INTRODUCTION
Indigenous Health care system is one of the most popular way of treatment of various health disorders prevalent in tribal and rural areas of Madhya Pradesh. Up to certain extent, this system also being popular in urban places.

The root of this health care system goes into the depths of the culture of a society, as well as it is also fits in faith of its people. At present, not only in our country but also in western countries, indigenous health care system is gaining tremendous popularity. The basic factors behind this popularity are its medicines, which have no side effects. Now a days due to advanced research, more effective medicines has included in this system and now this system became able to treat those diseases which were hardly curable before decades.

Basically this system of treatment is directly and indirectly influence by the surrounding as well as living environment of their people. As a trend, new time demands new measures, in Geographical research, 'Geography of Health' is a new addition for the subject, which developed as a systematic branch of Medical Geography. This study represents a new combination of two sciences (medical and social) and such a cross fertilisation of knowledge is a unique product for the well being of human societies. Jackques, M. May defined Medical Geography as the study of the relationship between the pathological factors, which have been called 'pathogens' and the geographical factors, which propose to call 'geogens' 1

'Medical Geography is the study of (i) the spatial incidence of disease, morbidity and mortality (ii) the environment as it affects human health and the spatial organisation of health care the provision of medical centres, clinics, hospitals, etc. as related to the distribution of population, access etc. 2

Despite the fact, that health disorder and various health care services have been studied by the people of medical science but not much information is exist regarding their geographical distribution. Basically ‘Geography of Health’ includes three basic components –

(i) Study of Disease.

(ii) Food and Nutrition.

(iii) Health Care Delivery.

The major concern of human life is health. It has been declared a fundamental human right. This implies that the state has responsibility for the health of its people. But these services are not adequate in our country. The current criticism against health care services is, that these are urban oriented, curative in nature and accessible to a small part of the population only.

Health is influenced by a number of factors such as adequate food, housing, basic sanitation, life style, beliefs, customs etc. The frontiers of health extended beyond the narrow limits of medical care. The term medical care is not synonymous with health care. It refers mainly to those personal services that are provided directly by the physicians. It ranges from domiciliary care to resident hospital care; thus medical care is a subset of health care system.

Health care is one of the major component and basic aspect of human needs. It can be defined as the active process by which an individual achieves physical and mental well-being. Health care is a function of the interaction between the three components of medical technology, professional organisation and the more encompassing geographical, social and cultural milieu. It covers a broad spectrum of the health care services, ranging from health education and information through prevention of disease, early diagnosis treatment and rehabilitation and it also implies to the organisation, delivery, staffing regulation and quality control. Contemporary work in health and health care, emphasises the experience of health and illness and of seeking and receiving care. It is also the broader social context in which illness arises and health services
are organised and operated. This perspective is somewhat boarder than what is often implied by 'Geography of Health'.

Spatial aspect of the organisation of health care, can have a bearing on the general effectiveness of the system and also influence who gets care, where ideally every one should have health care very close at hand, at least when needed. This implies a high degree of spatial dispersal of health care personal and facilities, unless a highly mobile service can be devised. However, economics of scale and the needed to confine highly specialised services to certain places (generally the major city hospitals) make for spatial concentration.

It is now fully realised that the best way to promote health care to vast majority of under served rural people and urban poor to develop effective primary health care services. So health care services may be defined all those- personal and community. Research also directed towards protection and promotion of the health of community.

Thus the systematic study of spatial distribution of various health care components with reference to urban, rural and tribal areas in various system of medicine, particularly Allopathic, Homoeopathy, Ayurveda and Unani, the folk medicine of tribal and rural areas, with preventive and promotive health services through public and private sectors are the main.

