CHAPTER1

Introduction

Introduction-

'Health is of universal interest and concern'(Forest Clement, 1932).

Health care practices are indispensable for human survival. The socio-cultural dimension is the integral part of the health care practices of a community belonging to specific ecological surroundings in which they reside. More often the traditional health care practices continue in the day-to-days life style of a particular community and it is conspicuously evident among the tribal population. The perceptions of health, disease and treatment s vary according to the culture of an exact locale depending on ecological settings. Moreover, a particular culture of tribal area is led by the traditional belief systems which are guided by the environment and cultural value systems.

The cause of diverse nature in traditional tribal societies is due to various ecological surroundings, economic, religious and traditional faith in their own cultural pattern. My present medical anthropological research deals with etiology of disease, study of health care practices in light of socio-cultural dimensions, exploration of religious and supernatural practices related to health and focus on diagnosis with traditional method of remedial process among the Hill Kharia of District Purulia and Bankura, West Bengal. It highlights on the infrastructure and implementation of modern health care programmes of said tribal population in the particular areas.

1.1- Folk Medicine-

The term folk medicine refers to healing practices and idea of body physiology and health preservation to a limited segment of the population in a specific culture, transmitted informally as general knowledge or oral tradition. The concept of folk medicine depends upon the supernatural, cosmological and magico-religious practices as well as iconography or use of good and evil symbols on places of worship, inside households or in a boundary walls (Shrivastava. A, 2008). Folk medicine may also be understood Traditional medicine, Alternative medicine, Indigenous medicine and Natural medicine. However, the tribal population has great believes on folk medicine.

This system of medicine has still retained its traditional form in interior tribal areas where traditional medicine men and man dealing with magic or supernatural elements jointly conduct the health care system (Tarafdar, 2008). The knowledge of ethno medicine and its practices are still in oral form and transmitted to the next generation as time to time without changes.

1.1.2- Traditional Indian Medicine-

The coexistence of western medicine and so called traditional system of medicine is a feature of all health system outside Europe. India, the land and the cradle of Yoga, is also one of regions of the world where, far from disappearing the face of the success of modern medicine introduced by European's. This system of medicine is still practiced widely and offer advantages that meet the concerns of World Health Organization (WHO). This system of medicine is inherited from ancient medical system based on written tradition and popular which transmitted orally. In the past decades, there has been renewed attention and interest in the use of traditional medicine globally. The WHO has pointed out that the traditional medicine is an important contributor to its health goals. Today according to the WHO, as many as 80% of the worlds people depends on traditional medicine and in India, 65% of the population in the rural areas used Ayurveda medicine and medicinal plants for the treatment of different ailments (WHO, 2001). Indian Traditional medicine is also based on the various kinds of herbal medicine which can heal a variety of diseases. This Indigenous stream of herbal medicine is become popular now-a-days not only belonging tribal community but also in modern societies in different parts of World.

1.1.2.1- The Ayurveda-

The Ayurveda medical tradition looks onto a lively history of more than 2000 years in which it has continually developed. Ayurveda is one of several traditional medical systems that originate from the Indian subcontinent. It is now represented as the indigenous Indian medical

tradition *par excellence* (Shrivastava. A,2008). The origins of Ayurveda long predate the formation of an Indian nation and are not necessarily set within its geographical boundaries. D. Chattspadhyaya in *Science and Society in Ancient India* wasfirst to contest the traditional view that Ayurveda developed directly from the medicine of the vedic and ayurvedic medicine (Krippner. S, 2003).

The modern Hindu ascribe its authorship to their Gods, some to *Brahma* and others to *Siva* but in their philosophical writings they are all still attributed only to Siva, who in this respect is known as *Vaidiswar* and *Mundeshwar* (Gods of Medical and Medicine).

1.1.2.2- The Unani-

One of the important medical system originating from countries outside the Indian subcontinent, have been integrated into its culture and now form a part of its medical traditions. The earliest and perhaps most important of these system to be imported and acculturated is Unani medicine. The Arabic writers of the 7^{th} and the 8^{th} century A.D. where local peoples of Syria who has visited India on many occasions and eventually borrowed many Hindus medical culture, which they translated in to Arabic and Persian languages.

1.1.2.3- The Siddha-

The word *Siddha* comes from the word *Siddhi* which means object to be attained or *perfection of heavenly bliss*. Siddha Medicine is one of the oldest medical systems known to mankind. Contemporary Tamizh literature holds that the system of Siddha medicine originated in Southern

India, in the state of Tamilnadu. Reported that more than 10,000 years ago, the Siddha system of medicine is considered one of the most ancient traditional medicine systems, *Siddhargal* or *Siddhars* were the premier scientists of ancient days. *Siddhars*, mainly from south India, laid the foundation of this system of medication. *Siddhars* were spiritual adepts who possessed the *Ashta siddhis*, or the eight supernatural powers. *Siddhars* are the followers of Lord Shiva.

At present, The Central Council for Research in Ayurveda and Siddha (CCRAS), established in 1978, by Department of Ayurveda, Yoga and Naturapathy, Unani, Siddha and Homeopathy (AYUSH), Ministry of Health and Ayurveda and Siddha medicine.

