CHAPTER I
INTRODUCTION

The protection and promotion of health have been an important practical necessity for all societies. The link between social and factors that affect health and development of diseases has long been a major interest of humankind. Throughout history, people have generally tended to view health problems from the perspective of their own particular society and culture. Consequently, they have usually responded to the threat of diseases in predictable ways. Knowledge about values and beliefs, norms and social structures and life-styles has provided insight not only about the nature and causes of illness but also about the social organisation of human resources designed to cope with health hazards (Cockerham, 1989:1)

All societies make provisions for maintaining health and treating illness of the members. The burden of preserving physical and psychical well-being is entrusted upon the institution of family in many societies. The parents, in-laws, children and other relatives play a central role in caring and curing each other when they fall ill. Only when the family therapeutic practices fail to bear fruit, the specialist healers - traditional or modern - are called upon. Even the western societies continued to rely, until about 175 years ago, almost entirely on family therapies and prayer. "The modern era of scientific medicine
began in Europe in the 1820s and 1830s. Through careful observation of both the patients' symptoms and the history of their illnesses, scientists established that diseases had specific physical causes which produced distinctive effects" (Coser et al 1983: 353). As yielded by medical sciences, any disease is caused by particular aetiological agent(s) such as virus, parasite or bacterium and the use of advanced scientific methods and medical technology play the role in restoration of wellness.

HEALTH AND ILLNESS

Though medical science has developed extremely effective ways of treating illness in individual cases, the doctors can rarely do anything to remove the underlying causes of the disease. The drugs or surgical operations are effective in treating the ill or removing the symptoms of illness. Yet, these have not been effective on the occurrence of a disease or the environment causing it. "If the propose of the medical institution is to make people healthy in a positive sense by keeping us from getting sick then we must look beyond the symptoms of individual patients to the social world in which they live" (Cassell. 1979: 728). Cassell further argues that the medical explanation of disease does not tell the whole story of an illness. Treating the disease only solves part of the problem and the person may fall sick again unless other problems causing illness are not solved. "In fact, in stories of illness, there are always two protagonists - the body and the person.
There are the events that take place in the body. And there are those events that happen to the person either before the body events or as a result of the direct effect of the body events, or their meaning" (p.728). To see a disease only in body terms is as inadequate as viewing it only in "psychological" or "social" terms.

The mechanistic paradigm adopted by modern medicine, despite many apparent successes, is questioned in current times because it does not see the patient in a complex social environment and undermines the sociological significance of health and illness. The medical model individualises sickness and fails to consider the social factors producing ill-health (Doval and Pennell, 1979). In other words, while physicians care for the individual afflictions caused by diseases, social science transcends the individual human body and mind. It looks into the social angles of affliction in two senses: how disease originates and how it makes its appearance in a society at a given time (Lewis, 1963).

Medical sociology or sociology of health and illness as an important substantive area of general sociology recognises the significance of the intricate relationship between social conditions and the level of health of specific social groups. The discipline is also concerned with social causes and consequences of health and illness. It also deals with the form, distribution and severity of diseases which are seen as products of the social circum-
stances under which people live and work. Though it is held that the causes of death and diseases are not just physical but also social, the social model explains illness in terms of the social situation in which diseases occur.

Talcott Parsons was one of the first few scholars to lay the foundation for a sociological critique of the medical model of illness. In his analysis of health and illness (see his 1951, 1972 and 1975), health is the condition of having optimum ability to perform social roles and responsibilities. Contrarily, illness is a disorder in this capacity to carry out social responsibilities and obligations and thus a hindrance to the actor's social roles and performances. Thus, a physically or mentally ill individual who fails to perform her/his social roles is said instead to adopt the "sick role". But unlike others who deviate from social expectations, sick people are not held responsible for their role deviance. Rather they have a justified reason for failing to carry out their social roles but are expected to try to get well. According to Parsons (1951), medicine controls illness as a type of social deviance by monitoring it and by getting people back to health so that they can resume their social roles and responsibilities. "The patient is characterised as helpless, technically incompetent and emotionally involved, therefore, needing to put himself or herself into the hands of a professional who is technically expert, functionally specific and affectively neutral" (p.456).
From the sociological perspective, the impact of medical care is not very great compared to the impact of a healthier social environment. For instance, the introduction of clean water supplies, pasteurised milk, better nutrition, personal hygiene and more efficient sewage disposal has dramatically reduced exposure to infection. Over the last century, plumbers and sanitation workers have probably saved as many lives as physicians. In fact, two social factors - income and education - determine to a great extent the kind of health people have (Coser et al 1983: 354-359).