Normally, health care delivery reaches to vast majority of population by three ways- curative, preventive and promotive health care services. In curative health care delivery, ill people have been provided health facilities through doctors, hospitals, beds etc. by which essential health services reach to the different segments of population. Preventive health care always tries to avoid the spread of specific health disorder. In promotive health care, population is educated in the field of health and health disorder, which helps to create the healthy environment. Broadly health care delivery system can be divided into two parts -

(i) Allopathic Health Care Delivery System.
(ii) Indigenous Health Care Delivery System.
Most cultures of the past have their own glorious and useful system of medicine and health care. The medicines of Indigenous system have less sideeffects. Due to recent developments and research in this system, the more effective medicines are produced for various types of health disorder even more serious health hazards. In tribal areas due to less availability of Allopathic health care facilities and costly medicine, people goes for indigenous treatment, which is locally and easily available.

According to an estimate of WHO, the indigenous medical practitioners plays important role, as far as rural health care delivery is concerned. Evidence shows that urban population also depends upon it patronise traditional medical system due to their recent advancement. Indigenous health care system can be divided into two major groups -

(i) Professional Health Care Services - Ayurveda, Homeopathy etc.
(ii) Non Professional Health Care Services or Folk Medicine.

Indigenous professional system is rooted in well-organised system of medical knowledge based on observations experiments and clinical trails, while the non-professional system is a non-codified system and is locally developed. Folk medical system is confided to a relatively small group of people. But it is not surprising of find similarities between two professional systems, which prevail in two isolated areas. Thus a single group, practising indigenous non-professional system has much wider geographic extension than professional.

INDIGENOUS NON-PROFESSIONAL SYSTEM OR FOLK MEDICINE

Folk medicine has been in practice since ancient times throughout the country. This system is generally popular among the rural people of almost all developing countries. In India, among the rural people particularly of the tribal regions, where traditional values are still evident, this medicine system is the main source of health care delivery. There are many tribal groups residing in the state and each group differs from another in same way or the other with few common characteristics. Health care delivery is one of the common features, found in tribal societies.
Where wrath of god, mischief of evil spirits and magic of human being are regarded as the main causes of disease. The ancestral spirits expect to be remembered and provided for the occasion of their death anniversaries, if they are ignored them, spirits create serious consequences, such as disease and death. Secondly the ghost and churails, which are believed to live on trees and in isolated places, cause many diseases among them. One such important disorder is called ‘hawa’. Tribal people believe in the existence of witches who are particularly dangerous to the health of children. Their magic also influences the health of children and can result in to different disorders among them. Breach of certain taboos is believed by the tribal to be responsible for certain diseases like - Veneral diseases, which is caused due to illicit sexual relations with a woman, who has done any sin previously.

These supernatural causes related health problems are treated on the basis of folk medicine. Folk medicine has its own diagnostics, which lean heavily foretelling that is divination. Treatment is based upon the removal of causative factor through appeasing gods, exorcism (deliverance from evil spirits) counter magic, use of charms and amulets, jhar-phook and of course some herbal preparation.

It is fact that folk medicine is still practised in the 20th century and this system is generally popular among the tribal people of almost all developing countries. In our country among the tribal society where traditional values are still evident this medical system is the main source of health care.

Thus the systematic study of spatial distribution of various health care components in reference to tribal people areas in various system of medicine, particularly Allopathic, Homeopathy, Ayueveda including traditional health care system of tribal areas are the main concerns of the present study.
MEDICAL GEOGRAPHY

The growth of interest in geographical aspect of disease, nutrition and health care system have introduced a number of competing concept and definition of Medical Geography.

The number of articles, reviews etc. have been written during 15\textsuperscript{th} and 16\textsuperscript{th} centuries on diseases. In the 18\textsuperscript{th} century also further progress has been recorded but there was no substantial contribution in the field of Health Care Geography.

Dr. Jacques may (1950) was the first Medical Geographer, who mentioned the work on Medical Geography. Its methods and objectives, but it was all about diseases. Prof. A.T.A. Learmonth also did significant work on the related aspect.