1.2- Concept of Medical Anthropology-

Medical Anthropology is an interdisciplinary field which studies human health and diseases, health care system and bio-cultural adaptation. The term *medical anthropology* has been used since 1963 as a label for empirical research and theoretical production by Anthropologist into the social processes and cultural representations of health, illness and treatment (McElroy, 1996). Medical Anthropology is a distinctive way of understanding human experiences. This is because all human beings- irrespective of culture, class or historical epoch experience sickness and death (Tarafdar, 2008). Medical anthropology's bio-cultural approach expands the bio medical perspective that views health basically a biological issue. Human health and diseases derive from the interaction of human biological potentials through culturally, socially and individually

mediated experiences that have effect on biological process (Warren, 1991).

Medical anthropology is the primary discipline addressing the interface, culture and health behavior and incorporating cultural perception into clinical setting and public health programmes (McElroy, and Patricia k. Townsend, 1989). The cultural perceptions into medical anthropology are essential for providing competent care, effective community health programmes and patient education. With the evolution of man's intelligence and the occurrence of diseases, man tried to cure various ailments through trial and error method by indigenous or traditional ways.

In view of the significance of the phenomena of perception of disease and treatment for human societies, it is not surprising that the anthropological study of health and the occurrence and means of coping with the diseases and illness can involve one deeply in the manner in which people perceive their world. In this perspective, medical anthropology is not only a way of viewing the status of health and diseases in a society but also a way of viewing society itself (Aekerknecht, 1942).

Medical Anthropology is an integration of cultural and biological perspective; helps in better understand health problems and their solutions. The relevance of medical anthropology and cultural perspectives to biomedicine and the interaction of culture and health are illustrated in special features organized around bio-cultural interaction (Aekerknecht, 1942).

Medical Anthropology essentially involves a study of two main aspects, namely health and diseases. The anthropological study of social and

cultural influences on health and disease includes not only the subjects of immediate therapeutic relevance but phenomena that have special interest because of their effects on human ecology and cause of human evolution.

In most culture, there is a specialist who treats illness, injury, disease and related misfortune and quite frequently these persons correspond to the leader of religious practices (Tarafdar,2004).

1.3- AppliedAnthropology in Medicine-

Medical anthropology is a flourishing branch of anthropology and it has emerged as one of the most indispensible areas of anthropological research. The term medical anthropology has come into being only in the 1960s (Scotch. Norman, 1963) and since then cultural anthropologist has started emphasizing the important of social and cultural aspect of health and medicine in their new horizon of studies. As a total study of man, medical anthropology has contributed valuable techniques, concept and scientific facts to several branches of medicine and public health care delivery systems. In many different areas of medical anthropology reflect a growing trend of applying cultural knowledge as well as indigenous knowledge and intercultural perspective helps to facilitate relations among providers' culture, patient culture and institutional culture. Understanding the patient's personal life and social life in relationship to the treatment plan helps ensure effective communication, appropriate resource utilization and success of the treatment (McElory,1996).

Medical Anthropology addresses interfaces between culture and health in the following ways-

1) Tracing health care providers in cultural sensitivity and competency.

2) Try to find and researching health threats and their responses in a community.
3) Developing policies and programmes to create responsive health programme.

The scope of medical anthropology is very diverse which focuses on the interaction on the biological health matter, socio-economic and demographic factors. All societies have medical systems that provide a theory of disease etiology, methods of diagnosis of illness, and prescription and practices for curative or palliative treatment (Chaudhuri,B. 1993). Medical anthropology initially derived from anthropological interest in healing belief and practices of different cultures. These interest stemmed from a growing recognition of complex relationship between issue of health and sickness, culturally specified belief and healing practices and the opportunities and constraints afforded by larger social forces (Wellin, 1978).

Within medical anthropology, applied approaches can be categorized into two general domain i.e., applied anthropology in clinical setting (eg. hospital) and applied anthropology focuses on health care within biomedical settings and analyzes the effect of cultural and socio economic factors on doctor-patient interaction , adherence to treatment, and the experiences in healing. A growing body of literature within clinically applied anthropology demonstrates how knowledge of explanatory model can be used to improve cultural sensitivity in physician- patient communications (Kleinman, Eisenberg and Good, 1978). Major branch of

applied anthropology deals with public health policy making, programme and development and intervention.

Unfortunately very little work has been done on the interaction between traditional and modern medical practices among the tribal population. Data on health, concept of disease and the nature of treatment are rather scanty and specific studies on this topic covering the different facets are practically rare. In this context the following issues need to be considered:

a) Role and position of traditional healers in a society.
b) Supernatural belief related to health, disease and treatment.
c) Reason of illness and sickness and categorization of treatment.
d) Categorization of treatment on the aspect of different diseases.
e) Interaction between traditional and modern medical system in a particular area.

Some medical anthropologists have examined the cultural dimension of the public health. Similar to studies of biomedicine as a cultural system, now applied anthropologist are given more attention to the cultural beliefs, norms and implicit premises on which public health funding and administration are based (Justice, 1986). Frequently such research seeks to expose the cultural and administrative assumption within public health that create obstacle to the implementation of locally relevant, effective and culturally sensitive programme and plan.

