CHAPTER I
INTRODUCTION

As anthropologists study culture with a holistic perspective, looking at health and illness in the broad spectrum of culture, provides an in-depth understanding of peoples ethnomedical practices. A hallmark of Social-Cultural Anthropology has been its insistence on cultural relativity in the analysis of ethnographic materials. Medical anthropology has been concerned by this problem as much as its parent discipline.

Although anthropological research abounds in information about non-western medicine, during the first half of the twentieth century ethnographic data on illness and healing were often gathered and interpreted only as they related to subject matters central to anthropological interests of those times. Thus, shamanism and witchcraft for instance, drew attention of great many anthropologists more as magico-religious activities and methods of social control than as components of indigenous medical systems (e.g., Pritchard 1937, Parsons 1952, Nadel 1959, Kiev 1964, Middleton 1979 to name a few).

Anthropological interest in medicine in the last couple of decades, stems from the fact that “health and disease, though biological in nature are defined and interpreted culturally as they relate to people’s social belief systems” (Tribhuwan and Gambhir, 1995:61). The values and customs associated with ill-health are part of the wider culture, and cannot really be studied in isolation from it. One cannot understand how people react to illness without an understanding of the culture they have grown up in— that is of the lens through which they are perceiving and interpreting their world. In addition to understanding the culture, this process also throws light on the ‘health care system’- which includes the ways in which people become recognized as ill, what it is attributed to, the healers, and the ways that illnesses are dealt with.

The increasing borrowing of western medicine, its concepts and practices has brought the realization that cultures and sub-cultures vary widely in their views of what constitutes health, how it is maintained, and how departures from a
healthy state come about and the entailing treatment. Often the western biomedical models serve as the unit of comparison for health studies conducted and programs implemented. Ohnuki-Tiereney (1981) points out that, even anthropologists share with fellow members of western societies, an unconscious bias toward an unquestioning faith in western medicine as scientific medicine. In fact, western medicine is often looked at as if, it is culture free. The popularity and the wide spread use of it across culture apparently is the reason for this notion.

Gonzalez (1989) says that, the study of indigenous medical systems and their popular derivatives is of great theoretical and practical interest. Besides enriching medical and pharmaceutical science, the systematic and comparative understanding of different ways of conceiving and treating human physiological problems is also of crucial significance. Research in this field should even be considered with some urgency now, that the progressive extension of the cognitive patterns and forms of production and consumption of a single civilization to all the peoples of the planet, threatens to extinguish traditional therapeutic knowledge as well as the resources.

Indigenous people are too often pressurized to abandon their traditional therapies, while only a few of their medications are analyzed and partially assimilated by the pharmaceutical industry. At the same time, technological development is eliminating much of the natural biota of wide areas, including medicinal species known only to the local populations. These populations have, moreover, very limited access to modern medical resources because of the high cost of these and the deficiencies of public services in the areas they inhabit. The loss of natural and cultural resources, the introduction of foreign pathogens, the disruption of demographic, economic, and dietary patterns, the stress of acculturation, and the dependency created by inadequate services contribute to a decline in the level of health in the populations whose medical systems are the focus of ethnomedical studies (Ibid.).

During the post World War II period, there appeared a realization that human ailments may not simply be reduced to 'biomedical thing' (Fabrega 1975). It was begun to be recognized as beyond something merely biomedical.
Recognition that culture has a bearing on human ailments and has a deterministic influence on the health status of the populations increased. As a consequence, 'ethnomedicine' began to gain currency and now receives considerable attention and is considered an indispensable starting point even in biomedical approaches within medical anthropology. It is a field that is rapidly growing and is becoming central to the discipline of anthropology.

It is not surprising that an anthropological understanding of health, occurrence and means of coping with illness involves one deeply in the social systems, social values, beliefs and manner in which people perceive their world. Loudon (1973) has pointed out that health and disease are fundamentally connected with the reproduction, quality of life, preservation and loss of life. Therefore he says, in this perspective, medical anthropology is not only a way of looking at the states of health and disease in society, but also a way of viewing society itself.

Cultures have their indigenous medical system with related beliefs and practices for tackling diseases. To show that health is associated with religion, Elwin (1955) notes that pantheon of Gods are associated with diseases; cold, cough, small pox. He further explains that, propitiating the respective God associated with a disease either directly or through the priests, cures most of these diseases. Studies have also shown that health is related to ecology and social customs. The work of May (1960) in China for instance reveals how economy is related to health. His study in China revealed that those involved in rice cultivation had the problem of hookworm infection, because they came in contact with mud mixed with night soil. Whereas, those who were engaged in silkworm farming were not affected by the infection since they worked with mulberry leaves (cited in Lieban 1973).