The year 1972 was the turning point for Medical Geography because it was the year in which Mc-Glashan's edited volume of professional geographers appeared under the title of 'Medical Geography: Techniques and Field Studies'. In Mc-Glashan's volume, there was an introductory section on the approach and techniques used by medical geographers and an essay on medicine and Medical Geography (A.T.A. Learmonth). The section called Public Health Administration contains papers, which should be regarded as pioneer and worthwhile work in the field of Health Care Geography. During eighties (1970-80) Health Care Geography stream had become strong in North America and it was also in developing stage in Britain. But, at that time the health care scheme was rather separate from what might be called the ecological stream, though Prof. Pyles (1971) useful work combined these aspects to some extent. But the development was slow, even by 1976; the eastern block countries generally did not regard Health Care Geography as legitimate part of Medical Geography. They believed that it is the work of administrators and since universal health care is available there is no need for geographical analysis.

In 1974, A.W. Shanon and G.E.A. Dever made further development through the book entitled "Health Care Delivery: A Spatial Perspective' and
then Prof. Pyels in 1974 and 1979 wrote noteworthy papers on Geography of Health Care. But it was 1976, when Moscow Congress held and number of paper were presented on Health Care Geography, which started the outstanding development in this field. In 1978, Learmonth's introductory book on Medical Geography emerged as a milestone for the further study and also gave emphasis on Health Care Geography.

During 1979, in some of the western journals few noteworthy papers were appeared in the field of health care. By 1980 health care services were also projected on counters maps. Optimum size of hospital and distance decay were both analysed and since then number of books were written or edited by many geographers in this emerging branch of geography.

Capt. A.M.V. Heasterlow, who worked on disease of South India in 1929, introduced Medical Geography in India. Mc Clellend (1959) and McN mara also studied few aspects of Medical Geography in India. But it was Andrew Learmonth, who provided the scientific background to researchers in Medical Geography. The 21 International Geographical Congress (New Delhi, 1968) provided an encouraging opportunity for Indian geographers to contribute their research papers in this new branch of the subject. After International Geography Union (Delhi), Dr. R.P. Mishra (1970) wrote a good reference book 'Medical Geography of India'. In India some of the important worker in the field of Health Geography are Prof. M. Shafi, Prof. Rais Akhtar, Prof. Indrapal, Prof. Ramesh, Prof. Kailash Choubey, Prof. Jayanti Hazara and Prof. Jaishree De.

As for as author's knowledge is concerned, there is very limited contribution on Health Care Geography by Indian geographers. Though after 1970, when Strassburger discussed the problems associated with health care in southern India in 1973 and others geographers have examined the spatial distribution and growth of health facilities in Rajsthan (Akhtar, 1978) and Maharashtra (Shinde, 1980). Few other works in this field are Prof. Ramesh on Tamilnadu (1980), Begum and Vambus on Madras city (1981). Dr. Sukhdev (1981) has well examined the delivery of health care backward tribal areas. The role of traditional health care system in India has also been plotted into the limelight as it supports
western medicine even in metropolises like Madras (Hyma and Ramesh
1981). Banarjee (1981) also assessed the interaction of various system of
health care in India. Various components of health care service of M.P.
were also analysed by Prof. Kailash Choubey (1986).

Despite an enormous scope and well known existence of a
substantial traditional medicine sector, in most developing countries a
surprisingly negligible number of studies have so far been done by medical
geographers on indigenous professional system. Notable among these
studies are those by Ramesh and Hyma (Ramesh and Hyma, 1981, Hyma
They studied various aspects of Siddha system of medicine, which is
indigenous to South India. Ramesh and Hyma (1985) investigated the
current pattern of utilisation of Siddha medicine in providing basic health
care in the city of Madras. In another study, Hyma, Ramesh and
Shrinivasan examined the location and spatial distribution of Siddha
health care facilities in Salem, India. Hyman and Ramesh (1986) also
reported that for fevers, cold and coughs, digestive disorder, ulcers and
diarrhoea people usually consult practitioners of modern medicine
(Allopathic) whereas for rheumatism, and arthritis, jaundice and skin
disease traditional practitioners are widely preferred.

There is comparatively less published research work, specifically on
indigenous health care practices among the Indian tribe. As described
earlier, basically three important categories of researches have evinced a
keen interest in the subject i.e. (i) Sociologist (ii) Anthropologist and (iii)
Medical scientists. Here it is important to underline all the work in brief,
done by various persons, in different subjects in the field of tribal health.