HEALTH AND SOCIETY

Society and culture play a great role in the domain of health. As stated above, diseases and their social distribution are also seen in relation to the social environment and are treated as the effects of social structure. "The pattern of health and disease of a community can be analysed only when it is placed in the context of its socio-cultural framework. It is this socio-cultural milieu which determines the nature of illness and the line of cure. Further, society also shapes the organisation of infrastructural facilities of health care, processional services and faith of the people in each of these" (Mehta 1996:1).

As stated earlier, every community or society views health problems in the perspective of its distinct set of beliefs and practices, values and norms, cultures and
traditions though it cannot be denied that the people's perception of health is also influenced to a great extent by the external forces. Health and society are intricately interlinked for, it is society that determines the nature, cure and causation of diseases and the state of health of its members. On the other hand, the state of health of the people also contributes to the state of society. Often, health is considered as a state or a capacity in which the individual functions normally. But this state of normalcy is dependent on a gamut of factors like culture, social values, politics, philosophy, history, patterns of social structure and stratification, individual's caste, class, ethnicity, income, occupation and education. The state of health also largely depends on the psychological well-being of the person. The interaction between the human mind and body represents a critical factor in regard to health (Cockerham, 1989 : 2, 73).

It is pointed out, "Life stressors can play a part in causing serious illness and even death" [Dohrenwend and Dohrenwend (1981:1)]. Most, if not all, stress is socially induced as a consequence of social interaction (Moss, 1973). A few sociological theories (Durkheim 1951, Cooley 1964, and Goffman 1959) also show how social processes can produce social conditions considered stressful by the individuals concerned. If a society wishes to reduce diseases including those caused by stress then it must seriously promote both environment and change in individual's life styles that are conducive to health. It is suggested that "health may be
more a function of biological inheritance, environmental circumstances, and especially, personal life-style than it is of the availability and efficacy of medical care" (Mckinley, 1979 : 541)

The health status and its disparities among people are influenced by different attitudes determined by socio-psychological, cultural and other factors. The inclusive culture alone that structures the lives of a population has strong implications for the health status of the people. Some social and religious normative patterns, both prescribed and proscribed, exclusively relate to the health of individuals. "Cross-cultural studies of disease consistently show that the varieties of human affliction owe much to the inventiveness of culture as they do to the vagaries of nature. If disease is seen in its full dimensions as a phenomenon besetting persons in communities, its status as a culturally constituted reality becomes apparent" (Susser, Watson and Hopper, 1985 : 17).

Social values play their role in the origin, experience and treatment of illness. The definitions of physical and psychic problems are influenced by social values sometimes quite differently from the clinical conditions (Lewis, 1963: Eisenberg and Kleinman 1981). Reactions to disease and pain are also bound up with the values and beliefs of a society. Values are also determinants of behaviour of both the health professionals and patients. They exist not merely in the minds of active doctors and passive patients but also in
social practices of clinical encounters. "The clinical encounter is one context in which values are exercised. Doctors and patients, even when reared in the same society can have widely divergent cultural values and responses, and each is likely to interpret the other's behaviour in terms of his or her own values and beliefs" (Susse, Watson and Hopper, 1985 : 137).

Illness and poverty are interrelated. Illness causes poverty by preventing people from holding down a steady job. On the other hand, poverty appears to cause ill-health. In fact, the poor disproportionately impose the burden of ill-health in every country or society. Because of their unhealthy social and environmental living conditions -- a low standard of living, less access to health care, run-down living quarters, deficient diet, exposure to infection, stress of financial worries, poor education and lack of consciousness -- the poor are more likely to become sick. They have a riskier and shorter life expectancy than other income groups. Further, they use medical services less frequently than others as they cannot afford both time and money. However, Lee Rainwater (1974) theorises that because the poor are often treated with hostility or contempt by health personnel, they may put off visiting doctors and hospitals for treatment. He also cites evidence that the poor feel old at a relatively younger age and are, more likely than others, to accept disability and illness as normal. Even with equal access to medicare, these conditions give rise to more frequent and serious illnesses among the
poor than the non-poor. Besides income level, education also largely determines the health status of a population. It has been found that higher the level of education in a population, the lower is its mortality rate (Fuchs 1968).

No doubt, a lot of people are born unhealthy. But many of those born healthy also suffer from premature death or illness simply because of an unhealthy environment, their own living patterns, perceptions, attitudes, beliefs and so forth. Their belief systems and perceptions about body and mind. God and soul decide their health, behaviour and lifestyles. People's daily routines of eating and sleeping, their consumption of alcohol and tobacco, the amount of physical exercise and work they do, lacking in personal hygiene, exposure to disease-carrying rats, flies and mosquitoes, and the emotional stress and strain they undergo are far more decisive for their health and longevity than the number of hospital beds and doctors available. Thus, the individual is held increasingly responsible for his/her own health and well-being as the greatest potential for improving health lies with the people themselves.

