

Chapters 1

The Conceptual Framework

CHAPTER-1

The Statement of the Problem:

Education and Communication are important indicators of development in a given society as it relates to the patterns of health care and health seeking behavior in a transitional society like tribal society in India, where the traditional form is undergoing a process of transformation. We need to understand how people exist in active social network to understand the dynamics of information flow and the impact of contemporary education on a tribal society named, Barman tribe and its relation to health care. Education and Communication, specially, the media of communication believed to play a major role in promoting and creating health awareness in any society.

Issues of health and illness play an important part in what we do, how we do, fail to do and how we relate to others and how they relate to us. These considerations lead us to the subject matter of different health practices. In many primitive societies above the simplest level formal instruction is given at puberty, health education is another social activity which is not organized as a separate activity, provided by the family, the kin group, and the society as a whole to girls and boys before initiation as an adult member of society. But in complex societies, formal instruction, with a more specialized function, and a specialized occupational group acquires a greater importance. On the other hand, Mass media are the tools for the transfer of information, concepts and ideas to mass audiences. They are important tools in advancing public health goals. The tribal society which is undergoing a social change is now intended towards more specialized and formal institution. The study will examine the relationship between education and communication and its relation to the patterns of health care in the light of fresh empirical evidences in tribal society context. Conceptually, the study examines the interplay between three sociological concepts, education, communication and health care among the Barmans of Barak valley in

Assam. The Barmans of Barak valley that have been a part of greater Dimasa Kachari tribe largely influenced by Hindu Bengali culture. The study is an attempt to analyze the variation and effects of education and communication on health care in a tribal society of Barmans. The existing sociological literature on those concepts may now be reviewed for proper understanding of their interconnectedness and working process.

The Conceptual Framework:

Tribe: Meaning, Definitions and Characteristics:

In ordinary usage, the term 'tribe' is used to categorize those people who are primitive in nature, subsist on hunting, fishing or by simple forms of agriculture and those who are recognized by the state and central government and included in the sixth schedule of the Indian Constitution. Indian tribes are mainly territorial groups. The ties of kinship, one language, joint ownership and a political organization characterize them. Different authors have defined the concept of tribe. According to Imperial Gazettes of India, "a tribe is a collection of a family which have a common dialect and which prefers to occupy a common territory and which have been, if they are not, endogamous."

Mazumdar (1986:242) defines the term tribe "as a collection of families bearing a common name, members of which occupy the same territory, speak the same language and observe certain taboos regarding marriage, profession or occupation and have developed a well assessed system of reciprocity and mutuality of obligations".

T.B. Naik (1990:73) mentioned that Prof. Ehrenfels also made an attempt to define the term 'tribe' and according to him 'a tribe is nothing but a community, however, small it may be remain in isolation to compare with other communities within a geographical location. This may apply for both tribe and caste. The members of a true tribe, however, are generally not included into the traditional Hindu caste hierarchy and frequently speak also a common dialect, entertain common beliefs, follow common

occupational practices and consider themselves members of a small but semi-national unit”

Murdock (1937) defines tribe as “a social group which includes many clans, nomadic bands, villages or other sub groups which usually have a definite geographical area, a separate language, a singular and distinct culture, either a common political organization or at least a feeling of common determination against strangers.

Thus, we can define the tribe as a group of people who have the following characteristics:

- (1) They bear a common name.
- (2) They speak a common dialect or language.
- (3) They occupy the same territory.
- (4) They observe certain taboos regarding marriage and occupations.
- (5) They have a singular and distinct culture.
- (6) They have either a common political organization or at least a feeling of common determination against strangers.

General Review of Tribal Research:

Tribal studies have figured prominently in the history of anthropology in India, and this emphasis continued. These studies were given priority by the British administrators and scholars, as well as by foreign missionaries and travelers, for purposes of (i) colonial administration, (ii) cultural historical study of religious conversions and (iii) adventurous memoirs. The history of anthropology in India till recently has been the history of tribal studies. Such a history can be best understood in the light of the reviews of research activities made from time to time by scholars like S.C.Roy (1921), D.N.Majumder (1950a and 1956), G.S.Ghurey (1956), S.C. Dube (1956 and 1962), N.K.Bose (1963), L.P.Vidyarthi (1966a, 1966b and 1970) and Surajit Sinha (1968).

Roy recorded a bibliographical account of the publications on anthropological studies as early as in 1921. In his paper, he refers to the material published in the form of (i) articles in magazine, (ii) compilation in hand books of the different regions, and (iii) monographs on tribes

After a lapse of two and a half decades, Majumder, in the course of a memorial lecture at Nagpur University, reviewed the course of development of anthropology (D.N.Majumder, 1947) and brought out the impoverished progress of Indian anthropology in spite of the continued efforts of British administrators and British anthropologists. In these two review papers, mention of American scholars in any context was conspicuously absent.

D.N.Majumder (1950a) tried to relate the developing science of anthropology in India (which to him, at the time, was essentially study of primitive people) with theories of culture development in England and America. The most significant article by Majumder, however, is in the supplementary paper to Ghurey's presentation in the UNESCO volume (D.N.Majumder, 1956:161-177). In this paper he presented a very competent appraisal of teaching and research in anthropology in India in the context of cultural theories elsewhere.

Classification of Tribal Population in India:

Elwin (1964) divided tribes of India into four classes according to their stages of cultural development.

The forest tribal group, the purest of the tribal groups, comprising about two or three million people have been placed in the first group. These high landers do not merely live like other tribal groups, comprising about two or three million people have been placed in the first group. The social organizations of the tribes are unimpaired, their customs and traditions are unbroken and their religion and culture are alive.

Geographical considerations have largely protected from the debasing contact of the plain.

The second tribal class, according to Elwin's classification has been experiencing contact with the plains and consequently has been undergoing change. These groups, though, retain their tribal mode of living, exhibits the following characteristics in contrast with first group, that instead of communal life, this group lives a village life, which has become individualistic. Their communal life and traditions are only preserved through their village dormitories and the members of this group of tribes are more contaminated by the life of outside.

The third category constitutes the largest section of the total tribal population of India and members of this class of tribal group are in peculiar state of transition. This tribe has been affected by external contacts and has been exposed to the influences of economic and socio-cultural forces have also been subjected to missionary influence.

The tribe of the fourth group are most aristocrat, according to Elwin, and tribe under this group are Naga, Bhil, Gond etc. They retain the old tribal names and their clan and totem rules and observe the elements of tribal religion though they generally adapt the full Hindu faith and live in modern and even in European style. Elwin's classification has been so often used as something of a crusaders manifest, and therefore, it requires to be seriously studied. It takes the right stand in making a dynamic approach to the problem of tribal culture and advocating advance from one class to another without the despair and degradation that accompany the transmission at present, on the other hand, it suffers from some very serious drawbacks.

His analysis suffers from being based on a deep rooted, but illogical, prejudice against culture contact between tribal and non tribal people. He makes a fatal mistake when he says that the tribesman of the first and second categories have to advance direct

into the four classes. His fourth category is not eternal (Mazumder and Madan 1988, 263-265)

D.N.Mazumder gives another classification of tribal population of India. He mentioned two types of tribal culture that is assimilated and adaptive; the later type of transitional culture is divided into commonsalic, symbiotic and acculturative types. Commensalisms stands for common economic pursuits with neighbours, symbiosis indicates interdependence and acculturation indicates a one way traffic of culture traits. In his classification no mention is made of tribes listed in the first category of the previous classification, because there is hardly any tribal pocket in India today which may be said to have had no contacts direct or indirect with non-tribal ways of living.

The Indian Conference of Social Work (1952) appointed a tribal Welfare Committee with L.M.Shrikant as Chairman to deal with this matter and the committee divided the India tribal population into four categories : (i) Tribal Communities (ii) Semi-Tribal (iii) Acculturation tribal and (iv) Assimilated Tribal. But it is a difficult to mark a distinguishing line between the tribal with semi tribal and similarly acculturated with assimilated tribe.

On the basis of economic grading the classical classification of Adam Smith or the more recent classification of Thurnwold and Herskovits is mainly attempting to indicate the nature of economic difficulties experienced by the tribal communities. The first group is of those who have food gathering type of economic and they mainly depend upon forest, the cultivation of crops are very rare and if protected it is shifting cultivation. The second group is of those who practice both the food gathering and primitive agriculture, the Kamar, the Baiga belong to this group. The tribal populations which depend upon some form of agriculture with forest produce as a secondary support constitute the third group. Finally, a new economic category emerged in tribal society

due to the growth of industry in India and it driving the tribal people away from their traditional occupations.

On the other hand, L.P.Vidyarthi and A.K.Danda's zonal distribution of tribal population in India is worth mentioning. Vidyarthi pointed out that on the basis of geographical location the tribal people can be divided into four major zones namely the Himalaya Region, the Middle India Region, the Western Region and the Southern India Region with coastal Islands.

The Himalaya Region:

It is mainly comprises of Himachal Pradesh, Jammu and Kashmir, Tarai area of Uttar Pradesh, North Bengal, Assam, Meghalaya, Nagaland, Arunachal Pradesh, Tripura and Assam. This zone is further divided into three sub-zones: the North Western Himalaya Zone; the Central Himalaya; and the North Eastern Himalaya. The tribal belt of North Western Himalayas extends from the vicinity of upper Nepal in the east to the Pamir Knot in the North West. More precisely one may consider Dhauladhar Range of the Himalayas and the water shed of the Yamuna as the sub-division. For the sake of convenience, the state of Himachal Pradesh, Jammu and Kashmir and portions of Punjab fall under this region. The Central Himalayan belt begins from the water shed of the Yamuna in the west to the water catchment of the river Tista in Sikkim. This zone includes the district of Kumaon and Nainital in Uttarakhand, Champaran district of Bihar and North Bengal district of Bengal except Darjeeling. The North Eastern Himalayas mainly consist of Darjiling district of West Bengal, autonomous Hill Districts of Assam, Meghalaya, Mizoram, Nagaland and the Hilly parts of Manipur and Tripura. The important tribal groups of the region are Gujjar, Bhot, Gaddi, Kinnura, Thara, Kuki, Mizo, Dimas Boro, Garo, Khasi, Naga, Tipuri etc,

The Middle India Region:

In Middle India, he included West Bengal, Bihar, Orissa and Madhya Pradesh. The important tribal groups living in this zone are Mina, Bhil, Dubla, Dhodiya, Ganit, Koli, Mahadeo etc.

