Chapter 1
THE THEORETICAL FRAMEWORK

According to the Constitution of WHO (1948) "Health is a state of complete physical, mental and social well being and not merely absence of disease or infirmity". This broad concept of health implies a perfect harmony of man's internal environment with his external environment consisting of physical, chemical and biological surroundings. It can be measured on the basis of the parameters like sex ratio, literacy, marriage practices, age at marriage, fertility, mortality, life expectancy at birth, nutritional status and mother's health, forest ecology, child bearing and maternal mortality, maternal and child health care practices, family welfare programmes, sexually transmitted diseases, genetic disorder, etc. The health of a society is intimately related to its value system, its philosophical and cultural tradition and its social, economic and political organization. Since health is influenced by all these aspects it is not possible to raise the health status and quality of lives of the people unless such efforts are integrated with wider efforts to bring about an overall transformation of the society as a whole. So, the health problems and practices of any community are profoundly influenced by interplay of social, economic and practical factors. The common beliefs, customs and practices connected with health and diseases are intimately related to the treatment of diseases (Bali 1988). The influencing factors related to both internal and external environment vary from community to community in a vast country like India and, therefore, there is found variation of health among communities. Tribal health which represents the best of this conception is found changing. Hence, this chapter introduces the theoretical framework of the study aimed to understand tribal health in the context of the Mishing.

THE PROBLEM

Tribal communities are socio-economically the most disadvantaged groups in India. They constitute 8.2% (Census 2011) of its total population. Their numbers, however, vary from state to state. All of them cannot be clubbed together as a single

homogeneous group. They belong to different ethno-lingual groups; profess diverse faiths and are at different levels of economic, educational and cultural development. There are more than 400 tribal groups in the country, of which 75 are primitive tribes characterized by declining or static and low growth rate. Though the tribals are distributed in most of the states of India they are more concentrated in a few areas; viz., (i) North-East India comprising Arunachal Pradesh, Assam, Meghalaya, Nagaland, Mizoram, Manipur, Sikkim and Tripura; (ii) sub-Himalayan region comprising North Bengal of West Bengal, Uttar Pradesh and Himachal Pradesh; (iii) central India – the Chhotanagpur region covering the states of West Bengal, Bihar, Orissa and Madhya Pradesh; (iv) western India covering mainly Rajasthan, Gujarat, Maharashtra, Goa, and Dadra and Nagar Haveli; (v) southern India covering the states of Karnataka, Andhra Pradesh, Tamil Nadu and Kerala and (vi) the island region covering Andaman and Nicobar, and Lakshadweep Islands. Interestingly, the tribes constitute the bulk of the population in the North-Eastern Region, but it covers less than 15% of the total tribal population in India (Census 2011). Tribal groups of India have specific problems; some of these are their built-in problems and some are imposed upon them which jeopardize their overall development and progress, inclusive of their health. Tribal health is a complex field, consisting of material objects, tools, techniques, knowledge, ideas and values, and a part of social structure and organization which is a network of relations between groups, classes and categories of persons. Immense heterogeneity is observed in the area of tribal health, and beliefs and practices. It is sub-system of the social system which is continuously changing and adapting itself to changes in the wider society. Among the tribes the concept of health, disease, treatment, life and death is as varied as their culture. A tribal society is guided by traditionally laid down customs to which every member is expected to conform and magico-religious practices are resorted to for the treatment of diseases (Basu 1994).

Health status of the tribal people is very poor. The infant and maternal mortality among the tribal groups are comparatively greater than the non-tribal population. The unique problems of health, nutrition and medico-genetics of the diverse tribal groups, inhabiting widely varied geo-climatic and ecological conditions. Hence, the subject

'tribal health' assumes much significance. Distinctive health problems of the tribal populations are mainly governed by their habitat. They are exposed differently to various climatic and environmental stresses/ strains and are characterized by their distinct socio-economic, socio-cultural and socio-biological setup. Thus, the health of these tribal groups is as such a function of the interaction between socio-cultural practices, genetic characteristics and environmental conditions. Societal attitudes, varying belief systems and governmental negligence have created a gaping disparity in health status of tribals through out India. Genetic abnormalities and infectious diseases are rampant in the state of Madhya Pradesh, Maharashtra, Tamil Nadu, Orissa and Assam. Additionally, malnutrition, birth disorders and gastrointestinal diseases are pervasive among tribal populations and stark deficiencies are found in the amount of calcium, Vitamin A and Vitamin C, causing dismal health conditions. Apart from this, they are not targeted specifically in national health policies/ programmes, though the social/ health inequalities are clearly mentioned in national policies. The issue of 'tribal health' needs to be looked into from the angle of feasibility and practicability. India, with its sizeable tribal population of 84 million (8.2 % of the total population) consisting of 162 major tribes and 270 minor tribal communities, has much more to contribute to the health care system (Census 2011).

In Assam the tribal groups form an important element in its ethnically, linguistically and culturally heterogeneous population. Their population constitutes 12.8% of its total population (Census 2001). The tribal people in the hills and plains form about one eighth of the total population, more than 86% of the population in the hills and more than three fifths of the total area of the state. In the state the Scheduled Tribes usually living in the eight plains districts, termed as Scheduled Tribes (Plains), are distinct from the Scheduled Tribes (Hills) usually living in two Hills districts; namely, Dima Hasao and Karbi Anglong. Problems of health among the tribal groups of diverse socio-economic, socio-cultural and geographical conditions in Assam pose a challenge as much as in India as a whole. On the one hand, the tribal groups have had centuries' old health care system while in course of increased interaction with the non-tribal modern health care system has been influencing their traditional health system, on

the other hand. The emerging scenario of tribal health poses a host of problems in terms of conception of health, disease and etiology, health status, health seeking behavior, health care system and changes, and health needs and problems in India as well as in Assam. Hence, there is a need to examine tribal health in the changing scenario in India in general and in Assam in particular. Before this examination is taken up, a survey of the studies dealing with tribal health is being done here.

SURVEY OF THE LITERATURE

The related literature on the study is reviewed under the following categories:

(i) Studies on Tribal Conception of Health

Basu, Jindal and Kshatriya (1994) inform that the concept of health embodies different meaning in different social systems and the health seeking behaviour of a community cannot be studied in isolation from the social network of a community as it is deeply interwoven into every event of social, economic and biological aspects of a population. Each of these aspects has a deep influence on health. Mahapatra (1994) feels that in the context of socio-economic constraints it may be realistic to handle the concept of health in a bipolar nexus. The concept of health in almost all the tribal societies is functional one and not clinical. Health is threatened not only by the spirit, but also by persons producing evil. Usually, health is a part of bipolar conceptualization and is juxtaposed to disease at the other place. That is why 'health' and grossly conceived 'disease' are paired polar concepts. According to him, in the concept of health of the tribal people there are two components which are present almost universally. Firstly, the individual may be committing or omitting certain acts which may bring upon the individual or the household some affliction. But this individual's action may also cause some affliction to be harmful for the whole village, clan or larger group. Secondly, there is the belief in some benevolent and malevolent spirit and ghosts. In some cases, there is a belief in a supreme being or a hierarchical pantheon of anthropomorphic gods and goddess.

