

Proforma for synopsis (Clause 5 of the Ordinance - 45)

TITLE: Socio Cultural Matrix of Plural Health System among Selected Communities: A Contrastive Anthropological Study in Rural and Urban Areas of Bilaspur & Sarguja Districts of Chhattisgarh.

1. INTRODUCTION:

Today's approach is disease oriented approach; concerns of people are neglected to all the health and disease control programmes. This is necessary to know what people exactly do, for their health care. What are the cultural practices of people about health care and health promotion? The strong point of Anthropology is its holistic approach and in trying to understand the people's perception which are necessary for participatory democracy and sustainable development. If intervention or health programmes are to be organized in this way, so definitely peoples will have accepted that. That is why; Jawaharlal Nehru has advocated the approach of change or development, along the lines of cultural practices and values, to make the change acceptable and sustainable. Medical pluralism may be briefly defined as the synchronic existence in a society of more than one medicine system grounded in different principles or based on different world view. In the Indian context the chief systemic component of medical pluralism are Allopathy and AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy). Local medical systems are the units of observation for anthropological field research. Because they are embedded in local communities, they vary from one part of the world to another according to the family structure, religion, economic and political institutions (Mutatkar, 2007). The health status of people has long been a central focus for health scientists, economists and policy makers. Usually, the input of health care to the health status of the population has been difficult to quantify. The western world is now shifting towards alternative medicine, thanks to American medical system governed by insurance companies. People are tired of the side-effects of modern medicine and unnecessary and expensive use of diagnostic tools and techniques in the absence of clinical acumen on the part of the physician. In India, the traditional pharmaceutical interests are now demanding land in tribal belts for producing medicinal plants for production and export.

One can schematically distinguish two main traditions of health in India. One refers to the written traditions of the great classical systems of Ayurveda, Siddha, Unani and the Tibetan branch. The other refers to the poorly documented health practices spread across aboriginal and rural India, as well as many parts of the urban and even metropolitan India, known as local health tradition. It must also be said, in the same breath,

that these two main traditions were never closed off from each other. One is started to find that many aboriginal practices concretely echo procedures recommended in the codified tradition. Equally, many writers of the past have drawn on the wide knowledge of the forest communities to further armour their pharmacopeia with newer plants of rare medicinal value. It is one of the challenges of the modern renewal of tradition to ensure that the dialogue of the classical and the folk continues in the manner of the earlier centuries.

Local Health Traditions (LHTs) constitute the community health dimension of AYUSH. The carriers of these health traditions are ordinary households and local community based healers. The LHTs have traditionally played an important role in supporting the primary healthcare needs of rural households. LHTs have a symbiotic relationship with the codified streams of AYUSH. The AYUSH 2002 Policy of the Government of India under Section 9 has identified revitalization of LHTs as one of the thrust areas of the AYUSH sector. According to Department of Health, Government of India, the public or plural health system in India encompasses a set of state-owned health care facilities funded and controlled by the Government of India. Some of these are controlled by agencies of the central government while some are controlled by the government of the states of India. The main governmental ministry which controls the central government interests in these institutions is the Ministry of Health & Family Welfare. Public health is concerned with disease prevention and control at the population level, through organized efforts and informed choices of society, organizations, public and private communities and individuals.

Every community views health or illness from its own cultural perspective (Mehta, 1992). The beliefs, practices, customs and traditions of a community significantly determine the perception of the disease, interpretation of symptoms and the techniques of the treatment. According to World Health Organization (1946), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Disease and health are important component of all societies, part of man's view of the universe and his place within it. Humans everywhere, at all times and places and under all forms of cultural design, have had to deal with the threat of disease and illness. Although disease and health care are universal, they are always marked by variability, because it is culture, which largely determines as to why people suffer from certain disease and what types of treatments need to be followed and so on (Dubos, 1969).

