CHAPTETR 1
INTRODUCTION

PROBLEM OF THE STUDY

Environment is the study of physical objects, biological organism and atmosphere of a particular region. It influences the way of life of the people. The people, in turn, work with the given environment and shape up a style of life compatible with it. In the process they evolve their own customs, values, norms, beliefs, religion and social institution so as to blend with the environment harmoniously. In a way environment, society and culture are interdependent and mutually interacting with each other. We may categories the environment as physical environment and social environment. Physical objects, biological organisms and atmosphere describe as physical environment. Social environment encompasses all aspects of human life such as occupation, income, land holding pattern, economic classes, educational status, customs, values, beliefs, practices, religious, taboos etc.

Social environment influences the health problem and health practices of any community. Ever since the emergence of man on the earth, illness and diseases have become perennial problems for him. Each society, in this respect, is found to develop some kind of value system within its own ethno science for treatment of diseases. There are some universal perceptions of health and disease where all the human societies possess some common considerations and at the same time there are some social perceptions unique to a particular society. So far as the unique perceptions of the society are concerned, the concept and treatment of diseases are differently defined in different societies. The biological disorders in the body may be depicted as the disease in case of human being, but the biological explanation cannot delineate all about illness in human societies. Biological factors tell the basic causes responsible for disorders in the body, there are social explanations for various applications in the body and mind especially in the primitive societies. Social environment helps in the spread and control of certain disease. If the society is socially sound enough, there is a general trend for simultaneous improvement in the health status.

Social environment plays an important role in the tribal worldview of heath, disease, and treatment. Primitive concept of health, disease, and treatment is the integral component of the overall environment of tribal community. The usual theory of disease in tribal society is that it is caused by breach of some taboo or by hostile spirits, the ghosts or the dead. Sickness is the routine punishment for every crime meted out to them by the spirits. Accordingly, they have taboos and prayers. The *Pahan* (Village Priest) in addition to his religious functions act as the mediator between the people and the myth powers. When a person goes to traditional medicine man, he gets something more beyond physical health. It is the socio-physiological re-enforcement (Choudhury 1986 p1-11). Tribals of India have developed strong magico-religious health care system. They believe that evil spirits cause most of the diseases.

The tribal, broadly speaking, believe in four types of spirits (Vidyarthi, 1977). They are: (a) protective deities or spirits believe to safeguard the welfare of the village and worshipped at a communal level, (b) benevolent spirits who are worshipped at communal level and mostly familial level regularly, otherwise they may bring disease, death and calamities, (c) evil or malevolent spirits and deities control small pox, fever etc, (d) ancestral spirits who are very benevolent spirits and protect the family members. The tribal communities have number of deities connected with different diseases like Sitala, Manasa etc. When there is an epidemic like pox or cholera, Sitala is always propitiated. Manasa is the controlling deity of the snakes, and naturally her blessings are sought against snakebites.

Biswas (1934, p1-28) has illustrated primary concept of disease classification of Clement and Rivers. Disease is caused by breach of some taboo or by hostile spirits, the ghosts or the dead. Clement's classification of causes of disease may be represented as, (i) Supernatural Agency; soul loss intrusion, spirit of sickness, spirit of intrusion and breach of taboo describe as supernatural agency, (ii) Human Agency; evil eye, evil touch, evil mouth, and sorcery categories as human agency, where as (iii) Natural Causes refer to the disease object

intrusion. Rivers classification states that, (i) those in which some mobile object or substance is projected into the body of the victim. This is limited to Indonesia, Papuomenalaisia and America, (ii) those in which something is abstracted from the body. It is practice only in India and Africa, (iii) those in which the sorcerer acts on some part of the body of a person or on some object, which has been connected with the body of a person in the belief that thereby he can act on the person as a whole.

The present study will deal with the social environment and health care practices among some tribal communities in a comparative perspective of a few villages of the Tapan block of Dakshin Dinajpur District of West Bengal. In the study area, we have found Santal, Oraon and Munda as major tribes. The Santals and Oraons are the dominating tribes of the study area. The study will concentrate on these two communities. The primitive concept of disease and treatment among the Santals and Oraons are not equal. They are also not practicing modern health cares equally. The changing trend in health care practices of the tribals in the study area is interesting. Health culture of the tribals in the study area is mixed in nature. They do not entirely depend on their primitive medicine as well as on modern medicine. We shall state briefly the primitive concept of disease and treatment between these two tribes to have a clear perspective of the changing trend of health care practices of the tribals and factors responsible for these changes.

The Santals, the primitive people of India, have concept of disease of their own. According to them diseases are caused by a 'Tijo' (Bodding 1925), which may be large or very microscopic. 'Tijos' enter the body through foods. The Santals also have a belief that evil men by dint of their magical power intrude dirt's such as stone or wood or pebbles or lumps of hair in the body that cause unbearable pain. Children are mostly susceptible to such spells. The *ojhas* suck out these things from their body and they believe that by doing so they can be cured. The Santals believe that *bongas* or spirits have control over various natural phenomena and the natural calamities that often occur because of their

influences. The relation between the Santals and the *bongas* are often one of the reverential fear, submission, and propitiation. On the one hand, the performance of religious rites expresses the recognition of the existence of the supernatural powers that can be exercised by the *bongas* and on the other hand the power of the *bongas* are generally invoked to secure the good will of the beneficent ones and to avert the ill will of the maleficent ones. In other words, the instrumental aspects behind these religious rites express an alliance with the benevolent *bongas* and through them control of the harmful spirits. The expressive aspects is symbolized and manifested in a special manner in the various seasonal rites and festivals correlated to the annual agriculture and the recurring rites of passage (Troisi, 1978,p163).

The Oraon sercerer carries something with him a rag bundle what are known as *nasans* (destructive and harmful agencies), which include human hairs, nail pairings, claws, fragments of bone and legs of chikens and other birds and also small quantities of rice grains, mustard seeds and certain other grains. Sorcerer mixes this in the food pouncing appropriate spells, which kill the victim. The Oraons have a belief that there are among them some powerful sorcerers or witches who by some appropriate *mantras* extract the liver of an intended victim without the latter perceiving it. Only women are believed to practice witchcraft. Witches also influence the evil spirits as sorcery by using materials objects. A person may be harmed through black magic by a twig used as toothbrush by him. The dust from below the footsteps, paired nails, and hairs are also used for this purpose. Rheumatism of the lower limp may be caused by an energy getting hold of a little dust of one's feet and uttering some magical formula over it and sacrificing a fowl or making offerings of aura rice over the dust. While a wall of a house is under construction, a witch may secretly take away some earth of the wall and tie in a cloth, so that the wall may crack before completion. Another way of afflicting a person is to bury some medicinal herbs or roots using magic, on the path usually travelled by the victim. There are many kind of illness caused by witches. They depend on the witch doctor to cure them from this illness. This kind

of specialist occupies a high position in their society. Oraons also believes in the potentially beneficent ancestors appear and talk with them in dreams and they always keep their affectionate eyes on their descendants so that evil spirits may not cause harm to them.

The tribal communities of the study area are living side by side with the Hindus for number of decades. The constant and close interaction between them has led to the convergence of many aspects in their way of life. The tribals have also internalised some common Hindu values and customs. As a result, the tribals in the study area claim to be Hindus themselves though they still continue the practices of animistic religion. In general, the Santals are more advanced than the Oraons. The Hindu influences are also more among the Santals than the Oraons. The Santals do not claim any caste status, because they prefer to assimilate the Hindu system as a reference which they can reinterpret. The Santals duplicate the Hindu society, in order not to be absorbed by it, they take Hinduism as a possible set of symbolic conditions for remodelling their own society.