When medical anthropology blossomed in the early 1970's, the aims were to obtain new understanding of the nature of health and illness through ongoing research; and anthropologists could contribute to reducing the worldwide tolls of disease, disability, and human suffering. The excitement also stemmed from an awareness of medical anthropology’s potential for uniting theory and practice in a
new health science at once cumulative, comparative, integrative, and methodologically sound.

Medical anthropology is about how people in different cultures explain the causes of ill-health, the types of treatment they believe in, and to whom they turn if they become ill. It is also, a study of how these beliefs and practices relate to biological and psychological changes in the human organism, in both health and disease. According to Foster (1978) health may be defined as the state of being free from physical or mental illness or pain and medicine is the science and art of dealing with the prevention, cure or alleviation of disease. Medicine, in the broadest sense, has to be understood as a functional, integrated part of culture.

Lieban says “medical anthropology, encompasses the study of medical phenomena as they are influenced by social and cultural features, and social and cultural phenomena as they are illuminated by their medical aspects” (1973:1034).

Medical anthropology studies a wide range of phenomena like public health, trans-cultural psychiatry, beliefs related to health, illness, medicine, doctor-patient interactions, nursing, pediatrics, epidemiology, drug abuse and ethnomedicine. The ethnomedical approach in medical anthropology is to study how a people perceive and deal with health and illness. This approach therefore, includes study of medical beliefs, medical practitioners, and healing techniques as these aspects represent the culture and society in which they are found.

Ethnoscience and the ‘emic’ perspective are essential for studies in ethnomedicine in order to understand health and illness from the people’s perspective. Malinowski states that, “the final goal, of which an ethnographer should never lose sight ... is, briefly, to grasp the native’s point of view, his relation to life, to realize his vision of his world” (cited in Sturtevant 1968:476). Expressions such as ‘emic’ perspective or insider’s view are frequently associated with the ethnomedical approach; however, an ‘emic’ view does not exclude interpretation by anthropologists who are outsiders, even these interpretations gain significance because of the need for ‘holistic’ understanding of the culture. And also, because the ethnomedical beliefs and practices are interpreted in the light of the whole culture.
The term 'ethnomedicine' is used to refer to "those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine" (Hughes 1968:88). Thus ethnomedicine describes concepts of health, illness and healing among cultures. An important role of ethnomedicine is to describe concepts of health and illness, remedies and healers as they are seen by the people themselves. This knowledge can to a great extent help in modern health planning and programme implementation. Therefore, scientific approaches to develop traditional concepts, and classifications in the framework of 'ethnoscience' have profound value. And the traditional concepts, practices and institutions, once integrated into the developing of health care system would pave way for better acceptance of modern medical intervention.

The need for ethnomedical studies thus arises because of the following points. As Gonzalez points out

a) folk medicine includes objectively efficacious substances and practices,

b) human bodily functions are affected by emotions, diet, sanitary practice and general life style all of which are culturally determined and

c) different cultures define disease symptoms and causation entities in different ways, and these concepts influence their well-being (1988).

On a theoretical level, medical beliefs constitute a major element in every culture. Consequently, they are interesting in their own right and also for the insights they give into other aspects of the culture of which they are a part. On a practical level, knowledge of indigenous medical beliefs and practices is important in planning health programs for, and in delivering health services to, indigenous people (Foster and Anderson 1978).

Ethnomedical systems consist of the understandings that societies hold about illness etiology, treatment, and cure. Non-western ethnomedical systems frequently recognize diseases that have no apparent equivalent in bioscience. Such
illnesses are considered by biomedicine to be 'folk' illnesses in that, their clustering of signs and symptoms do not conform to bio-scientific diagnostic categories. Depending on the cause, the cure requires either that the spirit captors be appeased so that they will release the victim’s soul or that the freely wandering soul be brought back to be restored into the victim’s body. The somatic and psychological symptoms as well as culturally specific symbols may involve the sick person’s relationship to the community, to supernatural forces, or to the natural environment (Browner et al.1988).

Browner et al. note that “reductionistic and dualistic, bioscience assumes that although the biological changes by a specific disease may well be influenced by patient’s individual history, they will not be affected by that patient’s culture. Whereas, bioscience does not have the concepts required to understand many of the causes, effects, and consequences of illness reported by other ethnomedical systems, it does offer a set of standardizing measures and techniques with which one can compare human physiological processes across ethnomedical systems” (1988:682, 683).

In addition to its obvious interest for industrial societies, systematic understanding of traditional therapies and pharmacopoeias can contribute to the well-being of the indigenous populations. The indigenous therapies and pharmacopoeias instead of being expropriated from them, need to be incorporated into health planning and policies for the regions they inhabit in such a way as to reinforce the use of proven therapies and medications and to preserve their cultural and natural sources. This should not exclude the improvement of medical-aid services or the use of therapies not yet proven. One might even contemplate cooperation between traditional and modern medical systems (Gonzalez 1989).

