Chapter-I

Introduction

1.1. Introduction

"When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied."

-Herophilus

An excellent health is considered remarkable for every person in our society, as it encourages a healthy mental, physical and social health. Health diversifies considerately with income, gender, age, and family origin as it could be innate or acquired. Health is a condition in which all physical and the mental mechanism of an individual function typically. The word 'health' comes from the Anglo-Saxon (Old English) word root '*Hal*'. The term '*Hal*' used to express three words health, whole, and holy at one time thus, the meaning of the word 'health' is to have a sound mind and spirit in a sound body.

The concept of health has evolved significantly over the years, reflecting a shift from a narrow focus on the absence of illness to a more holistic view that encompasses physical, mental, and social well-being. The World Health Organization's 1948 definition was ground breaking for its time, emphasizing health as a state of complete well-being. This perspective aligns closely with earlier definitions, such as those from Webster's 1913 dictionary and Dorland's Medical Dictionary, which also recognized the multifaceted nature of health. The inclusion of health in the 1948 Universal Declaration of Human Rights further underscores its importance as a fundamental human right, integral to living a life of dignity. Today, this comprehensive understanding of health continues to inform public health policies and initiatives worldwide, aiming to improve quality of life for all individuals.

Health is more than being free of illness and disease. Health is a condition in which an individual can function well physically, mentally, socially and spiritually to express the full range of one's distinctive potentialities within the environment in which the individual is living. Essentially, health is a reflection of an individual's capacity to pursue their desired actions and goals. As we humans are dynamic living beings whose state of health can change from day to day or even from hour to hour, experts in the health sector propose that it is better to think of

every single person as an individual being. Health is a holistic concept and tri-unity of three parts: Emotional Health, Mental Health, and Physical Health. In general, health is somewhat we take for granted unless illness occurs to us. Next we see advice from a medical practitioner in hopes of reinstating our health. The practice of health differs widely from one culture to another and focuses on the cultural models that shape health and healing practices cross-culturally.

1.2. Medical Anthropology

Medical anthropology is one of the developed areas of anthropology and a subfield of social and cultural anthropology. It is an excellent example of how anthropologists have been able to relate the natural sciences to humanities. This subfield study how people in different cultures and societies experience health and disease, healthcare, and related issues. Such experiences observe through the community's knowledge about sickness and misfortune concerning moral and religious ideas.

Anthropologists have been interested in medical practices for many decades; however, medical anthropology as a distinct subfield is a relative newcomer in the world of academia. The identification of the field in medical anthropology is generally attributed to William Caudal in his paper from 1953 entitled "Applied Anthropology in medicine" (McElroy, A. 1996). Since that time, Medical Anthropology has established a degree of independence in Social and Cultural Anthropology. Earlier, the terms like "anthropology of medicine," "anthropology of health," and "anthropology of illness" used. The word "Medical anthropology" was chosen by some authors during the 1940s to refer to philosophical studies on health and illness, and it is a translation of the Dutch term "*Medische Anthropologie*". This term has been used since 1963 as a label for empirical research and theoretical production by anthropologists into the social processes and cultural representations of health, illness, and the nursing/care practices associated with these (Scotch, Norman A. 1963).

Medical Anthropology considers human's social, psychological, and biological factors that help to understand the unique experiences of an individuals or a group. Medical anthropologists can pursue both academic as well as applied branch of the discipline, at different stages of their career. Medical Anthropologists investigate the social and the cultural dynamics of diagnosis and treatment. Using this knowledge, they advise on and formulate strategies regarding public policy and healthcare delivery systems. Most Medical Anthropologist has been employing

ethnographic methods to answer specific health and medicine related questions. They have a demonstrable impact on professional and organizational practices as well as on the theoretical understanding of health and medicine.

According to Richard W. Lieban, "Modern medicine has had a primarily biological orientation, but the basic concern with social and cultural aspects of the maintenance of health and the etiology of a disease is deeply rooted in medical history." The Villerme of France, Virchow of Germany, and others have conceived medicine as social science, both in basic and in applied sense, and advocated that the social and economic condition has impact on health and disease. Besides, they have also stressed that a society has an obligation to assure the health of its members, and advocate social intervention to promote health and combat disease (Rosen, 1963).

The Medical anthropologists, tries to prove the same by observing and examining the health of individuals, massive social formations, and the environment which is affected by the interrelationship between humans and other species; cultural norms and social institutions; micro and macro politics; and forces of globalization as each of these effects common resident of the world (medanthro.net 2019). Also factors like biological, ecological, and socio-cultural dimensions of diseases/ ailments have resulted in the convergence of medical and social sciences (including social anthropological) interest. In the second half of the 19th century, relationship between microbes and illnesses was confirmed by the germ theory of disease. The modern science of medicine sets off with the establishment of the germ theory distinctly separating it from the art of medicines or various speculative medicines and medical practices. It is, however, increasingly understood that most diseases that persists in the human population are due to environmental, behavioural or cultural practices.

Cultural and systematic practice influence the prevalence and spread of diseases. Similarly, ethics, social perspectives and economic constraint also conditioned the perception and health-seeking behaviour. It is not only true for the rural and tribal communities but also for the highly educated urban people. Medical attitude and behaviour are primarily moulded by the state policies and politics that promotes and organize one or the other system of medicines often not formulated purely on medical ground.

1.2.a. Definition of Medical Anthropology

Medical Anthropology is a vast field that not only deals with the medical concerns of human population and the various ways to deal with the health related issues but a branch that study its effects upon the social, economic and cultural aspects of a human population. Medical anthropology, as defined by the Society for Medical Anthropology, is an interdisciplinary area within anthropology that applies social, cultural, biological, and linguistic perspectives to gain a comprehensive understanding of the factors affecting health and illness. It examines the distribution and experience of disease, the approaches to prevention and cure, the healing journey, the dynamics of therapeutic relationships, and the significance and application of diverse medical systems in cultural contexts. This definition of medical anthropology is both theoretical and applied which draws on traditional anthropological research among small communities as well as research in Large-Scale societies. It is both theoretical and applied, as the following description indicates (Womack, 2010).

And in terms of Medical Anthropology quarterly (1992) all inquiries into health, disease, illness, and sickness in human individual and populations that undertake from the holistic and cross-cultural perspective distinctive of anthropology as a discipline, i.e., with an awareness of species, biological, cultural, linguistic and historical conformity and variation. As defined by McElroy (1996), "Medical Anthropology is the study of human health disease, health care systems, and bio-cultural adaptation. The discipline draws upon four fields of anthropology to analyse and compare the health of regional populations and ethic and cultural enclaves, both prehistoric and contemporary. Applied medical anthropology deals with intervention, prevention, and policy issues, analyses the socio-economic forces and power differentials that influence access to care". Medical Anthropology is an interdisciplinary subject which accounts for the study of a community and their unique ways to treat illness or the way they perceive health related issues. With about 7.7 billion humans the numerous ways to tackle the health-related issues revolve around the modern medicine, ancient health solving issue.

1.2.b. Theoretical Aspects of Medical Anthropology

The Scope of anthropological inquiry into issues of human health, sickness, and healing are diverse. The subfields engaged in these inquires often overlap with one another. There are five identifiable basic approaches to medical anthropology: 1) biological and archaeological, 2) cultural-ecological, 3) ethno-medical, 4) critical, and 5) applied. First, two approaches focus

on the interaction of human and their environment from the bio-social and bio-cultural perspective, with a focus on the interaction between biological and health related queries along with socio-economic and demographic factors. The other three approaches emphasize on the influence of cultural patterns of thought and behavioural characteristics of a group.

- **Biological and Archaeological Approaches**

The research in biological and archaeological anthropology is concerned with important issues of human health and disease therefore, often comes under the domain of medical anthropology. Many contributions from it had helped to explain the course of action of evolutionary processes, genetic variation in human, capability of humans to be susceptible or resistant to diseases and other environmental stressors. The evolution of the disease and ancient ways to deal with those diseases helps to understand the changing patterns of health trends.

The shift towards sedentary living patterns and subsistence-based on plant and animal domestication, sometimes called the Neolithic Revolution, had a profound effect on human health. Skeletal evidence from populations undergoing this transition indicates an overall deterioration in health consistency with the known relationship between infectious disease and malnutrition (Pelletier et al. 1993). These emerging infections attribute to increasing population density, social stratification, decreased nutritional variety, water and sanitation problems, and close contact with domesticated animals (Cockburn, 1971; Fenner, 1970). Close contact with domesticated animals; unhygienic water and sanitation problem of current age a led to health threats amongst the rural population. Tribals inhabiting or in close touch with the urban areas are invariably facing these sorts of difficulties in their day-to-day life (Tarafdar, 2005).

The biological approach of medical anthropology takes into consideration the environment, individuality, and genetics. In accordance to some of the researchers a long time ago, humans evolved by adapting the food shortages and yet they somehow survived. Similarly, humans have adapted to live in the high altitudes by obtaining a larger lung capacity, also adapted to reside in the warmer areas by the ability to withstand higher UV radiation. Furthermore, to survive the ecological factors that led to food shortage humans developed the mechanism of storing excess fat into the fat cells which is a perfect interaction between the genes and our environment. And in recent times this evolution that helped our ancestors to survive is a matter of concern has resulted to obesity which is considered by most as a disease; a health issue. So,

the trend of changing an adaptive character into health issue is what the medical anthropologist are interested at.

The most recent threat to human health is from the outcome of civilization and modernization that led to chronic degenerative conditions such as heart disease, diabetes, cancer, and diseases that could not be diagnosed are the leading cause of mortality throughout the world. Many of these diseases share common etiological factors related to human adaptation over the last 100,000 years. Finally, biological and archaeological anthropologists provide important information regarding the ethno-pharmacological aspects of traditional medical systems that are proved to be helpful to the medical anthropologists. Nina Etkin defines ethno-pharmacological as the study of indigenous medicines that connects the ethnography of health and healing to the physical composition of medicine and their physiologic actions (Etkin, 1996).

- **Cultural Ecological Approaches**

Cultural Ecological refers to the study of relation of the human with environment. It can be inferred as the beneficial changes a human undergo in accordance to the inhabiting environment. The cultural ecological approach in medical anthropology is as common as the subjects we face in our everyday life like politics, economy, natural resources, culture, plants, animals, etc., which has the potential to influence a person's mental or physical health. This approach is helpful for anthropologists to figure out the reason behind the global trends. Anthropologists consider the relationship between organisms and the environment and examine how humans deal with these issues culturally and politically.

An example of cultural ecological approach to medical anthropology could be seen in the case of the disease Malaria caused by Plasmodium; a parasite found in the mosquito of the genus *Anopheles Sp.* Malaria has a long, sordid history in many societies, and it continues to be the major cause of human morbidity and mortality even today (Brown, 1997). At a cultural-ecological level, adaptation to malaria includes the highland Vietnamese building practices, in which stilted houses allowed people to live above the 10 feet mosquito flight ceiling (May, 1958). To minimize the contact with mosquitoes during peak malaria season, people mostly settled in the highland areas along with the cattle. From the above example, we could infer that people prevented the disease by adapting the higher grounds and therefore, this adaptation led to less death.

Another such example is the Ecological imbalance due to unplanned and uncontrolled use of insecticides and pesticides for the agricultural sector that may also affects the health of the population. It also affects the nutritional value of food products and increases the level of Bio-magnification at different trophic levels. In Thailand, the indiscriminate use of insecticides and pesticides killed the small fishes in the paddy field. Thus, the low-income families, who generally consumed this protein, were deprived of it (Chaudhuri, 2003). Cultural ecological practices can be used to control the disease causation and to produce an impetus to enhance the basic nutritional status of the population. There is a common practice among the Santals and Koras of India to offer hen on various occasions and circumstances. In every offering, family members, along with neighbours, are used to take hen as food, which has a certain nutritional values. These sorts of balances in the nutritional level is preventive to various diseases prevalent in the region. For instance, conspicuous consumption of hen seems to be preventive for tuberculosis in various contexts (Tarafdar, 2005).

- **Ethno-medical Approaches**

Ethno-medicine is a study of the plants and animals used in traditional medicine practices by various ethnic groups, especially those with little access to western medicines, often based on oral tradition. The area of Medical Anthropology began with the development of ethno-medicine. Medical anthropologist observes the many things such as health-seeking behaviours and how individuals decide when they are sick, as well as the efficacy of curing systems using the ethnomedical approach. The premise of this ideology was to gain an understanding of local medical beliefs and practices that could be beneficial in the provision of biomedical services to people in cultures were biomedicine was new and unknown. Fabrega (1975: 969) defined this approach as "the study of how members of different cultures think about disease and organize themselves towards medical treatment and the social organization of treatment itself."