There are number of agencies like Primary Health Centres, Non-Government Organisations such as the Tagore Society for Rural Development etc which have been working in the study area for a long period of time. However, the impact of modern system could not bring satisfactory impact on the life of the tribals. They still overwhelmingly cling to their traditional 'sub culture of medicine'. Their traditional animistic religion has a close inter-relationship with the belief in traditional practices of medicine and causation of disease. They still believe that causes of illness and treatment of disease are directly linked with the supernatural power. This might be due to the belief of the tribal communities in their traditional medical system because traditional medical system just fits in with their culture and their way of thinking. Tribal communities possess a unique health problem in regard to the acceptance and rejection of modern medicine. It is very difficult to understand the tribal health problem only by providing health

institutions, modern doctors, equipments and medicine to the tribal communities for the betterment of their health status. Inadequate service quality and western model of modern health services fail to meet the expectation of the tribal communities. The Tagore Society for Rural Development may play vital role to bridge the gap between tribal community and modern health facilities. We describe here briefly about the Tagore Society for Rural Development and its intervention in the field of community health among the tribals of the study area.

The Tagore Society for Rural Development is a non-government voluntary organisation founded in 1969. The organisation was initially involved with irrigation and agricultural programmes. The Tagore Society for Rural Development has undertaking number of development programmes and schemes including health programmes in three states namely, West Bengal, Bihar and Orissa. The Society has started functioning in the villages under the Tapan block of Dakshin Dinajpur district since 1977. The overall programmes of the society may be divided into two broad categories such as, (a) Income-generation programmes that includes credit facilities for the poor, development of the minor irrigation through check dam, renovation and excavation of ponds, social forestry etc, (b) Non-Income generation programmes, which includes adult and functional literacy, non-formal education for non-school going children and dropouts and health care services. The Society has started health care activities only after 1990 in the study area.

The Society has been trying to cultivate self-respect and self-reliance among the villagers by creating their own employment and bringing sustainable development in the field of economy, health and education to improve the standard of living of the poor people of the study area from the inception. The ultimate objective of the Society is the total development of the villages. As per the long term perspective plan of the Tagore Society for Rural Development, the major health problem being faced by the communities are (i) inefficient and inadequate government health services that do not provide comprehensive health care, (ii) high prevalence of diseases and conditions such as gastro-

enteritis, tuberculosis, acute respiratory infection, malnutrition, scabies and other skin diseases, (iii) lack of health awareness among the community leading to poor personal hygiene, acceptance of diseases as god's will and poor utilisation of existing health resources, (iv) high cost and irrational treatment being provided by private practitioners and quacks in the study area, (v) presence of superstitions, customs and beliefs leading to early marriage, harmful health practices and delay in obtaining services, (vi) poor communication (poor geographical accessibility) between the villages and government health centres, (vii) poor environmental sanitation, the practices of open air defecation, absence of drainage for waste water. The use of large number of open ponds in the area for multiple purpose are some of the factors that contribute to the poor environmental sanitation-the ponds also serve as a breeding ground for mosquitoes etc.

The Tagore Society for Rural Development is equipped with one trained doctor, four trained health supervisors and one health worker in each of the target villages. The Tagore Society for Rural Development also hires doctors from Kolkata or district town Balurghat during epidemic and for the health check up for pregnant women in the target villages. A Director, who is also the Joint Secretary of the Tagore Society for Rural Development manages the day-to-day functions of the Society at Balapur, Tapan block of Dakshin Dinajpur district of West Bengal.

The activities of the Tagore Society for Rural Development are: (i) diarrhoea control programme, which includes training of the members of the tribal communities, setting up of Oral Re-hydrations Solution distribution points, chlorination of wells and purifications of drinking water, (ii) mother and child health care, which includes compiling of eligible list for immunisation and registering ante-natal. There are few basic services like iron folic acid tablet supplementation, provision of tetanus toxide injection for the pregnant mother, nutrition education and health check-up camp for ante-natal mothers. High-risk cases were referred to the Block Primary Health Centre or District Hospital.

Training of the traditional birth attendants, post-natal visits by trained health workers are some of the other activities under mother care. Immunisation, treatment for malnourished children, nutrition education are some of the activities for child care, (iii) health education on selected topics, group meeting for women are being organised twice in a month in the villages. Diarrhoea management, immunisation, the use of safe drinking water, mother and child health care, nutrition, personal hygiene, communicable diseases and environmental sanitation are some of the topics frequently discussed in the meetings, (iv) school health check up by qualified doctors for the students of primary schools, (v) food supplementation, supplementary nutritious foods are being provided to under five years of age malnourished children, (vi) de-worming of the worm infected children in the age group of 0-14 years and vitamin-A administration to 0-6 years of age children, (vi) treatment of minor ailments by trained health workers, (vii) providing safe drinking water to the members of the tribal communities by sinking tube wells in the villages.

We shall also explain in some details the modern health facilities available in the study area other than the facilities of the Tagore Society for Rural Development. During the last 50 years a vast network of health care services has been built up in modern India, improved and high-grade facilities are available now. Still our health system is based on western model, services are based on urban hospitals with a curative approach. Before independence it was urban oriented and after independence, though a large number of Primary Health Centres and Rural Hospitals have been established. The community health scheme was introduced in the year 1978. More and more attention is now given on the problem of rural health particularly for the tribals and other backward groups, who are generally backward, but represent a sizeable population of the society. Instead of all these, the rural health services are not fully equipped because large expenditure is still incurred in urban hospitals. The benefit of modern health services does not reach to the poor or the bulk of the rural people. The basic health care services including mother and child health care services, family planning, health and

nutrition are inadequate in terms of outreach, range of services, quality and availability.

The Block Primary Health Centre situated at the block headquarter Tapan and the Primary Health Centre at Balapur extend both the preventive and curative services to the tribals of the study area. In addition to the Primary Health Centres, there are thirty Sub-centres. These Sub-centres are situated in different villages of the Tapan block under the Block Primary Health Centre. Only three of these Sub-centres are accessible to the tribal communities of the study area. Health workers run these Sub-centres. As per our observations, these centres provide only immunisation services to pregnant mother and children. These centres open once in every fortnight only. Staffs of the health centres have reported that members of the tribal communities often do not utilise the medical facilities of these institutions. The under-utilisation of the health institutions is very much prevalent in the study area. The reasons may be reflected such factors like attitude of the health personnel towards tribal communities, disregard of traditional system and physical and social inaccessibility. The tribals are often not informed about the available health facilities in the hospitals, if the tribal lack confidence in the Primary Health Centres, they may ignore them. Health workers including doctors do not understand the cultural and intellectual levels of the tribals with whom they have to work. As a result the primitive concept of health, disease and treatment is still exist in the study area.

The tribals of the study area have been interacting with the modern medical culture directly or indirectly for more than thirty years. They are living side by side with their Hindu counterparts for more than hundred years. They have now slowly opened themselves towards modern world. They have started sending their children to educational institutions. Some of these may be the out come of the work of the Tagore Society for Rural Development, though they are not able to explore all the benefits of the modern worlds due to their backward socio-cultural milieu. All these may be the reasons for gradual inclination of the tribals towards modern medicine. It may be stated here that modern and traditional concept of

health, disease and treatment exists side by side in the tribal communities though the tribals are gradually inclining towards modern concept of health, disease and treatment.

