

**CHAPTER I**  
**INTRODUCTION**

## CHAPTER-I

Encyclopaedia of cultural anthropology defines medical anthropology as the study of human health and disease, health care systems and bio-cultural adaptation. The discipline draws upon the four fields of anthropology to analyze and compare the health of regional population and of ethnic and cultural enclaves both prehistoric and contemporary (Ember and Ember, eds. 1996:p.759). But the sub-discipline has its root in the gap between 'western medicine and non-European medicine' that developed in the 'post-19<sup>th</sup> century medical science'. W.H.R. Rivers and C.G. Seligman trained medical research workers of their time to relate the 'magical causality' with the 'modes of treating diseases' (Fortes, 1976, pp. xii – xii). Fortes reminds us the task of social anthropologists as to look into the states of health not as clinical phenomena "... but as lived experiences of individuals, families and communities" (Fortes, 1976, p. xviii). "... the core of any anthropological study of a system of medicine, viewed as an institutional apparatus of defence against the incursion of pain and ever-looming threat of annihilation that is the human lot" (Fortes, 1976, pp. xix – xx). Leslie conceptualized a medical system should be understood not just as a system of knowledge, beliefs and practices, but as a set of social historical, practical and economic forces that are set in motion through medical personalities (Leslie, 1976). Kleinmann designated the medical system as a 'cultural system'. The clinical emphasis is based on the analogy between the traditional healers, a doctor who is treating an individual patient for a specific illness with a specific treatment to the favour of definite outcome (Kleinmann ,1980).

In a society all accruing diseases especially epidemic diseases have significant social political and cultural perspective. "... as a lawyer I think of medicine in its broad sense as being essentially concerned with the state of individual in the day to day processes of living, state which we evaluate by criteria derived from what are conventionally labelled as the opposed of health and disease (Loudon 1976, x)". "In eighteenth century a medical and pre-Tylorian version of animism and a closely allied doctrine known as vitalism, with their prophet Stons, Hoffman and Berther, were for a generation acknowledge as benign alternatives to an increasingly materialistic orthodox medical systems (Loudon, 1976, p.18)". In 1814 the court doctors in London encouraged its employees to investigate the value of local medicines and

medical texts. The Spanish people in the America utilize their indigenous medical processes with the American cosmopolitan medical system. The English East India Company encouraged its employee to rely local rather than expensively imported medicine. The native doctor took participation in the medical relief projects of colonial periods of India.

By definition, Indigenous knowledge research is a “small scale, culturally specific and geographically localized, infrequently encompassing regional ecosystems” (Sillitoe, 1998, p.233). Barth (2002, p.8) maintains that “knowledge in its different modalities can range from an assemblage of disconnected empirical detail to a ‘theory of everything’... as we are in a world constructed on principles of sociality and morality, not mechanical causality”. Indigenous knowledge is interpreted as local, transmitted by folk way, factual engagement with acquired experiences and not in theoretical, flexible in mitigate the reality of common mass. It is at completely distinct from the western ideology and knowledge world (Ellen and Harris, 1997). Indigenous health care is a part of indigenous knowledge, Atran finds indigenous knowledge structures similar to scientific theories in that they generalize from concrete experiences, but unlike scientific theories they are not systematically formulated into laws or methods (1999). The tribal cosmology, rituals and religious traditions fall within this concept of indigenous knowledge. People have world-view from these orientations and to act accordingly. Indigenous knowledge as a conceptual tool introduce a radical shift in the mind set from viewing native systems of thought as naive and rudimentary, recognition of local cultures know their plant, animal and physical resources also come in importance (Nazarea, 1999). Cumulative experience and observation verified in the context of daily life is constituted of oral communication (Ingold, 2003). Demand of indigenous knowledge to the academic researchers is to disseminate, interpret, and make institutionalization of indigenous knowledge (Mauro and Hardison, 2000).

### **Background of Research**

An Interregional Workshop on Intellectual Property Rights in the context of Traditional Medicine in Bangkok, Thailand, in December 2000 reiterated that countries should develop a national policy on traditional medicine. Official recognition of traditional medicine systems can only be achieved through researches on traditional medicines and its integration into the national health care system (Zhang, 2004). Each community has its own hereditary

health care system, reckoned as traditional health care system, which is almost same across the geographical boundary although the ingredients of the medicines are different. Mobility of people in course of time promotes the expansion of health care facilities due to close proximity to different ethnic groups. In this way scouting for healing process also transcends the ethnic boundary. European explorations of the non-Western world challenge the traditional medicinal practices. Western *materia medica* has made an inroad to traditional method of treatment system, which has been gradually decreasing against the accumulating 'scientific' discoveries of germ theory, antibiotics and advanced medical technologies (Slikkerveer, 2006). However, scientific study of indigenous health care does not place the socio cultural background of the patients and healers. This carries the utmost importance if the traditional medical systems are to be incorporated into the national health care policy.