The concept of health culture refers to a sub culture within a totality of population. It encompasses vast complexes of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals and symbols, which are related to health and disease. That means the socio-cultural aspects of health, the beliefs and practices relating to health and disease, the diagnosis and treatment methods, the healers and curers and

their recruitment, concepts and organization of medical system etc. Every society irrespective of degree of social organization, and design of culture, has its own sub-culture called health culture, because it is the beliefs and practices these people share to conceptualize the health and disease and produce the appropriate cultural methods to alleviate the pain and distress. In simple terms the health culture focuses on the nature of illness as it is conceived by the natives, their own methods and criteria of classification of disease, the causes and cures, types of therapists that seek to alleviate illness and their skills and social roles, preventive measures the relation between magic and religion, cultural aspects of ethno-medicine, introduction of western medicine into traditional villages, illness behavior and finally the ethno-psychiatry. As Banerji (1968), says the culture of a community determines its health culture – that is, culture, cultural meanings of the health problems of the community, and the means the community adopts to deal with them.

Anthropologists believe that culture influence all of man's activities both biological and non biological. As per Logan and Hunt (1978) culture determines to a large extent:

- a) The type and frequency of disease in a population
- b) The way people explain and treat disease and
- c) The manner in which persons respond to the delivery of modern medicine

According to Freud (1933) the overall impacts of culture on diseases are:

- 1) Culture patterns disease
- 2) Culture produces personality types, especially vulnerable to certain kinds of illness
- 3) Some cultures may produce a higher incidence of given psychiatric disorders through certain child rearing practices
- 4) Cultures may severe certain diseases through proper sanctions and structure on acceptable behavior
- 5) Culture may perpetuate malfunctioning by rewarding in it certain prestigious roles
- 6) Culture may produce psychiatric disorders differently in given segment of the population through certain stressful roles
- 7) Complexity of a culture may per se, produce psychiatric disorders as voiced by Sigmund Freud in civilization and its discontents
- 8) Culture effects breeding pattern selectively
- 9) Culture through patterns of faulty hygiene can produce toxic and nutrient deficiencies influencing the health condition of the people.

It is in pursuance of this, that the present research has been designed.

2. A BRIEF REVIEW OF THE WORK ALREADY DONE IN THE FIELD:

Rivers (1924) specified his model by defining three types of worldview and associated belief-systems and three corresponding modes of behavior. The bulk of medical anthropological research has been based on systems approach and a holistic view of health and disease in the context of cultural systems. Anthropologists have also shown that some cultural or ritual practices cause or prevent certain diseases. That illness is caused due to a wrong doing is a belief among some people. The attribution of illness to misconduct is a very early form of social control in the development of human societies (Hallowell, 1940). "As Ackerchnecht (1942) says "disease and its treatment are only in the abstract purely biological processes. Such facts as whether a person gets sick at all, what kinds of disease he acquires and what kind of treatment he receives depend largely on social factors. The choice of therapy is guided by practical concern rather than ideological. According to the report of WHO (1946), over 80% of the world population depends on traditional systems of medicines, largely plant-based, to meet their primary health care needs. There are nineteen WHO's collaborating centres for traditional medicine, eight of which are involved in training and research on acupuncture, while the others are conducting research on herbal medicine. The 'Health Survey and Development Committee Report' popularly referred to as the Bhore Committee. The committee came up with a detailed plan of a National Health Service for the country, focusing on providing universal health coverage to entire population funded through a state run welfare scheme. The document has been lauded by many scholars as a very well researched and minutely documented plan (Bhore and Joseph, 1946). The importance of ecological aspects besides socio-cultural, was advocated by Livingstone (1958), Alland (1966, 1970), Wiesenfeld (1967), Dunn (1968), Me Cracken (1971) and others. The ecological orientation is concerned with dimensions of disease that is how do factors of biology, culture and environmental pressure influence the process or distribution of disease.