We have a number of studies on the health problems of the tribal communities. Unfortunately, specific study on the tribals dealing with health, disease and treatment in relation to social environment is practically absent. The interacting influences of social environment and the role of non-government voluntary organisation in relation to health care practices of the tribals should be deeply analysed. How the health care practices among the different tribal communities vary, if at all. It is not possible only by the government mechanism to accomplish the health need of all. There is a need to involve private and non-government organisations in the health sector. The studies related to the involvement of non-government organisations in the health sector and its impact on the health care practices are rare.

REVIEW OF LITERATURES

Sociology of health is comparatively a new development in India. The interest of Sociologist and Anthropologist in the field of health and medicine is rather new. A number of articles are there covering the history and development of medical anthropology or sociology of health outside India as the subject is quite popular there. One can have a very brief idea about the development of this subject from the available articles in India. There are some studies on ethno-medicine, family planning, interaction between traditional and modern medical systems, medical professionals and cultural dimensions of health in general. This review is mainly based on the published research works on ethno-medicine, interaction between traditional and modern medicine and socio-cultural aspects of medicine in general.

Hughes (1968) has discussed that the term ethno-medicine is used to refer to those beliefs and practices relating to disease that are products of indigenous cultural development. Man devises causes for the significant events in life. The afflictions that beset body and mind are explained in both naturalistic and super naturalistic terms. The explanation is based on some conceptual framework founded in common sense empiricism. Widespread through out the world are five basic categories of events or situation on which folk etiology are believed to be responsible for illness: (i) sorcery, (ii) breach of taboo, (iii) intrusion of disease object, (iv) intrusion of disease causing spirit and (v) loss of soul. Hughes has described that a theory of disease implies a theory of normality. Though the normal is in no way easy to define for all times and places. Afflictions common enough to a group to be endemic, though there are clinical deformities, may often be accepted as a part of life. Therapeutic practices in ethno-medicine address themselves to both supernatural and empirical theories of disease causation. All human groups have a pharmacopoeia and at least rudimentary medical techniques. A great part of the task of the folk medicine especially preventive medicine is borne by cultural practices, which have important functional implications for health. Theories of disease generally have major relevance to moral order, that is, to the control of human behaviour in the society. A therapeutic attendance upon occurrence of disease may also have socially cohesive result. Folk medicine does not change easily under the impact of sustained contact with industrialised world, or even as a result deliberate attempts of introducing new concept of disease and hygiene. It is also observed that it is easy to bring behavioural changes than to bring changes in belief's systems.

Singh, Jayaswal, Arora, Choudhary and Jabbi (1987) in their study in two tribal blocks of Ranchi district have observed widespread ignorance and miss-conception about family planning, childcare and breast-feeding. Majority of the tribals want to prevent childbirth after having desired number of children. A vast majority of them believes that vasectomy makes a man impotent. There are

strong son-preferences because most of the tribal have felt that a son is a necessity for continuation of the lineage of the family. A majority of them also do not know that the sex determination of the child entirely depends on the father, and mother do not have any role in it. Tribal males as well as females have inadequate knowledge of immunisation, weight of the child at different ages, sign of dehydration and facts of child development. Majority of the tribals have miss-conceptions and ignorance about breast-feeding. Tribals consider first breast milk harmful to the baby. They also believe that during illness of mother, she should not breast feed her child as it may cause harm to the child. Tribals also have no idea about supplementary food to the child after 4-5 months. They believe that the child can be kept healthy with breast-feeding till one or one and a half year age of the child.

Mathur (1982) in a study has discussed the disease curing techniques among the tribal of North Wynad of Kerala. He has observed that the tribals of Wynad are generally healthy. They use garlic, turmeric, pepper, ginger and various roots and tubers in their daily diet. They have knowledge of medicinal value of herbs. They also believe in sacrifices in honour of their deities. They are not totally immune from all diseases. Majority of them believe in supernatural powers. Their beliefs in supernaturalism are reinforced by their illiteracy and poverty. The tribals of Wynad believe in the powers of forest deities, family gods and supernatural agencies. The tribals of Wynad believe that reciting of *mantras* is the most popular and effective technique to cure disease. The tribal medicine man is the mediator between the people and the deities. The diagnosis of disease is based on the intuition and mediation. The supernatural agencies like spirits and gods are propitiated at regular intervals as a measure of prevention.

The article by Gupta (1986) has discussed the tribal concept of health, disease and remedy. Tribal concept of health, of disease, of treatment, of life and death is as varied as their culture. The tribal society is guided by traditionally laid down customs and every member of the society is expected to conform to it. Unseen forces intervene human affairs in the tribal communities. In the tribal society the

real enemies of human health and prosperity are the gods and dead. The usual theory of disease in the tribal society is that diseases are caused by the breach of some taboo or by hostile spirits, the ghosts or the dead. Sickness is the routine punishment for every crime meted out to them by the spirits. In tribal society magico-religious treatment of disease is resorted to. Tribals also hit upon some herbs in some way or another and found it efficacious. They have then tried the same for complaints other than those it was originally used for and have in this way, been guided by experience.

Hockings (1980) has presented the various practices relating to diseases among the Badagas of South India in his book - 'Sex and Disease in a Mountain Community'. He has highlighted that each folk medical systems develop over the course of several centuries within a particular social framework. The context of development includes four shifting factors such as environmental changes, cultural shift, relation between various social units and successful innovations. Personal hygiene and sanitation is quite good among the Badagas. The range of therapeutic practices is varied. All medicines are more or less liquid. No indigenous pills or powders are administered. Changes in diet may include the diets that give the patient cooling or a heating effect. Surgery is practiced. Offering of prayers to god/goddesses are common among the Badagas.

Pal, Bhattacharjee and Guha (1986) have discussed the tribal concept of diseases in traditional system. They have a belief that most of the diseases are caused by evil spirits, anger, of clan gods, *bongas* and breach of taboos. As per the tribal concepts evil spirits causes most of the diseases of women and children. Epidemic diseases are caused by the anger of clan gods and *bongas*. Personal diseases are caused by breach of taboos and venereal diseases are caused by breach of sex taboos. They have also highlighted the connection of traditional and tribal system of medicine. Like other medicine, tribal medicine has curative and preventive sides with the application of herbs, minerals and animal products.

Henry (1981) has studied a North Indian healer and has identified the factors that help Indian healer in winning the confidence of the people. He is of the view that to understand a folk healer's effectiveness, it is necessary to understand his pertinent mental culture, his role and the image of himself he projects. The confidence in a healer is further strengthened by his role as a *sadhu*, his literacy and his stern demeanour.

Srivastava (1974) has studied folk medicine in some of the villages in Rajasthan and Uttar Pradesh. It has been noted by the author that the villagers generally use traditional knowledge and practices, habits and customs, charms and incantations, magical and religious practices as folk medicine in the treatment of diseases. However in case of serious illness they take the help of modern qualified doctors.

Mann and Mann (1986) have brought to the light the religious attributes and cure among the tribal. They have discussed the cases of Onge, Nicobares, Hikkipkki, Garasia and Bhil. There is a wide recognition of spirits and ghosts in the tribal communities. Supernatural, if disturbed through any gesture or forgetfulness, can cause any severe condition that would prove damaging to the community health. Maintenance of religious structures, images, symbols and places is an essential job for a tribal. The cure role of supernatural is largely recognised by all categories.

