CHAPTER: 1

INTRODUCTION

1.1. Introduction

Medical anthropology is the primary discipline addressing the interfaces of medicine, culture, and health behaviour and incorporating cultural perspectives into clinical settings and public health programs. According to Joshi (2016), medical anthropology is a discipline dealing with the phenomenon of ill health with a cross cultural focus aims to make universal generalisation about the behavior and practices concerning ill health, including concepts and belief about illness, causative theories, diagnostic method, preventive and protective measures, Therapeutic choices and medical pluralism, health seeking behavior including adhearence and issues concerning efficacy (Joshi, 2016). Medical Anthropology is not really a subfield (like biological anthropology, prehistoric archaeology, cultural anthropology or anthropology linguistics), partly because these subfields generally have a central theoretical paradigm. Medical anthropology is simply the application of anthropological theories and methods to questions of health, illness, and healing procedures.

The cognitive component of a medical system centers on theories of etiology or causation of illness. It usually involves taxonomy of disease categories grouped by causal agent. The study of cultural knowledge about illness and its linkages to differential diagnosis and curative actions is called ethnomedicine (Inhorn and Brown, 1990; Hahn, 1995). The behavioural component of medical systems concerns the social interactions of healers and their patients in a cultural and economic context. Social mechanisms through which healers are trained, division of labour among the healers and organisation of the institutions through which medical services are delivered to a population consider important parts of the medical systems.

The perception about health, disease and treatment are not the same across culture. It varies from culture to culture as an integral part of human ecology and cultural ways. Human cultures as a part of their cognitive development have complex ideas regarding causes of sickness and ways of recovery.

Health is a prerequisite for human development and is an essential component for the well being of mankind. The World Health Organisation also emphasised on the "highest possible level of health" that allows people to participate in social life and work productively (WHO, 1992). Health involves social and personal resources in addition to physical conditions; a sense of overall well-being derived from work, family, and community; and other relations, including psychosocial and spiritual (Durch and Stoto, 1997).

Illness and disease are often varies from culture to culture, society to society and person to person. Similarly, the methods considered acceptable for curing illness vary significantly. The ways of understanding and curing illness in one culture may be observed differently by another. Illness can be defined as a feeling of not being normal and healthy while disease is an objectively measurable condition of the body. In many cases perceptions of illness are culture related. The health problems of any community are influenced by interplay of various factors including social, economic and political. The common beliefs, customs, practices related to health and disease in turn influence the treatment procedure of a community.

1.2. Theoretical Orientation

In 2017 the discipline of medical anthropology celebrated approximately fifty eight years of existence. In 1959 one of the first references to 'medical anthropology' was made in a publication by a physician as-well-as anthropologist named James Roney (1959) titled "Medical Anthropology: A Synthetic Discipline." Roney and Margaret Clark, George Foster, Charles Hughes, Charles Leslie, and Benjamin Paul were among the founders of this nascent field, which blossomed in the 1960s. Through their teaching and programmatic development, these first-generation pioneers spawned a second generation of medical anthropologists, many of whom went on to develop the field in significant new directions. When both George Foster (University of California, Berkeley) and Benjamin Paul (Stanford University) passed away in their nineties in May 2006, medical anthropologists from around the world mourned the "passing of an era" in medical anthropology. This feeling was reaffirmed in September 2009 with the death of

Charles Leslie, one of the first medical anthropologists of Asia and one of the founding editors of *Social Science & Medicine*.

Since its inception, medical anthropology has been broadly defined as the study of health, illness, and healing through time and across cultural settings (Foster and Anderson, 1978; Nichter, 1992; Helman, 2007). Medical anthropologists study human suffering, as-well-as the medical systems in place to alleviate that suffering (Hahn 1995; Scheper-Hughes, 1992; Strathern and Stewart, 1999). Around the world, medical anthropologists analyse the relations among health, illness, social institutions, culture, and political and economic power (Doyal, 1979; Baer et al., 2003) combining biomedical perspectives with those that address social and cultural problems through health advocacy and activism (Brown, 1998; Singer and Baer, 2007). Medical anthropologists have contributed to the study of the production of medical knowledge (Berg and Mol, 1998) in fields ranging from reproduction (Ginsburg and Rapp, 1995) to international health development (Frankenberg, 1980) to the new chronic and infectious diseases (Inhorn and Brown, 1990; Manderson and Smith-Morris, 2010). They have examined questions of stigma, marginality, and the disabled body (Ablon, 1984; Frank, 2000). They have probed critical issues of bio-politics, immigration, race, citizenship, and health disparities (Harrison, 1994; Fassin, 2007). They also look at the intersections of disease and environment (Leatherman, 2005) and the structural violence triggered by processes of globalisation, neo-liberalism, and global capitalism (Farmer, 2003). Amid these macro-structural forces, medical anthropologists have examined the social construction of illness categories, the individual illness narratives used to articulate them, and the social and political hierarchies such categories may produce or maintain (Kleinman, 1988; Lindenbaum and Lock, 1993; Mattingly and Garro, 2000; Good and Good, 2008).

The anthropological inquiry on the issues of human health, sickness and healing often overlap with the five identifiable approaches of medical anthropology, i.e. (i) biological and archaeological, (ii) ecological, (iii) ethnomedical, (iv) critical, and (v) applied.

According to Barrett et, al. (1998), all the five approaches in Medical Anthropology share four essential premises: first, that illness and healing are basic human experiences that are best understood historically in the complex and varied interactions between human biology and culture; second, that disease is an aspect of human environments influenced by culturally specific behaviours and sociopolitical circumstances; third, that the human body and symptoms are interpreted through cultural filters of beliefs and epistemological assumptions; and fourth, that cultural aspects of healing systems have important pragmatic consequences for acceptability, efficacy, and improvement of healthcare in human societies (Brown, et. al. 1998).

1.3. Tribal Health Scenario in India

The tribal communities have their own beliefs and practices regarding health and diseases. In a tribal situation, plants; flowers; seeds; animals and other naturally available substances provide the raw material for treatment. These traditional medical practices always influenced by religion, supernaturalism and magico-religious belief. Health is relative and discernible matter of the concerned person and may vary by virtue of different biological and socio-cultural variables like age, sex, food habit, education, economy, community, environment, place of habitat, communication and culture (Tarafdar, 2007).

It has been observed that among the tribal people the universal index of a threat to health is expressed through inability to normal work capacity in any individual. Mahapatra (1994) explored health situation among tribal groups as a functional but not clinical concept. Sachchidananda (1994) observed the field of tribal health aspects as a cultural concept as well as a part of social structure and organisation which is continuously changing and adapting according to the inevitable changes in the wider social phenomena.

Health is one of the important assets which every individual has posses but it varies depending on how they maintain and perceive. Almost all tribal people over the world believed in the presence of benevolent and malevolent spirits and deities possessing some supernatural powers which may be harmful if they neglect or ignore the concerned

spirits and deities. They seek magico-religious practices for recovery of different diseases that are believed to cause by the hostile spirits. They have the experience of different magico-religious methods by propitiation and prayers to calm down the wrath and anger of spirits and supernatural powers. Concerning about their health they depend on traditional healers, sorcerers and shamans.

Various studies made on the traditional concept of health and disease have reached the conclusion that different diseases can be cured through controlling the anger of the hostile spirits or the supernatural powers by tranquil the wrath with various magico-religious practices. The belief or cordial relationship between an individual and supernatural power can be established through magico-religious practices and human suffering can be reduced or cured considerably through such practices. In addition to magico-religious methods of treatment, the tribal people also use various herbal medicines. The methods of treatments depend upon the symptom of diseases and they also have their own system of diagnosis and treatment procedure. It depends on the willingness to access and utilise the existential health services as-well-as the contact with the other cultures and degree of adaptability with the complementary health facilities. The study of traditional healthcare system helps us to understand the different stages of life cycle, beliefs, values and culture that ultimately control the healthcare system of the tribal people.