Swain (1994) examined in depth the etiology of perception of health and perception of illness prevailing among the different tribal groups of India. It has been realized that diseases are not only due to physical, chemical or biological processes but

also due to a number of socially and culturally determined factors. The tribals whether the most primitive or the relatively modern are in various stages of transition. The concept that the tribals are resistant to modern medical care system has not been found to be true. Wherever facilities are available, their system of health seeking has tilted in favour of modern medicine. He is of the view that health and disease are a continuous process and interlinked with the health seeking behaviour of the community. There is no single/ simple answer to the most difficult question as to why one feels sick and why only a few seek medical advice when a number of persons residing in the same geographical, socio-cultural environment become sick. Zola (1964), Mechanic (1978) and Rosenstock (1960), each, have identified a number of variables with regards to health seeking behaviour of individuals. Life style of the person, financial demands, availability of treatment resources and cultural pattern of the community are some of the common variables. Tribal populations have distinctive health problems which are mainly governed by their habitat in difficult terrains and ecologically variable niches. The health seeking behaviour of a community is one of the major issues in the health status measurement and it governs the morbidity and mortality pattern.

Sachchidananda (1994) writes that health is man's natural condition, which is now recognized as a birth right of all citizens. It is the result of living in accordance with natural laws of body, mind and environment. These laws relate to fresh air, sunlight, exercise, rest and relaxation, sleep, cleanliness, elimination, right attitudes of mind and above all lifestyle. He views the field of tribal health in two main aspects: (a) as a cultural complex, i.e., a complex of material objects, tools, techniques, knowledge, ideas and values and (b) a part of social structure and organization, i.e., network of relations between groups, classes and categories of persons. The traditional system can be seen as a system of values, beliefs, knowledge, objects, tools and techniques and an organization of roles, activities and relationships. These have to be studied with reference to their distinctive notions of different aspects of diseases, health, food, human anatomy and facility, their medical techniques, particularly for making diagnosis and prognosis. Studies of the relationship between these systems of medicine and other spheres of social life such as religion, astrology, magic and mortality will make our knowledge

more meaningful. The other approach to the study of traditional systems would be to view it in the process of interaction. This will give us an idea as to why some elements of the modern system are accepted and others are rejected. He feels that in India the attention on tribal health is not adequate. This is because of three reasons: (i) the general belief that tribal people are living close to the nature and they enjoy an environment which is conducive to good health; (ii) the tribal people are regarded as not very amenable to the western systems of medicine as they still depend very much on supernatural cures and (iii) the difficult terrain which they occupy is difficult to adequate access of health services.

Dash (1986) is of the view that the basic concept of illness among the Paraja of Orissa is explained by magico-religious beliefs. Besides the magico-religious treatment of the diseases, the herbal therapy is also very much prevalent among them. Rizvi (1986) examined the health practices of the Jaunsari tribe of Uttar Pradesh and described their concept of etiology. These people believe that most of the diseases originate from supernatural causes. They do not know that surroundings and dietary habits may produce illness. Ramesh Menon (1988) explained how the tribes of Arunachal Pradesh attribute every disease or misfortune to a particular evil spirit. He found that patients suffering from psychosomatic ailments respond forwardly to their shaman's treatment. Vidyarthi, and Rai (1977) explained the belief of different tribals like Ho, Jaintia, Korwa, Maler and Oraon in malevolent spirits and powers which can cause diseases, famine, infertility and even death. These tribals also believed that there are some other spirits who protect the people from sickness and other misfortunes. Thurston (1907) described the beliefs in connection with charms, magical spells, witchcraft and sorcery for curing diseases and protecting people from evil spirits. While discussing the religious belief of the Travancore tribes Krishna Iyer (1941) mentioned about their medicine man who cures all their ailments and is a practitioner of magic. He said that propitiation of gods is intended to restore man's confidence when shaken by crises like accidents and diseases. Sengupta and Biswas (1956) conducted a dietary and nutritional survey among the Malapantaram, the Muthuvan and Ullatan tribes of Travancore and made a comparison of the differences in the quality of their diet and its influence on their health and physical

growth. With a description of the disease causing spirits, taboos and the initiation and functions of the medicine man of the uralis. Gnanambal (1955) also noticed that the Uralis make a fine distinction between the diseases of pathological origin and those of spiritual origin. Chaudhuri (1989) made a research study covering a wide range of important issues related to health from cultural and environmental perspectives with cross cultural data. He showed how socio-cultural factors like marriage pattern influence transmission of disease and how consumer culture is related to health. Yang-ed, Samaniego & Minger (2009) studied the health practices and beliefs among some ethnic groups in the province of Benguet, considering some aspects of health, such as health practices, health conditions as well health remedies, causes of human discomforts and health needs. The study revealed that the people of those ethnic groups rarely consult doctors, nurses and other health workers concerning health practices and conditions. They believe that the causes of human discomforts are natural and climatic factors, spirits, and even modern scientific findings on the harmful effects of virus and bacteria. There is a felt need for more doctors, nurses, and other health workers in the communities inhabited by the ethnic groups. Mathur (1982, 1987) examined the etiology of illness, occurrence of diseases, curing techniques and the efficacy of ethnomedicine among the different tribal communities of Wayanad. He pointed out that their contact with the non-tribals had introduced new diseases and the spread of these diseases adversely affected the growth of their population. Majumdar (1961) puts forward the opinion that social and cultural factors do play a major role in the spread of a disease. On the other hand, Troisi (1970) made a fine analysis of the magic and witchcraft beliefs of the Santhals of Bihar. He said that the Santhal look upon most of the diseases as something unnatural, ascribing them to the agency of evil spirits and malevolent forces, witches and the evil eye. Mahapatra (1986) found that the Santhals of Bihar believe evil spirits and witches as the ultimate cause of disease and death and this belief influences their attitude towards life and community. They are convinced that the administration of medicine has to be supplemented by the practice of exorcism and divination. Elwin (1955) studied the religious life, ethnomedicine, and culture of Saora tribe of Orissa. He said that the etiology of illness among the Saora tribe is based on supernatural beliefs.

According to them all diseases originated due to the wrath of the gods, dead ancestors and sorcerers. They identify no natural causes for the occurrence of diseases. Offering sacrifice to the supernatural forces and thus appeasing their anger is the only remedy for illnesses.