Some social-anthropologists have underlined the importance of
studies of traditional system of values, belief, knowledge, object tools and
techniques on one hand and organisation of roles, activities and
relationship on the other hand. They have studied these system
specifically with reference to (a) Their distinctive notions regarding different
aspects of disease, health, food etc. (b) Studies of relationship between
system of medicine and other spheres of social life, such as religion,
astrology, magic, etc. Marriot (1955) and Carstairs pointed out, that allopathic medicine does not fit into social system of the villagers. Hasan (1967) says that there are two types of social and cultural factors that affects the health of any community (a) Factors directly affecting the health of the community because of certain customs, practices, beliefs, values and religious taboos etc. create an environment, that helps in the spread or control of certain disease and (b) Factors that indirectly affect the health of the community as they are related to the problem of medical care to the sick and invalid. Khare (1983) and Jaggi (1973) have discussed how the nature of treatment varies with the typed caused identified.

The importance of indigenous health practices and like could draw the attention of Dunbar (1915), Shrivastav (1962) Vidyarthi (1963) Saikia (1964) Mittal (1978) Pulu (1979), Malhur (1982) and others. Besides this, there are number of studies particularly on the curative aspect of plant/herbs, which are used by tribal (Jain, 1968, Khan 1999, Khare and Khan, 1999, Kapanee 1986).

It is clear though that we have a number of studies on various aspect of tribal health in different subjects particularly in Sociology, Anthropology and Botany. Unfortunately in Geography, specific study on indigenous non-professional health care system (Folk medicine) among tribals, is absent. Choubey (1986, 94, 99, 2000) have discussed health care delivery system among different tribal community i.e. Bharia, Baiga and tribe of Bastar. He discussed about the total health care delivery facilities available in well-known tribal district Bastar in detail. He also studied different causes of diseases and the role of traditional healer (folk practitioner) in tribal community and concluded that the folk medicine man in such communities plays an important role and works as a chief health care provider. He also found that tribal people depends on the folk practitioners for each and every health problems. Tiwari (1992) and Gour (2002) of Sagar University have also discussed, indigenous professional and non-professional health care system in detail in their doctoral work.
STUDY UNIT PROFILE

The area under study "Upper Narmada Basin" comprises between 22° 12' North to 24° 18' North latitude and from 79° 21' East to 81° 56' East longitude. The area comes under the tropical belt and the location of the area is itself significant for the upper basin of Narmada in between Gangatic and southern Peninsular of India.

Study unit spread over 23429 Square Kilometer, in four district of the Madhya Pradesh i.e. Jabalpur, Mandla, Katni and Dindori. The area consist 14 tahsils and 29 development blocks. The area under study is surrounded by Panna and Stana districts in the north, Shahdol in the east, Bilaspur, Rajnandgaon in south east, Balaghat in south, Seoni in south west and Damoh and Narsimhapur in the west.

According to 2001 census study unit comprises a total population of 47 million persons. Region witnessed 19.36 per cent growth rate during the last ten years. The density of population of the basin is 200 persons per square Kilometer. The literacy rate of the unit is noted 68.13 per cent, male literacy rate in 83.71 while the female literacy rate is noted 51.68 per cent. Sex ratio of the study area is 944 female over 1000 male population.

The study area is well known predominant part of the central tribal zone of the Madhya Pradesh- Gond, Baiga, Kol and Pardhan are the major tribes and spread all over in the region un evenly. Some of the places, one tribe is more predominant but some where they noted minor. This is also noted down that many of other places two are more tribes resides. They have their own culture custom and belief as well as health care system.