As a democratic nation India has to cater services for welfare of its people in the spheres of economy, education and health. Policy level decisions to reach the mass require detail study in order to understand the whole gamut of health care system available to the inhabitants at grassroots. Official public health care services are more acquainted with western science and technology having different type of socio cultural milieu rather than traditional / indigenous health care system. In spite of intensity to knowing about the traditional health care system, personnel involved with modern medicine express an inferior attitude to the traditional health care system. This fact creates some conflict in patients' mind during medication and thinking about the health care phenomenon. Many research outcomes have proved that traditional societies do not get the most needed psychological security in western medical system as it ignores essential cultural components of diseases and treatment prevailing in a given society. John Bryant (1988) sees the involvement of the individual and the local community in primary health care services not as a social nicety rather as a medical necessity. Diverse and deep-rooted social and cultural phenomenon of a society play crucial role in traditionally well accessible health care systems.

Alternative models should be developed in order to evaluate traditional medicines within the framework of clinical research. The research and policy on traditional medicines enhance focus on the clinical and experimental medicine (safety, efficacy and mechanism of action). The contribution of traditional medicine is very important to fill up lacunae of wider public health dimensions, such as social, cultural, political and economic. The ethnicity,

culture, familiarity and religion have a vital role in the usage of traditional medicine. Exploration on safety, efficacy and mechanism of action has received more importance from the funding agencies than the public health research; because of the response the funding agencies received from the biomedical community and not from the public health research community (Bodeker and Kronenberg, 2002).

National Planning Committee (1938) suggests that the responsibility of public health should go to the state. Bhore Committee (1946) and Mudaliar Committee (1962) have recommended that health system must be based on the people's need. The first two Five Year Plans were induced to build up infrastructure and to train health personals. This approach also states new initiatives in governmental activities on family planning and preventive measures. Fifth Five Year Plan (1971-79) and Alma Ata Declaration (WHO, 1978) were effective in minimum need programme in health sector. The National Health Policy of 1983 protected and provided health care system to the grassroot level. The private enterprises got permission to commence their activities in health sector. Seventh (1985-90) and Eighth (1992-97) Five Year Plans made emphasis on minimizing difficulties of health personals, equipments and other factors to combat existed lacuna. In this phase some programmes and schemes were launched to follow tribal needs. Tribal areas get 50% central assistance to continue National Malaria Eradication Programme. In 1994-95, cent per cent central assistance was available for tribal belt of north-eastern region. National Leprosy Eradication Programme and National Tuberculosis Control Programme are also with a special provision for tribes. The scheme as "Medical care for remote and marginalised tribal and nomadic communities" was launched by ninth Five Year Plan Period. Indian Council for Medical Research (ICMR) and All India Institute of Hygiene and Public Health (AIHPH) coordinate these schemes.

With the advent of new millennium, Indian people were captured by dreadful diseases like, malaria, polio that became epidemic. This perspective of National Health Policy of 2002 enhanced the performances of private bodies. To make a tinny wave in indigenious population this policy makes an effort to cater primary health care through three-tier Panchayati Raj Institution and with special focus on deficient area. State Government will have a flexibility to design separate schemes, tailor made programmes to cater the health needs of different socio-economic sections of society including the tribal. To achieve

people's need Central Government launched National Rural Health Mission (NRHM) on 12<sup>th</sup> April, 2005. However the health policies remain divorced from the realities of the crying need of a moribund population.

### **Survey of the Previous Researches**

Davis Arnold argues that participation of the Indian practitioners diminished with the perceived western medicine. Public health with synchronized medical system has been utilized as tool to dominate the indigenous people (Arnold, 1989). The Indian students of western medical education who understood local customs and beliefs were effective in promoting new system of medicine. The British doctor had too much dislike in indigenous treatment system. They levelled it as full of 'irrationality', 'superstitious' etc.