The Western Region:

Three State of this region, namely, Rajasthan, Maharashtra and Gujrat, contained tribal communities like Minaad Bhil in Rajasthan; Bhil, Dubla, Dhodhia, Gamit and Shayadri group in Gujrat; and Bhil, Koli Mahadeb and Kokha in Maharashtra. Bhils are found throughout the region.

The Southern India:

The different States and Union Territories of this zone comprise of mainly Southern Parts of India namely Andhra Pradesh, Tamil Nadu, Kerala, Pondicherry and Karanataka, with few Islands such as Andaman and Nicobar and L.M. etc. The main tribal communities are Gond, Koya, Yanidi, Yerukula, Irula, Malakum Ravan, Toda, Naikoda, Marati, Pulayan, Kadar, Andamanese, Nicobari, Jarwa and so on.

Danda (1996) divided tribal population of India into six geographical zones, namely, North Western India (Delhi, Haryana, Himachal Pradesh, Jammu and Kashmir, Punjab and Uttar Pradesh), Middle India (Bihar, Madhya Pradesh, Orissa and West Bengal), Western India (Dadar and Nagar Haveli, Goa, Daman Div. Gujarat, Maharashtra and Rajasthan), Southern India (Andhra Pradesh, Karnataka, Kerala, Pondicherry and Tamil Nadu), North Eastern India (Arunachal Pradesh, Assam, Meghalaya, Manipur, Mizoram, Nagaland, Sikkim and Tripura) and Island Territories of India (Andaman and Nicobar, Lakshadweep, Minicoy and Amindivi).

When these two classifications are compared, it becomes clear at the very first look that both the classifications are more or less similar. The only difference between

the two is that Danda divided the category of Himalaya Zone into two regions-North Western and North Eastern and separated Islands and territories from the Southern Zone. Both the classifications are useful in analyzing the sociological and anthropological studies of Indian tribes.

Major Trends of Tribal Research in India:

At the very outset, it seems appropriate to summarize the trend reports of L.P.Vidyarthi (1974), Sachidananda (1985) and Danda (1996) in order to understand the major trends of researches in the context of tribal societies. According to Vidyarthi (1974), Tribal Researches in India can be divided into three phases, namely, Formative (1774-1919), Constructive (1920-1949) and Analytical (1980-onward)

Formative Phase:

According to Vidyarthi (1974), since the foundation of the Asiatic Society of Bengal in 1774, the British Administrators, missionaries, travelers and a few other anthropologically oriented individuals collected data on tribal and rural groups and wrote about their life and culture in the Journal of the Asiatic Society of Bengal, (est. 1784), Indian Antiquary (est. 1872) and latter in the Journal of Bihar and Orissa Research Society (est. 1915) and Man in India (est. 1921).

These generalized works were followed by J.Shakespeare (1912), P.R.T Gurdon (1914), J.P.Mills (1922 and 1937), N.E. Parry (1932), W.G.Grigson (1938) and a few others who wrote competent monographs on specific tribes. Here worth mentioning British Anthropologists are Rivers (1906), Seligmann (1911), Redcliff Brown (1922) and J.H.Hutton (1931) who worked on the tribes of India and published their monographs. Under these influences, the first Indian to write exhaustive monographs on the tribes of India was S.C.Roy who published his first epoch-making work on the Munda tribe in 1912. It was followed by a series of five monographs on the Oran (1951a), the Birhor

(1925), Oran Religion and Customs (1928), the Hill Bhuiyan (1935) and the Kharia (1937).

Constructive Phase:

Social Anthropologist witnessed a phenomenal change when it was included in the curriculum of the two important Universities in Bombay (Sociology in 1919) and Calcutta (Anthropology in 1921). During this period, a few anthropologists studied and analysed their data critically and brought about a certain amount of theoretical sophistication in Anthropological researches. Srinivas's work on Marriage and Family in Mysore (1942) and N.Bose's publication entitled "Hindu Methods of Tribal Absorption" (1928, 1941) were a turning point in Indian Anthropology.

Verrier Elwin and the publication of his problem oriented studies on the tribes of Madhya Pradesh and Orissa, like the Baiga (1939), the Agaria (1942) and Maria (1942a), gave further recognition to Indian Anthropology. Furer Haimendorf's (1943) publication on the tribes of Hyderabad and other successive publication (1945 & 1946) provided refined models for research worker in India (Vidyarthi 1974: 39)

Analytical Period:

During the period American Anthropologists like M.E.Opler (1948 and 1950) of Cornell University, Oscar Lewis (1954) of the University Illinois started the village, caste and urban studies as well as the problem-oriented researches of power structure and leadership, of religion, of culture and personality which emerged in this period. The tribal studies were also given an analytical and action oriented approach. D.N.Mazumdar's and G.D. Barremen's studies of Polyandrous Khasa, Surajit Sinha's study of the Bhumji, Vidyarthi's of the Maler Hills village and a mixed tribal village of Chotonagpur and Edward Jay's study of a Maria Village.

In course of time, a number of tribal research institutes were established. For example, at Chhindwarain, Madhya Pradesh (est. 1954), Ranchi in Bihar

(est.1954),Calcutta in Bengal, Bhubaneshwar in Orissa (est.1955),Shillong in Meghalaya,Udaipur in Rajsathan (est. 1964), Hyderabad in Andhra Pradesh and Poona in Maharashtra to undertake problem-oriented researches for the effective formation and implementation of development programmes in tribal areas.

During the 60's the Census Organization of the government of India commissioned a large number of ethnographic studies on a set frame.

Historical Period in Tribal Studies:

Historically, the development of tribal researches in India, as mentioned earlier, may be reviewed in three phases: Formative (1774-1919), Constructive (1920-1949) Analytical (1950-). While this categorization is broadly useful, it should be remembered that these phases are not mutually exclusive and that the different rate development of anthropological researches in various parts of India leads to regional distinctiveness and delimitations. Before describing the details of tribal studies in different regions of India, it would be worthwhile to spell out the state of anthropological researches during the three phases at an all India level.

Since the foundation of the Asiatic society of Bengal in 1774, the British administrators, missionaries, travelers and a few other anthropologically oriented individuals collected data on tribal and rural groups and wrote about their life and culture in the *Journal of the Asiatic Society of Bengal (est. 1784)*, *Indian Antiquary (est. 1872)* and later in the *Journal of Bihar and Orissa Research Society (est. 1915)* and in *Man in India (est. 1921)*. During the census, especially in 1931 and 1941 some British and Indian anthropologists were associated with the collection of anthropological data on the tribes and castes of the different parts of India.

Some scholarly British administrators posted in different parts of India (for example: H.H. Risley,E.T.Dalton and L.S.O'Malley in East India,Russell in Middle India,E.Thurston in South India, and W.Crooks in Northern India) wrote encyclopedia

inventories of the tribes and castes of India which, even today provide basic information about the life and culture of the peoples of the respective regions. In addition to the handbooks on the tribes and caste of different regions, general books on Indian ethnology were also published by administrators like J.M. Campbell (1856), R.S. Latham (1859) and Risley (1891) with a view to acquainting government officials and private persons with classified descriptions of tribes and castes in India.

These generalized works about the land and people of the regions were followed by efforts to prepare detailed accounts of specific tribes and some castes. Among them, mention may be made on J. Shakespeare (1912), P.R.T. Gordon (1949), J.P. Mills (1912 and 1937), N.E. Parry (1932), W.G. Grigson (1938) and a few others who wrote competent monographs on specific tribes and W.G. Briggs (1922) who wrote on the 'Chamar'. A few missionaries like P.O. Bodding (1925), J. Heffmann (1924, reprinted in 1950) and several others in different parts of India were also attracted to ethnographic and linguistic researches.

Under these influences, the first Indian to write exhaustive monographs on the tribes in India was S.C. Roy who published his first epoch-making work on the Munda tribe in 1912. It was followed by a series of five monographs on the Oran (1915a), the Birhor (1925), Oraon Religion and Customs (1928), the Hill Bhuiya (1935) and the Kharia (1937). These works of Roy were acknowledged by contemporary British anthropologists as competent studies.

Constructive Period:

Social anthropologists in India witnessed a phenomenal change when it was included in the curriculum of the two important universities in Bombay (Sociology in 1919) and Calcutta (Anthropology in 1921). These two centers for sociological and anthropological researches attracted academicians and trained scholars to undertake significant researches. Very soon, specialized subjects like kinship studies, social

organization, etc. were undertaken by trained scholars like Ghurey (1943, 1952, and 1954), K.P. Chattopadhyay (1922 and 1925), Srinivas (1942 and 1946), D.N. Majumder (1937), Karve (1940-41) and a few others.

A big jump came in 1938, when a joint session of the Indian Science Congress Association and the British Association, on the occasion of the Silver Jubilee of the former, reviewed the progress of anthropology in India and eminent anthropologists from abroad deliberated with Indian anthropologists and discussed plans for future anthropological researches in India. During this period, a few anthropologists, after completing doctoral assignments, provided some theoretical leads in social anthropological researches. They studied and analyzed their data critically and brought about a certain amount of theoretical sophistication in anthropological researches. For instance, Srinivas's work on marriage and family in Mysore (1942) and N.K. Bose's publication entitled *Hindu Methods of Tribal Absorption* (1928, 1941) were a turning point in Indian anthropology.

The entry of Verrier Elwin and the publication and the publication of his problem oriented studies on the tribes of Madhya Pradesh and Orissa like the Baiga (1939), the Agaria (1942b), or Maria (1942 a) gave further recognition to Indian anthropology. Furer-Haimendorf's (1943) publication on the tribes of Hyderabad and other successive publications (1945, 1945b and 1946b) provided refined models for research workers in India.