STATEMENT OF THE PROBLEM

Tribal community is a part of Indian society, which is surviving against various economical and natural problems. Tribal communities also have few problems, such as social-cultural and economic problems; ill health is the main problem. There are many basic factors, which are responsible for health problems among trible community, including social level, complex, environment, economic matters, illiteracy, food habits, traditional beliefs and deficit in the health services.
In the study unit most of the tribal population resides in dense forest and distributed unequally. Actually, they are fully dependent on the raw natural resources, provided by nature in their surroundings. It is true, that tribal people are dependent on ancient and traditional pattern of disease cure for the solution of various health problems even upto present time. In order to maintain their traditional beliefs, they ignore the modern health services provided by the government. All such factors like traditional beliefs, customs, social status, geographical environment are still helping them to be traditional. There are the few causes, which helped in theoretical development of present study. The study undertaken is related to tribal people and generalised ideas about these people, in reference to study region, are as follows -

(i) Tribal people are the inhabitant of dense forest and different places. So they are unaware about today’s scientific development.

(ii) These tribal people are still living alone with their deep-rooted traditions and customs. Their socio-cultural environment is differing in many views than from developed society.

(iii) In the tribal areas, local folk practitioners i.e. Gunia, Baiga and Ojha, are the chief health care provider. Their status and role in such communities is most considerable.

(iv) This traditional health care system (folk medicinal system) plays a primary and important part for cure of their day-to-day health problems. Their faith on traditional practitioner is as equal to god. They also believe, that medicine men are sent to them by god for their help.

(v) Due to their deep-rooted beliefs, tribal people do not accept modern medical facilities, easily. They only give preference to it, when traditional health care treatment fails.

(iv) In the tribal areas the availability of modern health care facilities are unsatisfactory and distributed unequally.

Thus the present study is related to the health of the tribal people, which is one of the burning problems in our country. Basically the present work is an important effort, to study the prevalent health care practices
and their components in detail, in a particular tribal area i.e. study region. The important aspect of the health care system is popular health related beliefs available health care facilities, available medicinal plant and various traditional methods used in the treatment of various diseases are studied deeply and analysed in present study.

Thus health, which directly affects the well-being and labour productivity of the population, is the basic consideration for all the planning efforts. A study of all the factors detrimental to human health and happiness is, therefore, prerequisite in the formulation of an optimal spatial organisation of health care activities, which in turn, is responsible for bringing up huge level of social welfare. Thus, there is an imperative need for conducting such studies that deal with the investigation of prevalent health care system and find out the distribution pattern of health care services. Such studies reveal not only the existing distribution of resources, health care facilities and diseases but also indicate the actual requirement of those pursuits and way of planning for them. At present, there is a pronounced awareness of the importance of understanding the geographical aspects of the problems of human health.

**OBJECTIVES OF THE STUDY**

The main aim of the present work is, to detect different aspect of health care delivery, which is available among the tribal people of the study unit. On above referred problem of tribal community, we have some objectives of the present study, which are as follows-

1. Examine the effects of relative locational distance and environmental perception on the accessibility and use of traditional health care.

2. Study of different causative factors related with various health problems of tribal people of the study area.

3. To identify the role of traditional health practitioners (folk practitioners) as the health care provider in the study area.

4. To discuss the various preventive treatment methods practiced in the tribal society.
5. Study of prevalent herbal cure for different health problems in the study unit

6. Study of different aspects of folk medical practices and determines their effectiveness and necessity among the tribal people.

7. Study of nutritional status of the people of study region.

**METHODOLOGY**

On the basis of above objects, the entire work is based on primary as well as secondary data and information. For the secondary data various relevant government offices and library has been personally visited. Beside above, for extensive study, scholar conducted a field survey with the help of various schedule, in selected tribal villages of the unit. For the selection of village following procedure is applied.

At first, all the blocks of the region are arranged in descending order, according to proportion of schedule tribe population of the particular block. Then these blocks are classified into four major groups, using break of continuity method (below 25 per cent, 25-50, 50-75 and above 75). Then two blocks have been selected from each group through stratified random sampling. This way eight blocks have been selected for study. Same procedure has been adopted for the selection of villages. At first, all the villages having more than 50 per cent tribal population of the selected eight blocks have been arranged alphabetically. Then two villages from each block (8 for pre selected block) have been selected randomly. In this way total 16 villages have been selected for extensive study.