Traditional therapies, especially in indigenous societies, often combine various therapeutic measures, not just herbal, but also those of a psychosocial or psychosomatic and/or physical nature (rites, chants, dances, massage, etc.), and this complexity is not often taken into account. The biochemical validation of medicinal herbs and the bioscientific verification of organic pathologies diagnosed in the terms of different cultures certainly constitute significant advances, but
study of these important aspects of the medical systems remains under shadow (Ibid.).

When an analysis of literature existing on medical beliefs of people is made, it comes to light that knowledge of diseases, their classification and etiology is part of all cultural systems. Theories of disease generally have relevance to the moral order, that is, to the control of people's behavior. Disease is frequently seen as a warning sign among most cultures, a visitation from punishing agents for a broken taboo. But this is so very different from the perspective of the biomedicine.

Browner et al. say that, there is a growing body of evidence which demonstrates that many indigenous remedies have important physiological effects that can be attributed to either placebo effect or magic; the implication for medical anthropology in as much as most ethnomedical studies attribute the healing that results from the use of folk medicines to symbolism, the healer's charisma, or placebo action, fail to assess the contributions of plant chemical components to a patient's improvement. The biomedical framework has significantly obstructed the wide anthropological and comparative study of disease/illness, health and ethnomedicine, because it has ethnocentrically devalued, if not excluded, the knowledge of other ethnomedicines, including lay beliefs and practices (Ibid.).

Browner et al. (1988) have proposed a set of procedures for assessing the empirical validity of herbal medicines. They involve-

1) obtaining an accurate botanical identification,
2) searching the chemical literature for the plant's known chemical constituents,
3) searching the pharmacological literature to determine the known physiological effects of either the crude plant, related species or isolated chemical compounds that the plant is known to contain and
4) comparing the medicinal effects known to bioscience, with the effects users in study community seek, in order to assess their congruence and the nature of disagreements when they occur.

Medical anthropology also studies therapeutic measures. This understanding helps in not only understanding the 'emic' categories but also to
obtain a cross-cultural understanding in terms of theories. “Most of anthropological reports on ‘primitive theories’ of disease have consisted of statements about social structural-functional interpretations of disease/illness. Such statements represent the result of an examination into the meaning of disease/illness to the individual in the light of certain identifiable functional implications of cultural health practices” (Mering Ott.von 1979:275).

In the study of indigenous medical systems the concepts that are most often debated are the differences between ‘illness’ and ‘disease’. It is essential to distinguish the meanings of the usages of ‘illness’ and ‘disease’ because in the popular usage, often these two terms are used synonymously. However, in the Social-cultural approach to ill-health in ethnomedicine, understanding is gained by contrasting the concept of ‘illness’ with the concept of ‘disease’.

Cassell uses the word ‘illness’ to stand for ‘what the patient feels when he goes to the doctor’, and ‘disease’ for ‘what he has on the way home from the doctor’s office’. Disease then is something an organ has; illness is something a man has. Illness is a subjective response of the patient and of those around him, to his being unwell; particularly how he, and they, interpret the origin and significance of this event; how it affects his behavior, and his relationship with other people and the various steps he takes to remedy the situation. It not only includes his experience of ill-health but also the meaning he gives to that experience. Medical definition of ill-health, according to Feinstein is largely based on objectively demonstrable physical changes in the body’s structure or function, which can be quantified by reference to ‘normal’ physiological measurement (cited in Helman 1994).

Howard explains that “disease is a concept referring to a pathological condition of the body, or of some part of it, in which its functioning is disturbed or deranged. ‘Illness’ is a cultural concept: a condition marked by pronounced deviation from what is considered a normal healthy state. Even though beliefs about disease and patterns of incidence may be viewed as sociocultural phenomena, diseases themselves are strictly physiological processes. Illness, on
the other hand, is a broad concept referring to how people conceive of deviant mental and physical states” (1989:394).

Among Kumbri Marathi where the present ethnographic research has been conducted, people make a distinction between naturally and supernaturally caused ill-health conditions. When the cause of ill-health condition is believed by the people to be due to supernatural causes, then it is labeled as sik, and due to natural reasons, then they categorize it as roga.