1.4- Health and Indigenous Knowledge-

The origin of indigenous knowledge can be traced back to the ancient period. Peoples used such knowledge from generation. It is accepted that the tribes all over the world owning their own culture based on that they

developed their own system of medical practices, which are being addressed as folk medicines. The study indigenous knowledge is a new revolution set in the domain of Anthropology. A holistic perspective on human knowledge would help us understand the implications of indigenous knowledge especially in the area of health and disease. The health problem of any community are influenced by inter play of various factor including consciousness of the people, socio-cultural, demographic, economic, educational and political factor (Prasad. S. et.al, 2010)The common beliefs, customs, practices related to health and disease in turn influence the health seeking behavior of the community.

The term indigenous knowledge has different connotations such as traditional knowledge, local knowledge, community knowledge, rural people's knowledge. Although the concept has different forms the meaning appears to be synonymous. According to Grenier (1998) indigenous knowledge is the traditional knowledge existing within and developed around the specific condition of women and men indigenous to particular geographical area. Basu (2009) do not find the restrictions of the concept and expanded its scope in that the term indigenous knowledge is not confined to tribal group or the original inhabitants of an area. It is not confined to the rural people rather any community possessing indigenous knowledge rural or urban, settled or nomadic, original inhabitants or migrants. Indigenous knowledge is referred to not only to the knowledge of indigenous people but also the intellectual property of other communities. There are many facets involved in the indigenous knowledge such as, information of the Communities, beliefs on religious

faith, in health care and medical practices etc. indigenous knowledge is found in people's memories and activities and is expressed in the form of stories, songs, folklore, dance, myth, cultural values, beliefs, rituals, community laws, equipment materials, plant species and animals breeds (Basu, 2009).

Indigenous knowledge (IK) has recently been regarded as an important commodity in global health development. Although recommendation by the World Health Organization (WHO) in the Health for all Declaration (1978) highlighted the need to include local people, their traditions and practices in primary health care (PHC), this was largely ignored. Evidence suggests that up until recently IK and Traditional Medical Practices (TMP) was largely seen as a barrier to modernization and progress.

Traditional medical knowledge spans various dimensions relating to medicines, food and nutrition, rituals, daily routines and customs. Indigenous knowledge on tribal health can range from home level understanding of nutrition, management of simple ailments and reproductive health practices to treatment of serious chronic illness. Inter linkages to geography, community; worldviews, biodiversity and ecosystem make indigenous health practices diverse and unique. It is important to mention that indigenous knowledge on health is not restricted to any particular period in time, and constantly undergoes revaluation in the local context. Local pharmacopeia has also been developed over a long period of human-biodiversity interactions and is unique in terms of compatibility to local contexts, easy accessibility of resources.

Global development strategies have changed in recent years. People's participation and inclusion now high on the development agenda, including IK is the latest trend in this change. IK is now firmly accepted by most lead development Programme (UNDP) even the World Bank. (WHO 1996; 2003; World Bank 1998). This increasing acceptance has both local and global dimension to it.

Indigenous knowledge (IK) is local knowledge- that is unique to a given culture and society. Such knowledge is passed down generation to generation in societies by verbally. Indigenous knowledge has value not only for the culture but also for scientists and planners striving to improve conditions in rural localities (warren, 1991, 1992).

Giarelli (1995) warns that IK system "*cannot be reduced to the empirical knowledge they contain"*. Indigenous health knowledge and Traditional Medical Practitioners (TMP) are usually a part of a wider system of knowledge about health, illness and relationship between humans and nature. Lama (2000) and Takeshita (2001) support this with his concern over the use of IK as a "*biomedical utility*"; as if it were just matter of fact information rather than knowledge which is "*embedded in beliefs about life, death, disease, healing and ancestral heritage and are anchored in people's cultural identity".* Currently, traditional knowledge based on health practices are promoted either by the state, which predominantly focuses on health care delivery; by tribal society as well as civil society whose focus primarily relates to conservation and health; or private sector through production and marketing of medicine, supplements and health care resources. Folk and indigenous knowledge system of the tribal

community in India particularly on medicinal plants is depended on forest resources.

1.5- Health and Government policies:

The policy seeks to bring Scheduled Tribes to improve their condition through a multipronged approach for their all-round development without disturbing their distinct culture.

Tribal people, who are self-reliant and self- sufficient, have over the centuries developed their own medical system based on traditional and indigenous knowledge system for diagnosis and cure diseases. They believe in taboos, spiritual powers and faith healing. There are wide variations among the tribals in their health status and willingness to access and utilize health services, depending on their culture, level of contact with other cultures and degree of adaptability. Against this background, the Government policy seeks to promote the modern health care system and also a synthesis of the Indian systems of medicine like ayurveda and siddha with the tribal medical system.

Health is considered as an outcome of personal attributes, habitual experiences and interaction with the environment, whereas well-being can relate to multiply factors such as maternal comfort, health, freedom of choice and action, social support system and security (Payyappallimana, 2010).

The relationship of health with regard to development is well articulated by the WHO, which states as follows:

Health is both a resource for, as well as an outcome of, sustainable development. The goals of sustainable development cannot be achieved

when there is a high prevalence of debilitating illness and poverty, and the health of a population cannot be maintained without a responsive health system and a healthy environment. Environmental degradation, mismanagement of natural resources, and unhealthy consumption patterns and lifestyles impact health. Ill-health, in turn, hampers poverty alleviation and economic development.(BOYACIOĞLU. Ebru.Z,2012).