The study of traditional healthcare has become a very important area of study in India. India is a homeland of different tribal groups living in different geographical conditions and various socio-economic, socio-cultural and ecological settings. According to the Census of India, 2011, Scheduled Tribes population) constitutes 8.6% of the total population of the country. The Tribal people of India present an important degree of culture and ethnic diversity. The so-called development process is far away from their habitation and they are lacking behind from education, financial and health consciousness. The economic status of the individual or a community is very important for the well-being of the people; large populations of tribal people living in isolated or remote areas are most vulnerable to disease which affects their health condition.

In recent decades the tribal people have witnessed an unprecedented wave of non-traditional elements entering into their social and cultural life. The concept of health and treatment is not an exception in this regard. The inflow of western concept of healthcare system and changing social and physical environment has placed the traditional healthcare system of tribal community in a complex situation. The tribal people are exposed to medical pluralism. Prevalence of traditional healthcare practices and nature and extent of acceptance of modern healthcare practices among the tribal people in India has been mentioned by various scholars in recent years. Chaudhuri (2003) pointed out that most of the tribal people depend on the forest products for food and medicines. Traditional treatment and medicines in some societies are in the verge of disappearance because of the rapid deforestation and various forest acts.

Nagdda (2004) noticed that among the tribal people of Rajasthan, illness and consequent treatment is not always an individual or familial affair. At times the whole village or the community may be perceived as affected by such diseases and healing must be done at the community level. Such perception shows the integrity and responsibility of entire community towards an individual or family and vis-a-vis which is defined by existing culture. In such cases modern system has nothing to do in treatment. In India, most of the tribal communities have a rich knowledge of folklore with the health beliefs. The common beliefs, customs and practices related to health and disease in turn influence the treatment procedure of the community.

Tarafdar (2006) revealed that the acceptance of a particular healthcare system among the tribal people mostly depends on its availability and accessibility. Guite and Acharya (2006) noted that, while the tribal communities following traditional religion and use traditional medicines by putting the religious or supernatural value on it, the converted Christian tribes use the same medicine excluding its religious tune. Pramukh and Palkumar's (2006) study shows that the tribal groups namely, the Savaras, Bogatha, Konda Dora, Valmiki, Koya, Kond Reddi etc. believe in the power of prayers and rituals that enable some herbs to act as medicines to heal diseases among them. They attribute diseases to certain deviant acts of self and others towards elders, nature, and divine rules. Thus, their first priority is to get spiritual cure in a traditional way.

1.4. Review of Related Studies

The important studies consulted during the present work are categorised into different segments, which includes international studies in the field of medical anthropology, the medical anthropological studies conducted in India as well as in West Bengal, and the previous studies carried out among the Rabha.

1.4.1. International Studies on Medical Anthropology

Lewis (1959) had noted that advantage in learning about the traditional belief and practices of the community is the insight they give into the total world view, which is also reflected in other sphere such as agriculture, politics and interpersonal relations. Jelliffe and Bennett (1960), two medical workers with wide experience, have suggested that in African systems there are three varieties of illness: (i) trivial or everyday complaints treated by home remedies; (ii) European diseases, i.e. diseases that respond to western scientific therapy, such as yaws and malaria; and (iii) African diseases, which are not likely to be understood or treated successfully by western medicines. They also put together a list of traditional treatments in more than one tropical area. They pointed out the physiotherapeutic treatment which includes massage and poultices and other counter irritants include cupping and scarification. Herbs are also used as medicine in many parts of the world and operative techniques cover cataract removal and circumcision both for male and female.

Williams (1963), in his study of the TIV in Central Nigeria stated that – in relation to health and sickness the traditional picture was that of diviners, herbalists and men that performed special rituals. Sickness is generally known by the term '*Akombo'*. Basically *Akombo* is non-human forces that can be manipulated by people. As regards illness *Akombo* stands for the symptom of a disease, and can, therefore, be differentiated into various syndromes designated by a separate name. If a person falls ill, particularly if it is persistent or very serious, it is assumed that *Akombo* has caught him. Then he consults a diviner who advices him what to do, this means calling together either his father's kin, or his mother's kin, or in some cases both together and participating in a ceremony which is known simply as 'repairing the matter'. The ceremony is conducted by a man

who is known as a man of *Akombo* and consists of sacrifice of chickens and goats. Various small actions and repetitions of phrases performed by both the patient and the man of *Akombo* cumulating in the application of medicine mostly extracts of plants and a meal in which all the kin and spectators participate. The illness is then considered to be repaired.

McCleary (1977) summaries the topics discussed at a National Rural Conference sponsored by the American Hospital Association (AHA) including man power, availability and accessibility of services, alternative delivery systems and cost and financial resources.

Dixon (1979) briefly reviewed current research on health, nutrition and medicine in rural Alaska. She states that few anthropologists are currently involved in such activities but that many non-anthropologists similarly engaged are cognizant of the cultural attributes of the problem under investigation. Anthropologists have much to contribute to future health research in Dixon's view, including work as both consultants and researchers.

Young in 1979 discussed about the health history of the Indians in Northern Onterio and illustrate the devastating impacts of changes occurring during 250 years of Euro-American contact. Accidents and injuries have recently surpassed infectious diseases as major health hazards while changing dietary patterns and increased alcohol consumption have produced the paradox of a poverty-ridden culture suffering from disease of affluence.

One of the most notable medical anthropologists of the late 1960's and 1970's was Arthur Kleinman, a psychiatrist trained in anthropology. His research focused primarily on Taiwan, but he has also conducted some interesting comparative work as well. While defining the goals of medical anthropology Kleinman (1981) argued that Medical anthropology must help widen and deepen the non-biomedical cultural perspective on health, sickness, and healthcare. Medical anthropologists must frame their research investigations in terms of the ethnomedical mode's orientation to the meaning context of illness and healthcare. By studying the everyday context of health and sickness in the popular sector, anthropological studies should do more than simply demonstrate the

inadequacy of the epistemology underlying the biomedical framework. They should focus attention on the non-professional side of the health field and especially on its positive adaptive features, which deserve to be better understood.

While studying the relationship between 'magico-religious' systems and healthcare in *East Asian Medicine in Urban Japan*, Margaret Lock (1980) uses the heading "East Asian medicine" in reference to contemporary practices in Japan which trace their history to Chinese medicine. She uses the term "cosmopolitan medicine" to refer to Western bio-medicine and the term "folk medicine" to refer to practices influenced by Shinto traditions. Her ethnography of the popular medical system of urban Japan is notable for its depth of historical and ethnographic research. After tracing the history of medicine in Japan, which includes ancient Chinese, Shinto, and Western (by way of Germany) influences, and exploring the religious and philosophical traditions of each, she examines Japanese socialisation practices vis-à-vis medical and religious beliefs and practices through time.

According to Eaton, Konner and Shostak (1988) obesity and high consumption of refined carbohydrates and fats are related to increased incidence of heart disease and diabetes. Human susceptibility to excessive amounts of these substances can be explained by the evolution of human metabolism throughout million of years of seasonal food shortages and diets low in fat.

Mark Nichter (1992), in his introduction to a valuable collection of recent academic studies in critical medical anthropology, stresses the importance of avoiding 'theoretical closure'. Two types of theoretical closure are tempting in medical anthropology and indeed any ethnographic or ethnological work more generally. One kind of closure, which Nichter calls 'analytical involution', is the decontextualisation of healing systems and illness as discrete domains of empirical inquiry. This leads to an ethnocentric, disembodied ('etic') classification of terms whose meanings remain nominal and reveal nothing of their pragmatic uses, polysemic qualities, or cultural significance. This type of theoretical closure is often found in biologically oriented approaches to medical anthropology. Nichter (1992) argues, bringing to mind Lutz' (1988) view of "Western

ethnopsychology," that contemporary American biomedicine is one of many forms of 'ethnomedicine' and that science, in general is motivated by a political economy. This critical view is not to be found among biological anthropologists working in the field of medical anthropology, where the paradigm of biomedicine is often used as a scientific yardstick by which to measure the rest of the world's health regardless of socio-historical circumstance.

Robert Edgerton (1992), in his book *Sick Societies*, has called for a re-evaluation of ethnographic contributions that effectively sustain the 'myth of primitive harmony,' his own earlier work included. Edgerton's thesis is that ethnographers have relied too heavily on a stance of cultural relativism (Boas, 1887), without documenting some of the more 'maladaptive' cultural practices.