In colonial period, the government couldn't give their attention to health phenomenon of common mass. They were generally careful about British soldiers and Indian employees of the company. On that time the western doctors couldn't make able to understanding the language and conception about health hazards. At the time of each and every epidemic the British medicine raised several misconceptions among the populace. Colonial people lacked proper intimation about foreign medical processes and treatment procedures. Officers of Indian Medical Services (I.M.S) constituted basically of the British doctors were mainly duty oriented and uninventive. Therefore, they had not acquired skill to utilize the western medicine (Dutta, 1987).

In 1757, to combat the epidemic among company's labour troop, some skilled indigenous healers made notable contribution (Ramanna, 2002). Crawford (1984) notes a tendency of British officials to treat their patients by indigenous healers. The epidemic diseases became image of death in first quarter of the nineteenth century and in this time textual indigenous tradition revived with the British affiliation (Kriple, 1953). The epidemic diseases of colonial India gave a strong blow to weakening the indigenous health care system. After middle half of the nineteenth century an adverse effect of epidemic rendered a blow to colonial government, and then they introduced the western medicine as a tool of the empire. In this phase, indigenous treatment system faced a severe challenge. Some of them onto employed as *tikadar* (vaccinator) by training (Arnold, 1988).

The indigenous medical system functions in society's social cultural complexes and its deeply rooted processes. This system reflects certain values, traditions and beliefs based on people's way of life. It is a continuous process to meet the mental requirement of people with their cultural identity (Wijsen and Tanner, 2002). Every culture has its particular explanation for ill health. Culture provide people with ways of thinking, that are "simultaneously models of and models for reality", Geertz (1973) and Frake (1961) in the diagnosis of disease among Subanum of Mindanao, described sickness as a vehicle for pursuing other interests. The explanatory model of illness creates order and meaning and gives plan for purposive action which helps to produce the conditions required for their own perpetuation or revision (Kleinman, 1980). Knowledge and use of local medicinal plants and herbs, rendering adequate care for health problems like dislocated joints and broken bones, chronic diseases, gastrointestinal illnesses, child birth complications, mental disorders and cultural-bound syndromes have a origin in the root of regional version of beliefs, thinking and perceptions of regional perspectives (Bannerman et al., 1983).

The curing ceremonies are observed as 'socially reconstituting and reoriginating' (Kapferer, 1996). The shaman seeks to restore the patient's relationship to the physical, metaphysical and social worlds to return the imbalance that is the root cause of illness. Curing ceremonies not only act in patients' body but also in the community mind. Unlike the linear cure-for-disease equation of modern (allopathic) medicine, the local medicine practiced by shamans who use herbs is located in a more complex 'socially reconstituting and re-organizing' context (Harper, 1957). Shamans do their practices on holistic epistemologies of illness and curing handed down through generations (Rajpramukh, 1976; Kakar, 1982). In their therapeutic interventions, shamans seek to manipulate the bodily, spiritual and social domains at once. They do not sharply differentiate between organic and supernatural causes of disease – all sickness has both aspects, though prevail in varying degrees, and both aspects must be treated if the patient is to be cured. That procedure requires materials like "*korra*' flour, *sindhur*, turmeric powder, *sambrani*, eggs and different types of fruits and flowers. He also chants some mantras. If the patient dies in spite of the shaman's efforts, the blame is passed on only to the powerful evil spirits, but not to the shaman (Raj Pramukh and Palkumar, 2006).

Tribal people live in varied habitats, climatic conditions and ecological niches. The common beliefs, traditional customs, myths, practices related to health and disease in turn influence the health seeking behaviour of the people (Balgir, 2004a). Health care is one of the most important of all human endeavours to improve the quality of life especially of the tribal people (Balgir, 1997; 2000a, 2005a). Individual take decisions about health care matter in respect to personal experiences and preferences. Tribal people depend upon multiple and simultaneous usage of home remedies and multiple therapies depending on the cultural logic based on medicine of body fluids and supernatural dimensions (Bhasin, 2003). Tribal communities of India are mostly forest dwellers. Their health system and medical knowledge over ages known as 'Traditional Health Care System' depend both on the herbal and the psychosomatic lines of treatment. While plants, flowers, seeds, animals and other naturally available substances formed the major components of health care, this practice always had a touch of mysticism, supernatural and magic, often resulting in specific magico-religious rites (Balgir, 1997).