Guha (1986) has focused on the folk medicine of the Boro Kacharis, a plain tribe of Assam. She observes that, in all human groups, no matter how small or big, there exists a body of beliefs about the nature, causation and cure of diseases and their relation to other aspects of group life. Religion, morality, disease and its cure are often inter-linked. The Boro society is no exception to this pattern. They believe that good health is the outcome of an honest and pure life, where as disease and sufferings are results of dishonesty, immorality and incest. At least one *ojha* resides in every village. Apart from conducting religious rites he treats ordinary ailments. The Boro-Kacharis classify supernatural causes into six

categories, (i) Wrath of God, (ii) *Mowdai Hamnai*, (iii) *Manshi Kalamnai*, (iv) Evil eye, (v) Sin committed, (vi) Breach of taboo. Besides supernatural cause, improper food, inclement weather, dampness of the locality and excessive indulgence in sex can lead to disease like dysentery, diarrhoea, cold, cough, scabies, loss of vitality etc. These diseases are diagnosed by symptoms and have physical remedies. Supernatural caused diseases are diagnosed in various ways like (a) Divination and (b) Interrogation. Treatment involves propitiation with or without sacrifices of animals and this way evil spirit leave the host. Precaution is taken against epidemics throughout the year.

Das and Ghosh (1986) in their paper have dealt about the child care practices, belief and tradition connected with the method of feeding, role of person in the childcare, medical services soughted among the Santals of Dhadkidh village of Sinnghbum district of Bihar. The Santals do not usually possess an elaborate knowledge regarding the health care of a child. Whatever, they have been traditionally is apparently inexplicable to them from the health and hygiene point of view. The customs, beliefs and practices directly or indirectly influences the child health care practices. The health care practices of the tribals are not to be confused with the modern concept but rather it is to be understood in relation to their environment, economy, religion and socio-cultural beliefs and practices.

Bhowmick (1980) has discussed the concept of diseases of primitive man, the disease associated with gods and goddesses. He observes that primitive man attributed disease to the spiritual and supernatural agencies rather than biological causes. This lead to the origin of disease gods and goddesses and formulation of certain set ritualistic procedures to appease them for cure. Through systematic patterns of behaviour and belief systems, primitive man attempt to deal with man's relation with the non-empirical world and all other basic contingencies of life. Man also suffers from diseases and naturally for the satisfaction of the human urges, needs and for safety he has to depend upon and surrender to some supernatural power. Author also observes that the belief in sorcerer, magician or *ojha* is on the decline.

Shalina (1989) in her study amongst the tribals of Mandla and the slum dwellers of Chandigarh explores some of the co-relation and variations in regard to the mother child health status and value of child. Slum dwellers and tribals both are poor but the women and children of the urban slum dwellers are deprived of adequate physical care and they are socially victimised also. The slum dwellers have all the medical facilities but the utilisation is very poor. Pregnant women are taken to the hospital only when they become critical and beyond any medical help. They depend on magic cure of disease for child health care. Children are loaded with *taveej* or magical charms. Women are merely treated as economic assets and reproductive units to the society. A male child is normally better cared and his health diet is primary concern of the parents than a female child. Slum dwellers are aware of modern medicine and its effectiveness but they ignore to use modern medicine. However the mother child health status amongst the tribals presents an equally dismal picture but the factors responsible for the restrictive use of modern medicine by the tribals are dramatically different from that of the slum dwellers. Tribals neither oppose nor are immune to modern medicine. Their problem is of availability and reaches of modern medicine. Tribal worldview unlike the perception of the urban slum dwellers neither discriminates between male and female children nor women are treated as mere appended reproductive units to the society.

Sachidananda (1986) has discussed the socio-cultural factors related to the tribal health. He has pointed out that social organisation impinges heavily upon the beliefs and practices in regard to the health among the tribals. Tribal thinking, ways, magic and real knowledge are interrelated. In tribal society, medicine, religion, magic and morality are closely related. The tribal nature of treatment varies with the causes of disease.

The study by Choudhury (1986) in two rural areas, one is a tribal village away from urban area and the other is a multi-caste village that is not very far away from urban or semi-urban areas where good medical facilities are available has brought to the light the relationship of medicine and culture. Tribals believe that a

man becomes ill due to natural causes, spirit-possession or influence of evil eye and sorcery. They believe that only a *deona* can save by his magical power. They also attribute a few diseases to a particular deity. They regularly worship the deities. Tribals still have clung to their traditional modes of beliefs and practices. When facilities are available few tribals consult the doctors when the deona fails to help up the disease. Interestingly, the authority of traditional medicine men is less in the multi-caste village where tribal exposed to modern medicine. In the multi-caste villages traditional view of disease exist side by side with modern concepts.

Mital (1979) through his study on the Santals has thrown light to the interaction between modern and primitive medicine. The Santals generally do not avail modern medicine, if they do so they do it while having a strong faith in primitive medicine. The Santals have strong belief in *ojhas* and witches. The *ojhas* have two separate roles to play, (a) spiritual leader and (b) medicine man or doctor. The remedies used by *ojhas* are rudimentary. He gives medicine made out of herbs, roots, barks, shrubs, plants or fruits. The Santals believe in three sources of diseases such as natural source, supernatural source and human source. They also divide the illness into two categories like physical illness and mental illness. All diseases, they believe are mental but in course of time they affect a person physically. To diagnose a disease the *ojha* takes two *sal* leaves rubs oil on it, sprinkles vermilion and chants *mantras*. After a while he looks into the leaves and reads. It is believed that the *ojha* can see the cause and cure of disease in the leaves. Treatment of diseases is done in two ways through divination, magic and through medicines. Theories of diseases and clinical diagnosis are not known to the Santals. The Santals believe that if a modern doctor treats someone he is sure to die. The Santals refuse to accept modern family planning methods but they have a well-planned family. They take resource of herbals medicines to terminate pregnancy.

The study by Chowdhuri, De and Debnath (1986) in four blocks of Purulia district has highlighted that the tribals are less aware of many of the diseases. The

knowledge in health, hygiene and preventive measures of the tribals are very poor. The tribals have still believed on traditional health care practices. In the initial stage of the disease tribal patient goes to their village medicine man. In some case's medicine man prescribes prayers, as it is known to them that few diseases have specific time period and in some case's medicine man also prescribe modern drugs. The benefit of the modern medicine is yet to be accepted by the tribal communities. Poor economies, non-accessibility of modern services are some of the reasons for this.

Hasan (1979) through his study of a village in Uttar Pradesh provides us with an idea of the concept of sanitation, personal hygiene and etiology of disease held by the people of rural India. He observes that the villagers have no idea of sanitation and disease causation. The villagers do not recognise the germ theory of disease. Cleanliness is identified with purification. Illness means feeling unwell so maladies causing to discomfort are not taken to be diseases. More than one cause is often attributed to one diseases and hence treatments are also many.

Hasan (1967) has also pointed out that the villagers seem to have developed their preferences for certain modern treatments. Thus combining both traditional and modern medicine they have developed a new system of medicine in rural India.

Gould (1965) has observed the similar practices in Sherpur village. It has been observed that the modern medical treatment is not totally opposed by the traditional rural people. Moreover it is noticed that the traditional healers, *vaids*, *ojhas* etc, who have partly adopted modern technique of diagnosis and treatment of disease have been more popularly accepted by the villagers than those who do not use modern medical instrument and treatment.

Sahu (1980, 1986) has made a comparative study between the Oraons who have access to modern health facilities built around the Rourkela Steel Plant and those who live in a remote rural area of Kokerma with no government health

centre facilities. Again this has been compared with some villages having government health facilities. The author has observed that instead of own cultural identity of the Oraons, access to effective health services determines the cultural response of the Oraons. The Oraons make great effort to seek services of practitioners of western system in spite of unfavourable conditions when they encounter serious problems. There is no significant cultural resistance for the acceptance of modern medicine as long they are available and accessible to the Oraons.