In his essay, "Imaginal Performance and Memory in Ritual Healing," Thomas Csordas (1996) takes a phenomenological perspective to discuss how healing performances work. He critiques the 'placebo effect' argument that relies on an 'interpretive leap' from trance, placebo, suggestion, or catharsis to efficacy as insufficient. His innovative approach examines sequences of imagery not as elements in healing performance but as performances in their own right, as a kind of performance within performance that may not even be observable. He finds these images closely associated with memory, and thus calls the process of Catholic Charismatic Renewal healing that he is investigating the healing of memories. In his discussion of imagination and memory, Csordas suggests that the experience of healing is actually a manifestation of genuine intimacy with a primordial aspect of the self—its *otherness* or *alterity*. This otherness is the possibility of experiencing oneself as other or alien to oneself, but it is also the possibility for recognising the existence of other people with whom one can have a relationship.

In the article 'Medical Anthropology: An Introduction to the Fields' Brown et.al (1998) pointed out that the wealthy Sardinians had less contact with mosquitoes because they did not have to leave the safety of the village to work in the field as did the labourers, nor did they have to stay in the village during peak malaria season when they could afford to take summer vacations abroad. The same article also gives an idea about

political-economic dimensions of disease in Tanzania, Meredith Turshen has described how a history of colonialism drastically affected the country's nutritional base, altered its kinship structure and imposed constrains on its healthcare system. This analysis is specifically designed to question the hidden assumptions behind the historic, scientific, epidemiological, 'natural history' approach to understanding disease and international health problems.

Rodrigues De Areia M.L. (1998) studied medicine and traditional doctor in Central Africa. In this work the researcher clearly distinguishes between the three agents of traditional knowledge, namely the diviner, the *curandero* (herbalist doctor) and the sorcerer.

Kaja Finkler (1998) studied two system of healing-Spiritual and Biomedicine- as practiced in Mexico. As a participant and observer of both healing regimes and their patients, he noted similarities and dissimilarities between secular and sacred healing that broaden the grasp of the two medicinal systems and result in different impacts on patients.

Chaudhuri in 2003 explained how the ecological imbalance due to unplanned and uncontrolled use of insecticides and pesticides for agricultural sector may also affect the health condition of the population. This may also affect the nutritional status of people, particularly the tribals. In Thailand, he found the indiscriminate use of insecticides and pesticides killed the small fishes in the paddy field and thus the poorer families, who generally consumed this protein, were deprived of it.

1.4.2. Studies on Tribal Health in India

In Indian context, there are various eminent scholars who have completed their studies on the related topics. Before 1950 there were very few studies in medical anthropology and it was also applicable in the context of studies among the health and diseases of the tribals. But P.O. Bodding made some remarkable studies in this context. He (1940) has critically examined different traditional medicine and medical practices among the

Santals. He has also observed different types of cultural norms and values behind those practices.

After 1950 there were some significant studies in the area of health, culture and tribal medicine. V. Elwin, M. Marriot and Oscar Lewis have done some conspicuous studies on traditional belief and practices regarding health, disease and treatment. Acceptance and impact of modern medical system are also another important criterion in this regard.

Elwin (1955) has tried to describe and analysis the relationship that exist between culture and tribal medicine. His study claims that there is an extremely close relationship between medicine and other subsystems like morality, religion and magic. Elwin observed that, there are Gods, associated with children's disease, disease of the pregnant women and disease of domestic animals. Most of the disease can be cured by supplicating and propitiating these Gods, directly or indirectly through Shamanism.

Marriott (1955) has critically examined the cultural problems involved in introducing more effective technicians to the conservative's Indian village of Krishangari. He took representative from different social strata and found out conflicts that were obstacles to the spread of western medicine. He suggested that successful establishment of effective medicine could largely depend on extend to which scientific medical practice could divert itself of western cultural impact and adopt itself to the social life of an Indian village. In a North Indian situation, a western physician – Gould (1957) had considerable difficulty in trying to find out why the village people talk about 'country medicine' and 'doctor medicine'. They also distinguish chronic non-incapacitating illness such as typhoid, malaria being on the border line between two, villagers hold that chronic illness can be treated by 'country medicine' where as the others need 'doctor's medicine'.

Lewis (1958) has noted that advantage in learning about the traditional belief and practices of the community is the insight they give into the total world view, which is also reflected in other sphere such as agriculture, politics and interpersonal relations.

During 60's and 70's different eminent scholars made their study in the different aspect of medical anthropology viz. folk medicine, ethnomedicine and modern medicine in the rural and tribal areas.

Khare (1963) in his article 'Folk Medicine in a North Indian Village' focuses only on medical belief held by the residents of Indian village and stresses the fact that these beliefs quite often link with the contrasting medical system. This research explicitly shows the influence of these beliefs on the implementation of modern medical programmes.

Opler (1963) pointed out that, different diseases found among the tribes and peasant people are due to the malfunctioning imbalance of forces which control health, lack of moderation or inappropriate behavior in physical, social and economic matters. He has tried to give a cultural definition of illness in an Indian village, emphasizing the role of cultural factors in acceptance of medicine and understanding of the nature of diseases.

Hasan (1967) in his study' Cultural frontiers of health in a village in India' noted two types of social and cultural factors that affect the health of any community: (a) certain customs, practices, beliefs and taboos create an environment that helps in the spread of or control of the disease and factors which directly affect the health of community as they are related to the problem of medical care to the sick and the invalid.

Leslie (1967) contrasts professional and popular health culture on a different basis. He uses professional health culture to refer to the realms of practitioners in both systems, but does not include the medical sphere of folk specialists. A distinction is made between professional health culture and popular health cultures. The first term refers to the institution's role, values and knowledge of highly trained practitioners of the traditional medical system and popular health culture includes the health values, knowledge, role and practices of layman and specialists in folk medicine. Therapeutic practices in ethnomedicine address themselves to both supernatural and empirical theories of disease causation.

Kakar (1977) in his book, 'Folk and Modern Medicine' has done several in depth studies of the socio-cultural aspects of health and illness. He emphasises on the folk concept of etiology in a medium-sized village. Concerning this, he comes across the practice of three different types of medical systems in three different levels. They are primitive medicine, folk medicine and modern medicine. Next, his interest is on food beliefs and practice and the socio-cultural aspects of malnutrition in different villages of Laudhiana district of Punjab. He categorises different systems of medical practices as those who are not institutionally qualified traditional medical practitioners, which include the Ayurvedic, Unani and Siddha systems.

During 80's Chaudhuri made some significant studies in the context of tribal health and medicine. In his book 'Tribal Health: Socio-Cultural Dimensions on Health', a detail picture about the tribal health is depicted in the Indian context. In addition to that Chaudhuri (1986) noted the link between the causes of illness as the nature of treatment in his study among the Mundas. He also observed that the magico-religious performances occupy a prominent place in the treatment of diseases. For example, if the reason of illness is believed to be evil-eye, sorcery or witchcraft, the tribal always would call their own magicians instead of consulting a western doctor, as they strongly feel that the doctors are quite helpless against such evil forces which can only be counteracted by the magical performances of the magicians. Chaudhuri (1989) in another study revealed the fact that health and treatment also reflect the social solidarity of a community. He noticed among the tribal communities that the illness and the consequent treatment is not always an individual or familial affair but the decision about the nature of treatment may be taken at the community level. In case of some specific diseases, not only the ill person or his/her family, but also the total village community is affected. All the other families are expected to observe certain taboos and food habits. The non-observances of such practices often call for action by the village council. One cannot deny the impact of this psychological support in the context of treatment and cure, which is very common in tribal communities.

Along with Chaudhuri different important studies were also done by different scholars. For instance Joshi (1981) in his article 'Concept and Causation: Ethnomedicine in

Jaunsar-Baur', the Silogan medical system greatly emphasises the normal state of existence between the humans and the outside natural/supernatural forces. In relation to the human with the natural world, the humoural ideology (interaction of hot and cold forces) appears to be underlying base. This humoural ideology not merely remains at the level of belief system, but also passes through the natural experimentations. Shukla (1980) conducted a study of traditional healers in community health in Chiaigaon block, a rural field practice area attached to the Institute of Medical Sciences, Benaras, Hindu University, Varanasi.