Paul (1955) views culture as a system and the medical pattern as one of its subsystems and he also discussed what happen to the system and sub-system when they are disturbed, that is when new health related elements are introduced. Marriot & Castairs (1955) also establish that health problems of the people in India are as much a moral as a physical crisis. He find outs the cultural factors in the health and health problems. But finally he also propogated how the rural people could take on western system of medicine within their cultural surroundings. The impact of economic factors in the cause and perpetuation of a certain type of disease has been clearly brought out by May (1960). "Obuko" is a disease among the Ganda of East Africa. They believe that this is caused due to violation of certain taboos like not observing the restrictions that food should not be shared between parents-in-law and children in-law (Bannet and Magalulus, 1967). Hasan

(1967) find out in a village that, people attach no importance to health; their beliefs, values, customs and practices are directly related to the phenomenon of health and disease. He argues that there are some factors which directly affect the health of the community. These are related to certain values, religious taboos and beliefs. Further, the lack of knowledge in rural areas affects the health behavior of the people. In the policy making too, during the first two Five year Plans, the basic structural framework of the public health care delivery system continued where urban areas were dedicated three fourth of the health resources while the rural areas were given a "special attention" status under the Community Development Program. The special attention however failed to reap results and the government's own evaluation report confessed of its ineffectiveness and failure (Batliwala, 1978).

Primary health care approach is considered to be the basis for achieving Health for All' especially in the developing countries. The Alma Ata Conference described primary health care as: "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self- determination. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of continuing health care process" (WHO-UNICEF, 1978). Jorapur (1979) describes that the primary health centre being the lowest administrative unit, and the sub-centre being the most peripheral service delivery point for various primary health care programmes. According to Banerji (1982) every society has a health culture of its own – its own cultural meaning of its health problems, its health practices and its corps of practitioners.

Banerji (1982) one of the pioneers in the field of social aspects of medicine opines that interaction between certain aspects of the way of life of a community - its culture - and the environment, in the widest sense of the term determines the state of health and disease in a community. The culture of a community determines its health culture - that is cultural meaning of the health problems of the community, and the means the community adopts to deal with them. While discussing about alternative system of health services, Banerji (1982) proposed that the central premise of an alternative health service system will be to start with the people, instead of fitting people within a predetermined framework of health services. Panikar and Soman (1984), in their book 'Health status of Kerala: The Paradox of Economic Backwardness and Health Development' has attempted to relate socio-economic factors and public policy. It also examines the existing institutional structure and suggests improvements for the efficient execution of inter- sectoral action

program. They also found from hospital data that morbidity in Kerala is high while mortality is low. In a study conducted in a suburb of Lusaka Frankenberg and Lesson interviewed 1123 patients of traditional healers (ng'angas). The findings showed that two thirds of them had first resorted to cosmopolitan medicine (Duggal and Amin, 1989). Rural Social Transformation and Changes in Health Behavior by Banerji (1989), deals with the findings of a wide-ranging study of health behavior in 19 Indian villages spread over eight states. The study which has provided a variety of information on rural, socio-cultural and economic transformation on the one hand and changes in health behavior on the other, highlights the close correlation between the two and concludes that changes of health behavior can be measured as one of the indices of the degree of rural conversion.

“In conceptualization, health culture has been understood to be a mere component of wider cultural framework, which is very complex”. The health behaviour of an individual has been seen as one of the constituents determining the various health problems arising out of economic and ecological conditions. “Cultural response to these problems pertains in the form of people’s perception and meaning and in the form of practices as well as institutions.” Scholars have argued for the analysis of dynamics of health culture by understanding the dynamics of the wider or broader cultural setting which point out toward the influences of the mode of production and production relation. (Bir, 1990). Wasan (1990) through Status of Health in India and its future prospects revealed that health is related to economic development, anti-poverty measures, food production, distribution, drinking water supply, sanitation, housing, environmental protection and education. Kannan (1991) have focused on rural Kerala analyzing the connections between the health status and the socio-economic status, and the input of the health care sector to health status. The study has found that, per capita expenditure is the highest for the allopathy system followed by ayurveda and homoeopathy. The work also addresses the regional variations in health status to a limited extent.