Bhattacharya and Sengupta (1986) observed that the general concept of disease among the Birhor hints at intra-group hostility and a high degree of insecurity owing to activities of the spirits. So, they pay much importance to community cohesion and propitiation of spirits in order to prevent illness. Tiwari (1987) studied the concepts of health and disease among the Raj and the Shauka tribes of Uttar Pradesh. He found that most of their illnesses derive from some of their age-old habits, poverty and the environment in which they live. Marriott (1955) made an analysis of various indigenous medical practices in the Kishan Garhi village of Uttar Pradesh and re-examined the role of western doctor as it appears to the villagers in the context of their social organization and their own medical institutions. According to him, it would appear that if western medicine is to find a firm place in the village under present conditions its role must be defined according to village concepts and practices. With respect to etiological factors Saunder (1954) recognized three types of causation: empirical, magical and psychological. According to him, empirical diseases are those in which a known external factor operates directly on the organism to produce the illness. On the other hand, magical diseases are those in which the causative factors lie outside the realm of empirical knowledge and cannot be, thus, verified and psychological diseases are those in which a strong emotional experience causes the appearance of the disease symptom. Simmons (1960) analysed the etiological beliefs among the Mestizo communities in coastal Pero and Chile. Mestizo etiological conceptions seek no support or sanction from religious or moral considerations, although a few are defined in supernatural terms. Consequently there is no single all-embracing causative factor such as incurring the displeasure of the benign or malevolent gods that can provide a central integrated theory of disease. Instead, there are five major etiological categories that embrace all of the serious illness and the vast majority of the minor ones. Illness is caused by severe

emotional upset, contamination by ritually unclean persons, obstruction of the gastrointestinal tract, undue exposure to heat or cold, or exposure to bad air.

While giving an ethnographic account of disease causation and medicine in a tribal society, Glick (1967) pointed out that whereas in Western medicine causation has no essential relationship to socio-cultural context, in most other medical systems causation and context are so intimately linked as to be the ethnographer's principal concern. Causes may turn out to be as invisible as viruses, but never as impersonal. Causation has several dimensions, not all of equal importance. Hughes (1986) in his well known article 'Ethnomedicine', illustrated the primitive concept of disease classification of ailments, in which there are five basic categories of events or situations which, in folk etiology, are believed responsible for illness: (i) sorcery, (ii) breach of taboo, (iii) intrusion of a disease object, (iv) intrusion of a disease-causing spirit and (v) loss of soul. He further elaborated that not every society recognizes all five categories; indeed, many groups are selective in the emphasis placed upon one or a combination of causes. Foster (1976) in his account of disease etiologies in non-western medical systems identified two principal etiologies; namely, personalistic and naturalistic. A personalistic medical system is one in which disease is explained in terms of the active purposeful intervention of an agent who may be human, non-human or supernatural. In contrast, naturalistic system explains illness from such natural forces or conditions as cold, heat, wind, dampness and, above all, by an upset in the balance of the basic body elements. Karna (1976) divided the concepts of etiology, held by the dwellers of a Bihar village, into two categories; namely, scientific and conventional. The disease causing agencies under scientific concept are the external agents like mosquitoes and germs. The conventional concepts are further divided into natural and supernatural types of disease causation. The natural causes of disease include the quality of food, environmental conditions, personal habits, hard work without adequate diet, and taking beef. Wrong done to some god is the only cause that comes under the supernatural category of disease etiology.

In an exploratory study of the health culture of people in a North Indian village Hasan (1967) found that the village folk classified the causes of illness into two broad

categories; namely, supernatural and physical. The supernatural causes of disease include breach of taboo, sorcery, spirit intrusion, evil eye, wrath of gods and goddesses and ghost intrusion. The physical causes are the effect of weather, the effect of wrong food, contact with certain living organisms and blood getting impure, accident and natural calamities and unknown causes. While giving an account of the traditional Iguape medical system, Queiroz (1984) informed that in the analysis of any medical system the underlying notion of disease causation is crucial for determining diagnosis and treatment. The Iguape have three levels of causation for diseases. First, disease can be caused by negative feeling from others (evil eye, sorcery) or from within oneself (sadness, unsatisfied will, fright). Secondly, they can be caused by an imbalance between the individual and his physical environment, as through the consumption of things considered too hot or too cold. Finally, they can be caused by a deceased relative, by any evil spirit, even by the will of god. The first type of causation is social psychological, the second type of causation is natural and the third is supernatural. Murdock et. al. (1978) took a sample of 139 societies distributed fairly among the different geographical regions and classified their illness causation beliefs and theories. They are against the assumption that the primitive concepts of disease have little in common with those recognized by modern medical science and relate much more closely to the ideology of primitive religion.

Thus, the above studies show that the concept of health, disease and etiology occupies different meaning in different social systems. Broadly, these concepts can be divided into two categories, i.e., scientific concept and conventional concept.

(ii) Studies on Tribal Health Status

Anandraj (1995) observes that among the diseases of genetic etiology that affect the tribal community of India sickle cell anemia stands out as a major one, because of maternal malnutrition, nutritional anaemia, malnutrition of pregnant women and their nature of workload, the complication of pregnancy and of childbirth, the distribution of food within the family and its effect on the nutritional status of women, primitive practices of parturition, maternal mortality, birth weight of children, nature of maternal and child health care practices, attitudes towards family planning and prevalence of

sexual diseases. This disease invalued a shortened life span of the red cell leading to severe and often fatal anaemia. The disease was further characterized by enlarged spleen, painful crisis, organ damage, impaired mental functions and increased susceptibility to infection. According to him, as the tribals constitute almost 75 of the Indian population; therefore the magnitude of this condition one could appreciate, considering the fact that this frequency is as high as 435 in some of the tribal population, especially in hyperendemic malarial zones. Sen (1986) presented the demography, prevalence of illness, vices and health status of the Andamanese, which is one of the smallest tribal communities in India. In this regard he suggested some effective measures like age at marriage, increased nutritional status and mother's health, control of maternal mortality, provide maternal and child health care practices and effective family welfare programme to increase their fertility. Agashe and Karkare (2003) aimed to identify the differences of motor fitness between tribal and non-tribal sports persons. For this, they selected both boys and girls from tribal and non-tribal communities. They found that tribal boys and girls were having significantly high speed and agility ($p<0.01$). In vertical jump tribal boys were superior ($p<0.01$). No difference was found on this dimension in tribal girls and non-tribal girls. Regarding chin-up tribal boys showed significantly more strength compared to non tribal boys ($p<0.01$), but, surprisingly, non-tribal girls were superior in chin-up item compared to tribal girls. Results indicated that tribal boys and girls were much more fit than non-tribal boys and girls in motor fitness. Kapoor, Tyagi, Saluja, Chaturvedi and Kapoor (2010) conducted a cross-sectional study among adult Saharia, a primitive tribal group of Madhya Pradesh. In the study, a total of 364 subjects (168 males and 196 females) in the age range of 18 - 60 years, were divided into two groups based on their random blood sugar level. Stature, weight, waist circumference, hip circumference, skin fold thicknesses, fat percent, blood pressure and blood sugar level were measured for all the subjects. 8.9% males and 7.1% females were found to be having more than 140 mg/dl random sugar level. All the skin fold thicknesses, body circumference, indices of adiposity, fat percentage and blood pressure were found to be significantly higher among the 'pre-diabetic males'. The picture was not so clear among females. Saharia is a socio-economically weaker