The health of individuals is also dependent on the environment of the family even before their birth. The foetus in the womb can be harmed or helped by the health, nutrition, behaviour pattern, cultural beliefs and perceptions not only of the mother but of the whole family. However, the individuals and families have expected too little of themselves in preventing diseases by expecting too
much of medical institutions for their cure (Coser et al 1983: 374). But it is now well established that much of illness, whether in adults or children is dealt with at the home or in the community through various forms of self-care (Dunnel and Cartwright 1972), and is never brought to the health professionals (Hannay, 1979). As Keinman argues, "It is the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated (1981:50)".

It appears that besides the access to and availability of health care, the beliefs and practices, one's social background in the forms of caste or ethnicity and class, kinship, cognitive system, etc. deeply decide how and where the sick are treated and whether they receive any treatment at all. The responses of people to medical situation, like any other social situations, are influenced by the manner in which they are socialised and educated, and by the way of life typical of their society.

Health is defined both in both positive and negative senses. In the former, it is a condition of physical, mental and social well-being while in the latter, it is the absence of illness or infirmity. Thus, mind, body and society interact in reciprocity to produce health or diseases. Health is holistic and is thus seen in the entirety of intricate dynamics of human society. It is not only physical, biological or genetic but also has other dimensions like economic and political, social and
psychological, cultural, environmental, medical, individual and societal. Since health is holistic, both individual and society are the ultimate units of analysis. Although both individuals and society play their roles both in prevention and cure of diseases, it is argued that the individuals have greater responsibility than society for health maintenance and it is society that plays a decisive role for health restoration (Mehta, 1996).

Health is a valued good. It may not be the ultimate value in the lives of most individuals but certainly many normal and routine life events cannot be experienced without a modicum of health (Wikler, 1978, 1978). For proper and adequate functioning of any individual or society, good health is a prerequisite. People may get engaged in different activities only if they are of sound health. Otherwise, they are preoccupied with their state of health and, as a result, other pursuits are reduced to secondary importance. In fact, ill-health wastes a lot of time, energy and money. It prevents people from doing and continuing a steady job. Many people are poor simply because they are diseased and disabled. A healthy group attracts members and is integrated but a sick society repulses them and gets disintegrated. In other words, illness spreading through a society not only indicates its social disintegration and instability but also unmask a low group immunity and loss of morale (Scambler, 1987). A prolonged illness is fatal and a danger to development - social, economic and political.
Contrarily, good health is both a value and a goal. It is not only an end but a means to many ends. Its instrumental efficacy is exercised in bringing development in different dimensions. Good health has a positive, productive and anti-poverty character, and is a launching pad to eliminate poverty and to progress towards perfection and prosperity. Better health, in the economic term, means reduction in production losses arising from workers' illness. It also reduces absenteeism, debility and disability and raises income, productivity and proficiency. Besides helping people in democratic participation, political stability and security of all kinds, good health also contributes a lot in achieving better education both in quality and quantity. It helps them to be in their positions and also to climb up higher in social echelons. It not only accelerates social mobility but also makes mobile men and women perform their social roles in better and more efficient ways.

Health occupies a prominent place in peoples' hierarchy of values and is a vital aspect of human resource development. Hence, development of personal and social health is very essential for over-all development of individual and society.

The health status of millions of people in the world today is a cause of considerable concern and their plight is pathetic particularly in developing societies. The problems have fundamentally been the consequences of the ways these
societies are structured. The individuals in these societies have also been blamed for their unhealthy ways of life as not only have they suffered themselves but also have put significant burdens on societies (Wikler, 1978). However, these societies including India have accelerated their efforts, especially after the Second World War to develop human resources, particularly the precious endowment of health and quality of life and to protect people from premature mortality and morbidity. Along with medical services, efforts have been to make improve environment and water supply, sanitation and nutrition, socio-economic condition and educational level of the people.

HEALTH CARE IN INDIA

Health and illness have not only a clinical dimension but have also been influenced by the values, beliefs, customs, education, occupation, economic condition, etc. of people. Changes in socio-economic and cultural conditions of the rural people influence their health behaviour. Hence, changes in health behaviour are one of the indicators of rural transformation (Banerjee, 1989) like those of socio-economic improvement, education, social awareness and exposure to the outside world, etc.

After independence, conscious efforts have been made in India to carry the community health services to the total population. It has been stated (Jeffery 1988) that the post-1947 efforts for health planning in India have achieved
some real gains. The poor and rural areas were not totally excluded from participation in and benefits of the programmes though, in effect, there has been an urban upper class bias in the post-independent programmes for better health (Banerjee 1989). The unequal access to the health services has also expressed the ever-existing social inequalities.