Nichter (1981) focused on the innovative medical education, the training of traditional medical practitioners, the setting up of the referral networks, the use of allopathic medicine by registered medical practitioners and basic research priorities in the social sciences. He also emphasises that the improved rural healthcare delivery will depend on a mutual understanding between physicians and patients and co-operation between India's pluralistic medical personnel.

Goal, Sahoo and Mudgal (1984) have served the purpose of creating a wider awareness about the traditional knowledge regarding uses of plants, their collection, identification, utilization and conservation.

Some recent studies enlightened more on the concept of health, disease and treatment. Roy Burman (1990) in a paper 'Issues in Tribal Development' indicates how the development of health of the tribal is imbalanced due to commercialisation of forest.

Kar (1993) in a paper entitled 'Reproductive Health Behaviour of the Nocte Women in Arunachal Pradesh' has attempted to explore the qualitative appraisal of some relevant aspects of reproductive health behavior of Nocte women through a look at their social structure, culture, food habit, morbidity and traditional health seeking behavior.

Tarafdar (2005) showed that health condition of a person may be vary by virtue of different biological and socio-cultural variables like age, sex, food habit, education, economy, community, environment, place of habitant, communication and culture. In addition to the above connotation Tarafdar expressed categorical distinction between the

treatment result of traditional medicine men and the modern biomedical medical practitioner lies in this situation. In his study Tarafdar (2005) pointed out that the Santals and Koras of West Bengal inhibit in a close touch with adjacent dominant Bengali culture. In terms of concept of health, disease and treatment a prominent influence of dominant culture take place and it is more intensified upon the Kora than the Santals.

According to Tarafdar (2006) Rituals of different phases of life cycle (birth, marriage and death) are linked with health issues and health status of concerned population. He recorded that the use of different types of herbal ingredients, auspicious articles and special things in different rituals reflect the necessity of those in daily life for better health and protection. Tarafdar (2005 and 2007) pointed out that the tribals residing adjacent to an urban center not mean that they are getting better medical facilities than the other. In some cases far away villagers with good communication can avail it much better than the town adjacent villagers. In other context tribals are living adjacent to rich forest resources can use the herbal medicine properly. Tribals are also devoid of getting proper treatment whenever they visit a modern medical practitioner totally unknown about their economic and cultural background. Same cultural milieu of the healer and patient can give proper psychological treatment despite of unavailability of medicines and allied aids. Inadequate facilities and ill equipped infrastructure of modern health institutions are responsible for lack of dependency and faith towards the modern medical system.

In his study among the Totos of Jalpaiguri districts, Tarafdar (2010) showed the traditional concept of health, disease and treatment among the Toto population exclusively found in the Totopara of District Jalpaiguri, West Bengal. The study reveals that belief and continuation on traditional healthcare system is also depended on education, sex and different economic status of the population. Higher educational and income status generally leads to less usages of Traditional healthcare system.

In his another book entitled ‘Culture of Health Seeking Behaviour: A Medical Anthropological Study on the Drukpas of Buxa Duar Region of West Bengal’ Tarafdar (2017) pointed out that explanatory model of an individual belonging to a specific

culture plays a determining role for choosing appropriate health seeking behavior. He said, the behavior is actually a decision making process governed by an individual of a particular culture. Every culture has its own dimension of health care system and it is characterised with self-sufficient until it experiences inevitable interaction with the outer world. According to him, there is a consensus agreement that the health status of the tribal population is very poor specifically whenever they have been exposed and interacted with other complex culture.

1.4.3. Some Important Studies on Rabha Population

Apart from West Bengal, the Rabhas are also found in two other states, i.e., Assam and Meghalaya with the absolute majority in Assam. In all these three states the Rabhas are classified as Scheduled Tribe [the Constitution (Scheduled Tribes) Order, 1950]. The earliest report on the Rabhas is available from the account of the widely travelled colonial officer Francis Buchanon-Hamilton (1810) who has been described as one of the 'great surveyors' by Cohn in 1996. According to him the Rabhas are the part of Pani Koch and they have similar types of social and religious customs. The first accounting of the Rabhas in Bengal was in the 1911 Census with 734 (79,022 in Assam) Rabha population. The 1921 Census gives no numbers for the Rabhas in Bengal. In the next year Census in 1931, the Rabha population had increased to 3,056 in West Bengal (of which 2,076 for Jalpaiguri district, 938 in Cooch Behar district, and other 42 elsewhere). The figure Drops to 2,995 in the 1941 Census, but again increased to 5,113 in the 1951 Census. The number was 6,053 in 1961 Census and reduced drastically to 2,466 in the 1971 Census of which only 343 were counted in the Jalpaiguri district. The number of the Rabha population once again increases to 11,256 in 1981 Census. The 1991 Census reports total 6,325 Rabha individuals in West Bengal. According to 2001 Census total Rabha population was 15,014 with 12,221 in Jalpaiguri district. In West Bengal, the latest Census (2011) counts 27,820 Rabhas with 14,255 male and 13,565 female. Karlsson (2000) describes the reason behind the irregular number of Rabha population found during the entire Census period in his famous book *Contested Belonging: An Indigenous People's Struggle for Forest and Identity in Sub-Himalayan Bengal.*

Though the earlier accounts on the Rabha have been written by different eminent scholars like Martin (1838), Dalton (1872), Gait (1902), Playfair (1909), Endle (1911) but, the origin and history of the Rabha people are still unrevealed. The earlier accounts unfold various resemblances of the Rabha people with other northeastern communities like Kachari, Koch, Bodo and Garo. Martin in 1838 said that, before the Koch king Biswasingha, the Koches and the Rabhas are considered as the same community. Martin also mentioned that the Rabhas are a strong race of man, but uncommonly timid. Dalton (1872) in his book *Descriptive Ethnology of Bengal* gave an opinion that the Rabhas are a part of Kachari and they are very much related to the Garos. Hodgson (1849) and Porter (1933) are of opinion that the Rabhas are belong to the *Bodo* Group. According to Playfair (1908) the Kachari, Garo and Rabha came from Tibet and they are the part of large Bodo group. In his book *The Kacharis* Endle (1911) mentioned that in earlier the Rabha people occupy both plain and hilly parts of southern foothills of East Garo Hills and West Garo Hills of Meghalaya and Assam.

The post-colonial researches highlight on different aspects of the Rabha community inhibiting in the northeastern states of Assam and Meghalaya and West Bengal. In this period, the first evidence regarding any documentation of the Rabha culture found from the account of J. K. Barua in 1951. B.M. Das, the renowned Anthropologist, published some research articles regularly in 'Man in India' which gives a detailed account regarding the kinship terms (1956.a), physical characteristics (1956.b), family structure (1957) and blood group (1958.a) of the Rabha community. He also did some splendid research on the Rabha child mortality (1958.c), relative length of the first and second toes of the Rabha foot (1959) and inter-spaces between the Rabha foot (1960) in different reputed journals. In the book *Ethnic Affinities of the Rabha* (1960) Das opines that, like other ethnic communities of northeast India, the Rabhas also form a unique community having rich socio-cultural heritage.

Following B. M. Das, some remarkable studies on Rabha population have been done by M. K. Raha. Before completing his doctoral thesis on 'Social Organisation of the Rabhas of Jalpaiguri, West Bengal' in 1970, Raha published some research articles on the Rabhas of West Bengal (1963) and their kinship terminologies (1967). Along with A. K.

Das, Raha published a book from the Cultural Research Institute (CRI), Kolkata which gives a detailed account of the Rabha population of West Bengal (1967).

After completing his doctoral research, Raha continuously published some important articles from CRI, Kolkata. During this period he highlighted on the youth dormitory system (1972), structural analysis of the changing dimension of the society from matrilineality to patrilineality (1974), socio political movements (1978), and birth and infancy rites (1880) predominantly exist in the Rabha society. In 1989, he did a meticulous work among the Rabha tribal community of the districts of the Jalpaigari and Cooch Behar of West Bengal. The study highlights the changes in the fundamental structure and the function of the Rabha society from its traditional matrilineal to patrilineal system under the tremendous impacts of various factors like the heavy influx of refugees, modern education, communication, legislation, market and cash economy.