In a study in two villages of Rajasthan Carstairs (1977) has observed that the strong faith on herbals and magic cure exists among the people. Though acupuncture has a strong acceptance among those people who have come in touch with them, modern medicine has failed to impress the people. Like herbalists or the magician modern doctors never assure the patient that he will be cured. Some of the people accepted the modern medicine but not with total rejection of traditional system of cure. The author has also suggested that a new system should not be straight away introduced to a community. Awareness is to be generated first among the people so that they can accept the new system after introduction of the same.

In another work, Carstairs (1983) has discussed the beliefs existing among the rural folk regarding illness, their level of hygiene and their attitude towards western medicine. He has also pointed out the reasons why western medicine has failed to impress the rural people. He has observed that the villagers attribute diseases to supernatural invasion work of witches or sorcerers and imbalance of bodily humours. The villagers have strong faith in their assurance of cure. The modern western medicine is one of the many alternative methods when traditional medicine or magical methods fail. Due to advocators and practitioners, modern western medicine fails to impress upon the rural people. The doctors are never serious in their duties. The villagers are badly treated by them. They are not willing to promote western medicine.

Jayaswal and Singh (1987) in their study has brought to the light the extents of health modernity are very low varied from zero to two percent in the rural tribal population of Chotanagpur and Santhalparganas in relation to physical and mental health, diet and nutrition, family planning, child care and breast feeding and health habits. As per their observation the low level of health modernity is a consequence of illiteracy, poverty and also due to the absence of health education. All these are reflected among the tribals of both the area in the unhygienic living conditions, faulty food habits, lack of personal hygiene and environmental sanitation and intake of *haria* (rice-beer) and tobacco.

Bhadra (1997) in his study amongst tribals in four tea plantations in Darjeeling district having differential medical facilities has observed that tribal workers of tea plantations have still retained much of their health culture. It has also been observed from the study that there is a keen inclination among the workers towards modern medical facilities where medical facilities are better and easily accessible to them. Where as in those plantations where sufficient medical facilities are not available, inclination of the workers towards modern medical system is not noticed. An important observance of the study is of the contention, which the traditional culture of the tribal acts as barrier in acceptance of modern medicine does not seem to hold good in the present context. Availability, accessibility and the cost involved in modern treatment have a great role for the acceptance and non-acceptance of modern medicine.

Lieben (1973) has discussed that health and disease are related to cultural as well as biological factors. Modern medicine has primarily biological orientation but medical history shows that social and cultural aspect of health is also the concern of medical science. Much of the development of medical anthropology has taken place since the World War II. Anthropological study of social and cultural influences on health and disease include not only subjects of immediate therapeutic relevance but phenomena that have special interest because of their effect on human ecology and the course of human evaluation. Medical anthropology encompasses the study of medical phenomena as social and

cultural features and socio-cultural phenomena influence them as their medical aspects illuminate them. The domain of ethno-medicine is an indigenous medical feature. There are studies that reveal the significance of preventive measures in traditional medicine though preventive measure has been seen as less important in most traditional medical systems. Ethno-medicinal therapists are of various types; herbalists, diviners, midwives, masseur etc. The relationship between medicine and rest of the culture is very close. Etiology and diagnosis of disease is central to any discussion of the connection between medical phenomena and their culture settings.

Srinivasan (1984) has made an attempt to study the perceptions of rural population in utilisation of health and medical care services in selected Primary Health Centres in Tamilnadu. The study has revealed that rural populations are aware of modern medicine. People still preferred the traditional practice of conducting delivery at home. The attitude of the people towards modern medicine has changed, as they have now understood the efficacy of modern medicine.

In another work Srinivasan (1987) has discussed the role of Primary Health Centres in rural health care and the reasons for its failure. Primary Health Centres are the principal institutions providing integrated health services to the rural population but the people, especially women and children, living in interior and remote areas can not avail the services due to the problems of transport and time constraints. Beside this, clinical rather than community orientation of physicians, inadequate training of the health workers, inadequate and erratic supply of medicine, lack of social accessibility, non-participation of the community in the health care delivery system, indifferent attitude of the doctors and paramedical staff and the location of the Primary Health Centres are some of the reasons for under utilisation of the existing health care services.

Basu (1994) has presented that the tribal groups have developed a strong magico-religious health care systems and they wish to survive and live in their

own style. They live and interact within their own homogenous and culturally firm systems wherein common beliefs, customs and practices connected with health and disease have been found intimately connected with the treatment of disease. He has also presented the tribal ill health in regard to women's nutritional health, maternal and child health connected with unsanitary conditions, lack of personnel hygiene, health education and the ignorance of the tribal. The author has also pointed out the gap between the tribal health care systems and the culture of the Primary Health Centre. The inadequate nature of facilities in many tribal areas, lack of respect of the health providers for indigenous culture, lack of attention given to the patients are the main factors for non-acceptance and distrust of tribal people towards modern medicine. He has suggested to bridging the gap, short-term orientation courses on tribal culture, need to be organised for health workers at different level, simultaneously, traditional health practitioners need to be identified for training in public health. Tribal girls could be trained as nurses and midwives to generate better response.

Van and Klass (1981) have highlighted the reasons for the failure of the Primary Health Centres in the villages. As per the observation of the authors, the concepts of modern medicine are based on western model and it is often in clash with the structure of the traditional society. The structural factors are not only responsible for the ill functioning of the Primary Health Centres. They have emphasised the need to understand the social milieu for the introduction of modern medicine effectively.

Khan (1987) through his study has presented the reasons and factors associated with high infant mortality in Uttar Pradesh. He has observed that education of the mother is negatively associated with mortality condition. The level of mortality among illiterate mothers is much higher than that who has some years of schooling. Mortality level in that family is extremely high where untrained midwives attend deliveries and the infant mortality is much lower where trained professionals attend deliveries. The author has also observed the correlation between infant mortality and environmental sanitation, housing etc. The infant

mortality rate is the highest among those families who live in mud houses and source of drinking water is open well. While infant mortality rate is the lowest among those families when the source of drinking water changes from well to pipe water and the houses with concrete roof.

Roy (1989) has studied various aspects of health facilities, incidence of diseases and the use of health care facilities by the people in some villages of West Bengal during the time period of 1972- 1977 and 1977- 1982. During the period 1972-1977 the health facilities were entirely curative in nature, purely hospital oriented and depended on the western mode of treatment. The introduction of the community health scheme was intended to radically change the health care strategy in post-1977 as it gave special emphasis on the health team approach to bridge the gap between target population and the programme. He has observed very little change in regard to the health care facilities and pattern of treatment. The general condition of the access for the poor people has not change much. Villagers are using folk treatment in the post-1978. Roy has also observed that due to economic backwardness of the people and non-availability of the facilities not much improvement has been recorded in the period of post-1978 in public health and hygiene.