As health is seen both as a cause and consequence of overall development, India has developed a long and rich tradition of an inter-sectoral approach to improving the health status of its people. For instance, the overall development of people and elimination of their poverty, illiteracy and ignorance have been integrated with their health and family welfare. In other words, the programmes of socio-economic development, education, environmental sanitation, water supply, nutrition and health services have been adopted in an integrated scheme to improve social, economic and health conditions of the people in general and the weaker sections in particular. However, health has been a priority area and health care is a public supported social service. The centrist top-down approach is disapproved in support of a community health model where community involvement in health programmes is expected as essential.

With the goal of "health for all by 2000 AD" and the Primary Health Care as a way to achieve it (WHO, 1988), India has launched several health care programmes of curative, promotive and preventive health. There is an
enormous infrastructure of medical education, research and training centres, hospitals and dispensaries, Community Health Centres (CHCs), Primary Health Centres (PHCs) and sub-centres which serve the people. These infrastructural facilities in India are also aimed at serving especially the poor, weaker and under-privileged masses of which the tribals form a major chunk.

HEALTH CARE SCHEMES FOR TRIBALS

With great efforts by the government and international and local non-governmental organisations, there have been some improvements in the health conditions of people in general and of the weaker sections in particular. However, the achievements and performances have been far from satisfactory. The tribals particularly those living in backward areas have not had necessary access to health and other development services. Some of the schemes have been implemented among the tribals either defectively or ineffectively. Besides, the tribals have their own reasons as to why they reluctantly receive or even do not receive benefits of the modern health care schemes and stick to their traditional or indigenous curative care systems. Even those who are provided with the health care facilities have not been able to utilize such facilities properly due to various reasons. One such reason is that they have found themselves in a dilemma as it has been hard for them to strike a balance between traditional and modern systems of medicine. Thus, the reasons like hostile environment,
poverty, ignorance and illiteracy the tribals have led to a sad scene regarding their health. This has also been supplemented by their superstitions, dogmatic and spirit-oriented conception of health, illness, disease and death besides the lack of adequate health services among them.

The tribals constitute an important component of India's population. Since they have been exploited all through the ages, at present they are backward socially, politically and economically and in the field of human resources development, consisting of education and health. Living in isolation for long, the tribals have followed their traditional methods of treatment of sickness and diseases as mentioned above.

India's independence has, however, initiated an extraordinary era for development of tribals from the morass of sub-human social existence. The Constitution of India has enumerated them as 'scheduled tribes' and accepted them as a weaker section of society. Since then, significant advances have been made in many tribal areas through various programmes for all-round development of the tribals though some other areas have still been unattended to. There have also been both general and special component plans and programmes to protect and develop the health of the tribals. For instance, during the Fifth Five Year Plan, several schemes had been planned and implemented all over India under the Tribal sub-plan (TSP). One of these schemes is the provision for special nutrition and health care facilities
to the tribals. Under the special nutrition scheme, Balwadis have been established to supply nutritional food to the pregnant and nursing tribal mothers and their children. On the health front, the Community Health Centres (CHCs), Primary Health Centres (PHCs) and sub-centres have been set up in the tribal areas as mentioned above.

The recent government reports say that most of the tribal areas today enjoy the basic amenities. Even the remotest tribal pockets are being developed, at a faster rate, with communication and health infrastructures which would end the centuries-old isolation and illnesses of the tribals. However, tribals still make very little use of government health services as mentioned above. Instead, they prefer to be treated by unqualified, private medicine practitioners and spiritual healers.

In view of the above, many studies (Hasan 1967, Kakar 1977 and 1980, Karna 1976, Khare 1963, Madan 1969) conducted on the etiology, diagnosis and therapy of diseases in rural India found that the people see diseases from the perspective of body as well as external -- both natural and supernatural -- factors. But it is also found that despite the financial constraints and lack of organisational support, the scientific medical establishments remain supplementary to traditional health care and medical practices (Headley 1992). Yet, some other studies (Banerji 1975; Hocking 1980; Kakar 1976; Madan 1980) reveal that despite increasing utilisation of modern medicine and
resultant reduction in mortality and morbidity, the traditional or indigenous medical systems still persist and put an enduring influence on the health conditions, medical decisions and results in interior areas of India. This depends on the values, beliefs and attitudes of a community having strong influences on its people's interpretations of diseases and the techniques of their treatment (Kakar 1988). This is also related to the limited capacity of the local health centres to meet the growing demands of the villagers for health care facilities. As a result, there is a vast majority of traditional practitioners in comparison to a tiny minority of medical personnel of the PHCs serving a large number of villagers.