Ensuring access to good quality health care- whether physical or economical-has been a major challenge to policy makers. This has been the case since the 1970s, when the Alma Ata declaration (1978) mandated "Health for All" by the year 2000 and further called for an integration of traditional health practioners and traditional medical knowledge in public health policies to the more recent Millennium Development Goals (MDGs) (2000), where three of the eight goals pertain to health. Despite the multiplicity of policies, goals and targets with regard to health, environment and development, we are still achieving their objectives, chiefly because health development focuses more on biomedicine than broader determinants and inter-sectoral approaches. The MDGs do give more weight to achieving health objectives, as they relate closely to various development-related parameters. A primary health care (PHC) approach and the goal of universal health access are essential to achieve MDGs and this should be through appropriate, acceptable and affordable health care (Walley et. Al, 2008).

LP Vidyarthi was the chief architect of tribal development programme in India. On the basis of his suggestions multiple tribal development projects were introduced in India since fourth plan period. He introduced the idea

of developing Tribal Development Areas on the lines of Community Development Areas where schools, hospitals, irrigation, vocational training center, agricultural facilities should be extended to the tribal communities. Abandoning their traditional mood of livelihood, tribes can be participating in new system of production and tribal economy can be linked with the national economy efficiently.

The focus of health policies up to 5th Five year plan was on control of communicable diseases TB, malaria etc. Reproductive Child Health (RCH) programmes and population control, self-sufficiency in drugs and equipments. From 6th plan onwards health policies aimed at improving health infrastructure in the rural areas augmenting health human resources. The National Health Policy 2002 aims at achieving an acceptable standard of health for the general population of the country. Keeping in line with this broad objective, the Eleventh Five Year Plan had set upon itself the goal of achieving good health for all, especially for the poor and underprivileged. To achieve the objective, a comprehensive approach was advocated, which include improvements in individual health care, public health, sanitation, clean drinking water, access to food and knowledge of hygiene and feeding practices.

Planning Commission has constituted a high Level Expert Group (HLEG) on universal health coverage, seven Working Groups and Two Steering Committees to define the appropriate strategy for the Health sector for the Twelfth Plan. Out of pocket expenditure on health care is a burden on poor families, leads to impoverishment and a regressive system of financing. Increase in public health spending to 2.1% GDP by the end of

the 12th plan, cost free access to essential medicine in public facilities, regulatory measures proposed in the 12th plan are likely to lead to increase in share of public spending. At recent rate of decline of 2 points per year in Infant Mortality Rate (IFR), India is projected to have an IMR of 38 by 2015 and 34 by 2017 sane as recent rate of decline of 5.5% per annum in Maternal Mortality Rate (MMR) of 143 by 2015 and 127 by 2017 (http://planningcommission.gov.in,Access date- 01.09.2018 time- 10.44 am).

1.6- Some important concept and definition

There are several concepts and definitions related to tribal health and health care practices which are very important to understand the persisting concepts among the tribal communities.

1.6.1- Tribal Communities-

Vulnerable tribal groups are tribal communities among the STs who live in near isolation in inaccessible habitats. They are characterized by a low rate of growth of population, pre-agricultural level technology, extremely low levels of literacy and subsistence levels of economy, a stagnant or decline population. 75 such groups in 15 states and one UT have been identified and have been categorized as Particularly Vulnerable Tribal Groups (PTGs) The India is inhibited by 104,545,716 tribal population and they constitute 8.6% of the national total population according to the 2011 census (https://www.census2011.co.in, accessed date- 01.09.2018 time 10.48 am). They inhibit varied geographic and climatic Zones of the country. Their vocation ranges from hunting, gathering, cave dwelling

nomadic to societies with settled culture living incomplete harmony with nature.

1.6.2- Shaman

Shamanism was first recognized by Western observers working among traditional herding societies in central and northern Asia, and it is form the language of one of these societies, the Tungus-speaking peoples of Siberia, that the term *shaman* is derived. Shamanism is one of the controversially debated themes in recent anthropology and religious studies. Shamans are a part time religious specialist and healers who personify the most extreme elements of so-called primitive mentalities and magical thinking in tribal societies. Early missionaries often called shamans witch doctor, attributing their supernatural to the devil, and confronted them as enemies of Christianity. Government authorities often disapproved shamans because they sometimes used their powers within the community to organize resistance to Government programme and shamanistic curing practices frequently were considered contrary to modern medical sciences, if not actually dangerous.

Shaman is actually a part time religious specialist who has unique power acquired through his or her own initiative; such individuals are thought to posses exceptional abilities to deal with supernatural beings and powers. Shaman plays an important role in curing sickness by performing various rituals and indicates a cross-culturally religious attributes.

1.6.3- Witchcraft

The word *witch* is derived from the old English *Wicee*, meaning a female magician or Sorceress, are generally applied to both sexes and their magical activities. Among many people accident, sickness, death and other unwanted event have been thought to be caused by *witches*-individual who had magical power which they used for evil purpose (Bacon, 1953). Sorcery and witchcraft are ritual means of working harm against enemy. Both sorcery and witchcraft denote the projection of supernatural evil by human instigation. Both deal with supernatural and mystical power and thus are integral to the understanding or religion or cosmology.