Psychological problems reflect in individual body as physical symptoms. Yet a number of the symptom checklists used to determine disorders are designed to rule out physical health problems. Mental health problems among minority groups are special consideration in these perspectives (Vega & Rumbaut, 1991). Cultural beliefs exist as the causes and consequences of mental illness can also influence treatment process and expression of symptoms (Lawson, 1986; Meketon, 1983). Symptoms are specific to a given culture (e.g., belief in spirit possession) may be appear as bizarre to the clinician and can consequently result in misdiagnosis (Levine & Caw, 1995); differentiation of conceiving the cultural practices act as causes of misinterpretation and lead to misdiagnosis (Vega & Rumbaut, 1991), vulnerability to stress (Broman, 1989), willingness to discuss mental dysfunction, social support (Sue et al., 1995), likelihood of seeking professional psychiatric care (Neighbors, Caldwell, Thompson, & Jackson, 1993).

Theories of illness aetiology on tribal health are often multi factorial and multilevel (i.e. immediate and ultimate levels of causation) which permits the use of different treatment resources for different causal factors and levels (Cosminsky, 1977). According to Cosminsky (1980) the main strength of the Traditional Medical System of tribal is its capacity to stand as psycho support system. The explanatory model of Traditional Medical System mainly

emphasizes the notion of disharmony as a cause due to man's relations with the supernatural powers and other bodily related illnesses caused by improper drinking and eating. Cultural meanings are also local and contested. This aspect of culture highlights its dynamic, changing quality and gives weight to forces of change and interaction. From this perspective, culture is constantly being transformed (Trostle, 2005). The ethnography of a wide variety of tribal communities in the Eastern Ghats explores a native cosmology with a metaphysical balance. It is the belief that "continued human existence is predicated on the maintenance of cyclic cosmic balance that both affects and reflects earthly conditions" in terms of "harmony between the physical and metaphysical worlds" (Fischer, 1999,p.480).

As narrated by Kakar (1982, p. 5), one of the distinguishing characteristics of Indian healing practices is the role of the sacred. "The whole weight of the community's religion, myths and history enters sacred therapy as the therapist proceeds to mobilize strong psychic energies inside and outside the patient..." Kakar (2003, p. 672) holds that it is the faith in the paranormal powers of the healer, which is at the core of positive outcomes. Belief is in the person of the healer, not his or her conceptual system or specific technique, which is of decisive importance in the healing process. Kakar has gone through the basis of an in-depth analysis of the traditional healing systems in India that the healing powers reside primarily within the mind of patients rather than in the tenets of their various faiths and ideologies. India is a country of healers, shamans, mystics, doctors, *gurus*, *ojhas*, *tantrics*, priests, and faith healers who have expertise in variety of social and personal problems. Modernization cannot bring drastic change in this system (1982). Watts (1975) observed traditional healing practices are called primitive, mystical and esoteric because educational system does not prepare us to comprehend their sophistication. Kakar (1982, 2003) and Kleinman (1980, 1988) has brought attention on that most of these traditional practices are deeply entrenched in folk wisdom and sound theories of mind. Co-existences of multi-ethnic components can occur in the estimation of psychiatric disorders in health care settings and in epidemiological studies among community. Evaluation is also influenced by worldview of different community (Adebimpe, 1981). A comprehensive theory of therapeutic process must explicate the communication between moral and physiological domains of experiences in healing and may ultimately challenge the distinctions between body and self or physiology and mind (Sargent & Jonson, 1996, p. xii).

Neki (1975) advocates therapeutic value of the *guru-chelā* relationship, and of surrender before the guru. Healing powers of the guru were observed to reside in his or her ability to connect with the disciples psyche, informing him the messages of strength and reassurance. Some anthropologist (e.g., Mariott, 1955) considered folk practices as part of the little tradition, i.e., the beliefs and practices of the masses.

Mahapatra (1994), consider health among tribal groups as a functional and not clinical concept. Sachchidananda (1994) conceive tribal health as a cultural concept as well as a part of social structure and organization which is continuously changing and adapting itself to changes in the wider society. Research of indigenous knowledge is reflected in the theoretical shift from a structural to a processual and to a post-modernist perspective. Certain methodological advances to tailor interventions to local conditions have already been put forward by the anthropologists (Raj Pramukh and Palkumar, 2006).