Basu (1992) argued the issues concerned in raising the health status of India’s under privileged groups. The article points out that in addition to the social and economic factors causative to the low health status of the under privileged groups, cultural factors also play a role. Health culture has been considered as a sub-cultural complex of the entire way of life of the people. This change is the dynamic change of the culture of a community. As a component of its overall culture, the health culture of a community is shaped by the interplay of a number of social, political, cultural and economic factors (Basu, 1992). Thus, there is a change in health culture in different social setting. A study conducted in South India studies the practices of a physician with an MBBS degree who had adapted his practice by bringing in the conventions of the rural

area where the doctor in study grew up. A number of patients of this doctor were treated by proxy such as using distilled water in injections. He describes the clinics of rural physicians as 90 % quackery and 10 % medicine (FRCH, 1993). Kopparty (1994) has made an attempt to know the relationship of social stratification and health care in a rural community from a sociological perspective. This study is based on field study of villages in East Godavari District of Andhra Pradesh in India. It examines in detail the nature and the extent of the influence of social stratification on the morbidity pattern, health action, utilization of health resources and health practices in a rural community and the study concludes that social stratification plays a vital role in these cases.

Bajpai and Mitra (1997) studied indigenous medical practices of primitive Hill Korwa tribe. Narang and Mitra (1998) and Mitra (2000) studied health culture and ethno-medicinal practices of Abujhmara and Kamar primitive tribes respectively. Awasthi and Mitra (2002) documented ethno-medicinal practices of Birhor tribe. Mitra (2002) while working on CGCOST sponsored research project on Potential and Evaluation of Ethno-medicine and Health Management Practices among Hill Korwa and Birhor primitive tribes of Chhattisgarh, documented ethno-medicinal practices of two primitive tribes in School of Studies in Anthropology, Pt. Ravishankar Shukla University, Raipur (Chhattisgarh). National Health Policy 2002: Increase in health sector expenditure to 6% of GDP, with 2% by public health investment by 2010 is recommended by the policy. Existing 15% of central government contribution is to be raised to 25% by 2010 (Central Bureau of Health- GOI, 2002). Health Seeking Behavior of People of North Eastern States of India, through this paper, Mukherji and Somayajulu (2004) have made an attempt to get an understanding of the prevalence of problems such as, jaundice, TB, malaria, health-seeking behavior and reproductive- health problems. The paper also identifies the gaps in the health-service utilization and provides inputs for effective programme execution.

The Chhattisgarh State Integrated Health and Population Policy (2006), restate the commitment of the State to promote health for all and to make available quality health care services, especially to those are living in remote areas. Priority areas of working are Nutrition, Mainstreaming Gender and Women's Empowerment, Social Security for Health, Tribal Health, Involvement of Private Sector and Civil Society. Chhattisgarh State policy recognizes importance of AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy) system in addressing health needs. The State shall therefore mainstream these systems of medicines for contributing to better health care to all. In recent years reformers have drawn having on the example of the People's Republic of China, where traditional Chinese medicine has been incorporated in the state sanctioned medical system. The idea is to consider 'irregular medicine' in a more objective manner.

This way of conceiving the medical system opens the door to serious practical studies on how these therapies and their practitioners provide resources for health care planning (Mutatkar, 2007).

Virulkar (2007), Mishra (2009) and Shukla (2013) did Ph.D. work on ethno-medicinal practices on Muria, Sawra and Binjhwar tribes of Chhattisgarh respectively (unpublished Ph.D. Theses). Department of Science and Technology (DST), Government of India has sanctioned 'National Centre for Natural Resources' to Pt. Ravishankar Shukla University, in which documentation of traditional knowledge for correcting autoimmune diseases among Mahasamund, Rajnandgaon, Raigarh, Jashpur, Sarguja and Bastar districts.