Thus, Indian anthropology, which was born and brought up under the influence of British Anthropology, matured during the constructive phase also on the lines of British Anthropology. Except for a few studies of Indian institutions like caste (Briggs, 1920; Iyer, 1929 and Hutton, 1946), the tradition of making tribal studies the almost exclusive focus of anthropology continued till the end of the forties of this century. On the lines of anthropology taught at that time at Cambridge, Oxford and London, Indian

anthropology was characterized by ethnological and monographic studies with a special emphasis on researches in kinship and social organization.

Analytical Period (since 1950):

After the Second World War, and particularly after Independence, there was a positive increase in contacts with the American social anthropologists. Some American anthropologists like M.E.Opler (1948 and 1950) of Cornell University, Oscar Lewis (1954) of the University of Illinois, David Mandelbaum (1955a and 1955b) of the University of California and several students from Cornell University came and stayed in India with their research terms and created an atmosphere first, for a systematic study of Indian villages with a view to testing certain hypotheses, second, for refining some of the methodological framework developed elsewhere, and third, to assist the community Development Programmes in the Indian villages.

In addition to the villages, caste, and urban studies as well as the problem oriented researches of power structure and leadership of religion, of culture and personality which emerged in this period, the tribal studies were also given an analytical and action-oriented approach. Efforts are now being made to study the tribal communities in terms of inter-relations as well as in terms of differences and similarities among tribal and non-tribal communities. Here mention may be of D.N.Majumder's and G.D.Barreman's studies of polyandrous Khasa, Surajit Sinha's study of the Bhumji, Vidyarthi's of the Maler hill village and a mixed tribal village of Chotanagpur, and Edward Jay's study of Mauria village. Majumder (1963) presented a comprehensive study of the polyandrous Khasas and brought out the characteristics of the tribe-Hindu continuum. Berreman. However, accepts these people as Hindus without any doubt (1963 and 1964). Sinha's theme in the study of Bhumij of Manbhum is similar to the above studies as his analysis brings out clearly the prevalence of the Bhumji-Rajput continuum (1957b and 1962). Again Vidyarthi's work on tribal village of Chotanagpur,

shows how the Manjhi tribe has attained the status of a caste in the Munda village of Ranchi (1965). These researches open up a new era of understanding regarding changes among tribes in the setting of the mainstream of Hindu social organization.

Robbins Burlings (1963), an American anthropologist, is the first to publish a village study on a tribe in India. His study of Renganggri, a Garo village, with special reference to family and kinship ethnography in India. Vidyarthi's (1963) study of Maler culture was the study of a tribe in terms of nature-man-spirit complex. This work provides an alternative model for understanding tribal complex in terms of the interrelatedness of ecology, economy, society and spiritual beliefs and practices. In course of a number of tribal research institutes were established e.g. Chhindwara in Madhya Pradesh (est. 1954), Ranchi in Bihar (est. 1994), Calcutta in Bengal, Bhubaneswar in Orissa (est. 1955), Shillong in Assam, Udaipur in Rajasthan (est. 1964). Several publications like the tribal number of the *Journal of Social Research* in 1959-60), the comprehensive book on applied anthropology edited by Vidyarthi (1968a) several reports and papers bearing on the tribal problems prepared the group for the introduction of the teaching of applied and action anthropology in several universities in India.

With this brief introduction about the development of anthropology on an all India level, let examine the researches undertaken in the four major belts of tribal concentration in India during the three historical phases and, in the light of such a review, highlight the problems of tribal research that need to be tackled in the immediate future.

The region mainly consists of Darjeeling district of West Bengal, autonomous hill districts of Assam (united Mikir and North Cachar Hills and Mizo Hills), Meghalaya (Garo hills, and United Khasi and Jaintia Hills), five frontier districts of North-East Frontier Agency (Kameng,Subansiri,Siang,Lohit and Tirap), the State of Nagaland (with

three districts of Kohima, Mokokchung, Tuensang) and the hilly districts of centrally administered States of Manipur.

During a formative period, a number of persons belonging to the British administration, foreign missionaries, military officers and census officers wrote about the life and culture of the tribes of this region. Among the early scholars who wrote about the tribes of Assam in handbooks, ethnographic glossaries and district gazetteers, mention may be made of Robinson (1841), B.H. Hodgson (1848), John Butler (1855), Dalton (1872), Risley (1891), W.H.G. Cole (1912), Nevile and G.C. Bordoloi (1923), J.H. Hutton (1931) and others. In addition to writing notes and papers on the tribes of India, the Government of Assam took a decision in 1994 to bring all together all the scattered and fragmentary information collected by the previous investigators and after supplementing it with up-to-date information, to publish it in the form of monographs. In order to set a model before the other workers, Gurdon prepared an ethnographic monograph on the Khasi, the revised edition of which was published in 1914 (Gurdon, 1914).

In a series of notes in the Census volumes of 1921 and a number of papers, Hutton (1923, 1924) attempts comparisons and establishes affinities among different Nagas and other tribes in Assam. He finds that the tribes in Assam migrated from several directions, the west, southern China, from the south and the north-east. He also establishes striking connections between the material culture of this area and the Indonesian type.

Another administrator, J.P. Mills who worked under the active supervision and encouragement of Hutton, worked among Lhota Nagas for several years and published his book in the year 1922. While describing the Lhota culture, he was struck by the process of detribalization of the Lhota, firstly, under the impact of Christianity of the American Baptist Mission, and secondly, under that of Hinduism of the Nepalese

settlers. Mills, who was appointed the Honorary Director of Ethnography, Assam, after the retirement of J.H.Hutton, continued to work on the ethnographic studies of Assam tribes and wrote his third monographs on the Rengma Nagas which was published in 1937.

The isolated and wild terrain of the NEFA region remained unexplored till C.Von Furer-Haimendorf, was invited as a special officer to conduct an exploratory survey of the NEFA area (1944-45). In the course of his first visit, he made contracts with the three NEFA tribes, the Dalits, the Meras and the Apa Tanis, and published two books (Furer-Haimendorf, 1947, 1955) in the form of travelers' accounts. He made another visit to the Subansari Frontier Division of NEFA in 1957 and published another book, *The Apa Tani and Their Neighbours* (Furer-Haimendorf, 1962). It examines their economy and their interactions with their neighbours, the Dafla.

A systematic ethnographic study of this area, however, was under taken under the auspices of the NEFA administration by Verrier Elwin and his team of anthropologists posted in the headquarter of each division of NEFA. The first monograph to appear on this monographs on Tangsas of the Namchik and Tirap valleys (M.P.Dutta, 1959), the Idu Mismi of Lohit frontier division (R.R.P.Sharma, 1961), the Gallong of Siang Division (Srivastava, 1962), the Aka of the Kamong divisions (R.Sinha, 1963), and an analytical monograph on Padam Miniyong of Siang division (S.Roy, 1960). These monographs based more or less on the same model, give comprehensive descriptions of the social and cultural life of these tribes.

Tribal Researches in India:

Following Vidhyarthi's Classification, the tribal studies in NorthEast India can be classified in to three phases:

- (a) Formative Period
- (b) Constructive Period

(c) Analytical Period

Formative Period:

During this period, the studies done specially on tribes of Assam. Along with Historical and geographical information the Journal of the Asiatic Society of Bengal, Indian Artiquary, The Journal of Bihar and Orissa Research Society and Man in India collected through ethnographic data and published a number of monographs. Among the early scholars who wrote about the tribes of Assam in handbooks, ethnographic glossaries and district gazetteers mention may be made of Robinson (1841), Hodgson (1848), Jhon Butler (1855), Dalton (1872), Risley (1891), W.H.G. Cole (1912) and others.

Constructive Period:

During the Constructive Period of tribal studies in North-Eastern India, the monographs studies on the tribes of the region were adversely affected by the First World War. It was published for Hutton only in 1921, to revise the series with the publication of his monographs on the Angami Naga. In a series of notes in the Census Volumes of 1921 and a number of papers Hutton (1923, 1924) attempts comparison and establishes affinities among different Nagas and other tribes of North-East India. J.P. Mill another administrator who worked under Hutton done research on Lotha Nagas for several years and published his book in the year 1922.

The department of Anthropology of Calcutta University, which was established in 1921, also took interest in the study of the tribes of North-Eastern region. In 1931, T.C. Das with his students visited four Purum villages in Manipur. He stayed in these villages for about five months between 1931 and 1936 and published his monographs on Purum in 1945.

Analytical Period:

In this period, a systematic study of Indian villages started, firstly with a view to test certain hypothesis; Secondly, for referring some of the methodological framework

developed elsewhere; and Third to assist the Community Development Programmes in the Indian Tribal Villages i.e. the Tribal Development Schemes and so on.

Robbins Burlings (1963), an American Anthropologist, is the first to publish a village study on a tribe in India. His study Renasangri, a Garo Village with special reference to family and kinship provides a first rate model to the followed by a research in tribal ethnography in India. In these period Tribal Research Institute established in Shillong (1964) and it undertake problem-oriented researches for the effective formulation and implementation of development programmes in tribal areas of North-Eastern region.

B.S.Guha (1953), the then Director of the Department of Anthropology (Government of India) himself studied the *Moshik* Organization among the Abor. B.C.Gohain (1954) also studied the Abor with special reference to agricultural organization. B.Mukherjee in 1953 did field researches among the Garos and the Riang of Tripura and wrote about their kinship and social organization.

B.B.Goswami (1960), who made a study of the Kinship system of the Lushai (Mizo) and Sukumar Banerji (1964) carried out a special study of Phar kinship and residence pattern. The study of cultural dynamics, however, is rare and one come across only one paper by M.K.Nag (1965) on the effect of Christianity on Khasi culture in Meghalaya.