Kopparty (1989) has shown interest on social environment and maternal and child health practices. In a study in a village of Andhrapradesh, he has observed that social environment plays a significant role in morbidity prevalence, health action resorted to and maternal and child health practices. In Indian society one's caste status, high or low position in the social stratification, bring out a sharp contrast in their style of living, occupation, income, land holding pattern, education, values, norms, beliefs etc. All these are reflected in the sphere of health care practices. Women, being generally accorded low status next to males, are vulnerable to neglect either deliberately or by compulsion, this reflected in health practices also. Female in the low caste group has more minor morbidity's than the high caste group. In case of children more sick persons are found among males than females. In case of age (55 years+) more sick persons

are found among males than females. In case of middle age (15 years to 54 years of age) slightly more sick persons are found among females than males. In regard to health action for acute and chronic morbidity, females in the low caste group take less action than the female in the high caste group. He has also pointed out that high caste female takes special action regarding diet before and after delivery, than low caste females. Females on the high caste group not only depend on the Primary Health Centre, they also consult other agencies during pregnancies while female in the low caste group depends only on the Primary Health Centres. Similarly, female in the high caste groups starts weaning food and normal food supplementation for their babies much earlier than the females in the low caste groups.

Pool (1986) has discussed the avoidance of food during early pregnancy extending from conception to the beginning of the second trimester and late pregnancy extending from the second trimester to the immediate after delivery in a tribal area of Gujarat. Two main categories of food are connected with this period. Some food should be strictly avoided during the first period but these are recommended in the second period. Women avoid all kinds of hot food during the first half of the pregnancy fearing abortion. Cold foods are avoided during second phase to prevent difficulty in delivery. Hot foods are recommended during last month of the pregnancy to facilitate delivery. After delivery hot food is recommended in order to stimulate the expulsion of dirt. If the post delivery bleeding is excessive, hot food is to be reduced. Body constitution of the tribal women also plays an important role during pregnancy. Women with hot body constitution and those who perform hard physical labour are seen as more prone to have abortion than those with cold body constitution. Women in general take less food during pregnancy. The quantity of foods is specially reduced during last trimester. As foetus grows, it fills the stomach leaving little room for food. Some women also eat less deliberately in order to help the foetus to grow big, as big foetus needs more rooms.

Karna (1976) in his study in some villages of Bihar has pointed out that villagers are inclined to varieties of treatment. Some villagers explain some diseases in terms of supernatural factors, but they do not take to this recourse in every case of illness. There are varieties of concept of diseases existing among villagers, they rarely held common notion of any disease. He has also observed that two broad categories of diseases as scientific and conventional are present among the villagers. Two further categories of conventional diseases are natural and supernatural.

Bang (1973) has discussed some current concepts regarding small pox goddess Sitala in West Bengal. The people have a belief that goddess is present inside the patient during illness and the appearance of the pustules is a testimony to it. When a small pox patient speaks, it is believed that the goddess is speaking. Dietary prescription, herbal treatment and worshipping are the form the treatment for small pox. The professional vacillator claims that the eruption following variation show that goddess is present and failure of eruption indicates her anger. Earlier official attempt to introduce vaccination against small pox are opposed by the vacillators as these might threaten their profession.

Bhatnagar, Sharma and Nath (1985) have evaluated the utilities of *dai* training in infant care. Knowledge and practices of *dai's* knowledge in regard to putting the baby to breast earlier than six hours, use of colostrums, giving boiled cool water and oral dehydration in case of diarrhoea have improved after training. They have also noted the improvement in supplementary milk feeding regarding cleaning of feeding container, use of *katori*, spoon etc. The small change has noticed in case of practice of dilution of milk with water for supplementary milk feeding, while the knowledge of *dai's* on immunisation and oral dehydration therapy have showed extensive improvement. Knowledge of spacing method has showed small improvement but of terminal method, the knowledge of trained and untrained *dai's* is same. The authors have observed that the trained *dai's* have imparted correct knowledge to the mothers in infant feeding and childcare during their post-natal visit.

Bhatnagar (1989) in a study in three villages of Punjab has highlighted the community response towards available medical facilities. The utilisation of medical facilities is negligible in those villages which are away from the Primary Health Centre, while utilisation of medical facilities is significantly more in those that are located near the Primary Health Centre. In addition to access to services other reasons for non-utilisation of medical services are indifferent attitude of the medical practitioners, improper care, non-availability of medicines etc.

Khan (1986) has assessed the impact of rural development programme on the Santals of the Bolpur Police Station of the district Birbhum in West Bengal. Two sets of villages have been studied, the villages within the jurisdiction of Sriniketan of Visva Bharati and the villages away from Sriniketan. The Sriniketan Rural Extension office is situated at a distance of half kilometre from the first set of villages and the Subsidiary Health Centre is one kilometre away from other set of villages. The author has observed that the Santals lives in the villages close to Sriniketan have accepted modern health care practices related to antenatal care, delivery, child care and awareness of free health services, whereas Santals away from the Sriniketan are practicing traditional health care and they are reluctant to accept modern health care practices. The study has indicated the failure of the government health programme in motivating the Santals, whereas the health care activities initiated through Sriniketan influenced the Santals in a positive way.

Gurumurthy (1986) has studied the Yanadis, a tribal community of South India. He has observed that religion plays a vital role in the determination of fertility. Yanadis, much devoted to tribal gods, have higher fertility, but those who worship Hindu gods have lower fertility. The religious importance of having a son is also significant in fertility behaviour. They fear adopting modern family planning measures as these may bring God's Wrath.

The study by Khare (1981) has highlighted the village therapeutic system (folk medicine). He has observed in a North Indian village that the village therapeutic

as it is claimed to continues is based on such cultural makes as body and being *dava* and *dua*, *dharma*, *karma* and *daiva*. Ethical overlaps and differences between indigenous and modern western medicine have taken into consideration. The villagers in the treatment of diseases bring about a culturally holistic approach. The sick are qualified under a set of social factors and cultural values and treatment is done under a culturally meaningful priority.

In addition to the above-mentioned studies there are some other studies, which have dealt with the anthropological aspects of tribal health. Some of the studies have conducted by Dalton (1872), Bodding (1925) etc, presented the progress of the anthropological studies on relatively isolated populations in hills and forests of India, the so-called tribes. There are few more studies indicating the importance of understanding the social aspects of health and diseases. The studies conducted by Sarkar (1958), Ray, Chowdhury, Bhowmik and Das (1976) and Majumdar (1933) have emphasised the importance of understanding the social environment and cultural dimension of health and diseases. There are some more ethno medical studies among tribals in different parts of the country have taken up by a few Indian and foreign scholars. Among these, the studies conducted by Bhat (1976,1985) and Joshi (1978) are important to note here.

OBJECTIVE OF THE STUDY

Health behaviour of a community mainly depends on their social class, ethnic background, religion, occupation and education. Health behaviour changes with the change in socio cultural status of a particular community. In this study an attempt has been made to understand how the social environment influences the health care practices of the tribals in the Tapan block of Dakshin Dinajpur district of West Bengal. We will consider here ethnic background, literacy, classes, impact of the non- government organisations and the Primary Health Centres to

examine the health care practices in the light of modern medicine among the Santals and Oraons in the target and non target villages of the Tagore Society for Rural Development, a non government organisation working in the locality for more than twenty years. The existing traditional system of medical beliefs and practices of the Santals and Oraons will be studied in a comparative perspective to examine the existing tribal concept of health, disease, treatment and causes of diseases. The present study also proposes to assess the impact of the Primary Health Centres and the Tagore Society for Rural Development on the traditional health care practices of the tribals. To what extent the traditional health care system of the tribals have changed, to what extent tribals are aware of modern medicine, how far they have accepted or rejected modern medicine, what are the causes of acceptance or rejection of modern medicine, all these are to be considered in this study. The study will also examine the attitude of the tribals towards modern medicine and the similarities and variation of attitude among the Santals and Oraons in health care practices.