3. OBJECTIVES:

- To study the existing cultural practices, values, attitude, taboos influencing health seeking behavior of the communities under study.
- To study different dimensions of plural health system.
- To review the existing health policies and identify gaps for corrective measures.
- To identify barriers and stimulants for mainstreaming local health tradition into arena of Primary health care.
- To document and validate people's traditional knowledge and practices with standard codified texts for revitalization of local health tradition.

HYPOTHESES:

On the basis of background information, the following are the hypotheses to be tested for the present study:

1. Socio-cultural factors influence the health seeking behaviour of people and their choice of the system of medicine.
2. There exist significant variations in the preference pattern of the people of different community for different systems of medicine in rural and urban areas.

4. NOTEWORTHY CONTRIBUTION IN THE FIELD OF PROPOSED WORK:

Rivers was a pioneer in attempting systematically to relate native medicine to other aspects of culture and social organization. His primary contribution to medical anthropology as mentioned earlier, were Medicine, Magic and Religion (1924) and portions of Psychology and Ethnology (1926) both published after his death. His formal framework was based on two propositions. The first was that medical practices follow, logically from underlying medical beliefs that is that native medical practices ... are not merely disconnected and meaningless customs ... (but rather)... are inspired by definite ideas concerning the causation of disease (River, 1924).

National Congress around 1930, it was decided to accept Ayurveda and other Indian systems of medicine as national health systems after Independence. After Independence, modern medicine has become the national health system. Officially plural systems of medicine exist in India by way of medical colleges, research institutes, pharmaceutical industries, and Government departments in all systems under the umbrella of ISM, CCIM, CCUM, and CCRAS. However, the budgetary provision and the infrastructure of public health care delivery system clearly indicate bias in favour of modern medicine (Chand, 1969).

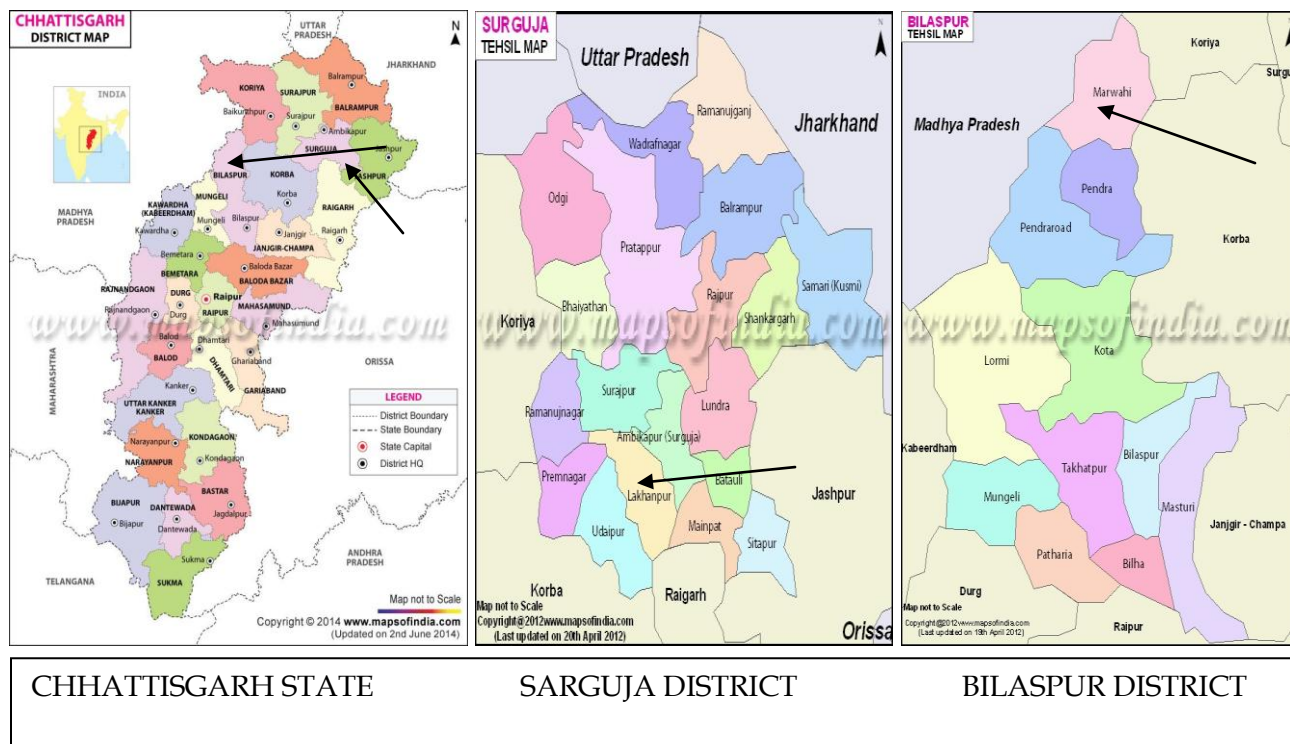
5. PROPOSED METHODOLOGY:

RESEARCH DESIGN:

Research design is based on scientific method as per guide lines of National Health System Resource Centre (NHSRC), New Delhi and Maharashtra Association of Anthropological Sciences, Pune as a nodal agency for all India Study on 'Mainstreaming of AYUSH under NRHM' on 2009. The study will include two districts from the state, one block in each district, two PHCs in each block, two sub-centre under each PHC and two villages under each sub centre for the study. Thus two districts, two blocks, four primary health centres, eight sub centres and sixteen multi-community villages will be included in the present study. One PHC nearby district head/ block head quarter and one far from the town will be included in the survey to find out the rural-urban difference.

The villages will be selected by purposive sampling method that will be based on concentration/ density of the targeted group. The proposed study will be based on material collected through community based field investigation of approximately 1000 households (at least 50 household in each village). Tribal communities especially from Sarguja district and general caste and OBC especially from Bilaspur district will be study to see the contrastive situation among the populations with respect to local health tradition and use of plural health system.

AREA:



TOOLS & TECHNIQUES:

Secondary data to be gathered from various reports from State and District level health and AYUSH offices, Census of India and Chhattisgarh etc while primary data mostly qualitative and will be documented during field visits with the help of following tools and techniques:

- i) **Interview schedule** – Interview schedule will be prepared in Hindi for interviewing health functionaries and common village people mainly from the three sectors namely people's sector, Government sector and Private sector. Those interview schedules will be used for Mitanin, Dai/TBA, Baiga, Anganwadi worker, ANM, Medical officer PHC/AYUSH Health Centers and households. Some formats will also prepare according to government norms for getting information about status of health institutions like PHC, Sub-centre, and AYUSH health centres.
- ii) **Case studies:** Important and striking features of the study will be document in details in the form of case studies from dais, baiga, patients etc.
- iii) **Observations:** While collecting information using interview schedule certain observations will be done about health institutions and will document it to support the qualitative data.

iv) **Focus Group Discussions:** Informal group discussion with people groups such as pregnant and lactating women, mahila mandals, paramedical workers, women from households to discuss a specific common subject helped to get deeper insight and information about the ground realities of utilization of government health facilities and common practices.

v) **Genealogy**

vi) **Photography/ Videography** will be done to support the data collected.

6. EXPECTED OUTCOME OF THE PROPOSED WORK:

The proposed study will find out the uses of plural systems of medicine by the people at grass root level. Village health workers and traditional healers are close to people comparing to doctor. Their practices and knowledge about health care will cover in this study. Health practices, health seeking behavior, traditional health care knowledge & believes, barriers in utilization of Government health care system and providers concerns about health care etc will be covered by the study. These outcomes will flow into recommendations, which will help to policy planners for planning and implementing health programmes and interventions.