In the mean time some other researches on Rabha community have been carried out by some eminent scholars. D. N. Majumdar in 1968 highlighted on the clan organisation exists among the Rabhas. Ray Choudhary (1970) pointed out some aspects of social mobility and movements among the Rabhas of North Bengal (northern part of West Bengal). In the year 1974, S. K. Chatterjee published a remarkable book entitled *Kirata-Jana-Kriti* from Asiatic Society. The book specifically deals with the origin and history of the major northeastern tribes and helps to understand the Rabha community in a more comprehensive way.

At the beginning of twenty first century, some good quality studies were done by the eminent researchers. According to B. G. Karlsson (2000) the Rabhas were forced to become labourers under the forest department when the Rabha's homeland come under the British rule and was converted into tea gardens and reserved forest. Karlsson describes the development of the Rabha people, their ways of coping with the colonial regime of scientific forestry and the depletion of the forest as well as with the present day concerns for wilderness and wildlife restoration and preservation.

K. S. Singh provides some important information about the Rabhas of Assam (2003) and West Bengal (2008) in his edited book *People of India,* published by the

Anthropological Survey of India. M. Rabha in 2007 stated that the society and culture of the Rabha community is strictly governed by democratic social system having certain rites and rituals, way of living, social beliefs, practices and customs. U. Barua in 2008, studied the Rabha community of Assam with special reference to their clan system.

P. Basumatary (2010) in his book *The Rabha Tribe of North-East India, Bengal and Bangladesh* analysed the Rabha culture from a purely linguistic point of view. According to Hakacham (2010), the social life of the Rabha community is governed by traditional but democratic social system having certain rites and rituals, social beliefs, practices and customs. In the year 2013, M. D. Rabha did an emic study and analytically discussed about the cultural heritage of the Rabha community. Biswas in 2014 carried out a socio cultural study on the Rabhas of Cooch Behar district of West Bengal with a focus on their livelihood conditions. R. Bora and A. K. Das (2015) conducted an ethno botanical study among the Rabha tribe residing nearby 'Chandubi Beel' of Kamrup District (Assam). D. M. Bhattacharyya, et al. in 2015 highlights on the status of HbE variant among Rabhas of West Bengal.

Roy and Tarafdar in 2017, explore the traditional healthcare beliefs centering the worshipping of Goddess *Rountuk* which is considered as the chief household deity of the Rabhas inhabiting the northern part of West Bengal. The study highlights various rituals related with the appeasement of the deity as a first hand remedial measure to achieve psychological strength to cope up with adverse health situations. The study also unfolds the continuity of supernatural beliefs among the Rabha as a conspicuous character of explanatory models which also govern their traditional health care practices irrespective of the emergence of changing situations.

1.5. The Present Study:

The tribal societies in India differ from region to region due to their socio-economic and cultural factors. The concept of health, disease and method of treatment for curing are traditionally handed down from generation to generation in rural and specifically in the context of tribal communities.

Present Study will explore the concept of health, disease and treatment procedures among the 'Rabha' population of West Bengal. This medical anthropological study will try to explain the concept of health, disease, medical system, medical belief, related religious practices, diagnostic and traditional treatment involving magico-religious performances. In addition, this study will also evaluate the impact of modern healthcare system and implementation of different healthcare programmes and policies on them.

1.6. Aims and Objectives of the Study

The main objectives of the present study are to understand the concept of health, disease and health seeking behaviour of the 'Rabha' population of North Bengal for emphatically exploring the traditional features related with the health issues. It will also explore the traditional healthcare system and impact of modern healthcare system. This anthropological study not only orients for the improving the quality of life of the community but it will also help to initiate various developmental programmes. The main objectives of the present study will orient under the following headings:

1. To study the concept of health, disease and health seeking behaviour.
2. To study the various method of health seeking behaviour undertaken by the concerned community.
3. To reveal the various traditional herbal medicines and the important implications for the same.
4. To explore their distinctive ethnopharmacology, life cycle related rituals, magico-religious performances and supernatural connotations.
5. To understand the role and position of women towards availing treatment modalities in a matrilineal setup.
6. To reveal the significant roles of traditional healers, methods of treatment and their age-old traditional knowledge system.

7. To observe the health consciousness among the present generation of concerned tribal community.

8. To evaluate the impact of modern healthcare system and implementation of different healthcare policies and programmes along with the existing infrastructure.

9. To know their acceptance and dependency towards the modern medical system.

10. To evaluate the interaction between traditional healthcare system and modern healthcare system.

11. To study the present health hazard faced by the population.

1.7. Research Questions or Hypotheses

- Concept of health, disease and treatment among the concerned population may vary due to different age, sex, education, economy, environment and communication. Further, in various causes of 'ailments' may leads to different categories of treatment procedures.
- Imposition of different forest laws may restrict the accessibility of herbal medicines which adversely affect the traditional healthcare practices. Deforestation and commercial afforestation may be added criteria in this regard.
- Success of different government healthcare programmes may depend upon the cultural ideologies of the concerned population; some healthcare programmes may be accepted by the population while other may not succeed up to the desired level of the government.
- Continuation of the traditional healthcare practices depend on the accessibility of modern healthcare services, economy, religion, transport system and interaction with the so-called mainstream population.

1.8. Methodology

A Methodology is the analytical study of methods which is a broad category includes many techniques through which a goal or an end to be achieved for a particular field inquiry. Technique is an actual device, a means or a procedure for collecting data in the particular contexts of a scientific inquiry. The method of collecting data in the field is an important factor; the value of reports depend on the methods of inquiry.

In the present study, different methods and techniques used for conducting fieldwork to collect contextual data are categorised under three major phases, i.e., (i) pre fieldwork, (ii) fieldwork, and (iii) post fieldwork.

1.8.1. Pre Fieldwork Phases

Before starting an anthropological fieldwork there are ample of work has to be done which are as follows:

1.8.1.1. Pilot Survey

As a very first step of the present study, pilot survey was conducted in the different phases to get a comprehensive idea about the Rabha dominated villages of West Bengal. During the pilot survey, there are forty Rabha villages has been identified in the northern part of West Bengal commonly known as North Bengal. The criteria of the selection of the villages have been chalked out during this period.

Pilot survey has also provided the valuable information and data required for making the future plan of work; it was also fruitful for framing the Preliminary Schedule Form (PSF), the essential tool for conducting the primary phase of field work.

1.8.1.2. Selection of the Population and Area

The present study has been conducted among the 'Rabhas' of West Bengal. Rabha is one of the important tribal community (enlisted as Scheduled Tribe in West Bengal) living in the dooars and plain land area of northern part of West

Bengal. According to various ritualistic performances the Rabhas are divided into a number of sub-tribes (*khels*) like *Randhania* Rabha, *Maitariya* Rabha, *Dahari* Rabha, *Kocha* Rabha, *Chhunga* Rabha, *Pati* Rabha, *Bitaliya* Rabha and *Totla* Rabha (Rabha, R. 1974). The section of Rabha people residing in the northern part of West Bengal is commonly known as *Kocha* Rabha. Generally they are devoid of performing *Khokchi or Baikho* worship which is performed by the other groups of Rabha community residing in the north eastern states of India (Rabha, R. 1974). They are one of the autochthons of West Bengal and specifically inhabited in the districts of Alipurduar, Cooch Behar and Jalpaiguri. On the basis of their habitation the Rabhas of West Bengal are divided into two categories, i.e., the 'Forest Rabha' and the 'Village Rabha' (Raha, M. K. 1989). Forest Rabhas are mainly inhabited in the forest areas of Alipurduar and Jalpaiguri district where as the village Rabhas are generally settled in the plain land of Cooch Behar district. As the village Rabhas are mostly inhabited in the plain land area so they are designated as 'plain land Rabha'.

There are nearly forty two Rabha villages in the above mentioned districts of West Bengal but the present study has been conducted into six exclusive Rabha villages which are systematically selected by using stratified sampling method. All the selected villages are categorised into three major divisions, i.e. (i) villages from the core forest region; (ii) villages from the fringe area of forest and (iii) villages near to the urban area. Two villages from the each category have been selected on the basis of availability and accessibility of health center.