Consequently, ethnomedical research is an interdisciplinary study of traditional medicines It also makes use of medical anthropology and ethnobotany techniques. Additionally, it makes use of medical anthropology and ethnobotany techniques. Medical Anthropological studies examine the cultural perception and context of traditional medicine. A medical anthropologist studying ethnomedical systems focuses on five major areas of research: a) ethnographic description of healing practices, b) comparison of the ethnomedical system, c) explanatory models of health and sickness, d) health-seeking behaviours, and e) the efficacy of

ethnomedical systems. Also, the ethnomedical systems has three interrelated issues; a) theory of etiology (causation) of sickness, b) method of diagnosis based on the etiological opinion, and c) the prescription of appropriate therapies based on the diagnosis.

The ethnomedical approach includes the understanding of illness and its treatment within a cultural context. It observes, the different health-seeking behaviours and decision making when they are sick, as well as the efficacy of the healing system. The ethnomedical approach to medical anthropology focuses on the way of identification and treatment seeking behaviour of individuals from different cultural settings which usually depends on the cultural context that individual belongs to. Nichter (1992) describes twelve areas of current ethnomedical work, including the study of the afflicted body as space where competing ideologies contest and new ideologies develop through medico-religious practices and institutions which guide the production of knowledge.

The ethnomedical approach defines three sectors of healthcare that people turn to when they are ill. First, the non-specialist or general sector, where an illness is first recognized, and then information about the disease is collected and treatment for the same done from outside the clinical or professional setting. Second, the professional sector i.e., Western medicine, which involves the diagnosis and treatment of the illness by legally sanctioned health care professional. The last sector is the folk sector, that includes non-traditional treatments from various types of healers and herbalists.

Cultural anthropologists often use the ethnomedical model to interpret the cultural response to disease. The ethno-medical approach has typically taken the form of a meaning-based ethnography of illness, that focuses on "words, situations, context and feelings which are associated with illness and give meaning for the sufferer" (Good, 1977). Health care systems, such as the practice of medicine, the presence of professional healers has been in practice for several centuries. There are instances of a definite system of medicine based on nature in the earliest Indian literature, the Rig Veda; and according to it, *Vaidya*- the traditional professional healer reasoned that the occurrence of disease was mainly due to the wrath of God and evil spirits. Hence the art of healing was followed by prayers, religion, rituals, offerings, and sacrifices as well as magico-religious rites. Traditional medicine is also linked very closely to

eating habits based on staple foods and food taboos which could affect one's health and related ailments.

- **Critical Medical Anthropological Approaches**

Another significant area of medical anthropology is called critical medical anthropology (CMA), which considers the political economy of health and the impact of social inequality on people's health by combining fundamental theory with practical ethnographic methods. The term Critical medical anthropology coin by anthropologist Merrill Singer and Hans Baer, plays an important role in its development, emerged in the 1980s as a critique of traditional medical anthropology (Singer and Baer, 1995). Critical medical anthropology focused attention on understanding the origins of dominant cultural construction in health, including which social class, gender, or ethnic group's interest particular health concepts express and under what set of historic conditions under which they arise (Singer and Baer, 2007). According to Joralemon 2010, Critical medical anthropology is a "theoretical perspective in medical anthropology which stresses the importance of political and economic structures, especially global capitalism, on the health of human populations (also known as the political economy of health)." The emphasis of critical medical anthropology is on cultural histories rather than on the biological, physiological, or social justification while considering the health of individuals.

Critical medical anthropologists carry out research encompassing various classes of people, consisting of individuals who may not be able to gain access to medical care. Utilizing critical medical anthropology is essential in this case as it explores the nature of how individuals choose their lifestyles based on their class and its impact upon their health. Meredith Turshen's work provides a critical examination of the political and economic dimensions of health in Tanzania, emphasizing the deep-seated influence of its colonial past. Her analysis uncovers the ways in which colonialism altered the country's agricultural stability, redefined familial bonds, and hindered the progression of medical services. This scrutiny presents an essential viewpoint on the enduring impact of colonial governance on the health-related social structures in Tanzania (Brown et al. 1998). Influenced by thinkers like Michel Foucault, critical anthropologists confront the assumption made by the medical anthropologist. They pointed out the assumptions and generalizations underlying the theory and practices of western medicine, which was historically exempted from the cultural analysis in medical anthropology. Hence, critical

anthropologists have proposed a new paradigm that views sickness not just as a quarantined event but as a product of complex interactions involving nature, society, and culture.

- **Applied Medical Anthropological Approaches**

Applied anthropology emphasizes the direct application of anthropological theory and method to particular social problem. It refers to the use of theories, facts, and methods from anthropology to the identification, evaluation, and resolution of social problems (Kottak, 2002). The applied approach of medical anthropology involves anthropologists' research directly with interviews, participant observation, and focus groups. Many a times anthropologist work for government, advocacy groups, tribal and ethnic organizations, etc. Anthropologist using this approach considers factors other than the biomedical ones, to improve their results, such as cultural impacts. Anthropological methods are practically applied to fields like industrial relations and the study of minority group issues.

Applied anthropology solves human issues by using the theories, practices, and ethnographic discoveries of anthropology. Applied anthropology includes practicing anthropology in three program options. These are communities or organizations, health, and education (California State University, 2002). Applied anthropology focuses on healthcare within biomedical settings and analyses the effects of cultural and socio-economic factors on doctor-patient interaction, adherence to treatment, and the experience of healing. A growing body of literature within clinically applied anthropology demonstrates how knowledge of explanatory models can use to improve cultural sensitivity in physician-patient communications (Kleinman, Eisenberg, and Good, 1978). A major branch of applied medical anthropology deals with public health policymaking, program development, and intervention. The medical anthropologist is being called on to consult with international and domestic health agencies to formulate health programs that are culturally sensitive, applicable to local needs, and effective in obtaining community support.

Anthropological perspectives are relevant to all the levels of public health processes, from the interpretation of disease trends to the design, implementation, and evaluation of programs. Such research seeks to expose the cultural and bureaucratic assumptions within public health that create obstacles to the implementation of locally relevant, effective, and culturally sensitive programs.

1.2.c. System of Medicine in India

Human society has sought to survive itself for its existence, with different types of knowledge on different parts of the world based on the development of culture, education, scientific knowledge, information system, and the materialistic development of different societies (Nagla,1997). The Aryans around 1400 B.C invaded India, and during that period, the Ayurveda and Siddha system of medicine came into existence. The beliefs in sins, demons, and magic as the cause of disease were deep-rooted and widespread in ancient India.

During the Vedic period, it appears, that there existed two main types of healing art and its adherents. The first type largely depended on incantations of magical verses and sacrificial practices to bring about cures. While the second type, based on the magical formula, depended more on the empirical-rational use of herbal and other medicaments. From the viewpoint of Jaggi, the distinction between these types of practitioners of healing art, become more marked; the herbal doctor became the Ayurvedic practitioner who practiced his sophisticated art amongst the people living in cities and towns. Whereas the practitioners of magico-religious medicine combined the ability to serve tribal and village populations; each fitting well into the cultural social life of his setting.

The post-Vedic period (600 B.C.- 600 A.D.) was dominated by the religious tendency of Buddhism and Jainism. Medical education was introduced in the ancient universities of Taxila and Nalanda, leading to the titles of Pranacharya and Pranavishra. During the reign of Rahula Sankirtyana, a comprehensive hospital system was established, catering to the health needs of men, women, and animals. This system was not only sustained but also further developed under the patronage of King Asoka, reflecting the era's emphasis on welfare and healthcare. Subsequently, the period between 650 and 1850 A.D. marked the ascendancy and decline of the Mughal Empire, a significant epoch in the tapestry of Indian history. The Muslim rulers introduced the Unani system of medicine sometimes around 1000 A.D. The Arabic system of medicine, popularly known as the Unani system, is traced back to Greek medicine.

In India, as politics changed, the great wisdom from the past wasn't as prominent anymore. The famous schools and hospitals from long ago slowly got forgotten. But they left behind important lessons that we can learn from and appreciate today. By the mid of eighteenth century, the Britishers brought with them their system of medicine- Allopathy in India, based on the scientific theories of science. Western medicine was introduced principally to serve the British

military personnel and selected groups of the civilian population. This medicine profoundly affected almost all aspects of medical education, including the institutions, the syllabi, and the value system and the outlook of local physicians. But due to the usefulness and efficacy of Ayurveda and Unani, the masses in the rural areas stuck to these systems as they were cheap, harmless, and most suitable for climatic conditions of the country.

Certain Indian practitioners of the indigenous systems styled themselves as a doctor and started treating the patients so, there was a need to protect patients from such deceitful healers. A more comprehensive bill encompassing the whole of British India was introduced in 1916 to prevent the unqualified persons of titles implying qualification in western medical science. Consequently, the Indian Medical Council Act was passed in 1933 and it states the establishment of a uniform standard of higher qualification in medicine for all the provinces and recognition of medical qualifications in states and countries outside British India. Since then, western medicine has come a long way and achieved a great deal of success in curing illness. Currently, there are 384 medical colleges in India imparting medical education in the allopathic system.

After discussing the historical and structural aspects of different systems of medicine in India in different periods, there was a certain shift on the ideological conception of different systems of medicine, their basic manuscripts, variation in the pattern of diagnosis, and treatment procedures. In this context, the system of medicine can be broadly categorized as traditional systems of medicine, which include Ayurveda, Unani, Siddha, Tantric, etc. and the modern system of medicine includes Allopathy. Ideologically, each system of medicine is different from the other. Folk medicine and yogic medicine are not regarded as a system of medicine in the modern sense. As they are based on assumptions, principles, and procedures concerning health and diseases. Homeopathy and Naturopathy are also a widely practiced system of medicine in India. Even though, they have practical purposes, they cannot include under either as traditional and modern systems of medicine.

- **The Ayurveda**

Ayurveda is considered by many scholars to be the oldest healing science, believed to be hand down by gods to sages and then to the human practitioners. Ayurveda is a system of traditional medicine knowledge originated in India more than 5,000 years ago known as 'the mother of

all healing'. '*Ayuh*' means 'life or longevity', and '*Veda*' means 'knowledge or science'. The '*Ayurveda*' a Sanskrit word meaning, 'the complete knowledge for long life'. The first recorded forms of Ayurveda as medical texts evolved from Vedas. Ayurveda is a discipline of the *Upaveda* or 'auxiliary knowledge' in Vedic tradition. The origins of Ayurveda are found in the Atharvaveda, which contains 114 hymns and incantations described as magical cures for disease (Narayanaswamy, 1981).

In Ayurveda balance of '*dosas*' i.e. wind, bile, and phlegm (*vata*, *pitta*, and *kapha*) are important to have a good health and its imbalance results in disease. These *dosas* are uniquely combined in each person which determines a person's characteristics and temperament also are solely responsible for the causation of diseases. So, it could be said that to have a good health one should be able to balance one's *dosas*. Ayurvedic system of treatment uses not only plant-based remedies but tends to follow a balance amongst metabolic, digestion and excretion system of our body through exercises, yoga, meditation and sattvic diet. Through insight, understanding, and experience, Ayurveda presents a vast wealth of information on the relationships between causes and their effects, both immediate and subtle, for each unique individual. Ayurvedic doctors regard physical existence, mental existence, and personality as a unit, with each element being able to influence the others. The holistic approach to use during diagnosis and therapy is a fundamental aspect of Ayurveda.

Ayurveda is an ancient medical system still used today. It has influenced other types of traditional medicine, like those in Tibet and China. These medical practices all share a common history with Ayurveda. This holistic medical approach provides comprehensive health treatment that addresses physical condition, mental balance, spiritual health, social well-being, and environmental variables (Pole, 2006). In 1970, the Indian Medical Central Council Act, was passed by the parliament of India that aimed to standardize qualifications for Ayurvedic practitioners and provide accredited institutions for its study and research.

- **The Siddha**

The word Siddha derives from the phrase Siddhi which means object to attain or prefect or heavenly bliss (Tarafdar, 2008). Siddha medicine is a traditional form of practicing medicine in ancient Tamilnadu (*Tamilakam*) in South India and Srilanka. Tamil Siddhars were the first to develop pulse-reading (*Naadi Paarthithal*) to identify the origin of diseases. Traditionally, it

taught that the Siddhars laid the foundation for this system of medication. Siddhars were spiritual adepts who possessed the *ashta siddhis* (eight supernatural powers). Agastyar is considered the first Siddha and guru of all Siddhars and believed that the Siddha system been handed over to him by Lord Shiva (Brooks, 2000; Weiss, 2009).

According to the Siddha medicine system, diet and lifestyle play a significant role in health and in curing diseases. This concept of Siddha medicine term as *Pathiyam* and *Apathiyam*, which is essentially a rule-based system with a list of 'do's and do not's'. The drugs used by the Siddhars categorized into three groups: *Thavarm* (herbal product), *Thadhu* (inorganic substances), and *Jangamam* (animal products) (Chillayah, 2012). Siddha exemplifies the essence of Ayurveda (plant extracts), Unani, Acupressure (sensitive points), Reiki (energy field), etc. in the theories of Siddha medicine. Siddha medicine utilizes plant extracts, and metal oxides with chanting of mantra during the preparation of medicines (Shukla, et al., 2011).