TENTATIVE CHAPTERIZATION:

CHAPTER-I Introduction

CHAPTER-II Review of Literature

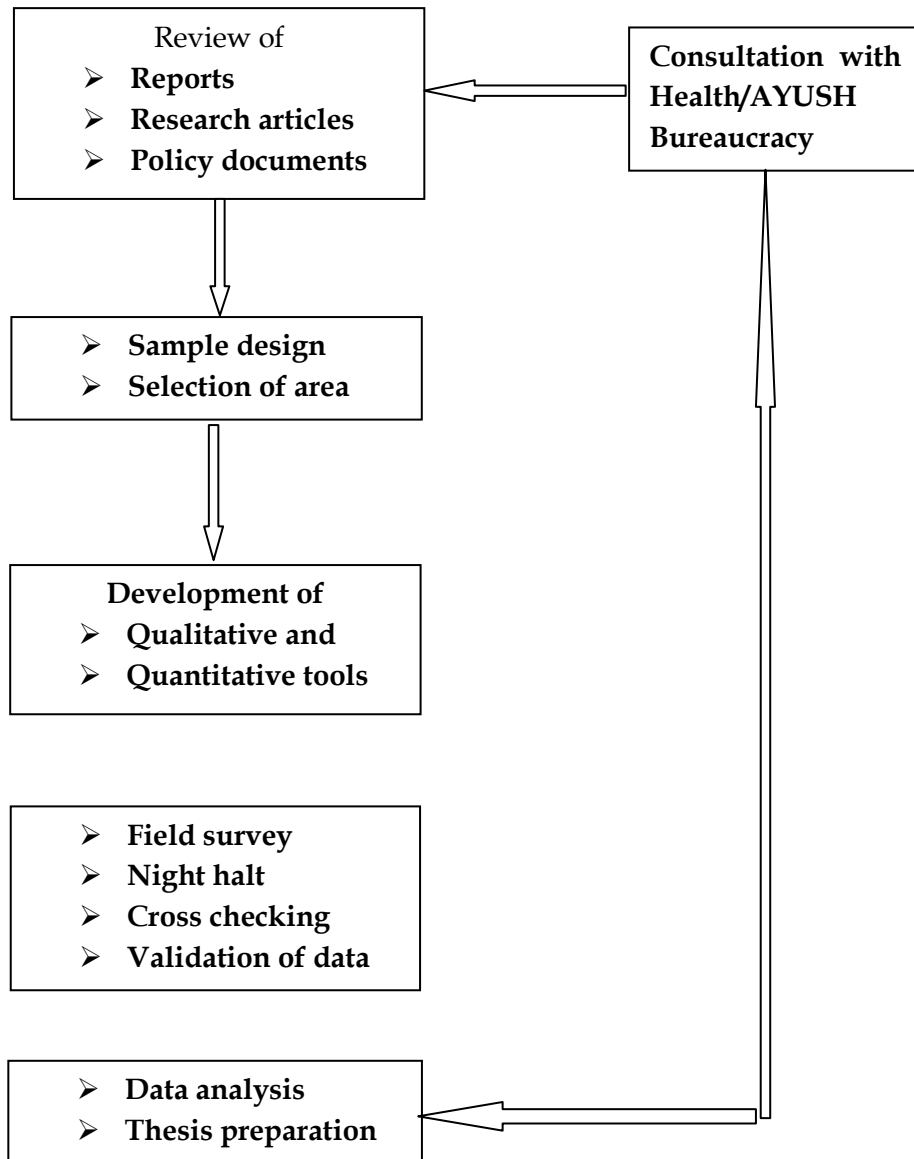
CHAPTER-III Subjects and Methods

CHAPTER-IV Results and Discussions

CHAPTER-V Summary and Conclusions

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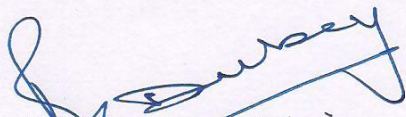
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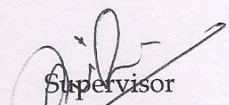
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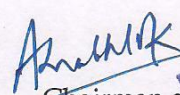


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