The causes are taken into consideration while categorizing are natural as well as supernatural. Natural factors are factors like hot-cold imbalance, climatic changes, diet. When it comes to sik though physiological symptoms are involved, the source of causation is supernatural. The category of sik is broader because the naturally caused ill-health can have an influence of supernatural. Further, in the course of treatment also ‘supernatural means of treatment’ can be sought. Because, if roga is not cured by medicine, either indigenous or modern then, it is looked at as supernaturally caused. ‘Disease’ can be looked at on two levels. One is, as it is perceived and labeled by the biomedicine and on the second level, as perceived by the people. What people perceive as ‘disease’ may also be labeled by the biomedicine as ‘illness’, because of the cultural connotations it carries. Sik and roga from an etic, biomedical perspective therefore, are illnesses because emic categories are involved. Even when people recognize physiological changes accompanying a disease, for the biomedicine it is ‘illness’. On the emic level, people identify the physiological changes based on their ethnophysiological concepts this can be understood as disease in the emic perspective.

The categorization of sik and roga is made basically on the perceived etiology of the ill-health condition. “In most of the non-western cultures classification of ill-health conditions is done in terms etiology” (Taylor, 1926:265). Supernatural beliefs are a major component of etiology and treatment in many of non-western societies. Rivers (1924), Clements (1932), Foster and Anderson (1978) are some of the earliest eminent anthropologists who have made efforts to make classification of beliefs regarding etiology.

Rivers’s (1924) classification of etiology is as follows:
When a mobile object or substance is projected into the body of the victim
When something is abstracted from the body.
When the sorcerer acts on some part of the body of a person or on some object which has been connected with the body of a person in the belief that thereby he can act on the person as a whole.

Tylor (1926) categorizes the cause of ill-health into two main theories. One is the notion that something alien has entered the body, such as evil spirit, a bone sliver sent by a sorcerer, or viruses and bacteria. The other theory is the concept of 'soul loss'. The intrusion of something alien or loss of soul may result from a variety of specific actions and circumstances, such as witchcraft, violation of a taboo, poor diet, falling down, fright, an encounter with spirits.

Clements (1932) says, widespread throughout the world are five basic categories of events or situations which, in indigenous etiology are believed to be responsible for illnesses. They are as follows:

- Sorcery
- Breach of taboo
- Intrusion of a disease object
- Intrusion of a disease causing spirit and

Similar categories of etiology of disease have been done by Kiev (1969). He also speaks of similar causes as Clements. The causative factors according to him involved are-

- Loss of soul
- Spirit intrusion
- Violation of taboos and
- Witchcraft.

Hasan (1967) based on studies on an Indian village has classified illness causation into two broad categories that is supernatural and physical:

Supernatural category includes

- Breach of taboo
- Sorcery
Under the categories of physical causes he speaks of:
- Excessive ‘heat’ and ‘cold’
- Wrong combination of foods and
- Impurity of blood.

Foster and Anderson (1976) speak of personalistic and naturalistic classification which explains illness causation. They say that dual division is sufficient to distinguish major categories of the systems. A personalistic system is one in which illness is believed to be caused by the active, purposeful intervention of a sensate agent who may be a supernatural being (a deity or god), a nonhuman being (such as a ghost, ancestors or evil spirit), or a human being (a witch or sorcerer). The sick person literally is a victim, the object of aggression or punishment directed specifically against him for reasons that concern him alone. In Naturalistic systems illness is explained in impersonal, systemic terms. Naturalistic systems conform above all to an equilibrium model; health prevails when the insensate elements in the body, the heat, the cold, the humors, are in balance appropriate to the age and condition of the individual in his natural and social environment. When this equilibrium is disturbed, illness results.

Among the Kumbri Marathi, etiology can be classified as supernatural and natural, in fine both personalistic and naturalistic systems are found.

The supernatural causes involve the following:
- Breach of taboo
- Affliction of spirits
- Wrath of deity
- Evil eye

On the natural level, etiology is seen as below:
- Excessive ‘heat’ and ‘cold’ caused due to foods, climate and seasonal changes
Body constitution susceptible to disease *nanj prakruti*

Nature of work

Age

The understanding of the etiological categorization reveals that there exists a strong personalistic theme in many cultures across the world. Studies on supernatural or magico-religious aspects, in terms of spirits, breach of taboo, wrath of deity and their effects on health has been delineated by eminent anthropologists. To name a few works on supernatural aspects of health and illness: Rivers (1924), Taylor (1926), Clements (1932), Pritchard (1937), Majumdar (1961), Kiev (1969), Hasan (1967), Kimball and Paul (1973), Nagubane (1977), Loudon (1976), Levi-Strauss (1979), Middleton (1979), Mann (1980), Tierney (1981).

The present study in these lines concentrates on interpretations of various aspects of ethnomedical practices of the people. As a result, the supernatural beliefs and practices have been dealt with as aspects associated with health and illness and have been focused upon for the role they play in the health beliefs of the people. The supernatural factors therefore, often are the starting point to understand not only treatment seeking behavior of the people, but also for understanding health-maintenance. In this context, one comes across a whole world of spirits, deities, rituals, which form the crux of understanding ethnomedical practices of Kumbri Marāthi.