This exposes the limited bias in earlier investigations (Opler 1962; Gould 1967; Carstairs 1955; Marriot 1955) showing incompatibility of rural communities with the modern medicine. For instance, Hasan (1967) has concluded that those who did not adopt the western medicine better than the traditional medicine, were backward. He not only passed judgements on the culturally patterned responses of the people to their health problems but also paid inadequate attention to the mechanism of reaching modern health services to them. Similar shortcomings may be seen in the findings of other studies also (Dhillon 1969, Takulia 1969, Djurfelt and Lindberg 1975 and Van der Veer 1979).

Further, several studies analysing the tribal health show that the tribals have adjusted themselves wonderfully
well to the inhospitable climate and are in good health. Of late, they have started believing in the natural or biological factors of illness and are taking the advantages of modern medicinal treatment in nearby health centres though they still strongly believe in the supernatural reasons of diseases which were to be cured indigenously. For instance, the evil eye or glance (najar) injuriously affecting the healthy growth and prosperity of persons including children and pregnant women, animals and crops were to be treated by a "Bharara" - the spirit doctor and medicine man - who was sometimes beaten up by the evil spirits. The spirit doctors were so important that they were to be consulted before going to the health centres. [For details, see Srivastava (1958)'s study of the Tharus of Naini Tal Tarai of U.P.]. Similar situation has been found among tribals of other states also. For instance, the Bhil tribes of Madhya Pradesh strongly believing in superstitions and supernaturalism, relied on the "Shamans" popularly known as "Jhar" and "Badawa" or "Badawain" (female one), who after being possessed during the Gangour festival treated the sick persons and also advised them to worship the deities on some definite days (Soni 1990). Similarly, the Balanis of central India depended on the "Jankas" and "Barwas" - the two types of practitioners of ethno-medicine (Stephen Fuchs 1964). While the Janka cures by divination, the Barwa effects his cures by magic. The Barwa claims to be possessed by a super-human spirit or by a deity in whose authority he acts and who speaks through him (or her), while the Janka uses only natural devices like finger-
pulling, measuring with glass-stalks, observation of the flickering light figures on the winnowing fan and so forth, to ascertain the type of disease, the identity of the offended deity or spirit, and the type and number of offerings necessary to effect a cure.

It has also been found that the folk-practioners are an inalienable element in the life of Dhimers of Madhya Pradesh whereas the modern doctors are outsiders to their socio-cultural realm. Dhimers are sceptical about the doctors and health centres, and lack understanding of the scientific aspects of health, hygiene, and illness (Banerjee and Jalota 1988). Other studies have also found more or less similar results (see for instance, Roy 1915; Bose 1972; Vidyarthi 1969; Roy Burmon 1964; Elwin 1943; Dannely 1927; Dube 1949; Naik 1956; Sankar 1958; Sinha 1958; Hussain 1950; and Bhowmick 1955). However, these studies have failed to provide a comprehensive view of the cultural meanings of the tribals' health problems and practices institutionalised in their ethnic existence and also their responses to the interference of the outside agencies.

Tribals generally suffer from the same diseases which are also found among the non-tribals. A few studies have focussed on their diseases like Yaws (Saxsena and Prasad 1963), Leprosy, Smallpox (Elwin 1953) etc. These diseases have been found among them due to the deprivation of the basic needs of nutrition, health and hygiene.
A few studies have also analysed the functioning of various health programmes (Dhillon and Kar 1965) and health centres (Narayan 1986, Sahay 1969) for the tribals besides examining their responses to family planning programmes (Roy-Burman 1958, Man 1968).

However, there are very few studies (Chandra 1957, Chaudhuri 1963-64, Das 1960, Sahu and Koshi 1990) on tribal health in Orissa. These studies have focussed mainly on the less significant impact of urbanisation and industrialisation on the health and fertility behaviour of Oraon and Kharia men and women of Western Orissa. The Oraon tribals particularly located in the industrial settings have been found actively looking, like many non-tribals, for health services outside their indigenous systems though their counterparts living in rural areas have met myriad barriers in their accessibility to modern medical institutions because of social, economic, religious, political and physical locational factors. In serious health problems, they have made active efforts to take advantage of modern medicine but found their 'felt needs' unfulfilled. Nevertheless, there is a continuity of change in their 'health culture' and behaviour (for details, see Sahu 1991).

The etiology and health care practices among the Santals of West Bengal and Bihar were studied as early as in the 1920's. For instance, Bedding (1925) had studied their notion of health and illness, diseases, their medicines and methods of treatment in relation to their folklore. He had
(1927) also discussed their general attitude towards life and death, the qualities of the 'bongas' or supernatural forces, the medicine men and their methods of divination and witch-divination, and various other matters concerning cause, continuity and cure of diseases, and the ways to face and fight them. He summed up the attitude of the Santals as both practical and superstitious. He had analysed how the 'Ojha' was approached to know whether the particular diseases were due to the anger of a goddess, the work of an evil spirit, sorcery, witchcraft or the breach of a taboo. Specific types of rituals, sacrifices or incantations were made to cure the diseases.