Lewis (1958) believes that the study of tribal health should be with reference to their distinctive notions regarding different aspects of diseases. The traditional medicine, healers and the priests can still relate a link between man, nature and the supernatural beings (Praharaj, 2007). Indian people from their inception practice and acquire the indigenous medicine through the women folk. 'The women have a profound knowledge of plants, medicine and their environment, traditionally, they have been a direct stake in their preservation (Singh & Singh, 2009). 'The political economic medical anthropology expands the horizon of analysis, bringing into focus womens' role in social reproduction related to health care (Sergent and Jonshon, 1996). Women have not any notable contribution in medicine as they are absent in all type of medical texts in colonial India. A renowned Ayurvedic scholar Sakharam Arjun (Ramanna, 2002) stated about some women *ayurvedic* practitioners as *dhangī vaidy* in suburban areas of Bombay. Women were not educated in medicine and in classical texts. Some exceptions are purely masculine.

### **Rationale for the Study**

India is the greatest democratic nation, which also caters services for welfare of its people by developing economy, education and health. Policy level decisions to reach the mass should be given due importance. Thus detail study is utmost necessary to understand the

whole gamut of health care system at grassroot level. Modern public health services are more acquainted to western medical system than traditional health care system. In spite of knowing about the traditional health care system, personnel involved with modern medicine express an inferior attitude to the traditional health care system. This fact creates some conflict in patients' mind during medication and thinking about the health care phenomenon. Many research outcomes have proved that traditional societies do not get the most needed psychological security in western medical system as it ignores essential cultural components of disease and treatment prevailing in a given society. Bryant (1988) sees the involvement of the individual and the local community in primary health care not as a social nicety rather as a medical necessity. Traditional and well accessible health care systems are more effective in diverse and deep-rooted social and cultural phenomenon of a society. In this concern to bring a model or enhance affectivities of national health care schemes in a holistic approach covering the social and political environment of the people can be explored.

### **Objectives of the Research**

Considering the social and cultural diversity of West Bengal and time available for completing the project following objectives have been framed to conduct the research.

- 1) Primarily the proposed research would be an exploratory one in order to understand the system of interethnic sharing of indigenous knowledge of health care system.
- 2) To explore the roles of women as care giver in domestic sphere as well as the neighbourhood.
- 3) To understand the roles of healers in providing cure of illness across the ethnic boundaries. Whether they interface primary health care programs of the State and Union Government and local indigenous health care system.
- 4) To analyse problems and prospects of indigenous health care system in concomitance with the national and state level public health policies and programs.

## **Methodology of the Research**

Medical ecology and bio-cultural anthropology are two of methodologies used in medical anthropology to study health Problems through the light of three established disciplines—anthropology, ecology, and medicine—construct a framework for understanding medical problems that differs from typical clinical investigations. Intermingled with evolutionary theory and field methodology, medical ecology has provided some key organizing principles for medical anthropology (McElroy and Townsend, 2009). This approach is developed in gradual process; there was a “broad tacit consensus” that ecology and evolution were core concepts of the discipline (Landy, 1983). George Foster, a pioneer in the field, distinguished three types of cultural studies as the roots of medical anthropology: the study of primitive medicine, witchcraft, and magic; analyze personality and mental health in diverse cultural settings; and utilization of this approach in international public health and planned community change programs (Foster, 1978).

Complex interactions between variables of knowledge, perceptions and practices in health care not only focus on the qualitative methodologies including symbolic analysis of ritual and myth, the structural analysis of social organization and research of local classification systems, but also includes quantitative techniques. Quantitative measure can elevate ‘subjective’ variables at the individual level, in case of complex perceptions, cosmologies and belief systems, to ‘objective’ variables at the systems level which can be regarded as specific cultural features of the local community. The main theoretical implications bring significance of both the emic view in the study of indigenous plant use knowledge and practice (Slikkerveer, 2006). Haile (1996) gives importance in focusing on indigenous knowledge, which has already resulted in reappraising theoretical as well as methodological aspects of anthropology. The notion of disease is applied not only to the condition of the individual, but to the condition of society as a whole (Silverblatt, 1983). Investigators have analyzed disease categories in an attempt to understand the structure of the conceptual word of different people. The use of componential analysis the investigation of semantic interrelationship of terms has been applied to words for sickness (Frake, 1961). Local interpretations of illness are shaped by historical and political contexts, it is therefore crucial to account for these variables in ethnographic analysis (Crandon, 2003).