Hughes explains, “the practice of ‘folk medicine’ is variously institutionalized. In all societies, some rudimentary medical knowledge is an aspect of enculturation. But beyond general protection there is always a specialist. In some societies, there are more complex social arrangements than the simple dyadic relationship between healer and patient. Even as the kin and co-villagers of the patient may be explicitly involved in the curative process, so too there may be a society of healers or several societies of healers devoted to diagnosis and cure of various diseases” (1968:91).

The therapeutic practices following occurrence of disease may also have socially cohesive results. Although such therapy may often be medically effective, it may serve ancillary functions in the total organization of the society. Typically,
the curative session involves not only the patient and the healer, but also the patient’s family and neighbors. Kleinman has suggested that, in looking at any society, one can identify three overlapping sectors of health care; the popular sector, the folk sector, and professional sector (cited in Helman 1994). Each sector has its own ways of explaining and treating ill-health, defining who is the healer and who is the patient, and specifying how healer and patient should interact in their therapeutic encounter.

The kinds of curers found in the particular society and the curing acts in which they engage, stems from the etiology that the culture recognizes. In personalistic systems with multiple levels of causation, there is requirement for curers with supernatural skills, for the primary concern for the affected person and his family is not the immediate cause of illness, but rather ‘who’ and ‘why’. The Bomvana are less interested to know: how did it happen? rather than who is responsible? (Jansent). Similarly, in Mali, the Ambara want to know why they are ill and not how they got ill (Imperato). And in Indian village studied by Dube the Brahmin or a local seer is essential to find out what ancestor spirit is angry and why (cited in Foster 1976).

The shaman with his supernatural powers and direct contact with the spirit world, and the “witchdoctor” with his magical powers, are primarily concerned with finding out ‘who’, and ‘why’. After ‘who’ and ‘why’ have been determined, treatment for the immediate cause may be administered by the same person, or the task may be turned over to a curer, perhaps an herbalist.

Naturalistic etiological systems, with single level of causation require a very different type of curer, a ‘doctor’ in the full sense of the word, a specialist in symptomatic treatment who knows the appropriate herbs, food restrictions, and other forms of treatment such as cupping, massage, poultices, enemas, and the like. The curandero of the Auyrvedic specialist is not primarily concerned with who or why, for he and the patient both usually are in complete agreement as to what has happened.

Foster and Anderson (1978) say personalistic and naturalistic etiological systems are also divided at the diagnosis level. In personalistic systems, the
shaman, diviner or witchdoctor diagnose by means of trance, or other divinatory techniques. Diagnosis — to find out ‘who’ and ‘why’ — is primary skill that the patient seeks from his curer. Treatment of the instrumental cause, while important, is or secondary concern.

In naturalistic systems, diagnosis is of very minor importance, as far as the curer is concerned. Diagnosis is usually made, not by the curer, but by the patient or members of his family. When the patient ceases treatment with home remedies and turns to members of his family and when he ceases treatment with home remedies and turns to a professional, he believes he knows what afflicts him. His primary concern is need for treatment to cure him of his condition. How is diagnosis done by layman? The answer has been pointed out many years ago by Erasmus (1952). When an individual feels unwell, he thinks back to an earlier experience, in the night the day before, even a month or year earlier, to an event that transpired in situation which he found himself, that is known to cause illness. In personalistic systems the primary role of the shaman or witchdoctor is diagnostic while in naturalistic system it is therapeutic (Ibid.).

Another crucial aspect of indigenous medicine is preventive medicine. With health-oriented behavior, it is a series of ‘dos’ and ‘don’ts’ or ‘should’ and ‘shouldn’ts’. Naturalistic etiologies correlate predominantly with ‘don’ts’, while personalistic etiologies correlate with ‘dos’. In naturalistic system, a personal health strategy seems to consist of avoiding those situations or not engaging in behavior, known to produce illness (Ibid.).

In personalistic systems, the basic health strategy is to emphasize the ‘dos’ and especially the need to make sure that one’s social networks, with fellow human beings, with ancestors, with spirits and with deities, are maintained in good working order and avoiding those acts that are known to arouse resentment. ‘Don’ts’ particularly means careful attention being paid to the rituals that are a god’s due, to positive demonstrations to ancestors that they have not been forgotten, and to friendly acts to neighbors and fellow villagers that remind them that their good will is valued (Ibid.).
Klienmann (1974) notes that classification of a disease is in fact, the first therapeutic act. This is true for Kumbri Marathi also. As a result, one finds that the people’s categorization of ill-health conditions involves, condition that are naturally caused and those that are supernaturally caused and also condition that exists prior to a person experiencing an illness or disease, a state that is neither healthy nor unhealthy. The understanding of health and illness among a people can be better obtained by understanding their explanatory model.