The objectives of the study are:

1. The Santals and Oraons in Dakshin Dinajpur district have originally migrated from the Chotonagpur region of Bihar (now Jharkhand) and Madhyapradesh (now Chhatrishgarh) who have been living here for a number of decades. Irrespective of their income level, there is a change in their social life due to influences of the Hindu communities and the intervention of the Tagore Society for Rural Development. In this context this study will examine the nature of changes in the concept of health, disease and treatment and causes of disease among the Santals and Oraons under the new socio cultural environment. It will also investigate to what extent the traditional health care practices of both these communities have been continuing.
2. The study will look at the impact of the Tagore Society for Rural Development and modern medical services on the traditional health care practices among the Santals and Oraons. The present study will also considers: to what extent their traditional health care practices have changed, to what extent the

Santals and Oraons are aware of modern medicine, to what extent the Santals and Oraons have accepted or rejected modern medicine with comparative perspective, what are the causes of acceptance or rejection of modern medicine among the Santals and Oraons. What is the attitude of the Santals and Oraons towards modern medicine and to what extent economic and social factors have motivated the Santals and Oraons in adopting modern health care practices are to be examined.

3. Medical practitioners and public health workers in India have been reporting that very often tribals do not utilise the medical and preventive facilities available to them. In this context the present study will examine the role and attitude of the modern medical practitioners in socio-cultural environment of the tribals.
4. The study will propose to emphasise the mother child health care practices and the changing trend in these practices among the Santals and Oraons in a comparative perspective due to intervention of the Primary Health Centres and the Tagore Society for Rural Development.
5. The study will see the concept of fertility and family planning among the Santals and Oraons and the use of traditional and modern practices of birth control. To what extent tribals are aware of modern family planning method, to what extent the Santals and Oraons have accepted or rejected modern family planning method and what are the causes of acceptance or rejection of modern family planning method, all these will be examined in this study.
6. This study will cover the environmental sanitation and personal hygiene of the Santal and Oraon communities. To what extent the Santals and Oraons have adopted modern hygienic health culture is a matter of investigation.
7. The study will look into the nutritional status and health culture of the Santals and Oraons with a comparative perspective.
8. It is also observed by a number of sociologists that tribals use to practice traditional and modern medical system simultaneously. This study will see the nature of interaction of traditional and modern medical practices among the Santals and Oraons.

9. Lastly, the study will look into the factors that are conducive, according to the tribals' own view, to the development and spread of modern medical practices among the Santals and Oraons of this region.

METHODOLOGY

The study is based on the fieldwork in four target villages under the Tagore Society for Rural Development and four non-target villages in the Tapan block of Dakshin Dinajpur district in West Bengal. Target villages refer to those villages where the Tagore Society for Rural Development has been working at least for more than 10 years for the overall development of the tribals. The non-target villages refer to those villages where there are no such interventions by the Society. Chamtakuri, Dudiakuri, Dakshin Keshrail and Chhiraikuri are the selected target villages, and Sondapukur, Balapur, Haribanshipur and Sotipukur are the selected non-target villages under this study. The Tagore Society for Rural Development has been working in 38 villages of the Tapan block at least for more than 10 years.

The target and non-target villages for this study have been chosen after considering certain criteria. The target villages of the Tagore Society for Rural Development and the non-target villages where the study has been conducted are under the two Primary Health Centres. The Primary Health Centre situated at Balapur covers three target villages and three non-target villages. The villages are Chamtakuri, Dudiakuri, Dakshin Keshrail, Chhiraikuri, Balapur, Haribanshipur and Sondapukur. Whereas Chhiraikuri and Satipukur villages come under the Primary Health Centre situated at the block headquarter at Tapan. Both the target and non-target villages are selected from the Primary Health Centres, which are away not more than five kilometres. The impact of Primary Health Centres in all the villages is almost same but there are variations of health care practices due to the additional intervention of the Tagore Society for Rural

Development for health development. All these villages are equally away from the district town Balurghat, where better health facilities are available. In all the villages sufficient number of tribal respondents belonging to either the Santals or Oraons are available. According to the representatives of the Tagore Society for Rural Development, the tribals in the selected target villages are slightly better responding to the health related programmes than the tribals of the non-target villages. Likewise in the selected non-target villages there is no such intervention of the Tagore Society for Rural Development for health development. In both the target and non- target villages, we have found the easy access of the tribals to the folk healers and other local health practitioners. All the target and non-target villages are situated on both sides of the connecting bus road between Balurghat, the headquarter of the district and Gangarampur, an important town of the district. Santals, Oraons and Mundas are the tribals living in these villages, along with some Hindus. Rajbansis, Karmakars, Bramins and Kaiyastas are the major Hindu castes living in the target and non-target villages. All the triblals living in the target and non-target villages practice animistic religion, though they claim to be Hindu themselves.

The fieldwork was conducted for a period of two years spreading over 1995-1996. We have applied different types of field techniques for collection of data. All the primary data were collected through census enumeration schedule, interview schedule, case studies, observations and group discussions. The secondary data were collected from library, offices, published documents, books and journals. For collection of the basic data at first census enumeration schedules were used. In the first phase after selection of the villages, census data of all the families of the tribals belonging to the Santals and Oraons were collected. Through the census, besides taking the number of family members of the tribals, information like place of birth, sex, educational qualifications of the family members, earnings, marital status, relation with the head of the family, occupation, affiliation with Church, land owned and type of family were taken.

The Santals and Oraons were identified as major tribal communities in the study area.

In the second phase, interviewing the family heads of the Santals and Oraons was done with an interview schedule. No sampling was felt necessary since all the heads of the Santals and Oraons were interviewed. We have studied all the families of the Santals and Oraons of four target and four non-target villages. When all the families were interviewed methodologically, we could ignore the sampling for selection of informants. Interviews were taken with the help of an interview schedule containing questions, pertaining to different aspects of health behaviour, traditional and modern medicine, housing, water, and sanitation, personal hygiene, food habits, intoxication, mother and child health care and family planning. The questions of the interview schedule are given below.

Interview Schedule

Name:

Ethnicity:

Age:

Village:

Health, Disease and Treatment

1. What is your concept about good health?
2. How do you know that a person is sick?
3. Who are the family members who suffered from diseases during last one year? (Name of the family members and diseases)
4. What are the causes of the above disease?
5. If Supernatural powers are responsible, name them according to diseases?

6. Who cured the above diseases? (Traditional medicine man/ Magician/ Modern doctor)
7. Do you think that diseases are caused because of the 'evil spirit'? If yes, which diseases?
8. How are these recognised?
9. What is 'evil eye'? What do you do in case of 'evil eye'?
10. Whom do you call first for treatment, traditional medicine man or modern doctor?
11. Before calling a medicine man do you try some treatments of your own? If yes, what are these?
12. Give the name of the common ailments of your area.
13. Are you in favour of magic cure of disease?
14. Which diseases have you seen being cured like this?
15. Have you heard from the elders of such cures?
16. Are you in favour of medical help for diseases? Reasons.
17. Do you generally try traditional medicine side by side with modern medicine?
18. What are the methods of treatment by which traditional medicine man diagnose diseases?
19. What are the methods of treatment of diseases? Give details of treatment of magical, supernatural worship, herbal medicine or any other.
20. When traditional medicines fail, do you go for modern treatment? Why?
21. In case of illness do you visit the Primary Health Centre?
22. If yes, why?
23. If no, why?
24. Why do you stick to traditional medicine?
25. Are you suspicious about modern medicine? If so, why?
26. What is your impression about the Primary Health Centre?
27. Do you get all facilities of modern medicine from the Primary Health Centre?
28. Do you feel that staff of the Primary Health Centre, do not behave with you properly and do not treat the patients with care?