The tribal societies of North-East India are passing through a process of Social Change. But a number of Tribal Studies in the North-Eastern region have not yet attracted the attention of the Sociologists and Social Anthropologist. The Barman of Barak Valley is also one of those tribes on which no Sociological Studies have conducted yet. Therefore, the present study is an attempt to study the relationship between education, communication and patterns of Health Care. However, there is less studies on relationship between these three variables

Communication:

Communication is the art of transmitting information, ideas and attitudes from one person to another. The word 'communication' comes from a Latin verb 'Communicare', which means to make common to share, to impart and to transmit. Through communication, people share each other's perceptions, control one another's behavior and organize themselves into groups. *The Oxford English Dictionary* defines communication as the transmission and reception of symbolic stimuli or message and commands.

According to **Stevenes and Schramm**, communication is the discriminatory response of an organism to stimulus. Communication occurs when some environmental disturbance impinges on the organism and the organism does something about it. **Charles Morris** has defines communication as follows: the term, communication, when widely used covers any instance of the establishment of common age, i.e. the making common of some property of a number of things. **Lumberg** defines communication in terms of the use of sign and symbols. He has used communication to designate interaction by means of signs and symbols. The symbols may be gestural, pectoral, and verbal or any other which would serve as stimulus to behavior.

Rogers and Shoemaker defines communication as the process by which messages are transferred from a source to the receiver. They describe the communication process in terms of this S-M-C-R model- A source (S) sends a message (M) via certain channel (C) to the receiving individual (R).

Harold Laswel proposed five questions to indicate what he left to be important variables in communication: Who? Says what? In Which Channel? To Whom? And With What Effect? Who is the generator of the message; 'Says What' is the messages which is separated; 'In which channel' indicates the media used for the messages to be

imparted; 'To Whom' is the attributor of meaning (receiver); and 'With What Effect' refers to the impact of the communication process.

Lowery and De Fleur (1988,1955) noted that a starting point for understanding the development of the earliest theoretical models used to study mass communication an effect was the concept society; Since the mid-18th century, these trends occurred that transformed western societies from feudal, agricultural and pre-industrial complexes. These trends identified broadly as industrialization, urbanization and modernization transformed social relationships, norms, values and material culture drastically. Sociologists, Historians and other scholars termed new communities, mass society. This was "an image of a modern society as consisting of an aggregate of relatively 'atomized' individuals acting according to their personal interests and little constrained by socialites and constraints"

The Communication has attracted the Sociologists in the early part of twentieth century under the influence of "Chicago School". The Chicago School developed a general approach to Social Theory that emphasizes the role of Communication (Cooley 1902, 1909, Dewey, 1927, Mead, 1934). Lynd and Lynd's (1929, 1937) is the most significant Chicago Style Studies of Communication conducted outside the Chicago sphere, studies on "Middle Town" (Desmond 1937, Lee 1937, Rosten 1937, 1941, Thorpe 1939). Mass Communication is a broad concept which has an impact on patterns of everyday life and in the creation of a national culture with the understanding of media institution as parts of a larger social process. During the period between the Second World War, the mass media were viewed as powerful instruments that could be successfully used to manipulate people's opinion and attitudes, and thereby behaviours in a relatively short period of time

After World War II, the centre of sociological communication research has shifted from the Chicago School to Columbia. Although, **Lazarsfeld** had more

substantial impact on the sociology of communication, but through the establishment of Columbia School, Lazarsfeld succeeded in translating the office into a general centre for applied research. Some of the significant works of Columbia research study were Lazarfeld (1940), Lazarsfeld and Stanton (1941, 1944, 1949), Merton (1946), Katz and Lazarfeld (1955) and Kalappar (1960). In addition to this, a number of reviews of research findings on mass media effects were Hovland (1953), and (1954), Klapper (1960), Berelson and Steiner (1964), Halloran (1965), Belson (1967).

The audience research studies, which have been mainly descriptive have looked at the audience in its social setting and attempted to map out the salient feature of audiences behavior, interests and options. The first independent research directed at the mass media audiences was Allport and Cantril's work on radio (1935), followed by a group of impressive and lucid studies, dealing with radio, print and film by Lazarsfeld and associates during 1940s. The arrival of Television has since promoted a new cop of studies in the radio research tradition (Bogart 1956, Stenier 1963, Belson 1967)

Doob (1961) says that the role of mass media in the transition of traditional societies on developing nations to a modern form, Lerner (1958), Rogers (1962, 1969) and Schramm (1964) has viewed that mass media prepare, instigate and undersigned the development of a modern society. Their prominent works on the role of communication in development are most influential.

Katz (1963) notes that "the model in the minds of the early researchers seems to have consisted of (i) the all powerful media, able to impress ideas on defenseless media; and (ii) the atomized mass audience, connected to the mass media, but not to each other. His predominance of interests in effects of media and effectiveness of channels led to other formations.

Communication became the object of scientific study. An influential model called the telephone model was developed by **Shannon and Weaver (1949)**, **Diaz-**

Borodenave (1977) has noted that several concepts such as signal, code, message, channel, source, destinations, encoding and decoding were first described in the Shannon and Weaver model. While the model was developed in the area of information theory, it was used analogically by behavioral and communication scientists. The other early models in communication developed by **Schramm, Berlo**, and other conceptualized communication as a linear and on way process always flowing from the other source of communication to a passive receiver. The earlier models of Schramm and the SMCR model of Berlo conceptualized the communication flow as a simple mechanistic process of message transmission (Diaz-Bordanave 1977). The study of propaganda and the powerful effects of mass media engaged some of the best minds in Sociology, Psychology and Political Science.

The work of other social scientists (Hovland et. Al 1949, 1953; Klapper 1960), further undermined the great power of the mass media in bring about direct and lasting effects on the audience. **Carl Hovland and et al.** made research on war propaganda films examines how and why individuals responded to persuasive messages, showing that the mass media were ineffective in improving the attitudes of soldier's toward their allies and increasing their motivation to fight. Rather, the social categories (for example the education level) to which people belonged and individual differences were more predictive of certain effects than mass media exposure. People defended themselves against persuasive messages in three ways: selective exposure, selective perception and selective retention.

Klapper (1960) suggested that people themselves to messages selectively. There was a tendency for themselves to expose relatively more to these items of communication that were consonant with their beliefs, ideas, and values. Further, regardless of exposure to communication, an individual's perception of ascertain events;

issues; person or place could be influenced by his/her latent beliefs, attitudes, wants, needs, or the factors.

The theory of minimal mass media effects contributed to the refinement of theories and methods in communication studies. With greater refinement in theoretical concepts and methodological designs; the “minimum effects” researchers were able to move away from the simplistic “bullet theory” and ‘hypodermic needle’ concepts of mass media effects.

The mass media were widely perceived by administrators and policy makers in third world nations as important vehicles for bringing about speedy behavioral changes among their peoples, particularly in favour of modernizing objectives of the state. The preoccupation with effects suggests that the mechanistic stimulus response model has not entirely vanished. It still underlines much thinking about the nature and role of mass communication in development. For some, the process of persuasion has remained synonymous with the process of mass communication (**Mc Quail Windahl 1981**). This is evident in all the approaches guiding communication to support modernization and micro levels.

Lerner posited that, on a micro level, the modern mass media were used in one way and top-down communication models by leaders to disseminate modern innovations to the public. Lerner (1961) saw the problem as one of “modernizing” traditional societies. Development was largely a matter of increasing productivity and the problem of stimulating productivity was basically “psychological”. He pointed out that development failed to occur because peasants were unable to ‘empathies’ or imaginatively identify with new roles and a changed and better way of life, and so remained fatalistic, unambitious and resistant to change. According to Lerner, the media as filling this need, of promoting ‘empathy’, the ‘physic mobility’ that was the prerequisite of the social and economic mobility that development required. He pointed

to the correlation between economic productivity and media provisions in different countries in support of his theory, the richest countries had the most Newspaper, Radio and so on and the poorest the least. Daniel Lerner (1958) points out that there is a close reciprocal relationship between literacy and mass media exposure. The literate developed the media which in turn accelerated the spread of literacy.

Schramm notes, “The less developed countries have less developed mass communication system also and less development in the service that supports the growth of mass communication” (Schramm 1964; 112). Therefore, information was considered the missing link in the development chain. **Wilbur Schramm explores the hypothesis that** an adequate flow of information, in particular, an appropriate use of mass media could make a substantial contribution to national, economic and social development.

Everett M. Rogers, a renowned communication expert has three works (1971, 1962, and 1983), based on a series of generalizations from research work on the diffusion of innovations and facilitate greater understanding of the diffusion process. According to him, the main elements in diffusion of new ideas include an innovation which is communicated through certain channels over time among the members of a social system. He talks of five attributes of innovations which determine the rate of its adoption, namely, relative advantage, compatibility, complexity, triability and observability.

De Fleur and Ball-Rokeach (1975) based on the three analysis propose an ‘Integrated Theory’ of mass media in which the idea of needs becomes the basis for understanding the media. They are: i. Understanding of social world in which they live; ii. Act meaningfully and effectively in that world; and iii. Experience fantasy-escape from daily problems and tensions.

Mc Quail (1972) suggest following five general conditions which bear upon the effect of media:

- i. The greater the monopoly of the communication sources over the recipient, the greater the chance or effect in favour of the source over the recipient.
- ii. Communication effects are greatest where the message is in line with the existing opinions, beliefs and dispositions of the receiver.
- iii. Communication can produce the most effective shifts on unfamiliar, lightly felt, peripheral issues, which do not lie at the centre of the recipient's value systems.
- iv. Communication is more likely to be effective where the source is believed to have expertise, high status, objectivity, or likeability, but particularly where the source has power, and can be identified with.
- v. The social context, group or reference group will mediate the communication and influence or not it is accepted.