The list of the Rabha villages found during the study is given in the following charts.

Chart: 1.1 The Rabha Villages of Alipurduar District

1. Andu basti	10. Haprangdum	19. Nimti Basti
2. Baniya Basti	11. Kalapani	20. North Mendabari
3. Barobisha	12. Khayer Basti	21. Panbari
4. Bilpara	13. Khurmai Basti	22. Vangapul

5. Debgram	14. Kodalbasti	23. Panijhora
6. Dhumchi	15. Kumargram	24. Poro Basti
7. East Salbari	16. Lephraguri	25. Rangamati
8. Gadadhar	17. Lothamari	26. South Mendabari Forest Rabha Basti
9. Rabhaline	18. Morishbari	

Source: Field Survey, 2014

Chart: 1.2 The Rabha Villages of Jalpaiguri District

1. Gosaihat	3. Mangalkata
2. Khuklung Basti	4. Mela Basti

Source: Field Survey, 2014

Chart: 1.3 The Rabha Villages of Cooch Behar District

1. Bansraja	5. Chhatrampur	9. Paglikuthi
2. Bhariya	6. Harihat	10. Rasikbil
3. Bochamari	7. Haripur	11. Talliguri
4. Chengtimari	8. Madhrubhasa	12. Tokoamari

Source: Field Survey, 2014

The present study also initiated and conducted among the Rabhas to know their distinctive cultural identity which can be explored through the aspect of health seeking behavior. One of the significant criteria for selecting the Rabha tribal community is for their age old affiliation with the forest regarding their health seeking behaviour which is now a day in a process of transformation because of the influence of the nearby dominant communities of Hindu religion and of conversion to Christianity.

For the convenience of the study, six Rabha villages were selected on the basis of various predefined and post confirmed criteria and categorised into two different categories, i.e., category – 1 and category – 2. Andu Basti, South Mendabari

Forest Rabha Village and Chhatrampur are included under the category – 1. These villages have the modern health institution (Health Sub-Center or Primary Health Center) within it or in the close vicinity of the village with very good communication through road. The village roads are always usable even in the rainy season.

On the other hand, category – 2 is comprised with another three villages namely Rabhaline, Dhumchi Rabha Basti and Bansraja. No modern health institutions are situated in these villages. The villagers go long way to get access of the modern health institutions. During the rainy season the village roads are full of mud and it is very difficult to access the roads.

Other than the accessibility and position of the modern health center the villages are also selected according to their physical environment. Each category has the core forest village, village from the fringe of the forest region and plainland village with the Rabhas from different religious groups. The categorisations of all the six villages under the study along with the distinctive characteristics are mentioned in chart: 1.4.

1.8.2. Fieldwork Phase

Fieldwork is the most important part in an anthropological research as it provides the primary data of the entire work. The techniques and methods used in the present study are as follows:

1.8.2.1. Establishment of Rapport

Rapport establishment is very essential to establish a better communication with the population under consideration. This technique helps to get as much information as well if good rapport is established with the informant. During establishment of rapport, lots of factors like everyday activity, traditions, customs, values, beliefs, etc. of the target population should be taken into consideration. Patience, good humors, and adjusting attitudes always help in developing friendly relationship

Chart: 1.4 Categorisation of the Villages along with the Distinctive Characteristics

Categories	Name of the Villages	Accessibility with the Nearest Modern Health Institution	Physical Environment of the Villages	Religion	Distinctive Characteristics
Category - 1	**Andu Basti**	Moderate Accessible	Core forest	Animist	Have the modern health institution (Health Sub-Center or Primary Health Center) within it or the close vicinity of the village with very good communication through road. The village roads are always accessible even in the rainy season.
	South Mendabari Forest Rabha Village		Fringe of the forest	Both Animist and Christian	
	Chhatrampur		Plainland Agricultural village	Animist with the influence of Hinduism	
Category - 2	**Rabhaline**	Less Accessible	Core forest	Both Animist and Christian	No modern health institutions are situated in these villages. The villagers have to go long way to get access of the modern health institutions. During the rainy season the village roads are full of mud and it is very difficult to access the roads.
	Dhumchi		Fringe of the forest	Christian	
	Bansraja		Plainland Agricultural village	Animist with strong influence of Hinduism	

with the village peoples, which sometimes even go beyond the professional interest.

During the entire research tenure all the six Rabha villages (Andu Basti, South Mendabari Forest Rabha Village, Chhatrampur, Rabhaline, Dhumchi, Bansraja) were visited with a good humour and attitude.

Participation in the traditional Rabha ceremonies and festivals gives a pace to win the confidence of the population under the study. It was also necessary to build the good rapport with the government officials, health workers and NGO members to continue the study in a smoother way. Good relation with smiling face, talking politely and patiently, ignoring unwanted instances and avoiding unpleasant comments catalyses the process of rapport establishment.

1.8.2.2. Village Layout

Layout of the villages is also considered as the significant technique for fieldwork. The layout of all the villages are clearly made which include the households, water tanks, village roads, school, shops, play ground, agricultural field, burial ground, religious institutions and medical institutions for future references.

1.8.2.3. Preliminary Schedule Form

Preliminary Schedule Form is a very useful method for collecting data from the field situation. It is considered as one of the important method for conducting field work in the Anthropological study. There are nine subsections in this form. At the first phase of field-work the data will be collected through that form and each house hold of the villages will be covered while taking data through preliminary schedule form (PSF).

The content/quarries of the form are as follows:-

I. General Information (Family level): a) Household number b) Name of the informant c) Age d) Sex e) Name of the tribe f) Clan name g) Name of the clan deity h) Religion i) Education j) Village name k) Name of the Panchayat l) Block m) Post Office n) District o) State p) Country q) Date of interview.

II. Demographic Information (Individual level): a) Serial Number b) Name c) Clan d) Sex e) Age f) Relation with head g) Marital Status h) Age at 1st Marriage i) Marriage Type j) Number of Children k) Education l) Religion m) Language Known n) Occupation o) Place of work.

III. Information regarding Present Work (Individual level): a) Birth place (Rural/Urban) b) Place of Delivary (Home /PHC/ Hospital/Clinic Nursing Home etc.) c) Who attended (Doctor/Nurse/ Pharmacist/ Mid-wife etc) d) Age of Menarche and Menopause e) Age at 1st child f) Disease in last five years g) Cause of it h) Way of treatment i) Institution/ Person consulted j) Distance of it k) Procedure of treatment (Modern /Traditional/ Both) l) How long it exist m) Is it cure now o) Expanse for the purpose p) Vaccination q) Pulse polio (Under five years) r) Attended ICDS (for pregnant mother and children) s) Agree in family planning (for the married adults only).

IV. Household Information: a) Number of rooms- i) Bed room ii) Kitchen iii) Varanda b) Use of it c) condition of it- i) Kaccha ii) Pakka d) Place of keeping family deity e) Place of keeping domestic animals

V. Technological Equipments: a) Household equipments b) Agricultural equipments c) Transport equipments.

VI. Information regarding Domestic Animals: a) List of domestic animals b) Number of domestic animals c) Disease of domestic animals which directly affects the family members.

VII. Health particulars (Family level): a) source of drinking water i) summer ii) rainy season iii) winter b) sanitation i) summer ii) rainy season iii) winter c) source of other water (bathing, washing) i) summer ii) rainy season iii) winter d) Use of herbal/ traditional medicine in daily life e) source of it i) collected ii) purchased f) Daily food habit i) morning ii) afternoon iii) evening g) Consumption of liquor and smoking (individual level) h) Sanitation i) summer ii) rainy season iii) winter.

VIII. Economic Information (Family level): a) Generation wise occupation b) Details of land transfer c) Land holding pattern d) agricultural category of the household e) Details of loan f) Monthly income and expenditure g) Any Economic Help (Given by Government/ Panchayat).

IX. Details of Forest Visit: a) Frequency b) list of the minor forest products (MFP) collected from the forest.

1.8.2.4. Observation

Both participant and non-participant observation techniques were followed during the entire study to understand the concept of health, disease and treatment of the Rabha population. This technique helped to know the villager's role in treatment procedure, different magico-religious performances related with the traditional healing, differences in the treatment modalities among the Animist and the Christian Rabhas, food habit and personal hygiene.