A few studies conducted at a later period have shown that despite the influence of outer civilisation and certain changes, the Santals have continued their customs and traditions, values, beliefs and practices concerning health, illness, treatment and cure as was found during the earlier period. For instance, in Troisie (1979)'s study of Pangro village of the Santal Parganas during 1972-74, it has been pointed out that the Santals attribute death and diseases not only to natural causes, but also to supernatural forces, mischievous spirits and witchcrafts. To avoid the misfortunes, the Santals look for help of the Ojha who attempts to answer the problems through magic and medicine. Besides, there are 'Raranics' who cured diseases including difficult cases of deliveries only through the herbal medicines (Archer 1974). When both the 'Raranic' and Ojha fail in their efforts for securing the birth of a child, the
tribal couple as a last resort visit the Hindu temples (Culshaw 1949; see also Goutam 1977, Kochar 1970 on importance of Ojha regarding health, illness and treatment of Santal tribe in eastern India).

Tribals have generally been regarded healthy due to their closeness to the vegetation and healthy ecological environment, though a very small number of tribals in rural Bihar and elsewhere qualify the test of the 'health-modernity scale' (Singh, Sinha, Jayswal and Jabbi 1987). This has been attributed to their unhygienic living conditions, inadequate and imbalanced food habits, widespread misconceptions about various aspects of health and high prevalence of diseases and death. Contrarily, the crude death rate of the Santals of Jhalakdiha was lower than that of the other Santals village, Palkia, due to better housing conditions and the availability of medical measures in the former (Sarkar 1970, 1971). So far as birth is concerned, a great majority of the married Santal couples wish to have more than three children. According to them, the greater the family size, the more will be its earning capacity. In other words, the Santal community in rural Bihar has been found highly fertility-motivated and culturally-oriented (Verma 1970). This is evident from the fact that despite some elementary changes among them and steady interaction with the outer world, the Santals of West Bengal have retained their cultural practices including their traditional medicines and methods of treatment (Mittal 1979; Gautam 1977). Even after adoption of the Hindu festivals
and deities and the impact of other external agents, the Santals of West Bengal have retained the bed-rock character of their religion, i.e. belief in 'bongas' or spirits (Mazumdar 1956).

Martin Orans's (1958) study shows that the industrial environment of Jamshedpur (Bihar) has been a great agent of change in beliefs and behaviour concerning health, illness and witchcraft among the Santals. Though the Santals of the Santal Parganas still believe in the existence of witches causing diseases and death, such belief has gradually lost its intensity in recent times especially among the youth. (Ray, 1975). Instead of seeing the magicians, they consult the doctors and are extensively exposed to the modern health services.

Yet, the Santals, diffused over Bihar, Bengal and Orissa lead a uniquely uniform life of a homogeneous community and have little local variations in traditions. In fact they have lived with the diffusion and continuity of the same traditions (Mukherjee 1962). They have been helped by the 'Ojhas' and priests in the problems of parturition and epidemics which, in their opinion, are because of the 'bongas', spirits and witches. Rout (1966-67) in his study of Mahuldiha and Kantabani villages in Bamanghati subdivision of Mayurbhanja district of Orissa has vividly described the modus operandi of the witches, their roles and statuses and the measures to check witchcraft resulting in many murders (see also Das 1966-67).
As stated earlier, many efforts and interventions have been made in recent years to attain the aim of health for all. Consequently, there is some improvement in tribal health, despite the inadequate budget allocations for the PHCs in the Five Year Plans and disillusionment and frustrations of the young doctors posted in the remote rural areas. The low growth rate of population among the tribals of Orissa during 1971-1981, has been attributed to the high rate of their acceptance of family planning (Bose 1988) though this has happened not because of their development but the monetary incentives offered (Mukherji 1981).

However, torn between tradition and modernity, the tribals especially of Orissa have been trying to develop new attitudes towards their health and healing, medicine and witchcraft. In response to the modern health programmes, the Santals of Orissa have been slowly adapting to the modern medical measures though they have been hesitant and hostile initially (Mohapatra 1986). On the whole, the Santals have not been very accommodative to modern medicine as the dispensary records show poor attendance of both the indoor and outdoor patients.

Yet, the fact remains that there is lack of major studies on various aspects of health of Orissan Santals in relation to their socio-cultural system particularly after implementation of the modern health programmes. Even then, it is a fact that the tribals in general and the Santals in
particular are slowly and steadily coming forward to accept the modern medicine while simultaneously retaining their traditional beliefs and practices. It has rather been difficult on the part of the Santals to totally jettison their tradition and socially deconstruct their concepts of health and illness.

