonly sought for the treatment of fevers, diarrhoea, bone fractures, snake bites, infertility and cases of spirit possession. Their deep-rooted knowledge of medicinal plants and ritual practices makes them central figures in maintaining community health.

These remedies are often passed down through generations and reflect a sustainable, community-based approach to health management. Together, *Ojhas* and women form the backbone of indigenous health practices, ensuring accessible and culturally relevant healthcare within tribal communities.

Case Studies of Traditional Healers (Ojha)

Case Study-1

Informant: Narayan Sabar - [Traditional Healer]

Age: 67 years

Sex: Male

Ojha Narayan Sabar, aged 67, is a highly respected traditional healer from Bhalia Ghati village, Jhargram District, West Bengal. With over 35 years of experience, he has played a pivotal role in sustaining the indigenous healthcare system among tribal communities. Ojha Narayan is known for treating more than 15 types of ailments using a repertoire of over 30 medicinal plants sourced from the local forest. His treatment approach includes herbal decoctions, poultices and ritual-based healing.

One of his most notable contributions is the treatment of malaria using a combination of

neem (*Azadirachta indica*) and tulsi (*Ocimum sanctum*), which he claims has shown effective results in many cases. Recently, under a local NGO initiative, he trained several younger community members in traditional medicinal practices, ensuring the transmission of indigenous knowledge across generations.

Ojha Narayan's work reflects a deep-rooted understanding of the local ecology and community health needs. His continued practice not only provides affordable healthcare access but also contributes to the conservation of ethnomedicinal knowledge, making his role significant in the broader context of community-based health and ethnobotanical research.

Case Study-2

Informant: Maloti Sabar - [Indigenous Herbal Caregiver and Birth Attendant]

Age: 65 years

Sex: Female

Maloti Sabar, aged 65, is a traditional herbal caregiver from Bhalia Ghati village, Jhargram District, West Bengal. Known locally for her care and healing practices, she specializes in treating children's ailments and offering maternal support using age-old indigenous methods. Her treatment for common colds and fevers among children involves warm compresses made of tulsi (*Ocimum sanctum*) leaves and onion, a remedy widely accepted in her community for its effectiveness.

In addition to paediatric care, Maloti plays a critical role as a traditional birth attendant. She manages home deliveries using turmeric-infused oil for its antiseptic properties and ensures warmth for the mother and newborn through controlled fire heat, reflecting her knowledge of postpartum care rooted in cultural practices.

Another notable remedy used by her is the application of burnt banana leaf ash to treat scabies, showcasing the use of locally available, sustainable resources for skin-related issues. Her practices, though undocumented formally, are widely respected in the region and represent a rich source of ethnomedical knowledge. Maloti Sabar's role underscores the importance of female caregivers in sustaining traditional health systems and preserving indigenous health knowledge across generations.

Case Study-3

Informant: Hiralal Sabar – [Conflict of Healing Systems]

Age: 65 yrs

Sex: Male

Hiralal Sabar, a 65-year-old male resident of Bhalia Ghati village, represents a case of conflict between traditional and biomedical healing systems. After being bitten by a snake, he initially sought treatment from a local ojha (traditional healer), relying on chants and herbal applications. However, his condition deteriorated rapidly, prompting his family to rush him to Debra Rural Hospital, where he received medical treatment and eventually recovered. The experience led Hiralal to lose trust in the effectiveness of traditional healing for serious conditions. Since then, his family has adopted a more cautious approach by integrating both traditional and biomedical practices. They now consult ojhas for minor ailments and spiritual concerns, while depending on formal healthcare services for emergencies and critical illnesses. This case highlights the tension and transition between indigenous and modern health systems within tribal communities, reflecting changing perceptions shaped by personal experiences.

Decline of Traditional Knowledge and Policy Recommendations among the Lodha Community

Traditional health knowledge among the Lodha tribe is rapidly declining due to deforestation, youth migration, the lack of documentation, and weak inter-generational transmission. Sacred groves and forest areas, once rich in medicinal plants, are shrinking, limiting access to herbal resources. Simultaneously, younger generations are moving to urban areas, distancing themselves from traditional healing practices. In response, NGOs like Pradan and the Livolink Foundation are promoting herbal gardens and reviving local plant-based healing systems. The ICDS has also begun efforts to integrate home-based indigenous knowledge into community healthcare. Additionally, Forest Rights Act (FRA) committees are working to protect customary rights over forest use, which is essential for the survival of traditional practices.