Evans-Pritchard, (1977) examined that *witchcraft* as the possession of an inherited power. The witchcraft can be viewed as a belief in a supernatural and mystical power that developed in some (usually adult) people and enables them to work evil directly without magic or spiritual assistance. The witchcraft power in tribal communities is regarded as a distinct category of supernatural agency. The dogmas of witchcraft, sorcery and magic are also relevant to the social inheritance system of tribal communities. The different method of magic and witchcraft are practiced by the Hill Kharias in Purulia and Bankura quite common in this region.

1.6.4-Traditional Medicine-

The term 'Traditional Medicine' (indigenous or folk medicine) describe medical knowledge system, which were developed over centuries in societies across the world, much before the era of modern medicine. The genera includes herbal, Ayurvedic and Unani medicine, acupuncture,

spinal manipulation, siddha medicine, traditional Chinese medicine, South African *Muti* as well as other traditional medical practices all over the globe.

The World Health Organization (WHO) defines [1948] traditional medicine as the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercise, applied singularly or in combination to treat diagnosis and prevent illness or maintain well-being.

Tribal people live in forests and depend completely on the land and forest for their daily needs. Hence, for their medical problems, they, they prefer to be treated by the *vaid raj* or *vaidya* (traditional healer) with traditional medicine, which essentially uses extracts from herbs found in the forests or animal products. Due to their easy accessibility and availability, these healers wield significant influence over the health seeking behaviour of the tribal group. The tribes, by and large, are animists, that is, they worship nature, and hence, they drive maximum comfort from organic materials and method of traditional treatment.

1.6.5- Ethnomedicine

Ethnomedicine refers to the study of traditional medical practices which is concerned with the cultural interpretation of health, disease and illness and also addresses the healthcare seeking process and healing practices. The practice of ethnomedicine is a complex multi-disciplinary system constituting the use of plants, spiritually and the natural environment and has been the source of healing for people for millennia (Williams, 2006).

Beliefs and practices relating to diseases are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine.

The tribal's are the real custodians of the medicinal plants. Out of 45000 species of wild plants, 7500 species are used for medical purposes. The disease-illness distinction is important conceptually in the study of ethno-medicine. Ethnomedicine of the tribal's has essentially very little to do with medicine as everybody ordinarily understands this term, for the tribal's do not share the understanding of disease processes as defined by modern medicine. For them the medicine is a social institution enhancing every aspect of individual security i.e., psychological, physical and social. However, ethnomedicine of the tribal's is now influenced by a number of forces external to the community, which are capable of bringing out changes into this traditional system. Modern medicine is the most important aspect to change influencing the ethno medical system.

According to the World Health Organization (WHO), ethno-medicine has maintained its popularity in all regions of the developing world and its use is rapidly expanding in the industrialized countries.

1.6.6- Traditional Health Care Practices-

The traditional health care system in India comprises of two social streams- local health beliefs and practices relying on instantaneously available local resources; and the codified organized knowledge based on the theoretical foundation (*Ayurveda, Siddha and Unanai*). Traditional health practitioners include herbalist, bonesetters, traditional birth

attendants (TBA), spiritual healers and other locally recognized specialist. It is frequently thought that traditional medicine only deals with natural and herbal cures.

1.6.7- Traditional Healers-

The traditional healers, as defined by the World Health Organisation (1976), is a person who is recognized by the community in which he or she lives as competent to provide health care by using vegetables, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as on the knowledge, attributes and beliefs that are prevalent in the community, regarding physical, mental and social well-being and the causation of disease and disability. Traditional or local medicine still remains an important source of medical care in the developing countries even though it is not officially recognized by the Government health care programmes.

1.7- Review of Related Studies:

From early days many Anthropologist, Sociologist has contributed related studies-

Studies Upto 80s-

Elwin (1955) has described and analysis the relationship between culture and tribal medicine. He had a great interest in tribal health and medicine. Actually he initiated work among tribes Mandla by starting a small medical center in Patangarh and he came to study tribal culture in totality.

Hasan (1967) in his study ‘cultural frontiers of health in a village in India’ noted two types social and cultural factors affect the health of any

communities; a) certain customs, practices, beliefs and taboos create an environment that helps in the spread of or control of the disease. And b) factors which directly affect the health of community as they are related to the problems of medical facilities to the sick and invalid.

Kakahr (1977) studied on socio-cultural aspects of health and illness. He focused on the folk concept of disease etiology in a medium-sized studies village. He emphasizes on the three level of medical system viz, primitive medicine, folk medicine and modern medicine.

Chaudhuri (1986) noted the link between the causes of illness as the nature of treatment in his study among the Mundas.

Studies in 90s-

Mohanti (1995) examines traditional health care in retrospect and recommends an integrated system of modern and tribal medicine.

Ali (1995) examines health care planning in Tribal district of Orissa.

Patel (1995) throws light on awareness of tribal health and medical care in Madhya Pradesh.