The government has started medical colleges and research centers like the National Institute of Siddha and Central for Research in Siddha. Its continuous service can identify the individuality to humanity for more than 5000 years in combating diseases and also in maintaining its physical, mental, and moral health while many of its contemporize had become extinct long ago. The Siddha system of medicine is a contribution of the Dravidian culture, one of the oldest civilizations in the world.

- **The Unani**

Unani or Yunani medicine is a form of traditional medicine widely practiced in South Asia, and the word Unani means 'Greek'. The origins of Unani medicine found in the doctrines of the ancient Greek physician Hippocrates, and Roman physician Galen, and developed into an elaborate medical system by Arab and Persian physicians most prominently by Muslim scholar-Physician Avicenna. During the Caliphate, the bulk of Greek knowledge translate into Arabic, part of that knowledge being the principles of medicine with additional contributions of medical wisdom from other parts of the Middle East and South Asia. The introduction of this element to India can be traced back to the 11th century, brought by Arab and Persian traders. Like traditional Greek medicines, Unani medicine based on the concepts of the four humor in a body: Phlegm, Blood, Yellow-bile, and Black-bile, but also been influence by Indian and Chinese traditional systems (Rahman,2001). Unani medicine based on a theory of the presence of an

element in the human body, and these elements are present in fluids, and their balance leads to health, and their imbalance leads to illness. The history of Unani medicine takes place as the work of its practitioners or hakims relied on natural healing based on principles of harmony and balance, uniting the physical, mental and spiritual realms. According to Unani medicine, the treatment of any ailment is dependent on its diagnosis. Proper diagnosis depends upon observation of the patient's symptoms and temperament. Today, India is one of the leading countries in the practices of Unani medicine.

- **Folk Medicine**

Folk medicine was practiced during the Vedic period and are still practiced during contemporary times. They are a set of assumptions, principles and procedures about health and disease. God, Goddesses and spirits are attributed to causation as well as cure and protection from illnesses. The notion that agents of cure such as *priests*, *ojhas*, *tantrikes*, *maulvis*, *sadhu*, *sanyasis* can be successful only to the extent that the patient himself remains morally, socially and physically responsible for his well-being. In this configuration, medicine is one of the components of therapy. If due blessings are there, medicine might expedite cure (Khare,1963). The folk medicine has often divided into sacred and secular subsectors, to indicate its roots in both religions (shamanism) and empirical (herbalism, bone setting).

The folk Practitioners are part-time, non-registered practitioners functioning within the context of village or organization (Kalla and Joshi, 2004). Their roles are validated by social recognition and regulated by the community conventions, the caste and village leadership. The folk practitioner administers simple folk medicines and remedies to the body of clients regularly. In return, they receive some form of direct or indirect remuneration, along with social recognition and prestige as significant rewards. They share some basic concepts with the Ayurvedic system, but there is much in their practice which Ayurveda will disapprove. The folk medicine system has served the rural population for thousands of years and still helps in many different ways. The folk practitioners know their clients and their problems personally, and the folk health system has deep roots in the local culture. The folk health system has rendered its services in anonymity and cultural negativism.

- **Yoga**

Yoga is a group of physical, mental, and spiritual practices that originated in ancient India. The Sanskrit word *yoga* derived from the root *yuj* 'to attach, join, harness, yoke' (Samuel 2008). Panini, a 6th century BCE Sanskrit grammarian suggests that the term 'yoga' may derive from one of two roots: *'yujir yoga'* which means to yoke, or *'yuj samadhau'* which signifies concentration. The term 'yoga' in the Western world often denotes a modern form of *Hatha yoga*, consisting mainly of the postures called *Asanas*. The origins of yoga have been speculated to date back to pre-vedic Indian traditions; as mentioned in the Rigveda. Yoga gurus from India later introduced yoga to the West, following the success of Swami Vivekananda in the late 19th and early 20th century with his adaptation of yoga tradition, excluding *asanas*. The ultimate goal of Yoga is *moksha* (liberation), although the exact definition of what form this takes depends on the philosophical or theological system with which it conjugates. Yoga usually defined as a union between the limited self and the divine Self. Someone who practices yoga or follows the yoga philosophy with a high level of commitment is called a *yogi* (may be applied to a man or a woman) or *yogini* (a woman). On December 1, 2016, yoga was listed by UNESCO (United Nations Educational, Scientific and Cultural Organization) as an intangible cultural heritage. Yoga works primarily with the energy in the body, through the science of *pranayama*, or energy-control. It teaches how, through breath-control, to still the mind and attain higher states of awareness.

- **Naturopathy**

The Naturopathic medicine system makes use of natural remedies to help the body heal itself. The term 'naturopathy' originates from '*natura*' (Latin root for birth) and '*pathos*' (the Greek origin for suffering) to suggest 'natural healing' (Jarvis, 2009). The goal of naturopathic medicine is to treat the whole person i.e., mind, body and spirit. The Naturopathic medicine not only seeks to alleviate symptoms but also targets the underlying causes of illness. It encompasses a variety of therapies such as herbal remedies, massage, acupuncture, physical exercise, and nutritional guidance. The goal is to support the body's natural healing processes and promote overall well-being. The practice of naturopathy is based on a belief in the body's ability to heal itself through unique vital energy or force guiding bodily processes internally (Atwood, 2003).

Naturopaths focus primarily on a holistic approach, totally avoiding the use of surgery and conventional medicines (Jagtenberg, et al. 2006). Diagnosis and treatment concern mainly alternative therapies and natural methods that help out the body's natural ability to restore health. Naturopath aims to prevent illness through stress reduction and changes to diet and lifestyle, often rejecting the methods of evidence-based medicine (Pizzorno,1999). The resurgence of Naturopathy in India can be traced back to the translation of Louis Kuhne's seminal work from Germany, 'The New Science of Healing'. This pivotal moment marked a renewed interest in natural healing methods, as Kuhne's philosophies and practices, once introduced to the Indian context, began to resonate with the country's longstanding traditions of holistic medicine. Shri D. Venkat Chelpati Sharma translated this book in Telugu language in 1894. Shri Shroti Kishan Swaroop of Bijnar translated this book into Hindi and Urdu Languages in 1904. It is an integration of folk medicine, ayurvedic medicine as well as Siddha medicine. Gandhi popularized the concept of Naturopathy through personal experiences and observances with nature care (arogyavihar.com date 01/05/2020).

- **Home Remedies**

It is a sub-section of folk medicine with a limited number of drugs that are readily prepared by housewives with materials available in the Kitchen or the area surrounding the household. It is only when home remedies fail that people go to the village Hakim or Sanyasi or modern physician. In-home remedies, illness is first experienced, labelled, and treated by the individual (self-care) or more often by family members and other members of a social network. The most common things used for the treatment are special foods, diets, local herbs, massage, blistering and other manipulative techniques, exercises, changes in lifestyle habits, use of biomedical drugs and apparatus for prayer, healing rites, including various kinds of talking therapies.

Home remedies, often shared by non-professionals, may possess certain medicinal qualities that could potentially treat or alleviate symptoms of various conditions. However, their effectiveness and safety are not always scientifically verified, as they are usually based on traditional knowledge rather than clinical research. It's important to approach such remedies with caution and consult healthcare professionals before using them as treatments. Many remedies are used as a result of tradition or habit or because they are useful in inducing the placebo effect. The placebo effect is a fascinating psychological phenomenon where an individual experiences a real improvement in their condition after receiving a treatment that has

no therapeutic value. This effect is not just about positive thinking; it's a complex interplay between the mind and body that can produce tangible health benefits (Tavel, 2014). The rising costs and complexities associated with traditional medicine have led to a growing preference for home remedies. These alternative treatments, often rooted in historical practices and natural ingredients, offer a simpler and more cost-effective approach to health and wellness. As individuals seek more control over their health care, the appeal of home remedies is likely to continue its upward trend. Beyond the convenience, home remedies have found favour with a public that wants to take a more holistic approach to their ailments.

- **Homoeopathy**

Homeopathy is a traditional form of medicine, originating from Germany over two centuries ago. Homoeopathy is practiced throughout the world as a form of alternative medicine where practitioners treat patients using highly diluted preparations. Homoeopathy claim that a substance that causes the symptoms of a disease in healthy people would cure similar symptoms in sick people. Homoeopathy is based upon two unconventional theories; a) "Like cures like"—the notion that a disease cured by a substance that produces similar symptoms in healthy people and b) "Law of minimum dose" implies that lower doses of medication may be more effective in treating symptoms than higher doses. This principle aligns with the ancient concept of "like cures like," attributed to Hippocrates, who, around 400 BC, recommended a modest amount of mandrake root to alleviate mania, based on its known effects in larger quantities. These historical insights contribute to the foundational beliefs in homeopathy and continue to influence alternative medicine practices today. Paracelsus, a 16th-century philosopher, coined the phrase "like cures like," suggesting that the cause of an ailment could also be its remedy. This concept has influenced various medical philosophies and treatments throughout history, reflecting the enduring search for balance in health practices. Similar to the subjunctive form "let like be cured by like" later used by German physician Samuel Hahnemann in 1796.

Treatments are individualized or personalized to each person, so it is common for different people with the same condition to receive different treatments. Homoeopathic products come from plants, minerals, or animals. Homoeopathic products are often made as small sugar balls placed under the tongue. Medications can come in various forms including ointments, gels, drops, creams, and tablets, catering to different needs and methods of application. To treat an illness, a homoeopath uses tiny doses of a substance in large doses would cause the symptoms

of the disease. The Homoeopathic practice has been criticized as unethical because it discourages the use of effective treatments, with the World Health Organization warning against using homoeopathy to try to treat severe diseases such as HIV and malaria. While some clinical trials may yield favourable outcomes, it's important to consider that systematic reviews often reveal these results can be attributed to random variation, research design issues, and selective reporting. This highlights the necessity for rigorous methodologies and unbiased reporting to ensure the reliability of research findings in the medical field. The continued practice of homoeopathy, despite a lack of evidence of efficacy, has led to characterize within the scientific and medical communities as nonsense, quackery, and a shaman.

- **Traditional Tibetan Medicine**

Tibetan medicine, based on the teaching of Buddha along with a centuries-old tradition, existed in the Himalayas and South Asia before Buddhism took hold in the region. Tibetan medicine, also known as *Sowa-Rigpa* (knowledge of healing). Traditional Tibetan medicine (TTM) influence by Ayurvedic traditions introduced from India and base on the belief that the human body balances three kinds of internal energies. It melds the ancient wisdom of Chinese medicine and Himalayan folk remedies with the spiritual insights of Buddhist teachings. Tibetan medicine employs a sophisticated approach to diagnosis, incorporating techniques such as analysis of pulse, urine, behaviour, dietary modification, drugs composed of natural materials (herbs and minerals), and physical therapies (Tibetan acupuncture, moxibustion, etc.) to treat illness. Tibetan medicine aims to mend the spirit and bring balance, harmony, and equilibrium back to the body, which can be disturbed by the "Three Interior Poisons" of desire, anger, and ignorance. This holistic approach integrates balanced nutrition, religious observances, mental well-being, and connections with deities to promote healing and wellness.

Diseases and health problems consider being cause imbalances involving the 'three humors' (the physical manifestations of the Three Poisons)- Lung (wind), Kris-pa (bile), and Bad-kan (phlegm). Tibetan healing practices are deeply rooted in spirituality, viewing both medicinal remedies and their tools as hallowed. Healers in this tradition concentrate on the spiritual aspects of wellness, treating the sacred instruments and medicines with great reverence. The rituals and methods used to make drugs observe as just as important as the ingredients. Tibetan medicine posits that the root of many ailments lies within our emotions, suggesting that managing these emotions can lead to healing. Treatments in this holistic approach encompass

lifestyle and dietary advice. meditation and mantra recitation, acupuncture, moxibustion—which involves the burning of mugwort—nutritional supplements, and massages using unique oils. This integration of various practices aims to harmonize the body and mind, addressing the underlying emotional imbalances that may manifest as physical symptoms.

Tibetan medicine employs a sophisticated approach to diagnosis, incorporating techniques such as analysis of pulse, urine, behaviour, dietary modification, drugs composed of natural materials (herbs and minerals), and physical therapies (Tibetan acupuncture, moxibustion, etc.) to treat illness. Tibetan medicine aims to nurture the spirit and reestablish a state of equilibrium, harmony, and balance within the body, which can be disturbed by the "Three Interior Poisons": desire, anger, and ignorance. This holistic approach emphasizes the importance of a balanced diet, spiritual practices, mental well-being, and harmonious interactions with deities to promote healing and maintain health. Diseases and health problems consider being cause imbalances involving the 'three humors' (the physical manifestations of the Three Poisons)- Lung (wind), Kris-pa (bile), and Bad-kan (phlegm). Tibetan healing practices are deeply rooted in spirituality, with healers often emphasizing the role of spiritual forces in health. The rituals and methods used to make drugs observe as just as important as the ingredients. Many illnesses are thought to be rooted in emotions and ideally can be cured by controlling these emotions.