Short-term policy interventions should include training ASHA workers to document

local medicinal knowledge and distributing illustrated leaflets in tribal languages on safe herbal remedies. In the long term, establishing a “Lodha Ethnomedicine Archive,” co-authored by experienced ojhas, could serve as a valuable resource for future generations. Integration of traditional healers into referral networks such as formal collaboration between ojhas and ANMs could improve trust and health outcomes. Lastly, herbal plantation initiatives under MGNREGS would support both ecological restoration and community livelihoods.

DISCUSSION

The findings of this study reaffirm the centrality of traditional healthcare systems among the Lodha tribe of Bhalia Ghati village. Despite the presence of governmental health infrastructure, the community continues to prioritize indigenous healing methods rooted in spiritual and ecological knowledge. This is consistent with earlier anthropological studies that have emphasized the Lodhas’ reliance on ritual healing, herbal medicine, and the role of Ojhas as culturally embedded health authorities (Bhowmick, 2004; Basu, 1987).

The high prevalence of beliefs such as evil eye-induced illness (80%) and the preference for traditional healers over biomedical professionals (72%) reflects a culturally cohesive worldview that blends health with cosmology. These findings support the assertion that PVTGs like the Lodhas perceive illness as both a biological and spiritual crisis, which necessitates ritual and medicinal responses (Sen & Roy, 2017). Furthermore, the mistrust toward allopathic medicine, perceived as “hot” and intrusive, indicates the persistence of humoral frameworks in indigenous medical reasoning parallels of which are seen in Ayurveda and Unani systems (Banerjee, 2013).

The demographic and occupational profiles reveal a predominantly young, economically marginalized population that is forest-dependent and largely engaged in informal labour. Gender-based disparities in occupational roles are evident, with women primarily engaged in domestic work and caregiving, while men dominate wage labour and forest-based livelihoods. Interestingly, traditional healers and birth attendants such as Ojhas and Dais often elderly men and women

still play a pivotal role in maternal, paediatric, and general Healthcare.

The ethnobotanical knowledge presented in this study reflects not only a deep familiarity with the forest ecosystem but also the systematic and skilful use of plant-based therapies. The recurring use of species such as *Ocimum sanctum*, *Cissus quadrangularis*, and *Azadirachta indica* underscores the pharmacological sophistication of tribal medicine, echoing observations from earlier ethnomedical studies (Jain, 1995).

However, this traditional knowledge is increasingly under threat. Field data indicate that deforestation, migration, and generational disconnect are leading to the erosion of indigenous practices. Moreover, community access to modern healthcare remains constrained by infrastructural gaps, linguistic barriers, and culturally insensitive service delivery challenges also noted by other researchers studying tribal health in eastern India (Patra, 2021).

Importantly, a transition is underway. ASHA workers and NGOs are playing a mediating role in bridging traditional and biomedical systems. Cases like that of Hiralal Sabar demonstrate the community's gradual shift toward hybrid healthcare behaviour utilizing formal medical facilities in emergencies while retaining traditional care for regular or spiritually interpreted illnesses. This dual engagement reflects the adaptive strategies employed by marginalized communities navigating multiple epistemologies of health (Nichter, 1994).

Overall, the Lodhas' traditional healthcare system is not an isolated relic but a living, adaptive structure influenced by ecological, cultural, and institutional forces. The preservation and integration of this knowledge, particularly through community archives and participatory health networks, holds potential for developing more inclusive, responsive, and culturally aligned healthcare strategies.

CONCLUSION

This study documents and analyzes the traditional healthcare practices of the Lodha community in Bhalia Ghati, Jhargram, revealing a deeply ingrained system of ethnomedical knowledge that continues to shape health-seeking behaviour. The reliance on Ojhas,

medicinal plants, and ritual healing is not merely a function of healthcare inaccessibility but reflects a culturally embedded framework of health, illness, and spirituality.