29. Do you have constraints to adopt modern medical treatment? If so, specify social, economic or any other constraints.
30. Does the traditional medicine man prevent you from going to the Primary Health Centre?
31. Does your neighbour prevent you from going to the Primary Health Centre? Or any other reason, please specify.
32. Do you think that due to lack of communication you could not adopt modern health practices properly?
33. Do you think that due to inadequate medical facilities you could not adopt modern health practices properly?
34. Do you think that proper or adequate medicines are not given to the patients in the Primary Health Centre?
35. What is the walking distance of the Primary Health Centre from your villages?
36. What is the means of communication?
37. Did you ever receive any health facilities from the Primary Health Centre?
38. What type of health facilities does the Primary Health Centre Provide?
39. What types of health facilities are provided to you from the Tagore Society for Rural Development?
40. Do you think, educational camp organised by the Tagore Society for Rural Development, helps to motivate you to adopt modern medicine? If yes, how?
41. Do you think that behaviour of the health staff of the Tagore Society for Rural Development is acceptable to you?
42. How and when you meet with the health staff of the Tagore Society for Rural Development?

Environmental Sanitation and Personal Hygiene

43. Do you have a lavatory in your family?

a. If yes, do you use it?
b. If no, where do you and your family defecate?
c. What are the consequences of open-air defecation?

44. In your family do children get warms?

45. Do you think warms are dangerous to health? If yes, why?
46. Do you give your children de-worming medicine?

46.1. If yes, what kind of medicine?

46.2. If modern medicine, where do you get from?

46.3. If no why?

47. What is your view about the general cleanliness of the house?
48. From where do you draw drinking water?
49. Do you purify water before drinking?
50. Where do you take bath? Do you take bath daily?

50.1. If no, why and after how many days do you usually take bath?

51. Do you use soap while taking bath?

51.1. If no, why you do not use?

51.2. If yes, do you use it on every bath?

51.3. If you do not use it on every bath, why is it so and after how many baths you use soap?

52. Do you wash your face and teeth daily? If yes, when do you wash?

53. What do you use to clean your teeth?
54. After how many days do you cut your nail?
55. When do you wash your hand?

55.1. Do you use soap while washing hand? Specify reasons.

56. Do you change your clothes daily? If no, after how many days do you change?

57. Do you wash your clothes daily? If no, why?
58. Where do you wash your clothes?
58.1. Do you use cleaning agent to wash your clothes?

59. Do you wear shoes?

59.1. If no, why?

59.2 If yes, do you wear shoes daily or occasionally?

60. Where do mosquitoes breed?

60.1. Do you think that the collected water near the house provides for mosquitoes?

60.2. Do you think that the mosquito bites is harmful?
60.3. Do you know if they cause any serious illness?
60.4. If yes, which ones?
61. Do you think that flies are also responsible for some diseases? If yes, which ones?
62. If 60.2 and 61 are positive, what do you do to prevent mosquitoes and flies from entering your house?

Nutrition

63. How many times do you take food in a day and what are the food items?
64. How many times have you taken milk, meat, and fish during the last seven days?
65. Does your meal contain food items prepared on previous day?
66. Do you care to select your food items according to their nutritive values?
67. Are there any special foods that have to be eaten or not eaten at certain seasons?

Intoxication

68. Do you smoke?
68.2. If yes, what do you smoke?
68.3. How many times do you smoke?
69. Do you consume liquor?
69.2. If yes, what do you consume, *haria* or country liquor or both?
69.3. How many times a day do you consume liquor and how much? Please give one week's consumption?
69.4. Are you aware of the harmful effects of liquor?

Maternal and Child health

70. What do you do when you learn about a women becoming pregnant in your house?
71. Is there any taboo during pregnancy in regard to food, work etc.? Explain in details.
72. What are the practices that are followed during the ante-natal period?
73. Whose help is sought for delivery?
74. What are the practices that are followed during the post-natal period?
75. Who takes care of the mother and child?
76. During pregnancy what kind of special food should a pregnant woman have?
77. What forms the diet of the neonate and infant?
78. At what age cereals are started?
79. At what age child usually switches to the adult type of food?
80. How long is the child breast-feeds?
81. Do you undergo ante-natal check-ups during pregnancy?
82. If yes, give frequency of check-ups and where you undergo this check-up?
83. Do you receive tetanus toxide vaccine during pregnancy?
83.2. If yes, what is the use of TT-Immunisation?
83.3. What is the worst possible outcome if a mother is not immunised?

83.4. What will happen if only one injection of tetanus toxide is given?

83.5. How many times the mother is given the injection and what is the correct period for taking these injection?

85. Have you heard of iron tablet?

85.1. What is the use of iron tablet during pregnancy?

85.2. Whether you received iron tablets during pregnancy? If yes, give numbers and correct period for taking these medicines.

86. Do you vaccinate your children?

86.1. If no, what preventive measures do you take up?

87. Have you heard of tetanus, diphtheria, whooping cough, measles and polio?

88. What is tetanus?

88.1. What are the symptoms?

88.2. How can it be prevented?

89. If you do not vaccinate can it be attributed to your ignorance or some other reasons? Specify reasons.

90. If you followed modern system for mother and child health, how were you motivated to do these?

90.1. Did any body talk to you about mother and child health?

90.2. Are there any contributions from the Tagore Society for Rural Development?

91. What are the ceremonies that are performed after the birth of the child?

Fertility

92. How many children do you have?

Sons- Daughters- Totals-

93. How many children did you have?

94. How many children did you want to have?

95. Do you want to have any more children?

95.1. If yes,

Sons- Daughters- Totals-

96. Do you think that a son is a must for each family?

97. Why do you want more sons/daughters?

98. If you have no children specify reasons.

99. Do you know how repeat childbirth can check?

100. Do you think there should be sufficient spacing of birth?

100.1. If yes, have you heard any method for that?

Group discussions were also conducted with the members of the Santals and Oraons to understand the social and cultural beliefs and behaviour relating to health care practices more intimately in the target and non-target villages. Discussion topics varied but mainly included services available and demanded for health care practices, reasons for under utilisation of the Primary Health Centre, role of folk and traditional medicines, beliefs, causes of diseases and treatment of diseases. One focus group discussion of each community was conducted. In total four focus group discussions of 6-7 members each were organised, two each among the Santals and Oraons separately in the target and non-target villages were organised. All these groups were mixed. Men and women participated equally in these group discussions. Case studies on the traditional beliefs in supernatural power concerning diseases, nature of interaction of traditional and modern medical practices and the cases of non-acceptance of modern medical practices were taken from the Santals and Oraons of both the target and non-target villages. The economic status of the Santals and Oraons in the study area is almost same with little variation. We conducted in-depth case studies of such families whose annual income was more than thirty thousand per annum to enable us to understand the impact of economy of the health behaviour of the tribal people. In addition to these, a separate interview guide was prepared on specific issues for interviewing the

key informants. Representative of the Tagore Society for Rural Development, Medical Officers of Primary Health Centres, traditional folk healers, quacks and other local health practitioners including *dais* and homeopathic doctors were interviewed. The anthropological observation method was also a part of the methodology for the study. We observed the actual health behaviour of the tribal people and compared them with the data provided by them through the interview schedule. This helped in checking and crosschecking of the collected data.