Klienman’s ‘explanatory model’ provides a useful way of looking at the way illness is patterned, interpreted and treated. It is defined as “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (cited in Helman 1994:94). ‘Explanatory models’ are held by both patients and practitioners, and they offer explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness. This model provides explanations for five aspects of illness:

1. The etiology of the condition,
2. The timing and mode of onset of symptoms,
3. The pathophysiological process involved,
4. The natural history and severity of the illness,
5. The appropriate treatments for the condition (Ibid.).

The explanatory model is extremely useful in understanding ethnomedical practices. However, explanatory model can be fully understood only by examining the specific cultural context in which they are employed. People’s assessment of how serious an illness is, how will it affect their life, may not only depend on how they are able to afford to be ‘off work’, but also whether they can afford modern health care, beliefs about efficacy of different therapies.

The questions that people ask in the process of diagnosing themselves as ill, have been addressed to in this study on ethnomedicine. These questions are based on the explanatory model of Klienman. These questions are:

What has actually happened? The question addresses organizing the symptoms and signs into a recognizable pattern, and giving a label to it.
Why has it happened? Tries to understand the causes for the condition. Why has it happened at this particular point of time?

Why has it happened to me? This question aims at associating the illness to different aspects of the patient like diet, and body constitution, taboos broken.

What would happen if nothing were done about it? This question considers its likely course, outcome, prognosis, and dangers. It tries to understand whether it will affect the income, or become severe if left untreated.

What has to be done next? This question aims at planning strategies for treating the condition, with reference to therapies and therapists to be sought.

The so called ‘modern’ or scientific concepts of disease causality have developed only since the sixteenth century, and in many parts of the world, people continue to adhere to alternative beliefs which vary considerably from each other, as well as from ‘scientific’ beliefs. Nevertheless, there are certain principles common to many of these belief systems.

Thus the study of indigenous medical systems provides an understanding into a whole range of health and treatment seeking beliefs and behavior. Chaudhuri (1986) says data on indigenous health, the concept of disease and the nature of treatment are rather scanty and specific studies on this topic covering the different facets are practically non-existent unfortunately, very little work has been done on the interaction between primitive and modern medical practices. He suggests the following issues to be considered critically:

- Supernatural beliefs related to disease and treatment,
- Role and position of traditional medicine men in the society,
- Reasons for illness and treatment,
- Disease, treatment and community and Interaction of traditional and modern medical systems of medicine (Ibid.).

Studies focusing on indigenous medial aspects in tribal areas like Kumbri Marathi are also lacking. Further, in India tribals constitute about 8 percent of the total population and are dispersed in most of the states. They do not represent a homogenous group, but show considerable variations in socio-cultural tradition,
economy, language and even physical features. They live in varied geo-climatic and environmental conditions and the concerned environment largely influences their economy. However, there are also many tribal populations which are not scheduled by the Government. Like Chaudury says not many in-depth studies in the area of health have been done on the so called ‘primitive groups’. Further, the studies that have been done often categorize the practices of the indigenous peoples as ‘superstitious practices’. There has been very little effort to understand the people’s medical practices in the light of their own beliefs and theories. Further, the vast ethnomedical knowledge of medicine consisting of herbal and animal extracts has not been recorded or analyzed. The studies of nutritionists, demographers, are often partial to modern medicine. The indigenous knowledge is also in fact valuable under the circumstance of fast disappearing forests and increasing adaptation of modern medicine.

Further, many populations with characteristics of tribe have not been brought under the list of Scheduled Tribes by the constitution as in case of Kumbri Marathi and in-depth, scientific studies are also lacking among them. Further, such tribes have not even been listed properly. Haimendrof says, “The notification of tribal groups as ‘Scheduled Tribes’ by the Indian Parliament clarifies in most cases at least, the legal position. Yet there remain borderline cases. Political reasons may motivate a State Government to include a particular community in the list of Scheduled Tribes, whereas in neighboring state more resistant to pressure groups the same community may not be notified as a Scheduled Tribes, and hence may not be enjoying the privileges granted to kinsmen on the other side of the state boundary. In so far as the tribes included in the foregoing list are concerned, there can be little doubt that they deserve the politically advantageous classification of Scheduled Tribes” (“Notification – is a legal term used in India – as in other previously British territories – for the promulgation of laws and government ordinances in the in the official gazette. Tribes notified as belonging to the ‘Scheduled Tribes’ and notified tribal areas are those whose special legal status was established by a ‘notification’ in the government gazette” Haimendrof et. al 1982:32).
Lewis says the concept “tribal society”, therefore, although having general utility as an idealized type of society, is in no sense an absolute category. Some societies are merely more or less tribal than others.” (1968:147). Indian tribals live in remote, hilly areas and are characterized by small, close knit communities. They have simple lifestyle with predominantly a subsistence economy. These remote areas in particular have poor infrastructure facilities including dismal communication net work of roads, drinking water facilities electrification, health facilities etc., The levels of facilities for the tribals are far below the state and national average (Vidyarthi 1977, Tiwari 2001).