population with very low literacy level but the clustering of higher blood sugar level, higher blood pressure and higher fat percentage is an indicator of a beginning of metabolic syndrome among this primitive tribal group showing a paradoxical situation.

The above studies indicate that the health status of tribal people is affected due to the emerging unfavourable social, economic, political and environmental conditions.

(iii) Studies on Tribal Health Condition

Health and economy of a tribe is highly correlated. Singh and Mahanti (1995) have traced out the possible contributing factors for dismal health conditions like the widespread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary living conditions, poor maternal and child health services, ineffective coverage of national health and nutritional services, prevailing among the tribal people. Tribal *groups are homogeneous; are culturally firm; have developed strong magico-religious* health care system and they wish to survive and live in their own style. Due to remote and isolated living, tribal groups are outreach groups. No proper and appropriate health services are available to them in any of the tribal areas of different zones of the country. They live and interact within their own groups with strong cultural ties and continue to live in a closed system. After all these years of Independence of India since 1947, there is no comprehensive policy for the protection and development of tribal communities, although various protective measures have been provided in the constitution. Provision of a separate component of tribal sub-plan within the five year plans reflects the keenness of the government and its concern for all round development of this underprivileged section of the society. Meher (2007) informs that the tribes of the Orissa not only deserve a sustainable form of livelihood, but also proper access to adequate health care facilities, as poverty and morbidity go together to cause vicious circle. Because of a higher incidence of poverty, tribals fail to acquire adequate calories, nutrition and vitamins to keep them immune from various diseases. On the other hand, poverty further diminishes their earning capability due to the affliction of various seasonal and endemic diseases round the year. Hence, for the capacity building of poor tribals to enable them to come out of the poverty trap, apart from livelihood-sustaining measures in an era of economic liberalization and globalization, strengthening of public

health care facilities in tribal areas needs foremost attention. Fuchs (1949) in his study of the common diseases affecting the Nimar Balahis, who is a group of scheduled caste people, found that their socio-economic backwardness and unhygienic sanitary conditions are the major reasons for the occurrence of epidemics every year. Kumar, Dolla, Verma, Goel and Sehgal (2006) explored the socio-economic and demographic correlates of infant health in Kamar tribe. They find that the average age of first birth was 18.2 years and most of Kamar tribe women are illiterate and almost all deliveries are conducted at home and about half of these are assisted by untrained personals. Basu (2000) is of the view that the widespread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary living conditions, poor maternal and child health services and ineffective coverage of national health and nutritional services have been traced out in several studies as possible contributing factors to dismal health conditions prevailing among the tribal population in India. So, in his study on dimensions of tribal health he focuses on certain interacting factors like the infant mortality rate, life expectancy, genetic disorder, sexually transmitted diseases, nutritional status, forest ecology, child health and health care practices which are generally responsible for determining the health status and health behaviour of tribal communities. Balgir (1995) said that there is a paucity of comprehensive health research among the tribal population of India and most of the studies isolated and fragmentary in nature. So, there is an urgent need for initiating the area specific, tribe specific, action oriented health research in consonance with the felt needs of the tribal communities. According to him the health scenario of tribes of Orissa presents a kaleidoscopic mosaic of various communicable and non-communicable diseases in consonance with socio-economic developments in the state. The wide spread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary conditions, poor maternal and child health services, ineffective coverage of national health and nutritional services, etc. are the major contributing factors for dismal health in tribal communities of Orissa. Kuriyan (1982) in his study focused on health in selected cluster of villages, called Peint Block. In his study he tries to link various aspects of land holding, production, income, family size, consumption, nutrition and health.

Thus, the above studies indicate that widespread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary living conditions, poor maternal and child health services and ineffective coverage of national health and nutritional services are the possible contributing factors to dismal health conditions prevailing among the tribal population in India.

(iv) Studies on Tribal Health Seeking Behaviour

Naik (1972) and Ahluwalia (1974) surveyed medical anthropological literature dealing with especially the tribal and rural communities. They opined that very often people do not utilize the medical facilities available to them because of low cost and easy availability of indigenous medicines. Besides, a description of their beliefs and practices about illness and medicine, and the interaction between modern and traditional medical systems also form an important aspect of the study. Verma and Babu (2007) discuss the communities' acceptance of and perceptions on contraceptive services provided by district health system among tribal and rural population of Andhra Pradesh, India. In their study, they find that around 72% of tribal women and 855 of rural women in Andhra Pradesh had used, or currently using contraception. Currently, the number of contraception users are higher among rural than tribal areas. According to them, the predominant method among both tribal and rural areas is female sterilization, i.e., tubectomy. These results suggest that despite the increased emphasis on contraceptive choice and on spacing method in government programme female sterilization continues to dominate the method-mix, and spacing method still account for only a negligible amount of contraceptive use. Kshatriya and Kapoor (2006) reported that one of the major issues in health status measurement is health seeking behaviour of a community which governs the morbidity and mortality pattern of a society. In their study on health seeking behaviour among the Bhils of Barmer they find that for the treatment of various diseases they seek help from the traditional healer (Bhopa) and allopathic and Ayurvedic service providers. Both private and government health providers are consulted for seeking treatment. The Bhils resort to herbal or indigenous medicine for treatment in various ailments, but a majority of them prefer allopathic system of medicine rather than any other system of medicine, although their preference remains with traditional healing