Tibetans adopt four methods of diagnosis (observation, auscultation and olfaction, interrogation, and pulse feeling and palpation), and pay special attention to the change of coating on the tongue and the first urine in the morning. They divide diseases into two types: hot diseases and cold diseases, and they divide patients into three types: '*Long*', '*Chiba*', and '*Peigen*'. Medicine treatment divided into two kinds: oral medicine and medicine for external application. The principle of "cooling the hot" and "warming up the cold" is adopted when treating with oral medication. Methods of treating are acupuncture, bloodletting, cupping, stanching bleeding with hot butter, applying distiller's grains to affected parts of trauma. Commonly used medicines are mostly patent medicines compounded with many kinds of "Materia medica", and there are over 1400 kinds of materia medica altogether among which some are specialties of the Qinghai-Tibet Plateau.

Tibetan Medicine continues to practice in Tibet, India, Nepal, Bhutan, Siberia, China, and Mongolia as well as more recently in parts of Europe and North America. It embraces the

traditional Buddhist belief that all illness ultimately results from the three poisons: ignorance, attachment, and aversion. Tibetan medicine is deeply rooted in the Buddha's Four Noble Truths, viewing health through the lens of spiritual and physical harmony. The Tibetan government-in-exile had also kept up the practice of Tibetan Medicine in India since 1961 when it re-established the *Men-Tsee-Khang* (the Tibetan Medical and Astrological Institute). The organization has expanded its reach, now boasting 48 subsidiary clinics across India and Nepal.

1.3. Tribal Studies

1.3.a. Tribes in India

The term and concept of tribe is controversial among anthropologists and other academics active in the social sciences. The term 'tribe' is derived from the Latin word '*tribus*'; earlier, Romans used this term to designate the divisions in society. A common definition for a tribe is a group of people having a common ancestry, or a common ancestor, a common culture, and live within their own enclosed society. The concept of a tribe is interpreted differently by various anthropologists, leading to a diverse range of definitions.

DN Majumdar describes a tribe as a group of families united by a common name, sharing the same land, language, and marriage and professional taboos. They uphold a recognized system of mutual obligations and support, reflecting their strong sense of community and interdependence.

Ralph Linton defined a tribe as a collection of bands that share a common territory and a sense of unity, which stems from a wide array of cultural similarities and shared interests. This basic form of social organization is marked by the cohesive force of shared traditions and goals among its members. Essentially, a tribe is a larger family, bound not just by kinship but also by a collective identity shaped through common cultural practices and perspectives.

According to Sinha, "isolated tribal groups depend on basic survival techniques such as slash-and-burn farming, hunting and gathering. These societies uphold an egalitarian social structure, which is entirely governed by unwritten ethnic customs and traditions. This reflects a way of life that is sustained through generations without the influence of written language.

India is a land of diversity- different cultures, faiths, lifestyle, traditions, rituals, etc., that are all interwoven, making it a vibrant nation with largest tribal inhabited land in the world. The tribal population of India is scattered all over the country depicting heterogeneous culture and socio-economic status. It is interesting to know the different types of tribes residing in the different geographical location and confronting different situation. According to the Indian constitution tribes are referred to as a category of people, included in the list of scheduled tribes. In none of the Indian languages there is no existence of the term 'tribe'. In India, the recent inclusion of the term 'Tribe' conveys a meaning of a bewildering and enchanting group of people who are preliterate localised social group that speak a common dialect. The tribal people are known by various names such as Primitive, Tribal, Indigenous, Aboriginal Native, Adivasi, Vanavasi and so on.

The Indian constitution has made an important provision for the development and welfare of the tribal community. Tribes who have been listed in the constitution are termed as Scheduled Tribes; an administrative concept of tribe. The term 'Scheduled Tribes' was coined in the Indian Constitution, where Article 366 (25) describes them as tribes, tribal communities, or groups within these communities recognized under Article 342 as Scheduled Tribes in the context of the constitution. This designation is crucial for the identification and provision of rights to these groups within India. There are some 705 communities recognised by the government as Scheduled tribes. According to the 2011 census, India's tribal population stands at 104.3 million, making up 8.6 per cent of the nation's total populace. 89.97 per cent of them live in rural areas and 10.03 per cent in urban areas. The decadal population growth of the tribal's from Census 2001 to 2011 has been 23.66 per cent against the 17.69 per cent of the entire population (Panduranga, 2014). A list of tribes was adopted for this purpose and has been modified from time to time. The total number of tribes and particularly vulnerable tribal group (PVTG) in different states and union territories (UTs) in India reflect the heterogeneity among them. There are 75 such groups identified as particularly vulnerable tribal group (PVTG) located in 17 states and in 1 Union territory.

Health Status of the Tribal People Inhabiting India

Tribal people inhabiting India, who constitute 15 per cent of the geographical area and nearly 8.2 per cent of the population, are truly disadvantaged and marginalized population of our country. Numerous tribal groups are facing challenges due to stagnant or declining populations, low literacy rates and financial hardships. Most of these groups are small in number and generally in habit remote localities having poor infrastructure and administrative support. Many of them are socio- economically under privileged and not benefited much from development projects and other initiatives.

The health conditions of tribal communities in India are notably less favorable than those in urban societies. This is attributed to a mix of social prejudices, diverse cultural practices, and lack of government support, leading to inadequate access to healthcare. Consequently, there's a stark contrast in the wellbeing of tribal people compared to city dwellers. Prevalent genetic disorders and communicable diseases, including sickle-cell anemia and infections like malaria, tuberculosis, and cholera, disproportionately affect tribal regions in states such as Madhya Pradesh, Maharashtra, Tamil Nadu, Odisha, and Assam. Additionally, malnutrition, birth disorders, and gastrointestinal diseases are pervasive among tribal populations, and stark deficiencies have been detected in gross amounts of calcium, vitamin A, vitamin C, riboflavin, and animal protein. Certain tribal groups are even facing extinction due endemic diseases and an unusually low sex ratio (Paliwal, 2004).

Sometimes health status of the tribal population is marked by negative features that one may find in the morbidity and mortality. They may suffer from some distinct health problems, not because they have some specific type of health but because of specific placement in different areas and circumstances under which they live. The health challenges faced by tribal communities are often attributed to a combination of factors, including poverty, illiteracy, and malnutrition. Additionally, inadequate personal hygiene, unsanitary living conditions, and a lack of health education contribute to these issues. Furthermore, insufficient maternal and child health services, along with limited access to national preventive health programs, exacerbate the situation. These elements collectively impact the well-being of these communities. Consanguineous marriage has also been found to affect the health status of the tribal adversely and also responsible for some specific illness including genetic disorders. Unfortunately,

facilities of proper health services are not available in many of the tribal areas; and sometimes the common beliefs, customs and practices connected with health and disease influence their choice of treatment methods. Apart from the above said problems the gradual encroachment by the modern society upon the natural resources of the tribal, depleting them of their habitat and exposing them to the alien aspect of globalization is making a continuous mental stress upon them.

Health and Government Policies

India the second most populous country of the world has dynamic socio-political, demographic and morbidity patterns that has been drawing global attention in recent years. Despite several growths orientated policies adopted by the government, the widening economic, regional and gender disparities are posing challenges for the health sector. Health policy can be defined as the "decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society". The World Health Organization states that a clear health policy can accomplish multiple objectives: it creates a clear picture of the future, delineates priorities and the anticipated roles of various groups, and promotes agreement while educating the public.

Manpower for health services is regarded as the "heart of the health system" in every country. It is one of the most important aspects of healthcare systems and a critical component of health policies. In India, there is no reliable source could give the exact number of the members of the health workforce as more than half of the healthcare professionals work in the unorganized private sector. However, National Health Policy (NHP) has compiled detailed health manpower availability in public sector. The total number of registered Allopathic Doctors upto 2017 is 1,041,395. Over the years, there has been a notable rise in the number of Dental Surgeons and Nurses available for every hundred thousand people.

Over the last two decades programmes like National health programmes, launched by the Government of India is playing crucial roles in tackling several serious health concerns regarding communicable and non-communicable diseases and promoting the traditional and indigenous systems of medicines at national level. National Health policy prioritise primary health care as the principal component of health system and proposed that 70 per cent of the health expenditure would be directed there. Out of the several programmes, Revised National TB Control Programme (RNTCP) is another programme implemented under National Health

Mission. The programme was initiated with the objective of ensuring access to quality diagnosis and care for all TB (Tuberculosis) patients. Several notable activities such as notification of TB; case-based, web-based recording and reporting system (NIKSHAY); standards of TB care in India; Composite indicator for monitoring programme performance; scaling up of the programmatic management of drug resistant TB services etc. were implemented in the past. NIKSHAY, the digital platform for TB reporting, has revolutionized the way patient data is collected and shared, even from the most distant health facilities across India. The National Strategic Plan (NSP) for TB Elimination, adopted in 2017, outlines a comprehensive strategy aimed at eradicating TB in India by 2030.

Similarly, Malaria has been a problem in India for centuries, at one time a rural disease, diversified under the pressure of developments into various ecotypes. Both the cases reported and deaths due to malaria have come down over the years as a result of the National Malaria Eradication Programme (NMEP). In India, the mortality rate from malaria saw a significant decrease, dropping from 0.10 deaths per 100,000 people in 2001 to just 0.01 in 2016. To achieve malaria-free country by 2027 and elimination by 2030, National Strategic Plan (NSP) 2017-22 for Malaria Elimination developed by National Vector Borne Disease Control Programme. Universal access to health care is a well-articulated goal for both global institutions and national governments. India's National Health Policy of 2017 aims to achieve optimal health and wellness across all age groups by integrating preventive and promotive health strategies into every aspect of development. It strives to ensure that every citizen has access to high-quality health services without suffering financial strain. Under health-related Sustainable Development Goal (SDG) good health and well-being, a commitment towards global effort to eradicate disease, strengthen treatment and health care, and address new and emerging health issues has been pronounced. More efforts, however, are required to reach the goals of Universal Health Coverage and those envisioned in Sustainable Development Goal (SDG). Ayushman Bharat Mission, world's largest health scheme announced in the Union Budget 2018-19, is the latest initiative for expanding the health insurance net and targets 10 crore poor and deprived rural families.

Major Diseases Affecting Tribal

In rural regions of India, a significant portion of health issues stem from communicable diseases like diarrhoea, amoebiasis, typhoid, and hepatitis, alongside vector-borne illnesses

such as malaria and dengue. Additionally, there's a prevalence of respiratory infections, tuberculosis, and reproductive health concerns. Concurrently, there's an increasing trend in non-communicable diseases, including cancer, cardiovascular conditions, diabetes, and mental health disorders, which are becoming more common across the country. This dual burden of disease highlights the critical need for comprehensive healthcare strategies that address both infectious and lifestyle-related diseases to improve the overall health of the Indian populace, particularly in underserved rural areas.

1.3.b. Tribes in West Bengal

The total population of West Bengal according to 2011 Census is accounted to 91,276,115. Out of which, 5,296,953 belong to Scheduled Tribes (ST) which is nearly 5.8 percent of which 2,649,974 males and 2,646,794 were females. States most of the scheduled tribe population are concentrated more in southern, western and northern parts of the state. In the state of West Bengal, as per the constitution (Scheduled Tribes) order, 1950, there are total 40 ethnic groups that are notified as Scheduled Tribes (ST) (adibasikalyan.gov.in, Retrieved 14th Nov 2019). Among these ethnic groups three tribal groups viz. Birhor, Lodha and Toto are notified as Particularly Vulnerable Tribal Group (PVTG) with the purpose of enabling improvement in the conditions with particularly low development indicators. Earlier these three tribal groups were under the status of primitive tribal groups (PTG). Birhor and Lodha mostly resides in the districts of Purulia and West Medinipur respectively; while Toto predominantly resides in Jalpaiguri district. Higher concentration of tribal population is seen in the districts of Darjeeling, Kalimpong, Jalpaiguri, Alipurduar, South Dinajpur, West Medinipur, Bankura and Purulia.