THE PRESENT STUDY

It is clear from the above review of literature that the perception of health and sickness heavily depends on socio-economic conditions, religious affiliations, literacy and educational levels, community and class consciousness as well as cultural circumstances of the people in general and the tribals in particular. In view of this, an important objective of the present study of the Santal tribes is to enquire into their health in relation to the overall conditions of their life. More precisely, the study of their health is to be located in their socio-economic, educational and cultural contexts which constitute the social factors of health and illness, their fertility behaviour, mortality and so forth. To substantiate the argument, it is also proposed to study the general health conditions of the tribals and their illness experiences simultaneously. It is, however, difficult to study sickness experiences and medical treatments of the tribals in absence of their wider belief systems about body, mind and soul. In fact, a tribal community views its health problems in relation to its distinct sets of norms, values
and beliefs and thus determines the nature and causation of
diseases and the state of health of its members. It is, therefore, intended to know their traditions and customs, values and beliefs. It is also proposed to know their perception of health, sickness, death and diseases.

Besides, it is interesting to investigate their health-seeking behaviour or what they do to keep themselves well (their health-seeking behaviour), and what they do when they fall ill. Do they fatalistically or stoically accept suffering when they fall ill? Who are the people who rely on medicine and of which types and in what conditions? What kind of practitioners are summoned or visited to? In the same sequence, there is a general impression that the tribals still stick to their traditional practices and systems and do not get attracted to the modern health practices. It is, therefore, intended to examine the reasons for it and to know their indigenous or traditional cure systems, the training and competence of the traditional health practitioners, their clientele, therapies and effectiveness and their role, status and success in the tribal society.

We have also seen in the above review of literature that a sizable section of tribals is attracted towards the modern health facilities though these are not properly and adequately implemented. Besides looking into the details of various health schemes and levels of their implementation among the tribals, it is necessary to examine the
weaknesses of and obstacles to these programmes and their implementation. Whether the distribution of benefits from the public health infrastructure has favoured a particular area, class or gender of the tribal people? Since the people's differential accessibility to the available medical facilities depends on the levels of their consciousness and awareness, it is intended to know the people among whom the utilisation of health care deliveries is higher than the other people. In these cases, it is interesting to find out both the proximate and immediate reasons for such differential distribution and its impact on their health conditions.

Another important aspect is to know the modern medical institutions, health professionals and their views, interactions and experiences. It is also interesting to enquire into their perceptions, practices, problems and responses in healing and dealing with the tribals. Equally important is to know the tribals' perceptions and experiences of the modern facilities and the health personnel, their responses to the modern health services especially in the wake of their inclination to their own traditional and cultural practices. By extension, it is also important to know as to what happens to a traditional society exposed to the influences of modernisation and development or the interfaces between its traditional values, institutions, etc. and the institutionalisation of modern health care facilities.
In brief, following are the main objectives of the present study.

1. To know the traditional belief and attitudes of the tribals towards their physical and mental health.

2. To enquire into their responses to the modern health measures.

3. To measure their stresses and strains in keeping a balance between the old and the new or the traditional and modern health care facilities.

4. To know the nature of belief created among them about the modern health care especially after overcoming the strains of reconciliation between the traditional and modern health care systems.

HYPOTHESES

In the light of the above mentioned objectives, it is proposed to verify the following hypotheses:

(1) The level of one's socio-economic status, education and awareness facilitates one's participation in and acceptance of the modern health care facilities or higher the level of poverty, lower is the health status of the tribals and higher the level of illiteracy and ignorance, lower is the health condition.
(2) Deeper the faith in traditions and superstitions, the more discouraging is the response to the adoption of the modern health practices.

(3) Nearer is the settlement to the town, more is the awareness and utilisation of the health facilities.

(4) Nearer is the location of the health centres to the tribal habitation and better the facilities along with friendlier attitude of the health personnel, higher is the degree of acceptance and participation in the modern medical facilities.

CONCEPTUAL EXPLANATIONS

The term 'health' has been perceived variously by different people. This, however, means a state or ability with which the individuals function normally. Health is a normal state in which people are fit to perform their roles and responsibilities. It also means the absence of infirmity and illness. A healthy society is one in which most of the members are healthy.

The 'modern health practices' are understood in terms of what the people are expected to do to promote their health, prevent illness and get well while ill. These practices include not only health-seeking behaviour but also the life-style that are better for good health. The health
seeking behaviour includes personal hygiene, physical exercise, good food habits, restricting drinking and prohibiting tobacco chewing and smoking. Thus, we have used the term 'modern health care practices' in the sense of practising prescriptions and proscriptions or prohibitions of the modern health care measures.