practices. The main reason might be the immediate effect of the medicines as most of them are daily wage earners. Bhowmik and Bagchi (1987) also examined the health and nutritional aspects along with the frequency of diseases and treatment pattern of the Lodha and the Mahali tribes of West Bengal. They found that these tribals suffer from communicable diseases due to improper sanitation, lack of pure drinking water, open air defecation, etc. Sonowal (2010) discussed that the perception of health and health seeking behaviour among the tribal people is intertwined with lots of factors such as their traditional beliefs, practices nature of interaction with physical environment and changing social, cultural and economic domain. According to him, the issue of health care in tribal society is one of the major areas that need to be addressed on war footing. The study tries to find out the impact of socio-cultural, political and economic environment on nutritional status of tribal children and reveals that shortage of land and forest resources, lack of suitable job opportunity at local level and exposure to non-tribal domain has made tribal people suffer from lots of health and nutritional problems. Qamra, Roy and Mishra conducted a study on 44 families of two selected villages of Bagh Block of Kukshi Tehsil of Dhar district of Madhya Pradesh and observed the food consumption pattern of Bhils and various ways of obtaining food including the associated habits, beliefs and notions. Besides, they also observed the special and selective foods taken by them during pregnancy, lactation, illness, etc. and also about the changes in food intake during different seasons. Gautam and Adak conducted an assessment of nutrition through BMI and evolutionary variation using the coefficient of racial likeness (CRL) among 9 tribes of central India to study their nutrition and genetic variation. They observed that out of 9 tribal groups four; viz, Snor, Korku, Bhil and Gond are found more vulnerable from the view point of low nutritional status. They require immediate intervention as 50-70 percent of their population fall under chronic energy deficient grades. Rao, Balakrishna and Laxmaiah (2006) said that the tribal people are vulnerable to undernutrition, because of their geographical isolation, socio-economic disadvantage and inadequate health facilities. According to them adolescence is a significant period of growth and maturation. So, the nutritional status of adolescent girls, the future mothers, contributes significantly to the nutritional status of the

community. Therefore, an attempt was made to assess the diet and nutritional status of adolescent population from the different tribal areas of India. The available database collected by National Nutrition Monitoring Bureau (1998-99) was utilized by them for this purpose. In their study they found a significant association between undernutrition and socio-economic parameters like type of family, size of land holding and occupation of head of household. Therefore, there is a need to evolve comprehensive programmes for the overall development of tribal population with special focus on adolescents. Gupta and Deb Roy (2003) revealed that awareness of 'family planning' and 'methods adopted for controlling childbirth' are two basic indicators of the reproductive health consciousness of mothers. These two factors are related with some socio- economic and demographic characteristics like age, economic status, educational level, occupational pattern and the number of children of mothers. In their study of Santal and non-Santal people they found that 63.6 percent Santal and 87.0 percent non-Santal mothers were aware about family planning. The family planning methods have been adopted by 45.0 percent Santal mothers among whom 70.0 percent have gone for complete sterilisation through tubectomy. In the non-Santal group 76.9 percent mothers have adopted family planning methods and 78.3 percent of them had complete sterilisation. According to them, for improving the situation it is necessary to educate and motivate the people particularly the santal mothers towards utility of family planning methods and at the same time it is also necessary. Jain (undated) found that the utilization of RCH services, i.e., contraception, antenatal and other services are comparatively poor among the tribes of India. His study was aimed to know about the utilization of family planning methods and its determinants among the Gonds which showed a fairly higher acceptance of sterilization (31.3 percent). But they have adopted sterilization only after having three or more children. Thus, the higher acceptance of sterilization in tribes may be due to monetary incentives provided by Government for those who accept sterilization.

Thus, health seeking behaviour among the tribal people is intertwined with lots of factors such as their traditional beliefs, practices, nature of interaction with physical environment and changing social, cultural and economic domain.

(v) Studies on Tribal Health Care System

The studies on tribal health care system are discussed under the following headings:

(a) Studies on Traditional Health Care System

In a tribal society, social and cultural activities revolve around gods and spirits. They have specific gods for each and every activity of life; they have gods for health, disease and calamities and they worship the deities to protect them from evil spirits, diseases and epidemics (Sinha 1994). Broadly, the tribals believe in four types of spirits (Vidyarthi and Rai 1977); viz., (i) protective deities or spirits believed to safeguard the welfare of the village and worshipped at communal level; (ii) benevolent spirits who are worshipped at the communal and familial level regularly, otherwise they may bring disease, death and other calamities; (iii) evil or malevolent spirits and deities controlling small pox, fever, abortion etc. and lastly (iv) ancestral spirits who are very benevolent and protect the family members. Thus, tribal myth indicates that the treatment of disease is intimately associated with the common beliefs, customs and practices and interwoven into the social and religious life. These are protective deities, benevolent spirits, evil or malevolent spirits and deities and ancestral spirits. Every culture whether simple and complex has its own beliefs and practices, concerning diseases, and evolves its own system of medicine to treat diseases in its own way, though they may appear to be irrational from the viewpoint of the western system (Chaudhuri 1994). However, socio-cultural tradition does play an important role in the context of health and treatment. The common beliefs, customs and practices connected with health and diseases have been found to be intimately connected with the treatment of disease. Further, in most of the tribal communities there are a number of folklores related to health. Certain practices are suggested to avoid illness or diseases in the folklores. These should not be ignored as mere folk beliefs; rather they need careful attention. Guha (1986) presents a descriptive account of the folk medicine of the Boro tribe of Assam. After giving the details of the etiology, diagnosis, treatment and prophylactic measures of diseases he makes an analysis of the impact of modern medicine upon the traditional one. Mahanti (1995) examines traditional health care in retrospect and recommends an integrated system of

modern and tribal medicine. Jose Boban (1998) examines the medical practices and healing rituals in two tribal communities of Kerala to evaluate the changes occurring in the traditional medical system as a result of the influence of modern medicine. His study treats the ethno-medicine of tribes not as a set of abstract beliefs and exotic practices, but as an essential part of the tribal social structure. Various ethno-medical beliefs and practices are closely related with the social organization and religious beliefs. Attention has been also given to each of them. Ali (1994) discussed the overview of the works done by various scientists on indigenous health and medicinal practices among tribals and remarked that the health problems faced by the tribals were nothing but the regional health problems. In his view the disease pattern and its remedial measures have a direct relationship with the eco-system and physical environment in which the tribal groups live. He believes firmly that the disease pattern and its specialized curative knowledge may be distinct for a particular region.

Paleker (1995) in his study on the health care delivery system of the Karjat Tribal Block reveals the existence of a well organised and functional traditional medicine system based on local health tradition which based on local health tradition and is autonomous and community supported. In his study he aimed at revitalizing the traditional health care system in the Karjat tribal block which has convinced that traditional medicine is of contemporary relevance and it can help rural and tribal communities in India to achieve self-reliance in their primary health care needs. Hockings (1980) presented an elaborate account of the indigenous medical system of the Badagas of South India. He showed that their understanding of human physiology is rudimentary and misinformed. Similarly, in a monograph of the War Khasis, Dasgupta (1984) gives the impression that they are using both indigenous herbal medicines and modern allopathic medicines for the treatment of diseases. He also said that the influence of Christianity and education minimized the belief in spirits as the causative agents of diseases. Egnor (1984) discussed how some healers in Madras established a special relationship with the deities and function as the vehicle of their power. It is found that during the healing session the deity will speak through the servant to each patient and the supernatural power action through the healer will cure the illness.