The Santal population represents more than half of the total Scheduled Tribes of the state i.e. 51.8 per cent. The Oraon (14 per cent), Munda (7.8 per cent), Bhumij (7.6 per cent) and Kora (3.2 per cent) are the Scheduled Tribes that occupy large population in West Bengal. Other tribal groups like Lodha, Mahali, Bhutia (Sherpa, Toto, Drukpa, Kagatay, Yolmo and Tibetan), Bedia and Savar represents one percent or more of the population whereas the remaining other Scheduled tribes are very small portion of the population size. The population of Scheduled tribes in West Bengal has increased since 2002 with the addition of major ethnic groups Limbu (Subba) and Tamang as they have significant number in the population. In West Bengal out of

total the Scheduled tribes' population 93.9 percent mainly resides in the rural area. Among Lodha, Savar and Bedia more than 95 percent resides in the rural areas; in contrary to the overall case of rural residence among the majority of tribes, Bhutia population has been recorded with the highest 34 percent urban population. The Mahali (10.2 per cent) and Kora (9.9 per cent) are the other Scheduled Tribe population having comparatively higher concentration in the urban areas. Of the total Scheduled Tribe population 74.6 per cent are Hindus, followed by 6.1 per cent Christians, 1.8 per cent Buddhists, and merely 0.4 percent Muslims. Of the total population of Scheduled Tribes, 43.4 percent of the population are literate, which is lower than the national average (47.1 per cent). And with the male literacy rate of 57.4 per cent and female of 29.2 per cent, show a gender inequality in literacy category. Among the total Scheduled Tribe population, Bhutia is ahead of other Scheduled Tribes with 72.6 per cent overall literacy, 80.2 per cent in male and 65.2 per cent in female literacy respectively. Whereas, Savar are at the other extreme with 26.3 per cent overall literacy, 36.4 per cent male and 16 percent female literacy rate (censusindia.gov.in, Retrieved 20th Nov 2019).

According to the Constitution (Scheduled Tribes) Order, 1950, the following were designated as scheduled tribes in West Bengal:

1. Asur	15. Ho	29. Mal Pahariya
2. Baiga	16. Karmali	30. Mech
3. Badia, Bediya	17. Kharwar	31. Mru
4. Bhumij	18. Khond	32. Munda
5. Bhutia, Sherpa, Toto, Dukpa, Kagatay, Tibetan, Yolmo	19. Kisan	33. Nagesia
6. Birhor	20. Kora	34. Oraon
7. Birjia	21. Korwa	35. Parhiya
8. Chakma	22. Lepcha	36. Rabha
9. Chero	23. Limbu (Subba)	37. Santal
10. Chil Baraik	24. Lodha, Kheria, Kharia	38. Sauria Paharia
11. Garo	25. Lohara, Lohra	39. Savars
12. Gond	26. Magh	40. Tamang
13. Gorait	27. Mahali	
14. Hajang	28. Mahli	

Source: Latest List of Scheduledtribes.pdf (tribal.nic.in), Retrieved 12th Dec 2019.

1.4. Review of Literature

1.4.a. Earlier Studies on Health Care Practices

Foreign and Indian scholars had undergone studies on the related topics of tribal health and these studies are useful for the better understanding of the current situation of tribal community. Before 1950's, a very few studies were conducted in the medical anthropology in the context of studies among the health and diseases of the tribals. But, after 1950's some remarkable studies in the area of health, culture and tribal medicine were done. V. Elwin, M. Marriot and Oscar Lewis made some conspicuous studies on indigenous belief and practices regarding health, disease and treatment. Acceptance and impact of modern medical system was also another important criterion in this context. Scholars during 60's and 70's touched variety of key aspects of medical anthropology viz. Folk medicine, Ethno-medicine and Modern medicine in the rural and tribal areas. Such studies enabled other medical anthropologists to get a perspective on health system among various tribal community living around the world and the changes undergone by them in their traditional way of treatment.

- **International Studies**

Clements (1932) has tried to trace the world-wide distribution of five basic concepts of disease occurrence viz. sorcery, breach of taboo, object intrusion, spirit intrusion and sole loss.

Gerlach (1961) in a paper on the DIGO people of Kenya, brings out the responsibility of the kin group in two types of situation. In cases where a traditional healer is sought for a patient's care, it is customary for the patient's family group to attend both the consultation and treatment sessions. Additionally, this family group is typically responsible for compensating the healer for their services. If the kin group decides to take the patient to hospital, he decides who goes with the patient, who stays with the patient, who pays for his transport and boarding and lodging of the relatives and who accompanies the patient.

Adair (1963) studied the role of kin in sickness among the Navaho Indians of the United States. He expressed the view that a person suffering from illness does not operate in isolation. The family is likely to take matters into its own hands its members known that one of their members is sick. After the diagnostician has indicated the root of illness, he suggested what sing should be performed, then the family goes off for a singer who know the required ceremony, and they

arranged with him what the fee for the sing shall be. No ceremony performed free of charge, a payment is essential for the efficacy of treatment.

Baxter-Grillo and Lesi (1964) in their study of African people, pointed out that the customs of people affect their physical health in obvious ways. It is scarcely surprising that *tetanus neonatorum* is common among the African people who apply the herbalist's mixture containing powder dung to the cut cord of each newly born baby, or where tetanus spores shed by domestic animals lie thick about the huts with their caked dung floors.

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 contribution to future health research in Dixon's view, including work as both consultants and researchers.

Young (1979) summarizes the "health history" of Indians in Northern Ontario and illustrates 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 poverty- ridden culture suffering from disease of affluence.

Bruce Goldberg (1997) in his book titled 'soul healing' describes the chapter 'shamanic healing' and it reveals shamanism is a religious phenomenon restricted to Siberian and central Asia. Every medicine man is healer. The shaman is protected by a spirit possession, breach of taboo, bad blood, and the war time between demons and diseases.

Kaja Finkler (1998) studied two systems 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 (2003) highlighted the adverse effects of haphazard insecticide and pesticide use in agriculture on ecological balance and public health. Such practices not only compromise the well-being of communities, especially tribal populations, but also disrupt local food chains. For instance, in Thailand, the overuse of these chemicals decimated small fish populations in rice fields, depriving low-income families of a crucial protein source.

Sjaak van der Geest and Kaja Finkler (2004) studied about hospital ethnography where they tried to evaluate how modern medical institutions can both reflect and reinforce dominant social and cultural processes of their societies. The authors also explored how dominant cultures can reshape contemporary medical perspectives and facilities. They delved into the ways in which prevailing cultural forces influence the development and delivery of medical services, potentially transforming healthcare practices.

In their 2013 study, Kate Senior and Richard Chenhall explored the health perceptions and practices within a secluded Arnhem Land Community in Australia's Northern Territory. They delved into the community's approach to health care, examining the interaction with local health services, the use of traditional remedies, and the reliance on spiritual beliefs during illness. This research sheds light on the complex interplay between modern healthcare and indigenous traditions in shaping health behaviours and decisions.

- **Indian Studies**

Dennehy (1927) recorded different treatment methods among the Nagas. They are propitiation of unknown spirits responsible for disease, exorcism of disease by the magical arts, cure or avoidance of ailments by the consumption of certain foods, and use of surgical methods. He also discussed about the good number of herbs used by Ao Naga, Lotha Naga and Same Naga communities in curing burns, coughs, diarrhea, fever, headache, leech-bite, smallpox, rheumatism, snake-bite, splee, stomach problems, etc.

Roy (1927) discussed folk beliefs about smallpox and cholera in Orissa. Smallpox is caused by the possession of goddess *Chandi*. In Bengal, goddess *Sitala* is held responsible for wrath of the goddess. The superstitions about cholera are more or less same as smallpox. *Yoginees*, the followers of *Kali* (a Hindu deity), are said to cause this disease.

E.T. Dalton (1872) in his book "Descriptive Ethnology of Bengal" compiled materials about the geographical settings, physical traits, economic, social and religious life of the Lepchas and Limbus of Sikkim and Darjeeling.

P.O. Bodding (1940) had critically examined different traditional medicine and medical practices among the Santals and also observed different types of cultural norms and values behind those practices.

Elwin (1955) has tried to describe and analyse the relationship that exists between culture and tribal medicine. He observed that, there are Gods, associated with children's disease, disease of the pregnant women and disease of animals. Most of the disease can be cured by supplicating and propitiating these Gods, directly or indirectly through Shamanism.

Marriot (1955) had critically examined the cultural problems involved in introducing more effective technicians to the conservative's Indian village of Kisangani. He took representative from different social strata and found out conflicts that were obstacles to the spreads of western medicine.

Johann Frick (1957) extensively discussed medicines derived from animal organs in China, where urine, perspiration, hair milk, placenta and many other parts of human beings and other animals go into prescriptions. Throughout South East Asia, particularly among the mongoloid people, animal medicines are extremely popular.

Lewis (1958) had noted that advantage in learning about the indigenous 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 relationships.

Khare (1963) in his article 'Folk Medicine in a North Indian Village' focuses only on medical belief held by the resident of Indian village and stress 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) says 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 behaviour 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 (b) factors which directly affect the health of community as they are related to the problem of medical care to the sick and the invalid.

Karna (1976) in his book 'Etiology of Disease: A Sociological Study in the Rural Context' has observed that the rural people of Madhubani district in Bihar accounts three categories of etiological factors in their disease perceptions. They are the external (such as mosquito, germs etc.), natural (such as food and drinks), and supernatural (such as wrong done to some god). However, in most cases a combination of all three goes together. For instance, malaria is believed to be caused by mosquito-bite, dirty living condition, attack of cold, etc.; typhoid is due to improper food or irregularities done during fever; tuberculosis is due to smoking, cough and cold.

Vidyarthi and Rai (1976) distinguished four categories of spirits in tribal beliefs in India. They are i) protective deities or spirits believed to safeguard the welfare of the village and worshipped at community level, ii) benevolent spirits who are worshipped at communal and mostly familial level regularly, otherwise they may bring disease, death and other calamities, iii) malevolent spirits and deities controlling all kind of diseases, and iv) ancestor spirits who are benevolent and protect the family members.

Kakhar (1977) in his book, 'Folk and Modern Medicine' has done several in-depth studies of the socio- cultural aspects of health and illness. He emphasizes 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 Ludhiana district of Punjab. His categories different systems of medical practices as those who are not institutionally qualified indigenous medical practitioners, which include the Ayurvedic, Unani and Siddha systems.

Joshi (1980) in his article, 'Concept and Causation: Enthnomedicine in Jaunsar-Baur', the Silogan medical system greatly emphasis 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 not merely remains at the level of belief system, but also passes through the natural experimentations.

Nichter (1981) focuses on the innovative medical education, the training of indigenous practitioner the setting up of the referral network, the use of allopathic medicine by registered medical practitioners, and basic research priorities in the social science.

Chaudhuri (1986) edited the book, 'Tribal Health: Socio-Cultural Dimensions on Health' where the overall tribal scenario of India is discussed in detail; their problems, changing scenario, various type of developmental programme are also discussed. His another study (1989) revealed the facts that health and treatment reflect the solidarity of a community. He noticed that among the tribal community the illness and its consequent treatment is not always an individual or familiar affairs but the decisions about the nature of treatment is taken at the community level. One cannot deny the impact of this psychological support in context of treatment and cure, which is very common in tribal communities. In his edited the book, "Cultural and Environmental Dimensions on Health" (1990) presents a comprehensive exploration of the interplay between society, nutrition, and well-being. It delves into the societal influences on health and dietary practices, the impact of culture on nutrition and development, and the intricate relationship between healthcare services, environmental factors, and health. Process of modernization of development in relation to health is also discussed. Chaudhuri (2003) showed that medical practitioner and public health workers have been reposing that very often people do not utilize the medical facilities available to them. Unless and until the reasons for failure or non-acceptance of these programmes are known, the very development programme cannot be successful.

B.K. Roy Burman (1990) in a paper 'Development Hazard to Health in Tribal India' (B. Chaudhuri, ed.) indicates how the development of health of the tribal is disbalanced due to commercialization of forest. He emphasised upon the four major points to explore the above statement: a) Rapid disappearance of forest, b) Commercialization of minor forest products including herbal medicine, c) Replacement of food crop by cash crop and tendency towards monoculture forestry and d) Privatization of communal lands.

Parthasarathy (1990) in an article on spirit possession among fishing communities' focuses on the divination processes and healing practices among the fisher folks for various disorders of body, mind and soul.

Behura (1991) in his research paper 'Anthropology of Disease, Treatment and Cure' mention about the cultural practices and the spread of diseases among the Santals and Hos. Cultural aspects that help in dissemination of disease among these two communities are sharing of the mouthpiece of smoking cylinder by several persons and eating of the leftover food.

Chowdhury (1992) has discussed the culturally recognised syndrome of Koro in Assam, West Bengal and Orissa; how social cognition of Koro is reinforced by medical personals' unscientific comments, and due to their inability to understand the disease it caused the spread of ailment in epidemic form. Kora is a culturally related psychiatric illness. In India, cases of Koro were reported from the above mentioned states in 1982. Koro is believed to be caused by i) body heat, ii) supernatural causations and iii) sex- organ cause. Due to conceptual inability to recognize such cases physicians made absurd comments (e.g. it is a very dangerous disease) and arbitrarily labelled the cause to be due to mischievous sexual natures or practices. This put patients in embracing situation, as mischievous sex is socially unsound and the patients stopped consulting the medical people and recourse to the local quakes.