Further, the term 'tribal development' does not mean only the economic upliftment of the tribals. It is the overall development in their lives including their personality and socio-cultural and ideological systems. However, here we have accepted the term tribal development in terms of progress in their health and health care practices by making use of and participating in the health care programmes. Thus, tribal development is accepted, for the purpose of the present study, as a process of participation in and the products of the health care programme leading to improvements in the health conditions of the tribals.

RELEVANCE OF THE STUDY

The present study is both academically and practically significant as it seeks to contribute to the body of knowledge about the condition of tribal health and certain ways and means to resolve the in-built malaise therein. More specifically, the present study is relevant because a backward state like Orissa carries the records of exceptionally high levels of malnutrition, morbidity and
mortality, particularly among the tribals who have been neglected since long. While their state of health has remained pathetically precarious, it has not yet been comprehensively studied and analysed.

Indeed, it is difficult to evolve a comprehensive strategy for the development of tribal health for the want of sufficient knowledge about their values, customs and practices which are intimately connected with their health, illness and treatment. Planning social change and implementing development schemes among them are also difficult when social, economic, political and physical factors decisively determining the causes of their illness and resisting implementation of various programmes of health have not throughly been explored. Hence, with only a few empirical studies on the subject and lack of sufficient data relating to the tribals' health conditions, the present study may, in a modest way, fill the void by providing a comprehensive and indepth sociological analysis of their health condition.

The present study may not only contribute to the academic and intellectual needs, but may also help the planners, policy makers and administrators in appropriately evolving, re-orienting and remodelling effective and meaningful policies and programmes for their successful implementation.
CHAPTER SCHEME

The present study is divided into six chapters. Besides this, the next chapter deals with the methodology adopted for the present study. It explains the identification and selection of the universe and the sample, and the techniques of collection, processing and analysis of data. Chapter 3 provides an account on the research setting by explaining the physical and socio-economic environment of the study villages. In other words, besides giving socio-economic profile of the study area, this chapter also enquires into customs and traditions, beliefs and practices of the Santals of the Nilagiri Block of Orissa. Finally, it explains socio-economic background - age, sex, education, occupation and income level - of the respondents selected for the purpose of data collection. The next chapter deals with the modern health programmes that have been introduced in the study area. More specifically, it describes the existing medical infrastructures like primary health centres, hospitals, health personnel, etc. Chapter 5 examines the level of implementation of the health programmes in the study area and analyses the responses of the tribals in general and the respondents in particular to these measures and programmes. This chapter also deals with the mechanism through which the respondents have been trying to maintain a balance between the tradition and modern systems of health care. Chapter 6 analyses views of the respondents on family welfare. More specifically, it examines their responses to the health care schemes for
mother and child, their adoption of the family planning methods, etc. Finally, the last chapter summarises major findings of the study and suggests certain ways and means to improve the health of the tribals in the study area in particular and the people in general.

REFERENCES


Bodding Skrefsrud and Konow 1982 Traditions and Institutions of the Santals (Bahumukhi, Delhi, 1994).


Djurfelt, G. & Staffan Lindberg 1975 Pills Against Poverty (SIAS, Monograph No.23 (1975).


Durkheim, E. 1951 Suicide (The Free Press).

Eisenberg, L. and A. Kleinman (eds.) 1981 The Relevance of
Social Science for Medicine (Dordrecht, Holland).


Elwin, V. 1953 "Folklore of Disease - Leprosy: Scourge of Sun God," The Statesman, April, 9, 1953.

-----------1953 "Folklore of Disease - Smallpox: The Old Mothers: The Statesman, April 12, 1953.


Gautam, M.K. 1977 "In Search of an Identity": A Case of the Santal of Northern India (Leiden, the Netherlands).


Hockings, P. 1980 Sex and Disease in a Mountain Community. (New Delhi: Vikas Pub.).


Kakar D.N. 1976 "Background Training and Role of Indigenous medicine Practitioners and Multipurpose Health Workers in a Development Block of Haryana". Indian Journal of Medicil Education, Vol.XV. No.2


1988 primary Health care and Traditional Medical Practitioners (New Delhi).


Marriot, M. 1955 "Western Medicine in a village in Northern India" in Healths, Culture and Community (ed.) B.D. Paul, New York: RSF.


Mehta, S.R. 1996 "Society and Health", (Vikas Publisher, Delhi).


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Sahay, B.N. 1969 "Pragmatism in Development": Application of Anthropology (Bookhieve, Delhi).


Takulia H.S. 1969 Rural Health Problems and preparation of Physicians, a Paper in a Seminar on Teaching of Social Sciences in Medical Colleges, New Delhi, (Mimeographed 1969).


Victor Fuchs, 1968 The Service Economy (New Delhi, NBER).