Goldberg(1997) studied about Shamanism. According to him the shamanism is protected by a Spirit of land during his extractive journey, loose the soul and war time between the demon & disease.

Narayan.K.V (1997) said that health status developed through the integrated development of society and examine the study is a degree of association between various socio-economic aspects of development,

rather than the presumed dichotomy between medical care and development in improving the health status.

Jose Boban (1998) has tried to trace the medical practices & healing rituals existing in two tribal of Kerala and in order to evaluate the changes in the traditional medical system as a result of the influence of modern medicine.

Tribhuwan (1998) studied in ethno-medical beliefs practices of various communities and also gives in-depth understanding of the and symbolism in tribal medicine, with reference to their concept of disease etiology, body symbolism, nature and role of ethno-medical specialists, mother and child care health practices, and health seeking behaviors.

Studies in Recent Decades-

Chaudhuri (2003) showed that medical practitioners and public health workers have been reposing that every often people do not utilize the medical facilities available to them. Unless and until the reasons for failure or non-acceptance of these programmes are known, the very development programme cannot be useful.

J.J.Roy Burman (2003) Studies the concept of disease and sickness, the different method of treatment, the official health policies over the years and also exploratory study of the traditional tribal medical practices which are prevalent among the autochthonous tribal population of Sikkim.

Tarafdar.P (2005), studies on the Santal communities in Jhargram Sub-division of West Medinipur District, West Bengal related to perception of

disease etiology and interaction between traditional and modern health care practices among them.

SL Malik and Sudipta Ghosh (2009) studies on status of health and availability of treatment and aids among Santals, a tribal community from Ranibadh Block of West Bengal, India. This study conducted at grass root level in the villages, the Santals of this region have gained awareness over time about their health and nutritional status.

Singh RK (2013) studies little knowledge, inadequate practices about malaria control among the tribals of Bihar which may be one of the important factors responsible for the persistence of malaria in tribal areas in Bihar of Jharkhand state.

Kshatriya Goutam (2014) studies on the changing culture and increasing lifestyle diseases among the tribal's of India. He has focused mainly on dietary habit and nutritional status and maternal and child health status among the tribals.

Balgir RS (2014) studies on the impact of consanguinity and inbreeding on homozygosis of recessively inherited genetic disorder among tribes of Central India and studies revealed that not only the small population or consanguine mating of the parents that results in inbreeding or increased homozygosity and consequently leads to lower fitness of the offspring's.

1.8- Scope of the Study:

The present study will reveal and explain the health care practices including magical belief related to religious practices among the Hill

Kharia and it will also evaluate different diagnostic, curative, protective, promotive health care activities found among them. The idea about health, disease and treatment are varies from society to society and also from culture to culture. It is assumed that a unique way of understanding is prevalent among the different indigenous communities in terms of their own perception of healthcare practices so the present study will provide a comprehensive understanding about the traditional health care system of the concerned community.

1.9- Objectives:

1. The main objective of this research is to examine the traditional and modern health care services in the family level and analyze the perceptions of peoples about traditional and modern maternal and child care practices as well as facilities in their own cultural and ecological dimension.

2. To understand the illness ideology of the Hill Kharia population under study areas from cognitive point of view.

- To understand the perception regarding origin and cause of illness in their communities
- To study the disease etiology and disease classification from cognitive point of view.
- To record the different types of pathogenic and supernatural agents, which cause illness, and to understand the role-played by this agents in the culture of Hill Kharia.

3. To explore the native's concepts about body physiology and a various symbolic elements, which find expression through body during patient's ill health.
4. To understand the symbolic and meaningful aspects of ritual healing along with prescription as well as application of herbal medicine – the knowledge which they acquire over generation.

1.10- Hypothesis:

The following hypothesis can be framed on the basis of the objectives of the study-

- Every culture has its own degree of belief regarding the concept of disease, illness and treatment; and in this context the variation can be measured on the basis of sex, perception of disease etiology, education and socio-economic condition of the concerned population.
- A patient from a tribal community is completely psychologically assured by the treatment of traditional medicine men or a magico-religious healer as both of them shared same cultural milieu. Tribal health ideology is very much assured by the magico-religious belief, which reflectson the psychological treatment pattern of theconcerned tribe.
- Environmental degradation and commercial afforestation is the conspicuous factor for the destruction of medicinal plants and reduction of its accessibility to those tribal's who are using herbal medicine. The constraints of forest policy are also responsible for decreasing the collection of medicinal plants and other related materials.

1.11- Selection of Villages:

The present research isdone among the particularly vulnerable tribal group (B.M.L Patel, 2013). In 2006, Government of India has announced the PTG as a particularly vulnerable tribal group (PVTG) (Singh K 2011). According to the PVTG list Government of India, the Hill Kharia is not enlisted as PVTG in West Bengal. According to the list, this tribal group is enlisting as PVTG in the state of Jharkhand and Bihar. The field investigation has been conducted among the above tribal communities of five villages representing different degrees of urban influence in terms of effective distance from urban centre. A criterion for selection of the villages has been fixed in terms of their accessibility from the concrete road and the highway in order to observe the impact of relative distance from the urban center. Two types of villages have been selected considering the scope and objectives of the proposed study. For covering the required population, two villages has been taken from Type-I category and three villages from Type-II category of villages. This 'Type' is chosen on the basis of different criteria, viz, distance from sub-divisional town as well as sub-divisional Hospital or other health care center, transport communication like bus, railways etc and other modern health care facilities surrounding the villages.