In his study of the health and ethnomedicine of some tribes of Kerala, Viswanathan Nair (1985, 1987) gives much emphasis on how a tribal community's health is affected by the disturbances in the habitat and alien cultural contact. The study indicates that those tribal communities whose natural habitat remains relatively undisturbed use more herbal medicine than those whose habitats are disturbed. Besides giving a brief description of the ethnomedical practices of the Kanikkars of Kerala, Radhakrishnan (1986) also showed that they know a large number of herbal medicaments for the treatment of various ailments. Sarkar and Dasgupta (2006) in their study on perception of indigenous knowledge for health care among Baster Tribe highlighted that majority of tribal people still depend on indigenous treatment, i.e., herbal therapy which is practised by Sirha (Sorcerer) or Perma (Priest). They observed that, the specialist in their society has a dual status as he is involved in agricultural work and also performs magico-religious ceremonies for treating illness. The medicineman makes use of magico-religious process almost in all cases as demanded by the treatment. Sajem and Gosai (2010) made an ethnobotanical investigation on the use of various plants by the Lushai tribe of North Cachar Hills (now Dima Hasao) district of Assam. In their study they find that the Lushais still depend upon their indigenous knowledge for healing their ailments. The study documents the usage by the Lushais of 31 medicinal plants species, belonging to 26 families and 31 genera. They also noticed that the use of above ground plant parts was higher than the underground plant parts. On the other hand, leaf was used in majority of cases, followed by fruit. However, different underground plant forms such as root, tuber, rhizome, bulb and pseudo-bulb were also found to be in use by the Lushais as a medicine. In their society about 41 types of ailments have been reported to be cured by using 31 medicinal plant species. Mukherjee (1986) carried out a research highlighting the gerentological problems in the Ho, the Munda and the Santal tribes of Bihar. He found that the health status of the aging members is more pathetic in acculturated hamlets than in the traditional ones. Goswami, Soki, Jaisi, Das and Sarma (2009) made an analytical study on the traditional health practices in the Tagin tribe of Upper Subansiri district of Arunachal Pradesh. In their study they enlisted almost 10 medicinal plants used by the traditional medicinal

practioners of Tagin tribe for use in traditional medicine. They use some parts of those plants such as leaves, fruits, bark and stems for treatment of ailments like diarrhea, jaundice, wound healing, fever, etc. Saikia (2006) describes about the traditional knowledge related to ethnomedicine of different tribes, e.g., Bodo, Mishing, Nepali and Santhal of Gohpur of Sonitpur district of Assam. He identified 20 plant species belonging to 17 families. In the study a total of 22 prescriptions of indigenous medicinal plants are recorded ,which are popularly used by them. After conducting an ethnozoological survey among the thirty five tribal communities of Madhya Pradesh, Joseph (1989) brought out the role played by reptiles in tribal medicine. He found that the traditional medical system is economical and without any side effects. Tamuli and Saikia (2004) conducted a study on the folklore medicinal uses of 33 plant species, belonging to 22 families for various ailments by the Zeme Nagas of North Cachar Hills district of Assam. The study reveals that the oral traditions practiced by the Zemes represent an autonomous, community supported health management system which efficiently and effectively manages the primary health care of these people. In their society traditional medicine is still alive and runs parallel to the state supported modern health care system, though its full potential is still not utilized scientifically.

Carstairs (1955) studied the occurrence of diseases and the healing method of the inhabitants of two villages in Rajasthan. From his own experience with the villagers, he advises that the western medicine must be presented to the people in such a way as will command conviction and acceptance. Again, he (1983) explained how the villagers believe that diseases are caused by the activities of witches. He observed the changes taking place in a village community from 1950 to 1981 and found that the people show a stubborn resistance to change in the field of health care. Rao, Busi, Dharma Rao, Bharathi, Rao and Venkaiah (2006) observed that indigenous treatment is available among Khonds for various ailments such as snakebite, blood motion, jaundice, vomiting, diarrhea, paralysis, induced abortions, delayed deliveries epilepsy, etc. The study also indicate the presence of seven different types of medical specialists such as general practitioners, traditional bonesetters, specialists in the treatment of diseases among children, poisonous bites, epilepsy, dental care, infertility and abortion. The medicinal

plants used by Khond tribes for the treatment of various ailments can possibly be used as a potential source for making herbal medicines against some diseases and can be treated as a document for preserving the ethnomedicinal knowledge for posterity. Pandey and Pandey (2010) conducted a study among the Raji tribes of Uttarakhand and found that ethnomedicine has an enduring and indispensable part in the social life of the Raji tribe. The study reveals that Rajis have classified three categories of diseases on the basis of their knowledge of disease and illness. They have placed different diseases and illness under sub-head, which are particular to their own culture. In Raji society when a patient becomes unconscious or they feel to take him/ her to the hospital then only they run for it, else they treat them with their indigenous medicines or shamanism. Jain, Baheti, Jain and Khandelwal (2010) carried out an ethnobotanical survey among the tribes of Satpuda region and documented a total of 67 medicinal plant species distributed in 37 families which are used to cure wound infections, skin infections, stomachache, fever, cough, diabetes, diarrhea, eye infections and general weakness. In their study it was observed that medicinal preparations practiced were freshly prepared. The knowledge of certain herbs, animals and minerals that have curative and palliative effects were transmitted from generation to generation. The traditional herbalists are integral part of the community and take care of the common ailments of the folk in their home setting. Rao, Busi, Dharma Rao, Bharathi and Venkaiah (2010) studied ethnomedical practices in the Savara tribe of Srikakulam district. The study provides data on 14 medicinal plants used by the tribe for curing various ailments along with their local names, methods of preparation and mode of administration. The ethnomedical system among the Savara is quite diverse and the local knowledge is used mostly in primary healthcare and the vast traditional knowledge of the tribe is mostly attributed to their cultural framework. Das, Barua and Das (2008) attempted to find out the beliefs and practices related to health care system of the Sonowal Kachari tribe of Assam. Their study reveals that the Sonowal Kachari believe that certain diseases are caused by malevolent supernatural forces and they try to cure them by pleasing the supernatural powers through prayers and sacrifices. They also used various locally available medicinal herbs for treating diseases. Village medicineman who have a good knowledge about the herbal

plants usually treat the patients. Sikdar and Dutta (2008) documented the wealth of 62 plant species used by the indigenous Nath Community of Assam in different types of health treatment. These plant species are generally used by most of the villagers as there is not a single traditional healer left out in the village and they do not have any formal institution. The women are found to be more familiar with the use of various medicinal plants. It is apparent that the community has rich ethnomedicinal knowledge and the knowledge is being transmitted from one generation to another.