1.8.2.5. Interview

Interview is considered as one of the important technique of data collection in Anthropology, where an interviewer asked questions to the interviewee. In the present study various interviews were taken from the Rabha people from different age, sex, religious and economic group. Both structured and unstructured interviews were taken from the

informants to get first hand information regarding the overall health scenario of the population under study.

In the interview method, different categories of questions were framed to know about their economic status, concept of health and disease, categories of treatment, different types of belief systems (natural and supernatural) regarding health and diseases, magico-religious practices, traditional knowledge on preventive, protective and curative treatment, impact of modern medical institutions in the six studied villages.

1.8.2.6. Focused Group Discussion

A focus group is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs and attitudes towards a product, service, concept, advertisement, idea, or packaging. The social focus groups allow interviewers to study people in a more natural setting than a one-to-one interview. In the present study focused group discussion (FGD) were carried out to understand the traditional medical system and practices, traditional belief towards good health, magico-religious beliefs and practices and it also helps to record the data about surrounding modern medical health facilities and programmes available to the Rabhas of the six studied villages.

In combination with participant observation FGD also helps to select the sites to study, sampling of such sites. Focus groups have a high apparent validity - since the idea is easy to understand, the results are believable.

1.8.2.7. Key Informant Interview

Key informant interview is another important technique for collection of data from the field situation. Key informant interviews were taken from the various persons who have a vast knowledge about the people and the area selected for the present study.

Sushil Kumar Rabha of Kamakhyaguri village is a famous Rabha educationalist and also known for his various articles and books written on the Rabha population inhabiting in the Sub-Himalayan Dooars region of northern Bengal. David Rabha, the Christian Priest and Romeswar Rabha, the traditional healer of Rabhaline; Gobin Rabha, the traditional healer of South Mendabari Forest Rabha Village were also selected as a key informant for the present study. Fulen Rabha, the panchayat pradhan of Dhumchi Rabha Village was also very much cooperative and enrich the study sharing his knowledge. Some aged knowledgeable persons like Rugna Rabha, Mangaleswari Rabha of Andu Basti; Upen Rabha of Bansraja and Shankar Rabha of Chhatrampur Rabha Village were also selected as a key informant as they have a vast knowledge of traditional medicines available in the nearby area.

Government officials of district block and forest offices helped lot by providing the necessary data.

1.8.2.8. Case Study

Case study is the technique of exploring and analysing the life of a social unit, be that unit a person, a family, an institution, culture group or even an entire community. In this technique informant generally asked to describe and states facts regarding a specific case in which he/she is personally involved.

In the present study different cases were taken to understand the different forms of disease causation and treatment procedure. As the six villages under study are categorised into two categories, i.e., category - 1 (Andu Basti, South Mendabari Forest Rabha Village and Chhatrampur) and category - 2 (Rabhaline, Dhumchi Rabha Basti and Bansraja), on the basis of certain criteria, so the cases were taken from all the six villages of both the categories to get the first hand information regarding belief systems behind their diseases. Case studies were also taken from the

disease affected persons from different sex and economic groups on the basis of the opted (traditional or modern or both) healthcare facilities. All these case studies were made from the persons of both the religious groups, i.e., Animist and Christian. The case studies of traditional and modern healthcare practitioner were taken to understand the present scenario of health seeking behaviour among the Rabhas of the studied region. Case studies related with the present work were taken by following the charts mentioned below:

Chart: 1.5

Outline of Case Study regarding Disease Causation

(Applicable for both Animist and Christian Rabhas)

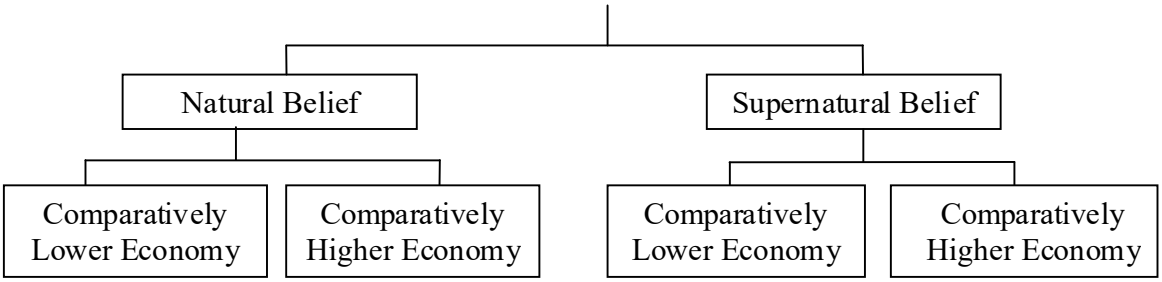
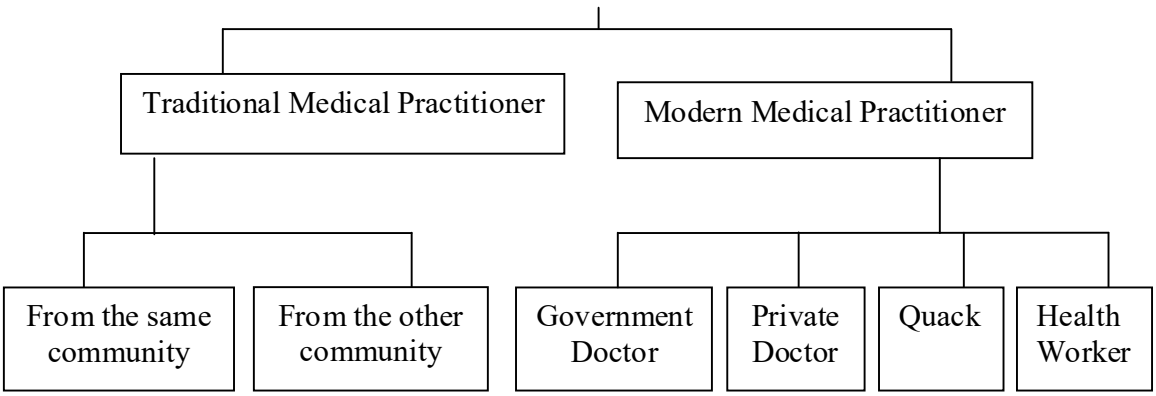


Chart: 1.6

Outline of Case Study of Medical Practitioner



1.8.2.9. Genealogical Chart

Genealogy of each and every family is collected through the Preliminary Schedule Form. For getting a genealogy of a family, at first an ego is identified and his/her relationship with the other members is noted and examined. The genealogical chart helped to trace out the instances of remarriages, polygamy, family structure, generation-wise transmitted cultural affairs and most importantly the disease causing genetic traits of every individual of the community.

1.8.2.10. Video and Photographic Technique

The video and photographs of different rituals and festivals of the Rabha community has been captured during the fieldwork in the villages under the study. During the fieldwork, every time it was not possible to note down the detailed account of the rituals/festivals or the statement of interview. In this context, video and photographic technique played an important role for the present study. In this context one thing should be mentioned that, while taking any video or photograph, it is recommended to take permission of the concerned people.