To get relevant and require information about the various aspect of the tribal people of the study area four detailed schedules has been framed. Overall 182 families of the all four tribes (Gond,Baiga, Kol and Pardhan) are interviewed. However, as for as the selection of the families is concerned, it is taken into consideration that every tribal community must be covered proportionately in reference to particular area. Apart from families of various income groups are also taken into account. Schedule
prepared for the tribal study covers various aspects of tribal life and prevalent Health Care concepts and practices, as follows -

1. To collect the various informations about basic amenities of sample-village, village schedule has been filled with the help of the Kotwar, Sarpanch or head of the village. Available health care system, educational center, means of transport, light, market day, and drinking water facilities are the major aspects.

2. To collect the various socio-cultural information of the tribal people of the region, a separate schedule has been formed. Detail information about socio-cultural characteristics i.e. cast, religion, family structure, house structure, economic status, occupation, food habits, food gathering, living condition etc. has been gathered.

3. For getting various information on the aspect of health and the problem of health care, 40 practitioners are interviewed by the scholar, personally. Selection of these folk practitioners was based on their availability in the sample village. So that they were selected through purposive sampling. Two health healers from each village have been selected normally, and (8) folk practitioners has also been approached out of sample villages, because they were well known health care provider for particular health problem i.e. snakebite, scorpion bite, bone setting etc.

4. Diet of a person is a good indicator of the health of any society. Food habits and consumption of the available foodstuff is varies from place to place. It is also affected by the culture and social as well as religious belief. Thus various aspects related with food habits and food consumption is included in the schedule. Food intake availability also influenced by the economic factor, so the information about this aspect also gathered. To know the nutritional status of the people of the region, a point ‘Food stuff consumed last day’ included and families interviewed through schedule.

In this way the scholar has been conducted diet survey in sixteen villages in which 182 families were interviewed. To select the family for interview, income group, family structure and community also kept in mind.
### Table - I

**Block wise Scheduled Tribe Concentration (per cent)**

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Blocks</th>
<th>Per cent</th>
<th>S.N.</th>
<th>Block</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bijadandi</td>
<td>82.30</td>
<td>16</td>
<td>Nainpur</td>
<td>47.52</td>
</tr>
<tr>
<td>2</td>
<td>Ghughari</td>
<td>76.88</td>
<td>17</td>
<td>Mandla</td>
<td>35.58</td>
</tr>
<tr>
<td>3</td>
<td>Mehadwani</td>
<td>75.87</td>
<td>18</td>
<td>Badwara</td>
<td>32.32</td>
</tr>
<tr>
<td>4</td>
<td>Mawai</td>
<td>75.53</td>
<td>19</td>
<td>Dhimarkheda</td>
<td>31.74</td>
</tr>
<tr>
<td>5</td>
<td>Karanjia</td>
<td>73.29</td>
<td>20</td>
<td>Katni</td>
<td>28.21</td>
</tr>
<tr>
<td>6</td>
<td>Narayanganj</td>
<td>71.55</td>
<td>21</td>
<td>Vijayraghavgarh</td>
<td>26.70</td>
</tr>
<tr>
<td>7</td>
<td>Kundam</td>
<td>70.97</td>
<td>22</td>
<td>Rithi</td>
<td>25.43</td>
</tr>
<tr>
<td>8</td>
<td>Amarpur</td>
<td>67.06</td>
<td>23</td>
<td>Shahpur</td>
<td>23.74</td>
</tr>
<tr>
<td>9</td>
<td>Bajag</td>
<td>66.35</td>
<td>24</td>
<td>Jabalpur</td>
<td>22.57</td>
</tr>
<tr>
<td>10</td>
<td>Samnapur</td>
<td>65.14</td>
<td>25</td>
<td>Bahoriband</td>
<td>21.67</td>
</tr>
<tr>
<td>11</td>
<td>Mohgaon</td>
<td>64.76</td>
<td>26</td>
<td>Mojholi</td>
<td>20.64</td>
</tr>
<tr>
<td>12</td>
<td>Niwas</td>
<td>62.59</td>
<td>27</td>
<td>Panagar</td>
<td>20.35</td>
</tr>
<tr>
<td>13</td>
<td>Shahpur</td>
<td>60.50</td>
<td>28</td>
<td>Sihora</td>
<td>19.11</td>
</tr>
<tr>
<td>14</td>
<td>Dindori</td>
<td>56.21</td>
<td>29</td>
<td>Patan</td>
<td>15.14</td>
</tr>
<tr>
<td>15</td>
<td>Bichhia</td>
<td>53.98</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Census of India report 1991 and District Statistical Books
Table - II