Kar (1993) in a paper entitled 'Reproductive Health Behaviour of Nocte women through a look at their social structure, culture, food habit, morbidity and traditional health seeking behaviour.

J.J. Roy Burman (2003) wrote the book 'Tribal Medicine: Traditional practices and changes in Sikkim'. The author specifically discussed in his book the concept of disease, sickness and the different methods of treatment among the Bhutias and Lepchas of Sikkim. He stated that along with the practice traditional treatments, the belief of superstition and faith healing are also common among them. People are more dependent on traditional practices and consult *Bongthings* and shamans for treatment and believe in supernatural power.

Tarafdar (2006) stated that the rituals of different phases of life cycle (birth, marriage and death) are linked with health issues and health status of concerned population. He recorded the use of different types of herbal ingredients, auspicious articles and special things in different rituals that reflects the necessity of it in daily life for better health and protection. The Santals and the Koras are accustomed to use them not occasionally but for day-today survival. In one of his study Tarafdar (2010) pointed out that the Santals and Koras of West Bengal living in close proximity to Bengalee culture may get influence and develop the dominancy of bengalee culture over their own culture. In terms of concept of health, disease and treatment a prominent influence of dominant culture take place and its effects are more intensified upon the Kora than the Santals. In various circumstances, the Kora do not even remember or pursue their ways of traditional thinking regarding the causation of disease and nature of treatment as more exaggerate and regular interaction has occurred between the dominant culture and the Koras.

Even some of the government initiated health care programmes also get influence and alter the vision and ideas of both the tribal groups of West Bengal. In another book 'Culture of Health Seeking Behaviour' (2017) he explore delves into the dynamics of how the Drukpas engage with healthcare services and the shifts that occur as modernization takes hold. It highlights how an individual's cultural explanatory model is crucial in shaping their health-seeking decisions.

Mishra and Sarma (2011) offers a comprehensive review of scholarly work on tribal health, illness, and medicine in Orissa, highlighting two main trends. One trend scrutinizes the morbidity and mortality patterns within tribal populations, often linking health outcomes to traditional beliefs that diverge from established scientific perspectives. The other trend delves into indigenous illness classifications, healing methods, and the significance of traditional healers. The authors critically examine these perspectives and underscore the need for further research in tribal health and medicine, especially considering the significant shifts in health care delivery and policies, such as those introduced by the National Rural Health Mission.

Chaudhary (2012) edited the book 'Tribal Health and Nutrition' where discussions are made on various issues related to tribal health and nutrition in India in specific context to their culture, local ecology, voluntary efforts and institutional intervention. Chaudhary (2013) discussed the two interrelated issues on health and nutrition, which have drawn the attention of various scholars across the world. He highlights the different issues related to tribal health and nutrition in India influence by their specific context of culture, local ecology and institutional intervention. Moreover, the author made a fruitful suggestion in different issues of health and related problems faced by the tribal people.

Prasad, R.S. and Sinha, P.K (2013) described about the interior areas of western Himalayan plants becoming the only source of medicine and well-being. However, the writers have discussed about the traditional healthcare practices and the herbal ethno-medical history among the tribal people of Indian context. Further, they discussed about the health status of women in India, overcoming the public health problems and practices among the tribes of India.

Islary (2014) study presents health as a state of well-being, perceived through a functionalist lens by tribal communities. This view associates illness with the inability to fulfil societal roles. Influenced by socio-cultural factors, these communities navigate various health care systems, often concurrently or sequentially, in response to health challenges. The research synthesizes

secondary literature to propose a model of health-seeking behaviour, reflecting the unique health conceptions, conditions, and practices among India's tribal populations.

Prakash (2015) examines the traditional healthcare practices of Uttarakhand's tribal communities, highlighting the pivotal role of forests and forest products in their culture, economy, and religion. It underscores the deep-seated bond between the tribes, such as the Bhotias, Rajees, Tharu, Boxas, and Jaunsarees, and their environment, which provides them with food, medicine, and more. The paper is structured into two main sections: the significance of medicinal plants and their specific use by these communities. This research combines historical insights with scientific analysis to shed light on the indigenous medical practices integral to the region's healthcare framework, as recognized by the World Health Organization in 1978.

Sarkar (2016) examined the health and nutrition of tribal women in Godam line village, Darjeeling District, West Bengal, revealing a high incidence of illnesses such as diarrhea, coughs, colds, and dysentery. Chronic conditions like hypertension, vision issues, and arthritis were also prevalent. The research highlighted the acute shortage of healthcare facilities, leading to many cases being neglected or untreated. Additionally, it was observed that pregnant women often consumed fruits and health drinks.

De (2017) observed that tribal communities were grappling with poor health due to insufficient food intake, leading to malnutrition and a higher susceptibility to diseases such as diarrhea, filariasis, malaria, tuberculosis, and anaemia. The placement of Primary Health Centers (PHCs) away from these communities exacerbates the issue, particularly affecting tribal women who also suffer from a lack of health education, resulting in minimal knowledge about HIV/AIDS. Additionally, disparities in health service access and utilization are prevalent, often due to ignorance regarding health and hygiene. Complications from early marriage further contribute to the health crises faced by these communities.

Roy and Tarafdar (2017) explore into the traditional healthcare practices of the Rabhas in North Bengal, focusing on the worship of Goddess Rountuk, a central figure in their domestic spirituality. The research illuminates the various rituals performed to placate the deity, serving as primary interventions for psychological fortitude in facing health challenges. Furthermore,

the persistence of supernatural beliefs within the Rabha community is revealed, underpinning their healthcare customs despite evolving circumstances.

1.4.b. Earlier Studies on Sherpa

Furer-Haimendorf, Christoph von. (1964) in the monograph *'The Sherpas of Nepal: Buddhist Highlanders'* provides an excellent background study of the ethnography of the Sherpas of the region of Khumbu, located at the foot of Mt. Everest in Nepal. The author, gathered the information for this study with several field trips to the area in the period between 1953-1962. Although the study focuses on the subject of the religion especially on the monastic life, but there is abundant subject matter on the geography and economy of the region, kinship and social organization, family life, the village political organization, and the values and moral concepts of the people. Furer-Haimendorf (1984) is able to document the social changes in the Sherpas as they became involved in the business of mountain climbing which came at a fortuitous time just after China closed the borders of Tibet in 1959 and Shut down the Tibet-India trade. He examines how the lucrative business of mountain guiding and porterage pulled young, men into the city of Kathmandu, where the successful ones established a second home and the absence of men in the village significantly impacted the traditional way of life which also inflicted changes in family and village life, monasteries, religious ceremonies and morality. He provides life history of each monk in one monastery and a 1953/ 1983 synopsis of each household in the village of Khumjung.

Ortner, Sherry B (1973) explores the relationship between explicit cultural forms ("symbols") and underlying cultural orientations. According to Ortner, "a system of symbols as a guide, or programme, or plan for human action in relation to certain irreducible and recurrent themes or problems of the human condition as conceptualized in particular cultures" governs the Sherpa people's customs just as it does any other culture. Symbols and action are therefore consistent in the sense that the former offers possible circumstances and settings for the latter. But if the symbolic system of Sherpa religion and culture was dominated by a Buddhist ethos, as depicted in anthropological literature, the question of the destruction of the environment should remain unanswered. Ortner, Sherry B. (1978) in the book '*Sherpas Through Their Rituals*' the author delves into Sherpa culture, exploring how their Buddhist beliefs intertwine with societal elements, offering insights into ritual and religious symbolism. Ortner's scrutiny of these rituals

uncovers a dual force: The Buddhist inclination to emphasize individual isolation and the worldly drive to counteract this isolation, fostering a sense of community and social continuity.

Oppitz, Michael (1974) wrote a paper 'Myths and Facts: Reconsidering Some Data Concerning the Clan History of the Sherpa'. The author participated in a German research project devoted to the anthropological study of the Sherpa, a Himalayan population of Eastern Nepal. The author and several members discovered certain significant documents found in private houses, temples and Buddhist monasteries of the Nyingmapa sect, which were of mixed character: some written in Tibetan, interwove old Tibetan or Sherpa mythological concepts with real genealogical enumerations of Sherpa ancestors and historical (or semi-historical) accounts of events extending over four to five centuries. The discovery of the above mentioned documents rendered it possible for the first time to formulate a number of historic hypotheses concerning the original homeland of the Sherpa people, their migrations and final settlement in Solu-Khumbu and the expansion of their clans. According to the author these hypotheses are also supported by oral traditions of the Sherpa as provided by the application of statistical data, collected during the expedition.

Paul, Robert A. (1976) This research paper is an interpretation of the structure and symbolism of a Sherpa Buddhist temple in north-eastern Nepal. The temple represents an objectification of a model of the mind in which underlies Sherpa religious thinking and also has interesting implications for the psychoanalytic theory of the structure of the psyche. The description and analysis applies only to one temple (Tibetan Buddhist temples/ monastery), though composed of similar iconographic and architectural elements, they differ widely from one another. Therefore, some points made here apply to all the temples, facts like they can be circumambulated, or that they contain a Srung Khung somewhere in the premises, the interpretation as a whole is not generalizable. Robert Paul's 1979 paper, "Dumje: Paradox and Resolution in Sherpa Ritual Symbolism," explores the Sherpa community's complex relationship with their environment. He put forward that what seems like a contradiction in their conservation and destruction of worms—protecting them during ploughing but killing them when they threaten crops—is a reflection of alternating cultural codes. These codes are not solely about survival; they also intertwine with the Sherpas' evolving history and their adaptation to changes in society and the natural world. The Sherpas' environmental actions, influenced by encounters with tourism and Western ecological thought, demonstrate a dynamic

interplay between tradition and modern influences. The 1989 book 'The Sherpas of Nepal in the Tibetan Cultural Context' delves into the intricate symbolism of Sherpa culture within the Tibetan tradition, merging psychoanalytic theory with structuralism and symbolic anthropology. It explores how Tibetan cultural monuments and religious texts serve as symbolic tools to navigate the generational paradox. The work connects various aspects of Sherpa life, from lineage and cosmology to festivals and epic narratives, revealing a complex web of symbols that resonate with the Tibetan system of governance and myth-making. The 1989 book 'The Sherpas of Nepal in the Tibetan Cultural Context' delves into the intricate symbolism of Sherpa culture within the Tibetan tradition, merging psychoanalytic theory with structuralism and symbolic anthropology. It explores how Tibetan cultural monuments and religious texts serve as symbolic tools to navigate the generational paradox. The work connects various aspects of Sherpa life, from lineage and cosmology to festivals and epic narratives, revealing a complex web of symbols that resonate with the Tibetan system of governance and myth-making.

Dawson and Uhrig (1984) in the paper entitled 'Sherpas and Sickness' mentioned about the Sherpas beliefs and practices with regard to their health. In this paper the authors' description and analysis are based upon the living experienced shared with the Khumbu Sherpas of Nepal. They had described some of the most common Sherpa beliefs about disease and illness and also part of discussion is about what Sherpas belief on the causes disease. Based on their experience of treating Sherpas at Kunde Hospital in the Khumbu region of Nepal and more importantly their two years' experience of living in the Sherpa Village, they explain how some of the Sherpa behaviour causes confusion to the Westerners.

Kumar, R (1988) in 'Paganism and Spiritism- A study of Religion and Ritual in the Sherpa Society' states that in order to know man, his society and culture anthropologists have to follow the concept of Nature-Man-Spirit complex propounded by Vidhyarthi. However, the study reported here is not exactly in tune with the study by Vidhyarthi (1963) as there is a great difference between the whole cultural surrounding of Malu of Santhal Parganas of the Bihar and the Sherpa culture of Nepal Himalayan region. The purpose of writing this article is to show how Sherpas are associated with nature, god and spirits (Supernatural forces) and it also explains why they perform certain rites and rituals on various occasions. For the purpose of

conceptually highlighting the religious scenario prevailing in the Sherpa society, this article is written on the basis of ecology, symbology and typology.

Fisher, James F. (1990) In the book *'Sherpas: Reflections on Change in Himalayan Nepal'* he combines the strengths of technical anthropology, literary memoir, and striking photography to study the rapid social changes in Himalayan Nepal. Beginning with his impressions of Sherpa society in pre-tourist days, he considers that the impact of tourism has only affected the 'surface' of a Sherpa society whose structure remains prevalent. But the issue of 'negative impacts' of tourism on the culture and the environment of the Sherpas seems more complex. Fisher examines the evolution of modern Sherpa society as it navigates the challenges posed by widespread education and booming tourism. He delves into the community's apprehensions about their future, exploring their perspectives on addressing and overcoming these issues. Fisher's analysis offers a window into the Sherpas' strategies for adapting to rapid societal changes while preserving their cultural identity.