Majumdar and Madan have pointed out the salient features of Indian tribes which are also found among the Kumbri Marathi. They say, “Kinship ties, common territory, one political organization, absence of internecine strife have all been referred to as the main characteristics of a tribe” (1986:240).

Majumdar and Madan (1986) say in India a tribe is definitely a territorial group; a tribe has a traditional territory, and emigrants always refer to it as their home. All members of a tribe are not kin of each other, but within every Indian tribe kinship operates as a strong, associative regulative and integrating principle. Members of an Indian tribe speak one common language, their own or/and that of their neighbors. The consequence is tribal endogamy and the division of a tribe into clans and sub-clans and so on. These clans etcetera, being kin groups, are exogamous. Vidyarthi says “members of the tribe marry within the group, and are sometimes guided by their own elders or political chiefs in their internal and external affairs. In other words, they form socially distinct communities to their neighbors” (1977: 25).

Most of the features considered by anthropologists as features unique to tribes are found among the Kumbri Marathi. The community is divided into various lineages. Kinship operates as a very strong bond among the Kumbri Marathi. Marriage occurs within their group and lineage exogamy operates. Kumbri Marathi have traditional boundaries *sime*, which is constitute of five to seven settlements *gaon*. Their traditional political organization is autonomous. Different types of chiefs take care of internal and external affairs. They speak a
dialect which is a mixture of different languages like Marathi, Konkani, and Kannada. Subsistence economy with a dependence on hunting and gathering is found. Their religion and their worldview differentiate them from other local communities. All these features become even more evident in the chapter on cultural profile of the Kumbri Marathi.

Hegade, L.R. (1981) in his book *Kumbri Marathigara kathegalu* says that he has made a request to ‘Havunur Committee’ appointed by the State Government for Kumbri Marathi to be included under Scheduled Tribes. He says Kumbri Marathi, Halakki Vakkalu, Gonda and Siddi should be considered in the list of Scheduled Tribes. But the committee has neglected to consider these groups in Scheduled Tribes list.

In *Kannada Vishvakosh*, an encyclopedia of Karnataka and its people, refers to Kumbri Marathi as tribe ‘budakattu’ of Uttara Kannada district of Karnataka state, meaning ‘tribe’.

Where as, Gonds have been declared as Scheduled Tribes, and Siddi have been proposed to the Central Government to be included as a scheduled tribe, Kumbri Marathi have not been considered for such a status. Even though Kumbri Marathi are not listed in the Scheduled Tribe list, their characteristics are typical of a tribe.

**METHODOLOGY**

To understand how people view the world and organize their daily lives, is to discover in so far as this is possible the ‘actors’ ‘perspective’ that is to see how the world looks from the perspective of a member of that society, anthropologists often carry out field work, using the participant observation techniques. Where by, they live with and observe people belonging to different cultures and learn to see the world through their eyes, while at the same time retaining the objective perspective of the social scientist. This often involves quantitative study such as counting the population, measuring their diet or income, or listing the inhabitants of various households (Helman 1994.)
In contrast to other behavioral scientists anthropologists carry out their research in a relatively unstructured, wide ranging, exploratory fashion. As Foster (1978) points out, anthropologists are less concerned to isolate tight little research design than to hit on general broad problems that will lead the worker along many lines of discovery. Anthropological research methodology stems not from the laboratory or from statistical correlations but from a natural history type commitment to field investigation where the essential mandate is to go out and find what is there. The primary data gathering technique evolved by anthropologists is "participant observation". Ideally, this means that the anthropologist lives in a community, participates in many aspects of its life and observes firsthand the behavior of the members of the group. It is in these lines that the present study on the indigenous medical practices of Kumbri Marāthi has been conducted.

The present ethnographic investigation was conducted in two stages: for a period of eight months that is from May 2001 to January 2002 in the first settlement (Angane) and for a period of five months, from February 2002 to June 2002 in the second settlement (Kogadde). After the completion of the fieldwork, frequent visits were made for making an attempt to fill the gaps in the study. In the first part of the stay, different Kumbri Marāthi settlements were visited to understand general patterns of life and to understand differences in treatment seeking pattern if any. Since the purpose of this study was to gain a comprehensive and holistic understanding of indigenous medical practices, the focus of ethnographic investigation was on the indigenous health perspectives of the Kumbri Marāthi. For this purpose, in-depth investigation was undertaken in the two settlements, wherein the first settlement possessed diviner and indigenous medical specialists and the second settlement had no diviner but had indigenous medicine men who were generalists to see how the presence of healers affects treatment seeking behavior.