1.8.3. Post Fieldwork Phase

After fieldwork the collected have been arranged properly to get a meaningful conclusion. The work schedules of post fieldwork phase are as follows:

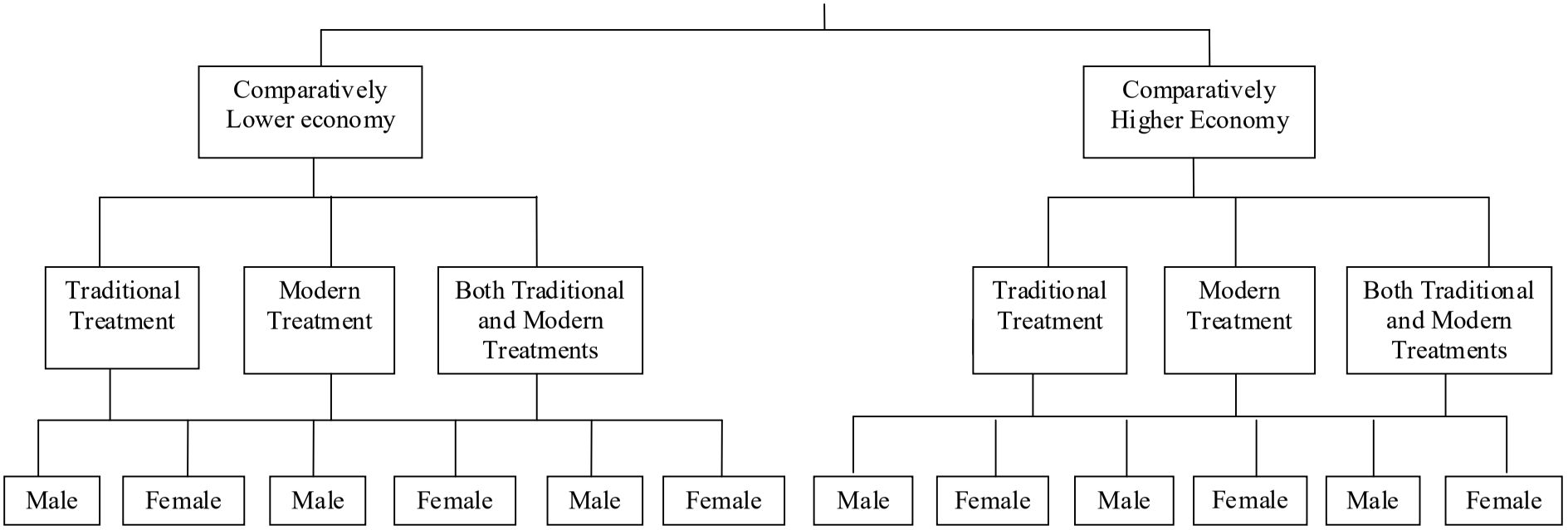
1.8.3.1. Data Analysis

For any anthropological research, data analysis is the most important part after completion of the fieldwork. In the present study, both qualitative and quantitative data are analysed for getting conclusion. Data for qualitative analysis consist of interview and focus group recordings and transcripts, field notes written during participant observation sessions, textual documents, and notes written about the data collection process itself. The techniques used for qualitative data analysis involve careful and repeated listening to the recordings and reading of transcripts, field notes, and collected textual documents.

Chart: 1.7

Outline of the Case Study of Patients

(Applicable for both Animist and Christian Rabhas)



Quantitative analysis has been made by the statistical data collected with the help of preliminary schedule form (PSF). All the quantitative data have been analysed manually.

1.8.3.2. Secondary Data Collection

Data were also collected through several secondary sources, like library books, journal, news papers, internet etc. Different health policies and health schemes implementation programme of the studied area were collected by the block hospital and primary health center. The details of the plans and schemes of Tribal Development under the Rural Development schemes launched in the area were provided by the block and panchayat offices.

1.8.3.3. Management of Data

Management of collected data from the six different villages was very important part of the present study. Both textual and electronic data have been preserved securely with proper backup for future reference.

1.9. Approaches

The different approaches adopted for the present study are as follows:

1.9.1. Ethnographic Approach

The ethnographic approach has been used to interpret and describe the symbolic and contextual meanings of the everyday practices in the natural setting of the population under study. The most important of this approach is the skill to systematically record of the field note collected through participant observation, case study and genealogical method. Following R. Bernard (2006), three kinds of field notes have been used for the present study, i.e. methodological notes, descriptive notes and analytic notes.

1.9.2. Qualitative and Quantitative Approaches

The present study is comprised with both qualitative and quantitative approaches, that means, data represented in the entire report are based on words as-well-as in numbers. Though the data collected through qualitative approach are spontaneous, open ended and usually less structured and planned than quantitative, but both are complementary to each other.

1.9.3. Comparative Approach

As the Rabhas of the area under study can be divided into several categories on the basis of their habitation (Forest Rabha and Village Rabha or Plainland Rabha), Religion (Animist Rabha and Christian Rabha) and the characteristic features, depending on which the entire studied villages are divided under two categories (Category-1 and Category-2). So, the intra-tribal comparison played a very important role in this regard to get an idea about different cultural practices associated with their various categories of treatment modalities.

1.10. Problems and Limitations

1. Though some of the Rabha villages are nowadays located outside of the forest vicinity, but most of the Rabha villages are located inside the forest area especially in the 'Jaldapara National Park' and' Buxa Tiger Reserve'. These villages are very difficult to access because of very poor communication and transport system.

2. During Field work it was found that some of the villagers were not present in their huts. Their neighbours informed that they have settled in another place and visit the village once or twice a year. While collecting data it was very difficult to find them available in their houses.

1.11. Organisation of Thesis

The thesis is divided into following six chapters.

Chapter – 1 Introduction : This chapter is basically a introductory note which primarily deals with different concepts related with the health, disease and treatment. At the very beginning, the chapter focuses on different theoretical orientations as well as the tribal health scenario in the present day context. The chapter also focuses on the review of previous studies related with the present work. The related studies are reviewed under three sub-headings, i.e., international studies on medical anthropology, studies on tribal health in India and some important studies on Rabha population. An analytical discussion regarding the aims, objectives and hypothesis of the present study is also an important subject matter of this chapter. The last part of the chapter highlights on the approaches and methodologies adopted to pursue the present work during pre fieldwork, fieldwork and post fieldwork stage.

Chapter – 2 The Villages and the People : The first part of the chapter focuses administrative location of the six selected villages, their physical environment and infrastructural facilities along with a short note on state and district profile. The second part of the chapter highlights the ethnic classification of the Rabhas along with their origin and migration. The demographic structure and the socio-economic factors of the considered villages constitute an important part in this regard. Further, the socio cultural life including the language, religion, concepts of clan, family, marriage, kinship, descent pattern and property inheritance rules, traditional political organisation, food habit and preparation of traditional country liquor are also a subject of discussion in the last part of this chapter which helps to get a holistic idea about the Rabha community under study.

Chapter – 3 Concept of Health, Causation of Diseases and Notion of Treatment: The chapter focuses on the various health related concepts existing among the Rabhas of the six villages considered for the present study. The

chapter also discloses some common health problems and concepts regarding the causation of different diseases. These concepts can be well understood in terms of the belief system. The chapter highlights on both the personalistic and the naturalistic belief system prevailing among the Rabhas. Personalistic belief system explains sickness as a result of supernatural forces like spirits, soul, ghosts, wreath of deities, etc., while naturalistic belief system explains sickness in terms of natural forces like germ theory of contagion, occupational health hazards, etc. Further, the occurrences of diseases and treatment categories (traditional, modern or both traditional and modern) opted by the selected Rabha population occupies a crucial part of the chapter.

Chapter – 4 Traditional Ways of Healthcare Practices

Traditional way of treatment procedures followed by the concerned tribal community is elaborately given in this chapter. The knowledge of traditional medicines and detailed procedure of worshipping of various deities and spirits (including magico-religious performances) are discussed here. The chapter also focuses on the detailed traditional treatment procedures followed by the Rabhas in order to get rid of their ailments. Further, the life cycle and health related rituals also constitute an important part of the chapter.

Chapter – 5 Modern Healthcare Facilities and its Acceptability

The first section of the chapter discussed about the health service scenario of the country along with different government policies formulated for the amelioration of socio- economic status of the tribal population. A short introduction on the health infrastructure of the country is made for better understanding of another section of the chapter.

Detailed discussion about the health facilities and programmes of the studied areas are given in the next section of the chapter. Treatment by modern medical institutions and practitioners along with the actual condition and treatment facilities provided by the modern medical institutions such as Sub-Center,

Primary Health Center (PHC), Block Primary Health Center (BPHC), State General Hospital and District Hospitals is also discussed in this section. Case studies of patients who availed the modern medical facilities in different circumstances constitute an important part of this chapter. The chapter also unfolds the various concepts, mechanisms and present day situations regarding Child healthcare practices, personal hygiene, techniques of family planning, water supply and sanitation particularly among the population under the study.

Chapter – 6 General Observation and Conclusion

The chapter provides a general discussion of all the above raised issues through which a conclusion about the whole work has been drawn along with some suggestive measures.