Despite efforts by state and non-state actors to introduce modern healthcare systems, the uptake remains uneven due to mistrust, cultural dissonance, and logistical barriers. However, a nuanced transformation is underway, where traditional and biomedical practices increasingly coexist. This dual engagement calls for culturally competent healthcare delivery systems that respect indigenous knowledge and integrate local healers into formal networks.

To ensure the continuity of Lodha ethno medicine, policy recommendations include capacity-building among ASHA workers to document indigenous remedies, creation of local-language health education materials, support for herbal gardens under MGNREGS, and the establishment of a community-authored "Lodha Ethnomedicine Archive." These initiatives can bridge epistemological divides and safeguard tribal health knowledge against ecological degradation and cultural erosion.

By recognizing the Lodhas not merely as healthcare recipients but as custodians of valuable medicinal knowledge, this research contributes to the larger discourse on health equity, indigenous rights, and culturally sensitive public health planning in India.

REFERENCES

1. Banerjee, S. (2013). *Cultural dimensions of health and disease in tribal societies*. Kolkata: Anthropological Survey of India.
2. Basu, A. (1987). *The Lodhas of West Bengal: Socioeconomic and cultural change*. New Delhi: Anthropological Survey of India.
3. Basu, S. (1987). *The Lodhas of West Bengal: Structural and cultural dimensions*. Indian Anthropologist.
4. Bera, S. (2016). Ethnomedicinal practices among Lodha tribe. *International Journal for Research in Applied Science and Engineering Technology (IJRASET)*, 4(3), 45–52.
5. Bhowmick, P.K. (2004). *Indigenous medicine and healers among the tribes of India*. Kolkata: Institute of Social Research and Applied Anthropology.

6. Census of India. (2011). *District Census Handbook: Jhargram* (Series 20, Part XII-B).
7. Directorate of Census Operations, West Bengal. <https://censusindia.gov.in>
8. Debnath, S. (2019). Ethnomedicine among the Lodha tribe in Jhargram, West Bengal. *Journal of Tribal Studies*, 21(2), 45–58.
9. Field notes and interviews. (2025, May–June). *Ethnographic observations in Bhalia Ghati village, Jhargram District*. Unpublished field data collected by the researcher.
10. Jain, S.K. (1995). *Manual of ethnobotany*. New Delhi: Scientific Publishers.
11. Livolink Foundation. (2024). *Indigenous knowledge systems and herbal care: Field initiatives in Odisha and West Bengal*. Retrieved from <https://livolinkfoundation.org>
12. Ministry of Health and Family Welfare. (2023). *National Health Mission: Annual report 2022–2023*. Government of India. <https://nhm.gov.in>
13. Ministry of Tribal Affairs. (2022). *Report on implementation of the Forest Rights Act (FRA), 2006*. Government of India. <https://tribal.nic.in>
14. Murmu, J., & Hansda, S. (2020). Healthcare seeking behaviour among particularly vulnerable tribal groups in West Bengal. *Indian Journal of Social Research*, 61(3), 45–57.
15. Nayagram Block Health Office Reports, 2023.
16. Nichter, M. (1994). The social relations of therapy management in South Asia. *Culture, Medicine and Psychiatry*, 18(2), 141–195.
17. Patra, A. (2021). *Healthcare access and inequity among tribes in Eastern India*. Bhubaneswar: Tribal Health Studies Institute.
18. Pradan. (2024). *Community-led herbal gardens: Reviving ethnomedicine in tribal India*. Retrieved from <https://pradan.net>
19. Sen, S., & Roy, A. (2017). Traditional healthcare practices among the Lodha community. *Eastern Anthropologist*, 70(1), 83–98.
20. Sen, S., & Roy, P. (2017). *Traditional health practices among the Lodhas of Nayagram Block*. Bengal Anthropological Forum.
21. World Health Organization. (2013). *WHO traditional medicine strategy: 2014–2023*. <https://www.who.int/publications/i/item/9789241506090>