He has classified the relationship between media content and the audience as following:

- i. Diversion
 - a. Escape from the constraints of routine
 - b. Escape from the burdens of problems
 - c. Emotional release
- ii. Personal Relationship
 - a. companionship
 - b. social Utility
- iii. Personal Identity
 - a. Personal reference
 - b. Reality exploration
 - c. Value reinforcement
- iv. Surveillance

Marshall Mc Luhan (1965) observed “In a culture like ours, long accustomed to splitting and dividing things as a means of control, it is sometimes a bit of shock to be minded that, in operational and practical fact, the medium is the message”. Though Mc Luhan (1965) agreed with critic who proclaimed that the Television was radically altering society, he sneered at their moralistic attempts to censor or curtail certain types of programmes. He claimed that the content of TV (programming) is irrelevant, what is changing society, rather, is the medium’s stimulation of new, more active ways of looking at the world, in which ‘information; is less important than patterns of feeling engagement.

Singhal and Rogers (2001) acknowledge the Internet for serving as invaluable resources in researching, writing and illustrating. They accessed a number of Indian newspapers, magazines and hundreds of other relevant web sites tracking down the source through Internet, bringing in an instant the physical distance.

Scott Wallstein’s (2003) study is a unique new survey of telecommunications regulators and other sources to measure the effects of regulations on Internet development. He finds that countries requiring formal regulatory approval for Internet Service Providers (ISPs) to operate have fewer internet users and hosts than countries that do not require such approval. In fact, his study suggests that developing countries’ own regulatory policies can have large impact on the digital divide.

Singh (2002) in his PhD research dealt with Network Education and Mobility in Legal Profession analyzed the social background, the patterns of intergenerational and intra-generational occupational mobility, role of social network in professional education and training of the lawyer and shaping his professional role performance of the lawyers of Meerut. One of the main objectives of the study was to explore how the social network of an individual plays a part in the process of educational attainment when he comes from a rural community to an urban setting.

Y.B.Damle's article (1956-1957) can be regarded as the first major work in the field of the sociology of communication in India. He studied the diffusion of modern ideas and knowledge in seven villages near Puna (Maharashtra) and showed that it was not merely the distance from the city that facilitated or hindered communication of ideas and knowledge.

Since the establishment of Indian Institute of Mass Communication (IIMU) in New Delhi in 1965 by government of India various types of researches have been undertaken in various dimensions of communication such as Communication and Elections, Communication for Tribal Development in North Eastern Region, response to visual posters, Role of Daily News Papers during elections and effectiveness of puppetry and film (Gupta 1985).

R.P, Patel (1969) in a paper presented at the UNESCO Conference on Family Planning and Mass Communication discussed mass education strategies for family planning in India. He has discussed the problems of media arrangements and media selection at central, state and district levels.

S.K.Sarmah (1971) discussed the role of Television as a tool for promoting family planning in India. He has also mention the importance of mouth media approach. P.Patankar and Lilian Dey (1973) have analyzed the role of village level workers in the communication of information on family planning programme amongst the villagers. P.M. Shingi and Bella Mody (1974) studied on the role of Television in the context of rural communication. They found that farmers watching agricultural programmes on TV were less ignorant than non-viewers.

Atal (1973), in his essay on "Dynamics of Nation Building: Insulator and Apertures" delivered as the Gandhi Memorial Lecture at the University of London, developed a communication model for analyzing nation building in which he discussed

social apertures and insulators as facilitating and obstructing mechanisms in the free flow of information.

Lakshmana Rao (1963) also suggested that communication was a prime mover in the development process. He selected two villages in India for his study: *Kuthooru* village on the verge of modernization, and *Pathooru*, a village isolated and steeped in traditional customs and beliefs. Rao suggests that the laying of a new road to *Kuthooru* from nearby city started the process of modernization. It was the quantity and quality of information that triggered change in *Kuthooru*, while *Pathooru* remained unchanged. The new road and the mass media brought in modern ideas and values from outside. There was a great spurge to education. Importantly, the new developments led to new jobs and higher productivity. As Schramm commented, "more productivity leads to improved income, to widening consuming habits, to increased economic activity within the village (such as shops and restaurants) to new appetite for consumer goods, to a seeking after new opportunities, and so on in a chain of related developments (Schramm 1964:49). While Lerner observed the role of communication as the harbinger of new ideas from outside, Rao concluded that new communication helped to smooth out the transition from a traditional to a modern community. The availability of new information to the people at the top and its eventful and autonomous trickle down to others in the lower reaches of the hierarchy increased empathy, opened up new opportunities, and led to a general breakdown of the traditional society.

Pye (1963) formulated three models of communication which are traditional communication, modern communication and traditional transitional communication system. He made a clear cut distinction at a theoretical level and discussed at length the problems of transformation of traditional societies to a modern one. In India, numerous studies in richer quality have been made on communication.

C.R.Prasad Rao and K.Ranga Rao (1976) have studied the village communication channels in three villages of Andhra Pradesh; their study examines the determination of the communication channel usage in a sample of 209 farmers. One important finding is that the knowledge imparted through broadcasting was significantly retained by the respondents even 30 days after the broadcast.

S.C.Dubey (1967) presented a summary of several communication studies and critically examined the nature, reach and effects of developmental communication in India. **Y.V.L.Rao (1966)** discussed the role of communication in two south Indian villages. **F.C.Fiegel and associates (1968)**, **J.E. Kivlin and associates (1968)**, **P.R.Roy and associates (1969 a, b, c)** and **L.K.Sen and P.Roy (1966)** have provided statistically sophisticated studies with interesting correlations on different themes in the general area of communication in the developmental setting of India. But many of those studies provide a veritable maze of statistical tables complicated graphs and charts.

Since 1st August 1975, through the Satellite Instructional Television (SITE) Development programmes were shown in 2,379 villages of Six States. A team of Social Scientist was employed by SITE to test the efficiency of Television on and improving agricultural practices and population control in promoting National Integration, in upgrading and expanding education and in promoting better health and hygiene for a better life in rural areas (Gupta 1985). Since, 1990's onwards the trends have been shifted to National Television Network i.e Doordarshan and more specifically to successful; launch of the Polar Satellite Launch Vehicle (PSLV) on October 15, 1994 marks an important milestone in India's space programmes (Mahajan 1988) in a study of patterns of Television viewing among girls in Meerut City found that television viewing increased knowledge about other countries and promotes the general feeling of universal brotherhood.

Iswar Modi (1985) studied the inter-relation between leisure, mass media and social structure in an empirical situation in Rajasthan. He provided of comprehensive description of traditional forms, folk motifs and cultural roots of leisure and the new challenges from the electronic revolution of the mass media and its encroachment on leisure, culture and social structure. Modi establishes that social structure influence the nature and form of leisure and the leisure itself helps in generating newer structure, social norms and culture.

Brown (1986) found that in any society, feminine personality comes to define itself in relation and connection to other people more than the masculine personality does. Yasuko (1977) found that the predominance of the perception of women is either wife or whore—the dichotomy already found in media portrayals. Studies on Television programmes have also shown that media present an extremely narrow range of female image a young in traditional feminine occupations- if employed at all, seeking identity through love, or marriage, deliberately home oriented, self-sacrificing and dependable.

Bhagat (1992) viewed that improved technologies for rural women are established to be the heart of development and innovations was thought to be the best single indicator of the multifaceted dimension called Modernization.

Rogers' (1976) suggested a new definition development as a widely participatory process of social change in a society intended to bring about both social and material advancement (including greater equality, freedom and other valued qualities) for the majority of the people through gaining control over their environment. The predominant role of communication has been: (a) transfer technological innovations from development agencies to the clients and; (b) to create an appetite for change through raising a climate for modernization among members of the public.

K.B.Mathur (1994) in his study on communication for development and social change, viewed traditional folk media as culture and community based media. He

observed that traditional folk media existed even before the advent of the modern mass media. It was through the utilization of these media that some of the dynamic religious movements spread for the wide.

Dharamvir (1990) has attempted to delineate the role of mass media in determining political awareness, sense of political efficacy and participation among prospective voters belonging to an urban locality Uttar Pradesh. He concluded that the level of mass media exposure affects one's level of political awareness and sense of efficacy. However, he also pointed out that higher exposure to mass media has a negative effect on political participation as the highly exposed tend to be less participative.

Mahajan (1990) in her study of Television and Women's Development investigated the role of television in the process of modernization. Based on the data collected from women college students she inferred that in terms of modernization process. Television is not an alloyed blessing and it can be counterproductive to the modernizing effort, if not rationally planned. He also found ambivalence among the respondents about the effects of television on traditional values.

Subhanarayan (1991) emphasized that light viewer can remain so he attends to his work and make a decent living provide, he does not fall for the glamour and glitter as provided by television. TV is like a magic box and it mesmerizes the audiences completely. To run away from the TV it needs a strong will power and education to cure him of the negative effects of Television.

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Fisk and Hartley (1994) viewed the impact of TV from a semiotic and cultural perspective leads us to pursue the relationship between the TV message the everybody reality of the audience and the functions performed by TV for that audience.

Parkin (1972), Hall (1980) in their studies on TV shows the power of the TV to construct its preferred meanings on the viewers. **Morey (1981)** points to the viewer's ability to make own meanings. Words do not have meaning; people have similarly different meanings to different people.

Fisk and Hartley (1978) also emphasizes that a "Television message is a meaningful only at the moment when the semiotic codes interlock with the cultural awareness supplied by the viewer, whose own context will play a major part in shaping that cultural awareness. Therefore, it is difficult to generalize on the individual behavioural aspects of the causes and effects of TV. It was also observed that "the written word (and particularly the printed word works through and so promotes consistency, narrative development from cause to effect, universality and abstraction, clarity and a single tone of voice. The Television on the other hand, is ephemeral, episodic, concrete and dramatic in mode. Its meaning is arrived by contrasts and by the juxtaposition of seemingly contradictory signs and its 'logic' is oral and visual"

Singh (2002), examines the relationship between mass media communication, modernity and social structure among the youth of Silchar town. The study reveals positive relationship between mass exposure and modernity level, in the sense that out of 46 respondents who have medium level of media exposure 41.66% has high level of modernity, but 54.2% respondents in this category have medium level of modernity and 4.2% low level of modernity level. It suggests that although there is a positive relationship between mass media exposure and modernity at the medium level but mass media exposure is not solely responsible for the modernity level of an individual. It may also be influenced by some other variables such as caste, class, occupation and

education of the subject. In order to analyze the relationship between social structure and modernity, the main elements of social structure such as caste, education level of the respondents, father's occupation and income group are taken into consideration. There seems no clear cut relationship between caste and levels of modernity. Higher caste subjects have medium level of modernity. There is a positive relationship between education and modernity. In the sense, that no respondents in the sample was having very low level of modernity. At the secondary level of education, 87.5% have medium level of modernity and only 12.5% have low level of modernity. Among the highly educated respondents 32.8% have high level of modernity, 56.3% medium level of modernity and only 12.5% have low level of modernity. It suggests that there is a positive correlation between education and modernity. But the modernity perpetuates more at medium level. It can be said that education is most important factor in the advancement of the modernity level from medium to higher level rather than exposure to mass media communication. The factors like religion and castes may have a negative impact to modernization.