Balasubramanian (2004) recommended that the Indian sub-continent contains a fascinating range and array of knowledge systems and practices that exist side by side even today. In his study on traditional and modern sciences and technologies in India he summarized the nature and characteristic of traditional Indian knowledge systems *drawing particular examples from some branches of sciences and technology and spell* out some specific ways in which these traditional knowledge systems differ from their modern counterparts. The study also reflect the possibilities of inter-linkages and cooperation between these varying traditions as they take place today as well as in terms of future possibilities. Mahapatro and Kalla (2000) studied the health seeking behaviour in a tribal setting and confirmed that 'quick therapy' is considered as a part and parcel of allopathic system among tribals. However, for any kind of illness, Bhattara women used home remedy on priority basis. It was also observed that tribal women were not against the use of modern allopathic treatment in spite of the prevalence of the extensive use of traditional treatment. Interestingly, though their work output reduced significantly during their illness, they were not used to take bed rest, unless they were seriously ill. Since they believe that measles (*gundi*) and chickenpox (*maa*), occur due to the wrath of the Goddess (*Thakurani*) on the patient, they visit the *Desari* rather than a medical practitioner. Pramukh and Palkumar (2006) studied the indigenous knowledge and its implications in tribal health and disease. Here, they attempted to illustrate the health status of the tribals of Eastern Ghats and their health seeking behaviour and beliefs. Their study reveals that despite the fact that tribal societies exhibit similarities in many aspects related to health and disease, local variations persist among them.

Thus, the tribal communities have a number of beliefs and folklores related to health care and it can help tribal communities of India to achieve self-reliance in their health care needs.

(b) Studies on Modern Health Care System

Aiyappan (1965) made a few general observations on the health problems of the villagers and showed how the caste factor influences the doctor-patient relationship. He also explained how ecological factors like lack of sanitary facilities, poor quality of drinking water and air pollution have led to the progressive deterioration of the health of the villagers. The Government hospitals in the tribal areas are handicapped by lack of equipment, medicine and well motivated staff. Singh (1984) examined the drawbacks in the health policies of the government and the shortcomings in their implementation among the tribal communities. Chowdhuri et al. (1986), after examining the impact of three diseases; namely, leprosy, malaria and tuberculosis which are more prevalent among the tribal communities in four blocks of West Bengal, concluded that the tribals are quite ignorant of many of the diseases; they are little aware of the importance of health and hygiene and the availability of modern medical facilities. Bello (2005) in his study on determinants of demand for traditional methods of health care services in Osun State, Nigeria, mentioned that before the advent of modern medicine in Nigeria and elsewhere in Africa, indigenous knowledge about cure was the main source of health care delivery. However, with the advent of modern medicine, people's confidence tilted from traditional to the modern medicines, thus, allowing patients to choose from a wide range of options when dealing with illness. He also mentioned that as different ethnic groups have different norms and values there are some basic sacred and secular belief systems within the cultural setting of every ethnic group. These beliefs run through the traditional health care systems and provide strong background to the utilization of modern health care services. After conducting an empirical study among the Oraons of Orissa, Sahu (1987) reached to the conclusion that they are aware of the modern health services available in various institutions and make a special effort to avail these facilities when confronted with serious diseases.

Thus, with the advent of modern medicines, they are little aware of the importance of health and hygiene and the availability of modern medical facilities.

(c) Studies on Interaction between Traditional and Modern Medicine System

Chaudhuri (1986) is of the view that the interaction of traditional and modern systems of medicine is an important aspect for study, particularly in the context of tribal health. A few studies conducted on this issue have yielded some answers to the question: Why are some aspects of modern medicine accepted while others are rejected? But validity can be established when there will be large number of studies available. Research on this problem is somewhat inadequate. Thus, there is a great need to understand the socio-economic and cultural dimensions of health and disease. However, some studies have shown that when both the facilities; namely, traditional and modern, are available the tribals often accept the modern system. In many cases the tribals are held responsible for not accepting modern facilities. The accusation has become something like a myth and, as a matter of fact, these facilities are non-existent in the area. Thus, it is essential to critically analyse the real situation. Here, a few questions arise: Are the tribal people really not interested in accepting modern medical facilities or are the modern facilities non-existent in the area? Is the socio-cultural dimension of health a myth or a reality? Another very important issue is that the wisdom of replacing the traditional system and introducing the so-called modern system in the tribal areas without critically examining their usefulness has been questioned by a number of scholars (Chaudhuri 1986), particularly in view of the fact that there does exist a traditional system of medicine like herbal medicines. After conducting an empirical study among the Kherwar, the Chero, the Kol, the Mar, the Oraon and the Munda tribes of Bihar Chakraborty (1986) found that these people prefer modern medicine because it brings speedy relief and is readily available. According to them ethnomedicine takes longer period to cure the patients and there is also scarcity of medicinal herbs. In a case study of the Asur, the Birgia and the Kisan tribes of Bihar, Upadhyay (1987) showed how changes in their natural habitat due to deforestation brought adverse effect on their health. The tribal medicinemen fail to cure the new diseases which occurred due to causes like pollution, change of diet and close association with the non-tribals. Similarly,

Reddy (1987) analysed the problems involved in the implementation of modern medicine among the tribal people. He suggested that a thorough knowledge of the indigenous medical beliefs and practices and the different cultural values attached to them has to be acquired and then, the modern medicine has to be introduced in a phased manner along with the native medicines.

The above survey of literature reveals that the tribal communities are following a distinct way of life, entertain their own cultural values, possess viable mechanisms to adapt to their not so hospitable environment and have various techniques to cope with the diseases affecting them. Almost all facets of tribal life are changing due to contact with alien cultures and the socio-political atmosphere of the country has accelerated this process of change. The above survey of studies also shows that (i) tribal health is a function of intricacies of three major aspects of life: namely, social, environmental and biological; (ii) health system may be approached for study in two ways; viz., as a sub-system of social system and as an interaction between the traditional and the modern health system; (iii) tribal health is determined by socio-cultural, socio-economic and socio-biological factors; (iv) tribal conception of health, disease, etiology and treatment, health status, health seeking behaviour, health care and changes, health problems etc. are various aspects of tribal health which have been examined in various studies, but none of the studies has investigated the issue of tribal health in a holistic perspective.