In-depth ethnographic investigation was undertaken in the first settlement for a period of eight months by choosing to stay in a house of Kumbri Marāthi (biggest in the settlement), located almost in the center of the settlement was also
big and all the community gatherings took place in this house. This helped to a great extent in understanding the interactions among Kumbri Marāthi as well as their interaction with the outsiders. The head of the family in this house was a medicine man, which helped further in understanding the minute details of their practices and complexities of Kumbri Marāthi culture. Staying with his family also provided unforgettable experiences of going for hunts and fishing since the head of the family was an accomplished hunter. These were also situations that provided opportunities to understand about their thinking and beliefs. Further, his brother was a diviner, as a result of which, it was possible to understand the intricacies of the supernatural world. For the first month or so I spent most of my time getting to know the people. In the process I learnt much about what constitutes good or ill-health from the Kumbri Marāthi point of view.

Immediately after settling in the field, there was a wedding in the family with whom I stayed. This provided an opportunity to not only participate in the ceremony but also, to meet people and also for the people to become familiar with my presence. Also my taking part in the agricultural activities in this settlement enabled the people to accept me as one among them.

Establishment of close relationship with the people, participation in their routine activities and the prolonged stay in the settlement, were of immense help in gaining insight not only into the socio-cultural life the of Kumbri Marāthi but also to understand their actual treatment seeking behavior. Participation in the healing processes of diviner, the indigenous medicine men enabled me to understand the processes of interaction and also the meaning that they carry for the people.

In the second settlement, an attempt was made to see how the absence of diviner and accessibility to modern health facilities affects the treatment seeking behavior of the people. The family with which I stayed in the second settlement owned a grocery shop and the house was situated near the bus stop. This location provided excellent opportunities to interact with people who came to the grocery shop as well as with those who go to bus stop.
The third settlement in the focus of study was visited often in order to understand differences in treatment seeking behavior when there is no diviner or medicine man within the settlement.

The household-census schedules administered in all these three settlements were helpful to get such quantitative information as, types of family, order of birth, sources of income, educational status of the individuals, hierarchy of health resorts to delineate the relationship between various socio-cultural factors and medical practices.

In-depth interviews with the key informants like diviner, medicine men, the elderly, the social worker from the NGO, helped in knowing minute details of health and illness. Interviewing the diviner was of immense value to gain an understanding about different kinds of spirits, their effects on people, the way the spirits are warded-off and the way social relationships operate in times of crisis. Interview with the doctors and other health providers gave an opportunity to know about the health problems of the people from the biomedical perspective. In order to respect the sensibilities of the people, the names of informants and the different settlements have been changed and pseudonyms have been used.

The ethnographic data obtained in this methodological context, has been arranged in the following chapters after a thorough analysis. The data has been classified into six chapters.

The scheme of the chapterization is as follows:

**First Chapter** focuses on introduction to the field of ethnomedicine, studies relating to indigenous medical systems, placing Kumbri Marathi in the context of tribe and methodology of the study.

**Second Chapter** deals with the cultural profile of Kumbri Marathi. It has attempted to understand the life of the Kumbri Marathi. An analysis of religion, economy, language, folk history, polity, family and kinship, and life cycle rituals has been made. The objective of understanding the different dimensions of people’s life is to obtain a holistic perspective of their health and treatment seeking behavior.
Within the broad framework of the culture of Kumbri Marathi, their ethnomedical practices have been understood.

**Third Chapter** attempts to understand the meaning of health for the Kumbri Marathi and the causes of ill-health (etiology). It also analyses the preventive measures followed by the Kumbri Marathi to ensure health and the hierarchy of resorts available.

**Fourth Chapter** emphasizes the role of supernatural powers in the understanding of the causes (diagnosis) and also focuses on natural diagnosis. It attempts to understand the world of spirits and also shows how the process of supernatural diagnosis and treatment overlap. The role of diviner, the process of warding-off affliction have also been dealt with in this chapter. Also preventive measures taken by the people have been analyzed.

**Fifth Chapter** analyzes the process of cure of ill-health (treatment). In this process, it has brought out the symptoms of different ill-health conditions, the role of medicine men, materia medica used as remedies, and the pattern of treatment seeking. The chapter also has made an attempt to list out the chemical composition of the different indigenous medicines used and the storage of medicine.

**Sixth Chapter** entails the summary and conclusions of the study.