The villages have been picked up according to the principle of systematic spatial sampling in order to make the data representative of the population in

the area of maximum concentration of the Hill Kharia, as recorded by the Dikshit Sinha in 1984 (Tetre Peter,1990).

Two types of villages were selected considering the scope and objective of the proposed study. For covering the required populations two or three villages are considered under each type. For pursuing specific objectives the villages were selected on the basis of 'type'. The 'type' has been framed on different criteria, viz, distance from the sub-divisional town [in case of Bankura (Khatra sub-division) and in case of Purulia (Purulia East sub-division)], modern health care institution, communication with the surrounding villages and urban center.

1.11.1-Type- One:

It has longest distance from the said sub-divisional town or urban center. The health care facilities are insignificant in comparison with 'Type two' villages. There is no a primary health center or sub centers in a short distance. The communication of this 'type one' villages with the sub-divisional town or nearest sub-urban center is very difficult. The absence of quack or any modern doctor and *Anganwadi* (ICDS) center in a shortest distance are the additional parameters for selection of villages. Two villages, viz. Rahidi of Maguria Gram panchayat from Purulia district and Ladda of Ambikanagar Gram panchayat from Bankura district were chosen under this type. The other ethnic group like Santal and caste community *Mahato* are inhabitant of those villages.

1.11.2-Type- Two:

In this type, selection of villages has been made on the basis of better communication with the sub-divisional town or sub-urban center. Further, there is a rural hospital or Block Primary Health Center in a shortest distance. The *Anganwadi* (ICDS) center is located near of this 'type two' village. Three (03) numbers of villages has chosen under this 'type two' category. Two villages from the district Bankura district viz, Barda savar para under Fuddi Gram Panchayat along with Sarasdanga at same Gram Panchayat and another village selected from Purulia district i.e, Damodarpur under Nawpara Gram Panchayat. These villages are fur better communicated to the sub-divisional hospital than 'type one' villages. All the villages are exclusively Hill Kharia villages except Sarasdanga from Bankura district where Hill Kharia reside with other communities (like *Mahato, Pal, Mudi*) at end of village and try exchange their cultural tradition with each other. But this situation is only practiced by the young Hill Kharia population. The details of administrative location of research areas are given in following table-

Chart-1 (Administrative Location of studied villages)

Type	**Villages**	**Sub-Division**	**District**	**Criteria for selection of Village**
One	Ladda	Khatra	Bankura	Long Distance from sub-divisional town and
	Rahidi	Purulia East sadar	Purulia	

				hospital
Two	Borda Sabar para	Khatra	Bankura	Short Distance from Sub-divisional town and hospital
	Sarasdanga	Khatra	Bankura	
	Damodarpur	Purulia East Sadar	Purulia	

1.12- Selection of the Population:

According to the KS Singh [1994] the Hill Kharia are mainly distributed in Jharkhand,Madhya Pradesh, Odisha and West Bengal. But in West Bengal they are inhabited in small pockets in districts of Paschim Mednapore, Bankura and Purualia. They are living in small population hamlet and totally isolated from others population group. But now at present scenario, Their habitation was in a single ethnic villages and trend to multi-ethnic villages, changes over to the occupation of agriculture and stone crasher from fishing, hunting, criminal activity and weaving as their tradition.

1.13- Tribal Status-

The Hill Kharia is known as 'Sabar' in West Bengal and enlisted as a scheduled tribe (Sinha D). They notified as a 'Particularly Vulnerable Tribal Group (PVTG)' by the Government of India in Jharkhand and Bihar. (*Singha K 2011*).Particularly Vulnerable Tribal Group (PVTG)

(earlier: Primitive tribal group) is a government of India classification created with the purpose of enabling improvement in the conditions of certain communities with particularly low development indices(www.*pib.nic.in, accessed date- 12..03.16 time -3 pm)*

According to 2001 census, Hill Kharia the population under study is having only 1% in comparisons with total scheduled tribe population in West Bengal. This tribal group has occupied a major portion of the rugged slopes of Ranchi, Lohardanga and furrowed incline of west and east Singhbhum and Hazaribagh of the Jharkhand. Only few numbers of populations are confined at Purulia, Bankura and Paschim Medinipur of West Bengal. The Hill Kharia is so-called because they used to live in and around the hilly tracts. Their natural abode was in the hilly regions, at one time covered by thick forests. The forests are now destroyed and hills denuded, except the isolated pockets. In such situation they have been trying to re-adjust themselves to settle down beside peasant villages.