The proposed study investigated various aspects of tribal health in its totality in the context of the Mishing tribe of Golaghat district in Assam. The following questions were attempted to investigate tribal health in the Mishing tribe:

1. What is the concept of health, disease, etiology and treatment in the Mishing tribe?
2. What is the health status of the Mishing tribe?
3. What are the indicators of health in the Mishing tribe?
4. What is the health seeking behavior in the Mishing tribe?
5. What are the traditional health care practices in the Mishing tribe?
6. What is the influence of modern health care system on the traditional health care practices in the Mishing tribe?

7. What are the health problems and their solutions in the Mishing tribe?

OBJECTIVES OF THE STUDY

The following are the objectives of the study:

(i) To understand the cultural conception of health, disease, etiology and treatment in the Mishing tribe.

(ii) To know the health status in the Mishing tribe.

(iii) To appreciate the health seeking behavior in the Mishing tribe.

(iv) To analyse the health care system in the Mishing tribe.

DATA AND METHODOLOGY

Key Terms: Conceptual and Operational Definitions

Tribe: A small group of isolated, non-literate, tradition bound and backward people who have a distinct name, culture and world view; however, most of the groups labeled 'tribe' are in the process of change, yet, they are retaining many of their traditional (tribal) values. In India most of these are labeled as Scheduled Tribes. In the study the term refers to the Mishing known as a tribe in the Golaghat district.

Tribal Health: The term implies the conception of health, disease, etiology and treatment, health status, health seeking behaviour, health care and changes, health problems etc. of tribal groups. In the study it refers to health of the Mishing people.

It is indicated by mortality, morbidity, nutritional status, health care delivery, quality of life, health policy, social and mental health. Other social indicators include socio-environmental dimension. Life expectancy, maternal mortality rate and child bearing, sex ratio, maternal and child health care practices, family welfare programmes, genetic disorder, status of women, educational and cultural levels, alcoholism, drug addiction, crime, juvenile delinquency are some of the common indicators of tribal health.

However, literacy, marriage practices, age at marriage, fertility, mortality, value system, philosophical and cultural tradition and its social, economic and political organization, common beliefs, customs and traditions, health seeking behaviour, marriage pattern and the interaction between the traditional and modern system of medicine assume much significance and determining role in 'tribal health'.

Sources and Types of Data

The study has encompassed field (oral) and documentary data. Oral data have been collected from the people of the two Mishing villages, namely; Namtemera and Baghedhara and the Mishing people living in the Golaghat town and documentary data have been collected from government and other official records, books, journals, etc.

Universe and Units of the Study

The Mishing tribe in the Golaghat town and the two villages have been considered as the universe while their households have been regarded units of the study for data collection. The study has been conducted in (i) Golaghat town, (ii) Namtemera village of Golaghat West Development Block and (iii) Baghedhara village of Gamaiguri Development Block. A total of 56 Mishing households have been found in Golaghat town, 151 Mishing households in Namtemera and 79 Mishing households in Baghedhara village. The two villages are located 35 km and 20 km in the west and the east of Golaghat town respectively. The former is located in the midst of non-tribal villages whereas the latter amidst the Mishing (tribal) villages.

Selection of Units

All the Mishing households in the Golaghat town, Namtemera village and Baghedhara village have been selected for data collection in the study.

Tools for Data Collection

For collection of data the interview technique was used for oral data and observation for morphological data. Therefore, the following tools were constructed and administered to collect the data:

(i) A basic data inventory schedule to collect data regarding attributes of populations, infrastructure and institutions in the village.

(ii) Interview schedule for collecting data from the households in the village.

The interview schedule was divided into seven major heads containing Personal Information of the Respondent, Social Background of the Respondent, Concept of Health, Disease and Etiology, Health Status of the Respondent and his/her Family, Health Indicators, Health Seeking Behaviour and Health Care System. The main aim behind the use of this interview schedule was to collect essential data on the respondents

and their households with special emphasis on the age, sex, educational qualification, income, nature of family and size of family. Secondly, the questions related to house pattern, ownership, food habit, sources of drinking water, land holding pattern, means of exposure to media, marriage system and religious activities performed in the family were included in the schedule. The questions with special emphasis relating to health were prepared to collect the data on the diseases which the family members suffer from, medical treatment taken so far, people's preference pattern for treatment, traditional religious beliefs about health, health care practices, health seeking behaviours, magico-religious and ethno-medical traditions. Moreover, the interview schedule includes questions about the health care administration, delivery system of health care services and its impact on health and interaction with the traditional system among the Mishing villagers and town dwellers.

SIGNIFICANCE OF THE STUDY

The present study has focused on the health and health care practices, customs, traditional beliefs about health, diseases and treatment and its socio-cultural, socio-economic and environmental dimension of the Mishing tribe of Assam. Therefore, the study is useful to understand the scenario of health in tribal societies in India and to develop policies on tribal health.

ORGANISATION OF THE STUDY

The study is organized into 9 (nine) chapters. Chapters 1 titled *The Theoretical Framework* discusses the statement of the problem in the light of an extensive review of the studies on tribal health, by designing methodological strategy consisted of universe, unites of study, sources and types of data, tools of data collection, organization and significance of the study. Chapter 2 titled *Tribal Health in India* makes an overview of the studies on tribal health in India. Chapter 3 titled *The Mishing* deals with the origin and growth of the Mishing, their social structure, occupation, religious beliefs, festivals, culture, education, language and literature, social institutions and health practices of the Mishing. Chapter 4 titled *Field of the Study* analyzes the attributes of the Golaghat district in general and of Baghedhara and Namtemera villages and Golaghat town in particular, and depicts the patterns like geographical location and surroundings,

structural aspects such as population, economy, education, health, social organization, power structure, status of women, marriage, religious beliefs etc. of the Mishing tribe in the contextual and historical perspective. Chapter 5 *Health Culture of the Mishing* brings out the Mishing concept of health, disease, etiology and treatment. Chapter 6 entitled *Health Status of the Mishing* discusses the status of health in the Mishing in the light of life expectancy, mortality rate, morbidity rate, infant mortality rate, maternal mortality rate, maternal and child health care practices, communicable diseases, sex ratio and hygienic condition of living of the Mishing households. Chapter 7 entitled *Health Seeking Behaviour of the Mishing* explores the health seeking behavior like, washing, cleaning, eating, sanitation, consumption of alcohol, purification of drinking water etc. at personal, household and community levels. Chapter 8 entitled *Health Care System of the Mishing* highlights both traditional health care practices; like herbal medicines, magico-religious practices, health care functionaries, health care delivery, etc., and modern health care services, health care functionaries, health care delivery and their influence on the traditional Mishing health care system. Chapter 9 entitled *Summary, Findings and Conclusion* summarizes the study, delineates its major findings and concludes the study.