Sample Villages Selected for study

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Group - Tribal Per cent wise</th>
<th>Selected Block</th>
<th>Selected Village</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Above 75</td>
<td>1. Mawai</td>
<td>i. Ghutas ii. Sijhora</td>
<td>Baiga, Gond</td>
</tr>
<tr>
<td>3</td>
<td>25 - 50</td>
<td>5. Rithi</td>
<td>ix. Baklehta x. Gatakhed</td>
<td>Gond, Baiga,</td>
</tr>
<tr>
<td>4</td>
<td>Below 25</td>
<td>7. Sihora</td>
<td>xiii. Indrana xiv. Gosalpur</td>
<td>Gond, Kol,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>xvi. Amahinota</td>
<td></td>
</tr>
</tbody>
</table>

Source – Based on field survey

DATA BASE

In order to collect the relevant data for the study, the respective sources, as discussed below, have been consulted -

1. Data and information about various health care delivery systems, the health statistics, have been collected from Directorate of Health Services Bhopal as well as from office of the District Health and Chief Medical Officer for the districts Mandla, Dindori, Jabalpur and Katni. For the data and information about indigenous professional health care system, Directorate of Indian System of Medicine and Homoeopathy Bhopal and office of Superintendent cum Ayurveda officer has also been consulted.

2. The general statistics and information have been taken from District Statistical Officer of the respective district.

3. The climatic data have been obtained from Regional Meteorological Office Nagpur.
4. For the population data census publications of the state have been consulted.

5. Considerable literature has been received from different libraries i.e. Library of ICSSR New Delhi, and library of Tribal Research Institute, Bhopal and ICMR Jabalpur.

6. Beside these, the other relevant information regarding the Indigenous non professional health care system (folk medicine) extensive field work have been conducted by scholar himself and various data have been collected through personal interview and well designed schedules.

**PLAN OF THE WORK**

To make the present study more effective, easily under standable and fruitful, it is divided into chapters -

The first chapter titled 'Physical Environment', deals with physiography, climate, geology, drainage, soil, natural vegetation and micro-environment of the study area, while second chapter covers various aspect of 'Socio-Cultural Environment' in detail.

'Life Style of the Tribal' is differ from modern people, which is discussed in chapter three. The fourth chapter 'Health Care System' has been discussed in introductory point of view. 'Allopathic Health Care System' has also been discussed in this chapter.

The fifth chapter 'Diet and Nutritional Status' of the tribal people of the region has been discussed in detail. In the sixth chapter health care facilities provided by various indigenous health care system have been discussed which include 'Professional Indigenous Health Care System i.e. Ayurveda and Homoeopathy'.

In the seventh chapter 'Folk Medicine' and various aspect of 'Folk Practitioners' have been discussed. This chapter also covers various aspect related with status and role of the folk practitioners in the tribal communities.
In the eighth chapter tribal concept of health disorders have been discussed in detail. This chapter also includes procedure of treatment and herbal remedies for different health problems of the tribal people.

At last the entire study is concluded and given in end of the work entitled 'Conclusion'.

DEGREE OF ORIGINALITY

The degree of originality of the present work upto certain extent depends upon the accuracy of data and information, which are collected from various offices and organisation. The study is also based on field work, so the information and data have been excepted by the author, as such were provide.

During study it was also observed that the records of various Health Care Services, which are provided by private sector, organisations and agencies are not available in authentic manner at any government level.