Health:

Health is the general condition of a person in all respects. It is also a level of functional and/or metabolic efficiency of an organism, often implicitly human. The World Health Organization (WHO), in 1948, **Health** was defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. And **Health Care** is the prevention of, treatment and management of illness and the prevention of mental and physical well being through the services offered by the medical, nursing and allied health professions.

Only a handful of publications have focused specifically on the definition of health and its evolution in the first 6 decade. In 1986, the WHO, in the Ottawa Charter

for Health Promotion said that Health is “a resource for everyday life not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capabilities”. As well-being stands for “the state of being happy, healthy, or prosperous” (Webster’s, 1969), evidently health will include physical health (healthy), mental health (happy), and social health (prosperous). Overall Health is achieved through a combination of physical, mental and social well-being, which together is commonly referred to as the Health Triangle.

The Alameda County Study examines the relationship between lifestyle and health. It has found that people can improve their health via exercise, enough sleep, maintaining a healthy weight, limiting alcohol use, and avoiding smoking. A major environmental factor affecting health is water quality, especially for the health of infants and children in developing countries. Studies show that in developed countries, the lack of neighborhood recreational space that includes the natural environment leads to lower levels of neighborhood satisfaction and higher levels of obesity; therefore, lower overall well being. Therefore, the positive psychological benefits of natural space in urban neighborhoods should be taken into account in public policy and land use.

According to the World Health Organization, the main determinants of health include the social and economic environment, the physical environment and the person’s individual characteristics and behaviors. Generally, the context in which an individual lives is of great importance on his life quality and health status. The social and economic environment are key factors in determining the health status of individuals given the fact that higher education levels are linked with a higher standard of life as well as a higher income. Generally, people who finish higher education are more likely to get a better job and therefore are less prone to stress by comparing to individuals with low education levels.

Prof. Meyer Fortes (1976) raise question that when one talks of the concept of health are we to concern ourselves with the concept of health as current in medical science (“etic” perspective) at a given phase of its scientific development in the world or the indigenous concept of health prevalent among each individual tribe or ethnic group (“emic” perspective). The concept of health according to the emic approach is a functional one, and not clinical. That is why a Kondh in Orissa having scabies, itches or ringworms s still considered to be capable of normal daily work like any normal healthy person. (Patnaik, 1973).

The **Lalonde report** is a 1974 report produced in Canada entitled *A new perspective on the health of Canadians*. It is considered the "first modern government document in the Western world to acknowledge that our emphasis upon a biomedical health care system is wrong and that we need to look beyond the traditional health care (sick care) system if we wish to improve the health of the public".

In the report, Marc Lalonde, who was the Canadian Minister of National Health and Welfare, proposed a new "Health Field" concept. He noted that the "traditional or generally-accepted view of the health field is that the art or science of medicine has been the fount from which all improvements in health have flowed, and popular belief equates the level of health with the quality of medicine". The new concept "envisage that the health field can be broken up into four broad elements: Human Biology, Environment, Lifestyle and Health Care Organization"; that is, determinants of Health existed outside of the health care system.

Health research findings increasingly suggest that behavioural and cultural factors on the one hand and material, environmental and structural factors on the other are interrelated and interdependent. **Hillary Graham's (1976; 1988)** work on young working class women who are regular smokers and have children under five indicates

that their smoking behavior arises regularly from their social circumstances. **Margaret Whitehead (1987)** gives another example, that of child accidents. The higher incidence of childhood accidents in lower social groups could be explained, she suggests, in terms of personal risk taking and parental neglect, but it could equally well be seen as the result of unsafe local environments which create supervision problems for parents. 'In later view, the environment is dictating the behavior of both mother and child' (Whitehead, 1987).

Society shapes people's health in four major ways: i. Cultural patterns define health. ii. Cultural standards of health change over time. iii. A society's technology affects people's health. iv. Social inequality affects people's health.

The Lalonde report suggests that there are four general determinants of health including human biology, environment, lifestyle, and healthcare services. Thus, health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society.

Raphael (2008) reinforces this concept: "Social determinants of health are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole. Social determinants of health are the primary determinants of whether individuals stay healthy or become ill (a narrow definition of health). Social determinants of health also determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment (a broader definition of health). Social determinants of health are about the quantity and quality of a variety of resources that a society makes available to its members.

The term “social determinants of health” grew out of researchers' search for the specific mechanisms by which members of different socio-economic groups come to experience varying degrees of health and illness. Everywhere, individuals of different socio-economic status show profoundly different levels of health and incidence of disease.

Another stimulus to investigating social determinants of health was the finding of national differences in population health. For example, the health status of Americans—using indicators such as life expectancy, infant mortality, and death by childhood injury rates—compares unfavorably to citizens in most industrialized wealthy nations. In contrast, the health status of Scandinavians is generally superior to that seen in most nations. It was hypothesized that perhaps the same factors that explain health differences among groups within nations could also explain differences among national populations.

A variety of approaches to the social determinants of health exist and all of these are concerned with the organization and distribution of economic and social resources among the population. The Ottawa Charter for Health Promotion identifies the prerequisites for health as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. Health Canada outlines various determinants of health—most of which are social determinants—of income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetics endowment, personal health practices and coping skills, healthy child development, gender, culture, and health services.

A British working group charged with the specific task of identifying social determinants of health named the social (class health) gradient, stress, early life, social

exclusion, work, unemployment, social support, addiction, food, and transport. And the U.S. Centers for Disease Control and Prevention highlight social determinants of health of socioeconomic status, transportation, housing, access to services, discrimination by social grouping (e.g., race, gender, or class), and social or environmental stressors.

The theories of Durkhiem, Marx and Weber offer valuable insights into contemporary issues of health work, such as the relationship between social structure, health status and health inequalities, and the nature of power relationships in health work organization. Weber's idea about bureaucracy have influenced current thinking about the nature of power relationships in health work organization .Their theories economic and social class cast a long shadow over most discussions of poverty, class and inequalities in health status. Functionalists' points out that health are essential to the preservation of the human species and organized social life. **Talcott Parson (1951)** expands on the functionalist position in his analysis of the **sick role**, a set of cultural expectations that define what appropriate and inappropriate behavior is for people with disease or health problem. Parson assumes illness must be socially controlled lest it impair societal functioning. He says one way societies contain the negative effects of health problems is through institutionalizing illness in a special role. **Marxists claim** that, although capitalism and professionalized medicine have improved standards of living, there is still glaring global and local inequalities in health- the social class gradients'- and there is still evidence of class conflict in health work. **Lesley Doyal (1979)** has argued that 'the way health and illness are defined, will vary according to the social and economic environment in which they occur.' Symbolic interactionists contend that "sickness" are culturally created meanings we attach to certain conditions.**Anselm Strauss (1963)** developed the concept of 'negotiated order' to describe the management of interactions between patients and staff in modern hospitals,

and **Strong (1979)** has written of the 'ceremonial order' that exists in clinic. **Erving Goffman in Stigma (1964)** explored how individuals understood and came to terms with their particular disabilities, and how they 'managed' and presented themselves in their relationships with others so that the dangers to self were minimized.

In the sociology of health and illness functionalist tradition have been prominent, in addition, conflict theories have questioned the whole interpretation of medicine and health work as naturally beneficent and Marxist critics, for example highlighted the links between capitalism and ill health.

Until 1960s the functionalist theories of Talcott Parsons (1902-79) dominated the field of health and illness in spite of all the criticism by other schools of thought. Talcott Parsons has a central place in medical sociology because he carried out major empirical research into the role of the medical profession in society. In particular he explored relationship between doctors and patients, and his findings informed his work on social structure. Parsons (1951) interpreted the role of medicine as a mechanism that was crucial to the smooth running of society. He conceptualized society as a system which had both 'instrumental' and 'expressive' needs. In instrumental terms there were evident economic and political imperatives: to continue to produce enough to satisfy people's physical needs and to create and maintain accepted authority systems. In expressive terms there existed social integration and cultural imperatives: to bind the 'societal community' together and to reproduce culture and tradition. Together these produced the four subsystems of modern, rational, achievement-oriented industrial society, a society in which role fulfillment and goal attainment were crucial for survival. The central role of medicine was to keep people healthy or, if they fell sick, to heal and reintegrate them into society as quickly as possible. Parsons' 'sick role' theory conceptualised medicine as a form of social control: that is, as a means by which

individual behaviour was modified and adapted to fit wider societal needs. Only by being healthy- fit enough to function – could individuals participate in society, and on their efficiency depended economic production and ultimately the society's survival.

Although Parsons (1951) was interested in several aspects of the management of illness, he is best remembered for his emphasis on the social importance of the sick role. Parsons stressed the motivation involved in being sick and getting better. That is, people have to decide that they are sick and in need of treatment. Since being sick means choosing to withdraw from the normal patterns of social behaviour, it amounts to a form of deviance, and hence the efficient functioning of the social system depends on the sick being managed and controlled. The role of medicine is to regulate and control those who have decided they are sick so that they can return to their normal tasks and responsibilities. In short, the sick role enquires a commitment on the part of those who feel unwell to return to normality as soon as possible.