Barbara A. Brower's 1991 study, "Sherpa of Khumbu: People, Livestock, and Landscape," offers a deep dive into the Sherpa community's relationship with their environment in Sagarmatha National Park. It highlights the complex dynamics between humans and land, showcasing the Sherpas' resilience and the multifaceted aspects that influence land-use changes. The narrative vividly paints the Khumbu region and delves into the evolution of Sherpa history and economy, noting significant shifts in traditional lifestyles. Central to this exploration is the role of livestock, especially cattle, providing a lens through which the broader examination of Sherpa society's adaptation and interaction with both local and global spheres is viewed. The study stands as a comprehensive and engaging portrayal of the Sherpas' symbiotic bond with nature.

Adams, V. (1997) The research paper discuss about 'Dreams of a final Sherpa' exploration of a Himalayan Sherpa ritual engages contemporary cultural anthropology debates concerning ethnographic essentialism, positivism, and so-called postmodernist approaches. He notes a parallelism between Buddhist Sherpa ritual processes that call upon patrons to engage in mimesis with idealized images of themselves and ethnographic representations that call for the Sherpas to become that what is desired by foreign others. A positivist interpretation of Sherpa culture suggests

we must reflect on how our narratives impact them and embrace a deliberate essentialism, mindful of its karmic impact.

Sherpa, L. (2008) wrote a book entitled, '*Through a Sherpa Window: Illustrated Guide to Sherpa Culture*'. The book gives a thorough guide to Sherpa culture and their way of life. The book introduce history, culture, spirituality and environment that shaped the Sherpa culture. This book is written from a Sherpa perspective to increase cultural appreciation among the younger Sherpa. This book presents an illustrated volume that is encyclopaedic yet accessible, a guide to Sherpa culture presented as part of a larger drive of sensitise the 'educated younger generation of Sherpa'. The author's goal is to try and preserve an understanding of the traditional lifestyle and beliefs amidst the fast paced changes that modernisation and tourism have introduced into the Khumbu region of Nepal. While the transformation is obviously a key concern of the author, bulk of the text is devoted to explain the aspects of Sherpa folk and high culture, lifestyle, household and terrain.

Bhandari, et al (2015) in this study, DNA samples from 582 Sherpas in Nepal and Tibet Autonomous Region of China were analyzed to explore their genetic diversity. Sherpas, renowned for their high-altitude climbing skills in the Himalayas, have a debated origin. The results of this study revealed that Sherpas share most of their paternal and maternal lineages with indigenous Tibetans, forming a recently derived sub-lineage. The estimated ages of two Sherpa-specific mtDNA sub-haplogroups (C4a3b1 and A15c1) suggest a genetic divergence from Tibetans less than 1,500 years ago. These findings challenge the theory that Sherpas and Han Chinese are dual ancestors of Tibetans, instead indicating that Tibetans are the ancestral population of Sherpas, who inherited their high-altitude adaptations from Tibetan ancestors.

Sherpa, C (2017) in this research paper author has discussed about the economic organisation of the Sherpas along with its changing pattern and tried to reveal some of the economic difficulties they are facing in their life. The Sherpa economic organisation has witnessed many upheavals. However, balance is maintained through a close relationship between ecology, economy and society. The Sherpa economy may be characterized as one of mixed agriculture and livestock rearing incorporated by cash from labour, trekking, mountaineering and trading. It further focuses on how most of the youth are attracted towards White collar jobs (both government and private sector). In this way Sherpa economy is gradually changing over into

market economy and this transition is causing problems in their patterns of life and cultural identity. As the studied Sherpa population pursues different economic activities, it is very difficult to find simple and precise form or trend of change in the economy as it is fast changing on local levels.

Sherpa and Tarafdar (2018) In this paper 'A Study on the health care practices among the Sherpas –A Hill Tribe of West Bengal' the authors attempts to know the various forms of traditional health care practices and beliefs existing among the Sherpa along with the evaluation of existing modern healthcare facilities introduced a few years back in the studied area. According to the paper it was found that the studied population has their own 'explanatory models' (Brown et al., 1997) for interpretation of the causation, treatment and outcome of sickness according to which they choose to cure the diseases. The main perspective of the paper is to understand the health care practices in relation to the worldview of disease causation and curative practices prevailing in the contemporary Sherpa community inhabiting in the area of Kurseong town, Darjeeling district of West Bengal. Sherpa and Tarafdar (2019) has discussed about the child birth and childcare experiences among the Sherpas of Srikhola and Gurdum areas of district- Darjeeling, West Bengal. They stated that one cannot overlook the rituals and traditional methods of treatment to cope up with fewer amenities available in their surroundings, isolated entirely from the modern world their own way of handling the circumstances help them to survive. Although with the introduction of modern technologies and programs the system of birth and its rituals in Sherpa society has undergone radical changes.

1.5. Scope of the Present Study

The present study bestows an opportunity to comprehend the various aspects of culture prevailing among the Sherpas. The research intends on findings of an ethnographic account of the origin of the community, historical background of the village and the people. Likewise, gathering information on the different physical features of the area, its administrative location, geographical location and the settlement pattern of the vicinity. The study also focuses on the background of the people, such as family, language, marital status, education, economic pursuits, clan organization, social stratification, property inheritance, the political system, and so on. Moreover, it concentrates on the findings associated with religion, festivals, their notion of the supernatural beliefs, the different magico-religious ceremonies and the reverence given

to specific objects as totems and forms of taboo existing among them. Studies have been done to get an account of the various stages of the life cycle, i.e., birth, marriage and death and related rituals practiced among the Sherpa people.

The principal perspective of the study is to have an in-depth understanding of the various fundamental conceptions on health and the numerous supernatural beliefs concerning its occurrence. This medical anthropological study is very new research among the Sherpa tribes of India. So, this enquiry will try to unveil and understand the notion of health, disease and traditional treatment involving magico-religious performances, life-cycle related rituals and their supernatural connotation. The type of practices as forms of Ethno-medicine as well as the various forms of health care received by the Sherpa people and their belief in the traditional practices or the use of modern treatment and allegory related with them. The importance of understanding the various forms and roles assigned of the beliefs and practices with some kind of social institution prevalent among them. An attempt had also been carried out to know the general conceptions and the various types of practices and beliefs that prevail among the studied population.

Furthermore, the various forms and use of different traditional practitioners for presiding rites-de-passage and the belief related to them are also discussed. In addition, the importance of various festivals has been studied to understand the embodiment of the collective bonds of the individuals and communities as a whole and the unity between them. Besides that, the role of traditional healers and usages of different Ethnomedicinal plants by the Sherpa people are investigated. It will highlight the issues of the modern healthcare system and the implementation of different healthcare programmes and policies on them. Here, a focus on the analysis of the family planning, the immunization process, the modern treatment and more are gathered. This study helps to understand the conception on health with the notion of diseases, their different uses and the practices of traditional healing systems prevailing among them.

The study among the Sherpa have occurred in many spheres is done to highlight the various trends prevalent among them with respect to richness of the culture distinctively possessed by them and changes that have occurred in many of their practices, both religious as well as health. Moreover, to comprehend the essential characteristics of the community that provides uniqueness to their culture and the entire structure of the society as a whole. Focus has also brought on evaluating the various trends that have emerged in the past and still practices today.

The following issues have been studied to understand the health, concept of disease and the nature of treatment: supernatural belief related to health, disease and treatment; reasons for illness and categories of treatment; role and position of traditional medicine-men in the society; disease, treatment and community; and interaction of traditional and modern system of medicine. A preliminary attempt has been made with view of understanding the cultural scenario prevailing among the studied Sherpa community of both rural (Srikhola Daragoan Gram Panchayat) and urban (ward no. VI and VII) areas.

1.6. Objectives

The objectives of the study are to have an in-depth understanding about the various underlying notion of health, disease and care seeking behaviour of the Sherpa of West Bengal for emphatically exploring the indigenous features related to health issues. The study also explores the traditional health care system, impact of modern health care system and syncretism of different health care alternatives prevalent among the Sherpa. This anthropological study not only orients towards improving the quality of life of the community but it also helps to initiate the various developmental programmes. So, the main objective of the present study will orient under the following headings:

i. To know the overall health situation of the population under the study.

ii. To study the concept of health, disease and sickness among the Sherpa.

iii. To study the different methods of treatment undertaken by the same community residing in two different areas.

iv. To reveal the supernatural belief and practices related to health, disease and treatment and also to understand the roles and position of traditional healers, method of treatment and their age-old indigenous Knowledge system.

v. To explore their distinctive ethno-pharmacology, life-cycle related rituals, Magico-religious performances and supernatural connotations.

vi. To identify and documentation of medical plants, their usages patterns and the important implications for the treatment within the Sherpa community.

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

viii. To evaluate the interaction between traditional healthcare system and modern healthcare system and how it has influenced the health and care seeking behaviour of the community.

1.7. Hypothesis

Considering the objectives of the present study the following hypothesis may be framed:

a) Concept of health, disease and treatment among the concerned population may vary due to different age, sex, education, economy, environment and communication. Further, the various causes of ailments may lead to different categories of treatment procedures.

b) Lack of proper infrastructure and less communication of modern medical system may sustain the population to show deep concern about the dependence and assurance of traditional medical system in the population residing in specific situation.

c) The traditional method of treatment act as a psychologically support for patients to get cure as both patients and healer share the same cultural milieu.

d) The absence of proper infrastructure and technology of the modern medical system may influence the population to manifest profound attention towards the traditional medical system.

e) The co-habituations with the other communities have led to the syncretism of culture governing their concept of health, disease and treatment.

f) The effectiveness of healthcare initiatives in addressing diverse health conditions is closely tied to the prevailing beliefs and practices of the community in question. It is essential for governments to consider a spectrum of factors, including economic status, educational levels, living conditions, and cultural norms, when devising policies.

g) The imposition of various forest laws, deforestation and commercial forestation may have adverse effect on the accessibility of traditional herbal medicines from the forest.

1.8. Methodology

Field work is regarded as an important method of collecting and analysing the information in a scientific way. The field work provides us the first-hand data an essential part of studying Anthropology. It is the fieldwork tradition that distinguishes Social-Cultural Anthropology from other Social Sciences (Chaudhury, 2004). The entire fieldwork procedure has two elements a) observation and collection of data (facts) b) A systematic analysis of the collected data and writing a report upon it. Creation of rapport in the field area is an important part of research as researcher has to create friendship and companionship in the field that will go a long way and helps to understand the native in totality. The relevant data and information for this study is mainly based on fieldwork conducted in the rural (Srikhola Daragoan Gram panchayat) and urban areas (Kurseong Municipality ward no. VI and VII) of Darjeeling District, West Bengal. Fieldwork was conducted in various phases from the year 2015 that extended up to 2019. The total 211 Sherpa families from both rural and urban have been covered under this study. The urban area for the survey is situated in Kurseong town where as the rural area selected for the study is a remote area that takes almost a day to reach the place. The rural area selected for the study was inaccessible to the basic facilities such as transportation, electricity and healthcare, etc. During the visit to the field area in 2017 the construction of the motorable vehicle road was at progress in the area from Srikhola to Daragoan and in the same year electric poles were erected. Even though, the work is slow but one could see the efforts of the administration to provide basic facilities for the people of the area the progress is going on in the area.

The pilot survey of both the rural and urban areas of Darjeeling district was done prior to start the fieldwork. A pilot survey is a preliminary survey carried out prior to the main survey, used to gather information to improve the efficiency of the main survey (Dictionary of Statistical

Terms, 2002). Methodology may be used to refer to theoretical discussion concerning the entire research proposal including the forms of thought of the research, application of the research, methods etc. thus a distinction must be made between methods and methodology. The word method usually means the several research methods such as interview method or observation method, or Genealogical Technological method, etc., but the word methodology refers to activities including the application of the research techniques. So, methodology can be defined as a system of broad principles or rules from which specific methods or procedures may be derived to interpret or solve different problems within the scope of a particular discipline. Methodology is the analytical study of methods that includes many techniques by which goal to be achieved for a particular field enquiry is accessed. Various aids have been adopted for conducting the field study and the measures adopted for getting the required reference of data, helps to have an overall analysis of the situation in hand.

There are different methods which is used to gather information that falls under two categories, i.e. primary data and secondary data. Primary data is known as the first hand or raw data and is collected for the first time by the researcher through direct effort and experience. The data collection is under direct control and supervision of the investigator/ researcher. The data can be collected through various methods like surveys, observations, questionnaire, interviews, case studies, etc. Secondary data implies to the second-hand information which is already collected and recorded by any person other than the user for a purpose. Secondary data is readily available through various sources such as census, government publications, reports, books, journal articles, website, etc. In this study although both primary and secondary data are in usage but my study is primarily based on primary data collected during the field work as minimal anthropological work is done in Sherpa population of the Darjeeling and Kalimpong district of West Bengal.