Traditional socio cultural environment is mother concern to nurture and sustain the age old health care system. Forest environments promote humans' mental and physical health in many ways, reducing stress and in recovering from attention fatigue, and both psychological and physical rehabilitation (Ulrich, 1983). Components of forests provide both in preventing illnesses by support in psychological strength and curative measures along with medication. Green areas can also help in establishing personal and community identity, social activity, and social participation (Irvine and Warber, 2002). Beside of benevolent role forest has also induced some vile in people's life. Closeness with forest may be exposed to forest related infectious diseases. The lifecycle of many infectious diseases involve the pathogen, the vector, and the human (Butler, 2008). The vectors are often insects, some cases in animals. Many infectious diseases such as Puumala virus (PUUV), Lyme borreliosis, Hantavirus cardiopulmonary syndrome (HCPS), and malaria, are associated with forests, which are the preferred habitat for vector and induced among host populations (Aydin and Bakirci , 2007). Occurrence of infectious diseases is linked among other things to deforestation, loss of biodiversity, habitat alteration, and human migration (Molyneux, 2003). Harsh affect in ecosystem causes emergence of the diseases by changing the ecological system as well as the habitats of hosts or vectors and parasites.

### **The Conceptual Tool**

The term health care has been used not to focus on how indigenous people maintain their health through daily way of life in terms of sanitation and hygiene, food, work, and in short, the indigenous concept of being in normal, good health following the traditional prescription. Rather, the study has focused primarily on what the stakeholders do when they are sick to return to normal health. Indigenous Health care system is the age old folk tradition is different from Ayurvedic tradition but have some similarities in diagnosis, identification of diseases and medication, it has no such documented information and no any organized system of training and transmission. Indigenous health care system is much closed to supernatural mode of healing. There are very few acknowledgements from government organizations for indigenous treatment system. In spite of that healers are used in different type of academic discourses. Many efforts are made to bring indigenous treatment system like Horopathy, Santal Medicine, and tribal medicine into institutionalized form but success is very rare. Therefore, beside of health care system of Santal tribe, many

tribal mode of healing still exist under the fold of indigenous treatment system. This is not a mere treatment system but an ideology, system of health care which exists among the marginal communities, rural and tribal peoples. For the present research two more or less same geomorphologic areas are selected for this study. Climatic varieties are also taken into consideration to make a comparison in respect of seasonal duration and associated factors. Social cultural environment has also been considered to trace the phenomenon of sustainability and transformation of age old traditional health care system. Tribal in the midst of non-tribal people share many contrast ideology in concerning religious and cultural processes. But these contrasts are governed by necessity of life care services rendered by the communal effort of villagers.

### **Method Adopted**

Following the mixed method, the study has been done on the basis of firsthand fieldwork in two villages of the districts of West Medinipore and Purulia of West Bengal by interviewing the respondents after getting their informed consent. A pilot survey was conducted for selection of field and community of West Bengal basically in the forest clad tribal belt. After collecting some general data on the indigenous health care system, a series of schedules have been prepared, tested and finalized. Case studies, interview, group discussion have also been done for collecting relevant data. Participant observation has also been utilized to verify data collected from the healers. To get the list of healers, snowball sampling has been used. Healers are selected from the surrounding villages from whom the patients of this village get clinical services. Especially the healers who have hereditary attachment have been selected for this study.

### **Selection of Field Sites and the People Understudy**

Nayagram block ( $22^{\circ}01'55''N$  to  $87^{\circ}10'41''E$ ) of West Medinipur district (now in Jhargram district) and Balarampur block ( $23^{\circ}05'48''N$  to  $86^{\circ}13'05''E$ ) of Purulia district have been selected for conducting fieldwork. Both of the blocks are situated in lateritic terrains and the selected villages are located at the margin of the forest. Balarampur has 32.76% tribal population and Nayagram block is also tribal dominated. Nayagram block is of lowest in rank in human development index (29<sup>th</sup>) in the West Medinipur. These two blocks lack district

hospital though primary and sub-health centres are present but not equipped to meet the public demand. People of some villagers have to walk more than 5-6 kms. to avail modern treatment accessories.