Marx saw industrial capitalism as largely to blame for the unequal distribution of illness and disease, for the premature death of the labouring classes and for unequal access to health-protecting social conditions, such as decent housing, diet and wages. He and his fellow writer Friedrich Engels had no doubt that poverty and immiseration caused by early industrial capitalism was responsible for the heavy burden of working class sickness.

Conflict theorists have attacked functionalist theories of the role of medicine and society on two main grounds. First, the characterization of medicine as a benign and supportive social institution was questioned. Instead of seeing medicine as a profession which helped people in difficult areas of social life, doctors could be viewed as a self styled 'expert' group which monopolised not only the production of health and illness

but also the terms on which illness was experienced. It could not necessarily be assumed that medicine policed the boundaries of sickness with social consent.

Freidson (1970) argued that the medical profession had extended its monopoly over health and illness both through subordination or exclusion of other health work occupation such as nursing, and through control of the process of diagnosis, treatment and hospitalization. According to functionalists medical knowledge about illness was seen as paramount: people took their symptoms to be diagnosed, and doctors claimed neutral and objective status for their theories and classifications of disease. But Freidson argued that illness was actually negotiated initially through lay culture. Moreover, when patients presented themselves, doctors did not just diagnose; they were also involved in treating illness and therefore in creating meanings and frameworks of social knowledge which they could impose upon patients.

Lesley Doyal (1979) has argued that ‘the way health and illness are defined, as well as the material reality of disease and death will vary according to the social and economic environment in which they occur. Doyal comments that, while today’s National Health Service provides a very much better system of health care than in earlier stages of industrial capitalism, it is by no means ‘a socialist health service’. Rather it was ‘an important part of the post-war settlement between capital and labour’ which institutionalized class, race and gender inequalities for patients and workers.

Marxist theory is concerned with the way in which the dominant economic structure of society determines inequality and power, as well as shaping the relations upon which the major social institutions are built. Medicine is a major social institution, and in capitalist societies, it is shaped by capitalist interests. Marxist accounts of capitalist medicine have been developed by a number of sociologists and health policy analysts, notably Navarro (1985). According to Navarro, there are four features that

define medicine as capitalist, or as he puts it, that point to ‘the invasion of the house of medicine by capital’.

- Medicine has changed from an individual craft or skill to ‘Corporate Medicine’.
- Medicine has become increasingly specialized and hierarchical.
- Medicine now has an extensive wage-labour force (including employees in the pharmaceutical industry and related industrial sectors).
- Medical practitioners have become proletarianised, that is, their professional status has gradually been undermined as a result of administrative and managerial staff taking over responsibility for health care provision.

Marxists also claim that health problems are closely tied to unhealthy and stressful work environments. Rather than seeing health problems as the result of individual frailty or weakness, they should be seen in terms of the unequal social structure and class disadvantages that are reproduced under capitalism. Patterns of mortality and ill-health (morbidity) are closely related to occupation, especially in the case of the industrial working class. For example, industrial carcinogens (asbestos, heavy metals, chemicals and so on) are responsible for over 10 per cent of all male cancers. While accidents at work may be regarded as the result of human error, research has shown that they also reflect pressure on workers to complete tasks at speed in risk-laden environments (Tombs, 1990; Wright, 1994). Legislation to control hazards in the workplace has been introduced over the years, and this has reduced the rate of death, injury and illness among workers. However, such legislation can only be fully effective if it is policed properly, and in the UK there has been considerable under policing of sweatshops and similar workplaces. Moreover, Health and Safety Executive reports show that it has been difficult to reduce injury levels below a certain threshold,

suggesting that these statistical levels represent the structural – and not the accidental – character of occupational injury and mortality.

Navarro argues that medicine is in a state of crisis, in that its growth is matched by an increasing inability to meet society's needs. Despite more and more money being spent on health care, more and more people are experiencing the system as ineffective. The state's response has been to deflect attacks on the medical–industrial–state complex by declaring that health problems are the problem of the individual, and that any difficulty coping with this is not the fault of the system but of the individual. The individual must be taught to become a discerning consumer of medicine, to take out extensive (and expensive) private medical insurance, allowing the state to reduce the burdensome cost of universal medical provision. This latter strategy will cause problems for the medical–industrial complex, since a reduced state budget will hit the secure drugs market enjoyed by the pharmaceutical industry. According to the Marxist view, this is to be expected in medicine as elsewhere, since in late capitalism there is never complete coincidence between the interests of powerful corporations and those of the state. The danger for the state is that larger multinational corporations will seek secure markets and cheaper labour overseas, so reducing the overall contribution they make to the state's GNP.

Social-conflict analysis points out the connection between health and social inequality and, taking a cue from Karl Marx, ties medicine to the operation of capitalism. Researchers have focused on three main issues: access to medical care, the effects of profit motive, and the politics of medicine.

Health is important to everyone. Yet by requiring individuals to pay for medical care, capitalist societies allow the richest people to have the best health. Conflict theorist

argue that capitalist medical care provide excellent medical care for the rich but not for the rest of the population.

Some conflict analyst go further, arguing that the real problem is not access to medical care but the character of capitalist medicine itself. The profit motive turns physicians, hospitals, and the pharmaceutical industry into multibillion-dollar corporation. The quest for high profit encourages physicians to recommend unnecessary tests and surgery and to rely too much on drugs rather than focusing on the improvement of people's living condition.

Although science declares itself as politically neutral, scientific medicine frequently takes sides on important social issues. For example medical establishment always strongly oppose government medical care programs. The history of medicine itself shows how racial and sexual discrimination have been supported by 'scientific' opinions about, say inferiority of women (Leavitt, 1984). Consider the diagnosis of 'hysteria', a term that has its origin in the Greek word hyster, meaning "uterus." In choosing this word to describe a wild, emotional state, the medical profession suggested that being women is somehow the same as being irrational. Even today, according to the conflict theory, scientific medicine explains illness exclusively in terms of bacteria and viruses, ignoring the damaging effects of poverty.

Interactionism represents one of the most important and influential attempts to study human action 'in and on its own terms' rather than within a tradition of scientific positivism. The writings of George H. Mead and Charles Cooley have been seen as important in formulating some central interactionist concepts. The meaning that an individual attributes to particular situation will never be fully shared by others, because that individual will have a unique set of experience. But through the medium of language, Mead suggested, human beings learn to share symbols and attribute common

meanings to actions and situation. Interactionism seemed to liberate individuals from the dead weight of the 'social system'; it would also liberate nursing research, it was hoped, from domination by abstract and quantitative research traditions of natural science (Dingwall and McIntosh, 1978).

Anselm Strauss (1963) developed the concept of 'negotiated order' to describe the management of interactions between patient and staff in modern hospitals, and Strong (1979) has written of the 'ceremonial order' that existed in clinics. Erving Goffman (1964) explored how individuals understood and came to terms with their particular disabilities, and how they 'managed' and presented themselves in their relationships with others so that the dangers to self were minimised. Goffman (1961) then paints a grim portrait of a rigid and hierarchical 'total' institution for mental patients, but he also highlights how inmates adapted to and sometimes 'psyched out' or sabotaged the system.

According to symbolic-interaction approach, society is less a grand system than a complex and changing reality. In this model, health and medical care are socially constructed by people in everyday interaction. If both health and illness are socially constructed, people in a poor society may view hunger and malnutrition as normal. Similarly many members of our own society give little thought to the harmful effects of a rich diet. Applying sociologist W.I.Thomas' theorem '*Social interaction in Everyday Life*', we can say that once health or illness is defined as real, it can become real in its consequences.

Social constructionism can be seen as one strand in the postmodernist enquiry into meaning, subjectivity and the rest of social reality. The question of 'how we know what we know' and the focus on social reality as essentially contested have become marked features of accounts in medical sociology. Social constructionism treats all

medical knowledge as problematic: what have been thought of as biological realities, such as diseases, come under review. As Wright and Treacher (1982) comment, we then go on to ask ‘how should it be that certain areas of human life come – or cease – to be regarded as “medical” in particular historical circumstances’. Some researchers have answered this by exploring how the fabrication of disease categories or other types of medical knowledge have served the interest of particular groups in society. For example, Figlio (1982) argues that the battle to construct ‘miners nystagmus’ as a disease category mirrored the class struggle in early twentieth century Britain.

Michel Foucault’s account of the fabrication of the human body has influenced sociologists in the field of health, particularly in relation to the thinking about the role of science and the development of medical practice. Foucault (1973) argues that the human body as we know it is not natural but has been fabricated through a ‘clinical gaze’. By this he means a particular way of ‘seeing and knowing’ the body associated with modern biomedicine. The clinical gaze, Foucault argues, obliterated earlier ways of seeing and knowing the body, but it is only one way of conceptualizing bodies. It might itself be replaced in the future by some new ‘truth’.

The modern way of thinking about ourselves – as individuals, free agents, autonomous human beings – has been brought into being by human sciences. David Armstrong (1983, 1993), who has applied Foucault’s ideas about medical knowledge to the twentieth century, notes that patients came and participate much more in monitoring and treatment. Indeed, by 1950s patients had become partners in health work, which moved beyond the hospital.

Public health reflects key ideological debates regarding the freedom of the individual, the authority of the state and the balance between individual and collective responsibilities (Mills and Saward, 1993). Three broad ideological perspectives are

relevant here: collective/socialism; individualism/libertarianism; and environmental/green ideology.