In anthropological study combine research method of quantitative and qualitative data are used. The quantitative data is one that deals with quantity or numbers. It is a set of numbers collected from a group of people and involves statistical analysis making it easy to present and elaborate the data using charts, graphs, tables, etc. Qualitative data deals with descriptive forms referring to the things that can be observed but not measured. So, qualitative data refers to the data that is interpreted as spoken or written rather than numbers and provide insights and understanding about a particular problem as it can be approximated but cannot be computed. As, a social-

cultural anthropologist my research work emphasizes more upon the qualitative research than quantitative research. Here, the quantitative data is used in conducting the field survey through the means of the schedule. As the quantitative data alone is not considered adequate for having in-depth knowledge of the actual situation in hand; so this could be accessed by means of the use of qualitative data through which proper analysis of the existing facts could be made.

Anthropological survey ranges from micro to macro study as micro means small and macro means large. Micro study refers to the small group of research and the interaction between them. While macro study refers to the embedding of such immediate fields within larger regional contexts focusing on large structure, pattern and conflicts across the whole of society. In this research work the main focus is provided to the aspects of the Micro study. The term emic and etic refers to two different anthropological study approaches. The emic approach is the insider's perspective that comes from within the culture where the project is situated and helps us to understand local reality. Whereas the etic approach is the outsider's perspective, the perspective that we have of a project parameter. Research conducted from an emic perspective typically yields a wealth of detailed and culturally nuanced information. This approach involves the researcher immersing themselves in the culture they are studying, allowing them to gain a deeper understanding of the society's practices and beliefs—elements that might be overlooked from an etic standpoint. The emic viewpoint is instrumental in generating comprehensive, descriptive accounts that reflect the insiders' interpretations of their own cultural rituals. In this study conducted among the population of the Sherpa the approach for the entire scope of study was emic as I happened to belong to the same community under study. The advantages of this approach are that the use of the language and some shared customs make first hand approach to the people accessible. The disadvantage is that at times the people belonging to the same communities have regional differences and certain fact are freely expressed at times to the stronger than to one of the own community as a result of the mixture of feelings possessed.

Schedule is a method used by the researcher for collecting data and generally depends upon the social surveys which refer to the standardised questions arranged in a definite order to which responses are sought from all the individuals constituting the sample with view to obtain comparable results. The schedule is a form of abbreviated questions which interviewer keeps with himself and fills out as he or she proceeds with the enquiry. Here, for the collection of

data, preliminary schedule forms were used to survey the various aspects such as age, sex, family, age at marriage, number of children, education, occupation, income, diseases suffering from and type of treatment. The schedule is generally filled out by research worker who can interpret the questions when necessary to attain objectivity. The purpose of schedule is to act as memory tickler and helps the field worker to remind him the different aspects that are to be particularly observed. The schedule also helps the researcher in tabulation and analysis of field data collected by him.

This study is based on in-depth interviews, observation and case study methods. This is very simple anthropological method which is applied by us to collect the data. The interview technique is highly regarded in anthropological research due to its accuracy, specificity, dependability, and credibility in eliciting information from individuals. The interview involves a face to face contact in which one person, the interviewer asks a person being interviewed, the respondents, questions designed to obtain answers pertaining to research problem. Interview helps to collect information about qualitative facts. The purpose of interview is to secure certain information from the subject which is known only to him/her and cannot be gathered from any other sources and study of verbal behaviour under give circumstance. Since the interviewer personally goes to the field and interviews the people, there is bound to be high response participation relevant to the study. The interviewer can cross check the information provided by the informant because in this method flexibility is possible to a considerable extent.

The interview method permits the interviewer to go deep into the problem of study which is not possible in other techniques of field work. The role of the informants is very significant in collecting the data. Among all the informants a person known as the key informant is chosen during the course of the study who being experienced and knowledgeable gives the important clichés required in knowing the details of the area under study. In this study the unstructured interview method is applied for interviewing the Sherpa population. Unstructured interview is also known as uncontrolled or indirect interview as the form of questions to be put is not pre-determined. In this method, the interviewers do not follow a list of predetermined questions and the interviewers are encouraged to relate their concrete experiences with no or little direction from the interviewer and reveal their attitudes and opinions as they see it. And the researcher has to derive conclusion from the discussions about the incidents, feelings and reactions of the subjects.

Observation is another important method used in research work. In this study attempts were made to devise ways and means to make observation more precise and unbiased in gaining insight of social phenomena. Direct intensive observation along with non-participant observation and participant observation are used by the researcher to understand the studied Sherpa tribe. Direct intensives observation is carried out on small groups or individuals therefore it is more detailed and has great depth. Direct intensive observation is based on individual contacts between the observer and the people observed. In non-participant observation, the observer does not actually participate but lookouts everything from distant. The investigator keeps an eye on every minute of social situation without trying to influence the social activity. But sometimes it is very difficult to be purely non-participant observer as one cannot penetrate into the problems without actual participation. In participant observation the observer is required to participate for a long period in the activities of the group whose behaviour is to be observed. A participant observation makes oneself a part of the group under study and by this way the group can be observed in its natural manner and more closely to get better insight of social phenomena. The participant observation method has its advantage because of access to the body of information. Observing social behaviours in their natural environment reveals insights that might otherwise remain hidden. It's a window into the authentic patterns and relationships that form the fabric of social life.

Case study method is more intensive in nature designed to explore and analyse the life of a social unit as a person, a situation or an institution. It is an approach that views social unit as a whole and conducted by personal documents like diaries, autobiography, memories, letters, etc. and by studying the various event of respondent's life cycle which can only be gathered by prolonged interviews with the respondent. In the study conducted among the community of Sherpa the use of case study method has also been applied in some case where the data from various informants had to be collected by undergoing an in-depth study of the various factors of the people. The method applied in this case by the means of unstructured interview and the description of the interpretation of cases in accordance to the points made by the informants. Efforts have been made to interview both the traditional and modern health care providers and receiver to capture the ground reality. The data for medicinal plants were collected mainly from elderly people and the lama who have a good knowledge on herbal medicines. For this work, few correlated case studies of the Sherpa population (male and female) of both rural and urban

areas have been considered for supportive help in research as case studies aimed at presenting people's actual behaviour in response to use of traditional and modern health care systems.

When an anthropologist conducts a field-work in the remote areas, he is secluded from the companionship of men of his own race and culture so that he could depend upon the natives around him for company, friendship and human understanding. Thus, an anthropologist has to create an environment of friendship and companionship in the field which will go a long way to create rapport in the field. In order to understand the native in totality, researcher should try to learn more and more about the native's languages or dialect, their usual way of greeting, their way of passing the leisure, etc. and try to mix up with them intimately so, that the natives accept the researcher as the member of their family or community. In this way, usually a rapport is quickly created by the anthropologist in the field which is an integral part of the field training in anthropology.

1.9. Selection of the Study Area

The present study was conducted solely among the Sherpa, a hill tribes residing in the two areas (urban and rural) of Darjeeling district in West Bengal. Total 211 Sherpa families from both the urban and rural areas of Darjeeling district have been studied.

- **Study Area- A (Rural)**

Srikhola Daragoan gram panchayat comes under the administration of Pulbazar, Bijanbari block in Darjeeling district. The study area is considered one of the remotest areas of West Bengal. The four villages namely: Srikhola, Gurdum, Bichgoan and Daragoan (Kalyan Daragaon) of Srikhola Daragaon gram panchayat have been selected for the present study, as the population under study is high in these areas. The studied villages have one sub-centre in Sepi and Primary health centre in Lodhoma.

- **Study Area- B (Urban)**

From Urban area two wards (VI and VII) of Kurseong Municipality are taken in consideration as the both the wards are in Kurseong town and are mostly habituated by Sherpa population. Both the wards are situated in the Dowhill road which is known also the old military road. The studied wards have one sub-centre health centre and sub-divisional hospital in Kurseong town.

Kurseong is 51 kms from Siliguri and 30 kms from Darjeeling so they can also access the health facilities from both the places.

Here the comparative study was done on health situation and care seeking behaviour among the Sherpa families of two selected urban and rural areas as stated above. The comparative study is an important aspect to understand the health hygiene perspective and at the same time for initiating further development strategies. This present study helps to orient the health conditions of Sherpa population highlighting on their traditional healthcare practices and beliefs, magico-religious beliefs and practices, supernatural connotations. Simultaneously, it also helps to understand the implication of modern healthcare system and the Government healthcare policies hindering their traditional healthcare practices and beliefs or not.

Areas under the Study		
Darjeeling District	Rural (Srikhola Daragoan Gram Panchayat)	Bichgoan
		Gurdum
		Daragoan (Kalyan Daragoan)
		Srikhola
	Urban (Kurseong Municipality)	Ward no. VI (Upper Sherpa Busty)
		Ward no. VII (Lower Sherpa Busty)

1.10. Organisation of the Thesis

The Thesis is divided into following five Chapters.

Chapter-I (Introduction): This chapter serves as an introductory overview, primarily addressing various concepts of health and care-seeking behavior in relation to health, disease, and treatment. It begins by exploring different theoretical perspectives that address different notions of health, along with an analysis of the current health situation among tribal populations. The chapter delves into the contemporary health situation among tribal populations, providing an overview of their unique health challenges and practices in the current context. The chapter also includes a review of previous studies on healthcare practices

along with the Sherpa community. This review critically analyzes existing research, highlighting key findings and gaps in the literature related to health care practices and the ways in which the Sherpas approach health and illness. A critical discussion on the scope, objectives, and hypotheses of the present study forms a key part of the chapter. The final section of the chapter focuses on the research methodologies used in the study. Additionally, the chapter addresses the selection of the study area, outlining the reasons for choosing the specific geographic or cultural context for this research.

Chapter-II (The Area and the People): This chapter is divided into two distinct sections to provide a thorough understanding of the research area. Section A focuses on the physical and administrative characteristics of the region providing a detailed profile of the state and district. The section also covers the geographical features, region's climate, flora and fauna of the area. Section B focuses on the Sherpa people, providing an in-depth exploration of their demographic aspects such as family size, marital status, literacy rates, occupation, income levels, and language spoken within the community. In addition, the chapter sheds light on the Sherpas' family structure, language, marriage customs, kinship systems, economy, religion, festivals, political organization, and material culture, providing a thorough and insightful that defines the community.

Chapter- III (Traditional Health Care Practices): This chapter offers a detailed exploration of the traditional healthcare practices within the Sherpa community highlighting the deep connection profound relationship between their cultural beliefs and medical practices. A key aspect of the Sherpa health care system is rituals performed to seek protection from deities and ancestors, which form a crucial part of the Sherpa's magico-religious practices linked to health. The chapter explores the various diseases common in the community and the associated treatments, showcasing a blend of practical knowledge and spiritual guidance. Furthermore, the chapter discusses the significance of life-cycle-related rituals and significant events that influence health-related practices. The belief in supernatural forces remains central to Sherpa's health care, and the chapter explores how these forces are thought to impact health, disease, and recovery. The role of traditional healers is also a focal point of the discussion. These healers, who are often highly respected members of the community, play a crucial role in both diagnosing and treating illnesses. They combine knowledge of herbal medicine, physical therapies, and spiritual rituals to guide the healing process. Overall, the chapter offers a

comprehensive depiction of the unique and deeply rooted healthcare system of the Sherpa community.

Chapter-IV (Modern Health Care Practices): This chapter provides an in-depth analysis of the modern health scenario in India, focusing on the various governmental health policies and planning strategies implemented to enhance public health. It offers a comprehensive discussion of the contemporary healthcare infrastructure in the studied area, including the accessibility, quality, affordability, and treatment options available at modern medical institutions such as Sub-health centres, Primary Health Centers (PHCs), Sub-divisional hospitals, and District Hospitals. The chapter further examines the effectiveness of these healthcare facilities, addressing the challenges that people face in accessing healthcare services. This includes an evaluation of the availability of essential medical resources, the level of healthcare service provided, and the barriers to accessing these facilities due to geographic or socio-economic factors. The chapter also evaluates critical factors impacting health, such as access to drinking water, personal hygiene, sanitation, and the prevalence of smoking and alcohol consumption within the population. The chapter also evaluates the community's awareness of and participation in various health initiatives programs such as immunization campaigns, family planning and the Integrated Child Development Services (ICDS) program. Case studies of individuals who utilized modern medical facilities in various situations form an essential part of this chapter, providing real-life insights into the impact of healthcare services in the region.

Chapter-V (General Observation and Conclusion): The chapter provides a comprehensive discussion of all the issues raised throughout the study, culminating in a conclusion that summarizes the overall findings. It also proposed recommendations aimed at improving the overall health and well-being of the community. These suggestions are designed to address the challenges identified during the research and suggest practical measures for enhancement.