The major part of the fieldwork has been done mainly in two villages located in two different community development blocks in West Bengal having slide different geomorphological and climatic nature. The first one is Bhaliaghati situated in Nayagram block of Jhargram under newly formed Jhargram district (West Medinipore district). The village is inhabited by the tribal communities namely, *Santhal, Munda, Lodha, Bhumij*, and *Oraon* along with other non-tribal Hindu low caste groups like *Majhi, Bagal*. Apart from agriculture and related works the tribal communities earn their subsistence collecting fibers, flosses, medicinal plants from forests and waste land as well as fishes from river bank of Subarnarekha. The other field site is the village Darda located in Balarampur block, which is a drought prone area of the Purulia district. Kurmi is the dominant community among the others namely, Santhal and Bhumij. They are dependent on agriculture and related works with considerable dependence on nearby forest. Both of the villages taken under this study are multi ethnic, old setting (more than 100 years), and play a crucial role to determine cultural webs of these region. These villages are located at forest fringe area. Villagers get the treatment system of modern medical, homeopath and traditional health care. In this relation interactions and acceptances of traditional health care system among the changing scenario are understandably prominent. Women healers and medicine vendors also perform their skill in both of the villages. Women healers express their different type role and status in different social situation. Medicine vendors from Manushmuria a place in Jharkhand state cater their service through weekly market. It appears that the indigenous healers of these areas get their raw materials for preparation of medicine across the regional boundary.

General inhabitants and patients are exclusively from these two villages. A few (not more than 5) patients are interviewed in Balarampur block outside the Darda village. Selections of the men healers in Nayagram are made on the basis of taking services of the patients from study village and according to their information only. All the men healers have been selected from Nayagram block. But in Balaram pur block indigenous health care system prevails with a greater strength. In this connection few men healers are selected from

Barabazar, Kashipur and Baghmundi, Hura and Arsha blocks also. These men healers are also selected after getting the information from patients under study village. The women healers are exclusively from the Nayagram under West medinipur (now under Jhargram district) and from Balarampur and Barabazar blocks only in case of Purulia district.

Multi-ethnic setting of villages is helpful to study the inter-community relationships in health care sector. Weekly markets even in the era of globalization play crucial role in availability of life support commodities. Herbal doctors as well as patients collect medicine and necessary suggestions from the vendors of weekly markets. Indigenous health care system of these areas cannot be understood without the study of weekly markets. The medicine vendors are selected from the weekly markets and having shops in these two block towns. Medicine vendors are selected for data collection from Gopiballabhpur-I and II, Nayagram and Rohini under Nayagram Blocks. In case of Balarampur blocks the medicine vendors are selected from Balarampur, Barabazar and Purulia I and II blocks. Group discussion with men healers, medicine vendors and patients are conducted in weekly markets under these two blocks only.

**Table-01:** Criteria of selecting and number of respondents

I	Criteria	NYGM	BLMP
MH	Purely in Indigenous treatment, Treated for a long time (5 years), treated more than 5 diseases, cater regular services, live and cater services at the catchment area of selected village	40	40
MV	Sell more than 10 medicinal items, selected men healers collect raw materials from them, cater regular services	20	20
WH	Especially from neighboring villages where patients of selected villages get service, treated more than 3 ailment, cater treatment at present, Purely in Indigenous treatment,	20	20
P	Sufferings are frequently, more than 30 years old, can express the feeling and information, inhabitant of selected villages	40	40
GI	Age with more than 40 years, from selected villages and a few cases from neighboring villages. Have knowledge about health care system.	40	40

ABBVR: Nayagram-NYGM; Balarampur-BLMP; Informants-I; Men healers-MH; Women healers-WH; Medicine Vendors-MV; Patients-P; General inhabitants-GI;

A large number of informants around three hundred and twenty persons from thirty communities have been selected for interview with the help of structured schedule and open ended questionnaires. They not only belong to the two main villages understudy but also they live in thirty villages under five blocks of Purulia district and twenty five villages from Nayagram block. These particular research areas represent diversity of social cultural landscapes. In respect of existing indigenous health care in rural West Bengal, they are knitted to a strong network among them for the sake of indigenous health care services. These categories of informants belong to two categories namely, service providers and service receivers in indigenous health care.

### **Scope of the Study**

The National Health Policy of 2002 makes an effort to cater primary health care through three-tier Panchayatiraj institution with special focus on deficient areas particularly tribal ones. To achieve people's need the union government has launched National Rural Health Mission (NRHM) on 12<sup>th</sup> April, 2005. AYUSH promotes some programs and schemes to preserve and develop the indigenous health care systems (Govt. of India, 1983, 2002). The proposed study is expected to enrich the knowledge about the indigenous health care system.

### **Limitation**

The present study is not confined to write ethnography of medical practices of any particular ethnic community or group. The ethnography encompasses a number of tribal and caste groups who live in close proximity of two understudy areas.