The Hill kharia are also called Pahari (meaning Hill) kharia, Savara/sabar, Kheria, sometimes referred to as *Erenga or Pahari Kharia* (Sinha D, 1984). *Outsiders* call them Kharia but they call themselves as Sabar. The tribe now use the mythical term *Sabar* as their name. S.C.Roy (1937), who wrote a monograph on Hill Kharias on the basis of the designation given to the tribe by the peasantry and most probably, also to differentiate them from the more evolved Dudh and Dhelki Kharia. Purulia peasants call them *Kherias* and this *Kherias* are likely to be known as *Sabar*, the mythical hunter of *Ramayana* (Roy S.C 1937). There are several *gotras* (clans) among the Hill kharia such as Golgo, Bhunia, Sandi, Gidi, Dehuri,

Pichria, Nago, Dhar, Tesa, Kotal, Kharmoi, Digar, Laha, Rai,Sal, Khan and Khiladi. Golgo seems to be dominant one because in every village that clan spelt out first whenever their clans were asked.

For their sustenance, they depend mainly on forest resources such as collecting honey, fruits, vegetables and herbs. The name Hill Kharia came to be known as "Criminal", though could not be ascertained, it was known to be fairly old. Even at the beginning of the early part of twentieth century, Coupland (1911) mentioned the Hill Kharia's participation in various kind of criminal activity like burglary, stealing, etc. As a consequence of this stigma they came under the purview of "Criminal Tribe Act" of 1924 declared by the British Government (Sinha D,1984) although this Act was replaced in 1952 and the Hill Kharia is re-designated as a "Denotified Tribe". Now-a-days the Hill Kharia finds that due to deforestation and scarcity of forest animals, hunting and gathering as an exclusive mode of subsistence is no longer possible at present situation. For Instead they are now compelled to seek in the agricultural economy of the region. Not only their previous based economy has been destroyed but their concept 'good life' has also been irrevocably changed.

1.14- Methodology:

The present research work is highlighted on the issue of healthcare practices among the Hill Kharia in Puruliaand Bankura district that is mainly the western part of West Bengal.

The present research has been done exclusively among the Hill Kharias of the district Purulia and Bankura which are chosen for its tribal dominating character and also large numbers of Hill Kharia population is found in the West Bengal (Sinha D, 1984)

The Hill Kharia is one of the endogamous (Singh; 1994) tribal groups of West Bengal. Empirical study was carried out in western part of West Bengal. In order to collect qualitative and quantitative data from empirical situation, five (05) villages were selected in which two (02) villages from Purulia district and three (03) villages from Bankura district and the selection of the villages are based on theirdistribution and isolation from urban centre, forest base ecological niche and coverage from modern light of medical development.Total 170 numbers of families have been covered in this research from two districts.

The data regarding research topic for analysis had been acquired through field field work in four divisions during my research work. **(1) Division-I**- filling-up of PSF (Primary Schedule Form), **(2) Division- II**- Case studies of traditional healers, modern medical practitioners as well as community person who is affected or not, **(3) Division-III**-Detailed interview which may be structured or un-structured form from traditional and modern medical practitioners and peoples from the communities **(4) Division-IV**- Evaluation of Government ICDS center and health workers, **(5) Division-V**- Collection of data through visiting to PHC, Block Primary Health Center (BPHC) regarding infrastructure and services towards the patients.

Socio-cultural profile was collected by using the household census (PSF), interview, and case study for getting the basic information about the population. The information of traditional and modern medical practices among the Hill Kharias was taken through the interview method. The traditional and modern health personal, political leaders, health worker and health related peoples have been interviewed and the relevant data were collected. The case studies had also been taken from traditional and modern medical healers as well as disease affected person from my studied villages which have been taken for supporting the different data in this regard. I have applied 3/3 procedure in case study selection at each village, where 1 male person practicing traditional medical practices, 1 male person practicing modern medical practices and 1 male person taking both medical practices. This process (1, 1, 1 =3) is also applied for the selection of case studies on the female persons. The details of medicinal plants have been taken from those areas for proper documentation of their indigenous knowledge regarding herbal medicine. Visit in the sub-divisional hospital and Primary Health Centre (PHC) gave me for proper understanding the health scenario in those areas. In this study, key informant interview was played imperative role for collecting the specific data about health related matter and others. One of the conspicuous techniques in field study is the photography which plays a vital role for collecting various socio-cultural and medical practices of the concerned population.

1.15. Data Analysis:

The data have been collected through household census or Primary Census Schedule (PSF) for this research in each of the five villages. The data had been analyzed in terms of age group, sex, marital status, occupation (primary and secondary), education and diseases of the individuals and treatment pattern. The data were also collected in terms of their disease pattern, last 5 years disease occurrence of every individual in each of the villages had been considered as prime factor. All the data relevant to the health care practices are analysed on the basis of the of the village 'Type' wise. Actually, the village populations have been analyzed separately on the basis of 'interior' and 'near urban' criteria. Persons belonging to the age group of 15-62 years have been considered as economically active population and persons below 15 years and those aged 63 years and above have been considered as young and aged sections of the population respectively. The special health problems and health care perception of the old (aged 60+ years) and children (aged below 14) as well as maternal health are important filed in this research. The pattern of traditional and modern health care practices have been analyses and study the trends of child (0-5 years age group) and reproductive women (15-45 years age group) are also studied on the basis of health care practices, perception regarding disease.

1.16. Organization of Thesis-

Chapter-1- Introduction

Chapter-2- Introducing the Area, Villages and Peoples

Chapter-3- Health and Disease: Traditional way of Treatment

Chapter-4- Modern Health Care Facilities and Programmes

Chapter-5- General Observation and conclusion