Collective and socialists place great emphasis on the role of the state and other collective arrangements (such as voluntary mutual societies and co-operative efforts) and are highly critical of self-centered individualism. In the early twentieth century associated with the work of social reformers such as Sidney and Beatrice Webb of the Fabian Society. Fabians argued that social problems could be solved through collectivism: that is, state intervention and collective provision of welfare services. They (collectivists) are particularly cynical about the ability of isolated individuals to produce their own solutions to complex social problems. There are certainly some foundations for this cynicism in the field of public health, where, according to Rose (1985), a preventive measure which brings much benefits to the population offers little to each participating individual'. This 'prevention paradox' implies that, left to their own devices, individuals have little incentive to contribute towards activities that improve public health. Collectivists have long argued that state intervention is the principal means of social improvement (Berki, 1975, Crick, 1987). The broader definition of public health certainly justifies a key role for the state in protecting citizens' health while providing a rationale for specific health policy interventions. From a collectivist standpoint, this includes ameliorating the health-damaging consequences of individualism and tackling the socio-economic causes of ill health generated by capitalism (Navarro, 1976; Doyal, 1979; Allsop, 1990). Indeed, as Beauchamp (1988) has argued, the protection of health depends in part on preventing the market from invading other sphere. Finally, socialist and collectivist perspectives on liberty (Green, 1990; Berlin, 1969) are given greater weight than negative liberty, the freedom from interference. Positive liberty concerns the extent to which individuals are in control of

their own fate and free from circumstances that limit their opportunities. Hence state interventions and collective actions can be justified on the grounds that such restrictions actually empower individuals to take control of their lives and make informed choices.

The liberal individualist perspective places a much greater emphasis on negative liberty, the freedom to pursue one's activities without interference from the state, providing others are not harmed as a result (Berlin, 1969; Mill, 1974). Those adopting this perspective argue that the collectivist state is not a benign or even neutral force, but a hostile entity that coerces and disempowers citizens (Hayek, 1976, 1988). They argue that individuals are in greater need of protection from the state than from the vagaries of the market. Individual liberty can be saved only by strengthening the market sphere and increasing self-reliance among ordinary citizens. Specifically in relation to public health, liberal individualist argue it is unfair for majority of individuals to sacrifice their personal freedom for an illusory common good. Proponents of this view call for an increase in individual responsibility for health and believe that individuals should make their own informed choices rather than be told what to do by the 'nanny state' or the 'food and drink police' (Bennett and DiLorenzo, 1999; Appleyard, 1994). Echoing Illich (1997) perceives a medicalisation process whereby the medical profession seeks to extend its expertise to other spheres of social and economic life. Liberal individualists are particularly fearful of the incorporation of such expertise into government, leading to the creation of an 'expert bureaucracy' that can dictate to and dominate individuals.

Those adopting a green perspective oppose the destructiveness of industrial society, in particular its pursuit of economic growth at any cost. They reject both the previously discussed ideologies, although they are arguably closer to the socialist/collectivist perspective, particularly in relation to concepts of social justice and the countervailing power of collectivism (Ryle, 1988). They place an emphasis on the

role of individuals and small, local groups in promoting a sustainable environment (Porritt and Winner, 1989; Dobson, 1990). However, as Adams (1993, p. 318) has observed, ‘ while there is a good deal of consensus about what Greens are against, there is much less agreement about what Greens are for’. There are in practice many shades of greens, which differ considerably in their aims, ideas and prescriptions for change. Green perspective adopted an ecological model of health (Hancock, 1985; Draper, 1991; Pietroni, 1991). This places an emphasis on the complex and multiple sources of illness arising from the environment in which people live. In particular mankind’s interaction with the natural environment and other species is seen as crucial factor in the maintenance of health. Hence many of the health problems of our time, such as food borne diseases linked to pollution are viewed as a product of the human exploitation of the environment. Greens believe that the social and economic structure of industrial society is also damaging in view of its tendency to create unhealthy lifestyles and working patterns, as well as to produce socio-economic inequalities that undermine health. They argue for sustainable development, balancing economic, social and environmental consideration. They also support ‘precautionary’ principles-believing that early intervention on the basis of limited information, rather than waiting for concrete evidence of irreversible and widespread harm, is warranted to prevent serious damage to environment and health (O’ Riordan and Cameron, 1994).

Medical Sociology

The name *medical sociology* garners immediate recognition and legitimacy and, thus, continues to be widely used—for instance, to designate the Medical Sociology Section of the American Sociological Association—even though most scholars in the area concede that the term is narrow and misleading. Many courses and texts, rather than using the term “sociology of medicine,” refer instead to the sociology of health, health

and health care, health and illness, health and medicine, or health and healing. The study of medicine is only part of the sociological study of health and health care, a broad field ranging from (1) *social epidemiology*, the study of socioeconomic, demographic, and behavioural factors in the etiology of disease and mortality; to (2) studies of the *development and organisational dynamics* of health occupations and professions, hospitals, health maintenance and long-term care organisations, including inter-organisational relationships as well as interpersonal behavior, for example, between physician and patient; to (3) the *reactions of societies* to illness, including cultural meanings and normative expectations and, reciprocally, the reactions of individuals in interpreting, negotiating, managing, and socially constructing illness experience; to (4) the *social policies, social movements, politics, and economic conditions* that shape and are shaped by health and disease within single countries, as well as in a comparative, international context.

The rise of contemporary medical sociology can be traced back to the immediate post-World War II period, when science and medicine were dominant cultural forces, fueling a modern optimism that many of society's ills could be eliminated. Several key contributions during the 1950s gave credibility and spurred scholarly interest in the newly developing subfield. Koos's *The Health of Regionville* (1954) and Hollingshead and Redlich's *Social Class and Mental Illness* (1958) addressed the connections between social circumstances and health status, and were instrumental in establishing a strong tradition of sociological research focusing on the social determinants of health. The finding that individuals in the lower socioeconomic levels of society experience greater morbidity and mortality has turned out to be one of the most consistent of these patterns. Also during this time, a number of sociology's most prominent theorists turned their attention to health and health care. They approached the topic not because their

primary interest was in health care or medicine, but out of a generic interest in authority and the maintenance of social order. Robert Merton, Everett Hughes, and Anselm Strauss all studied professional organisations and socialisation during the 1950s, focusing primarily on physicians and the process of medical education (Merton et al. 1957; Becker et al. 1961).

The theoretical work of the 1950s most influential for medical sociology was undoubtedly Talcott Parsons's *The Social System* (1951). In it, Parsons recognised illness as a major threat to the stability and productivity of societies and introduced the "sick role" concept to describe the social regulation of sickness and explain the mechanism through which individuals are induced to return to productive activity. Parsons argued that because sick persons were unable to perform their expected social roles, they were subject to being negatively sanctioned. On the other hand, if they had not intended to become ill and were motivated to get well, then, according to Parsons's analysis, they could claim and be granted temporary exemption without blame from normally expected role responsibilities. Rather than being held accountable for failure to perform, they would be excused as sick. Parsons's work generated enormous sociological interest because of its analysis of illness and medical care in terms of their broad social consequences and because of its focus on the structure and functions of social roles. His work also expanded the theoretical foundations of medical sociology by provoking equally compelling work from contrasting perspectives. Elliot Freidson in *Profession of Medicine* (1970) analysed the dominance of the medical profession, suggesting that power relations in health care were fundamentally contentious. He saw physicians as rising to dominate health care through a process of struggle with competitors in which they prevailed largely because they gained the support of political institutions, limiting the role of competing occupations. In contrast to the fixed roles in

structural functional theory, Freidson argued that illness definitions and illness behaviour were socially constructed through a process of negotiation. The debate over structure and agency represented in these early contributions laid theoretical pathways for subsequent scholarship and solidified medical sociology's ties to some of the central issues of the discipline.

Medical sociology became established in only a few sociology departments during its early years, typically in elite universities. It was not until the 1970s that most graduate departments of sociology began to offer medical sociology. Today, sociology courses on health and medicine can be found in nearly every graduate program in the United States as well as in many other nations, notably the United Kingdom and Germany (Bloom 1986). Research funding to support the growth of medical sociology in many countries has come from government sources. In the 1960s and 1970s, U.S. medical sociology expanded in part because social science research was held in favor by the federal government as well as by influential private foundations. Major funding sources at that time included the National Institute of Mental Health (NIMH) and, later, the National Center for Health Services Research (NCHSR).

It has been argued that the fortunes of medical sociology have shifted in relation to the social medical environment (Pescosolido and Kronenfeld 1995). Until the 1980s, medical sociology experienced relatively fertile conditions due in part to the fact that the health care system was dominated by professional medicine. Access to health care was the primary health policy concern, while research funding priorities focused on the biomedical and psychosocial aspects of disease, disease prevention, and patient care. This environment encouraged medical sociologists to pursue quantitative research, including surveys, national-level studies, and multivariate statistical models that predicted utilization of health services and the effects of risk factors and other variables.

Two particular lines of medical sociology research gained prominence as a result of this focus. The first involved researchers studying utilisation patterns for health services. There were two groups, each using a somewhat different explanatory model. Marshall Becker and his colleagues employed the Health Belief Model, a cognitive framework originated by Rosenstock (1966) and eventually applied in research, to explain a wide variety of preventive and health-related behaviours (Becker and Maiman 1975). Ronald Andersen developed the somewhat broader sociobehavioural model (1995), which included health beliefs but also emphasised economic factors and health needs. The second line of research concerned quantitative studies of social stress. David Mechanic, one of the founders of medical sociology, pioneered sociological research on stress and mental health as early as the 1960s (Mechanic and Volkart 1961). The “stress process” group that emerged in the late 1970s, however, was closer to an interface of psychology and sociology. Using multivariate analyses, they examined the relationships among stress (Aneshensel 1992), social support (Turner and Marino 1994), and coping (Pearlin and Schooler 1978). Much of this research was published in the American Sociological Association’s *Journal of Health and Social Behavior*, beginning in the late 1970s and continuing into the present (Thoits 1995).

The social-medical environment in the United States changed dramatically in the 1980s, threatening the autonomy and authority of physicians (Starr 1982). The federal government’s increasing role in financing health care (through the Medicare and Medicaid programs) combined with rapidly escalating health care costs and the concern expressed by business, leading to a major federal policy shift. Rather than inequality in access and social factors in illness, public policy attention was now placed on cost control and the cost effectiveness of care. NIMH support for medical sociology was weakened, and soon afterward, the NCHSR became the Agency for Health Care Policy

and Research with an agenda of research focused on managed care and evidence-based medicine. Research funding priorities gravitated from the behavioural and social sciences to economics and clinical medicine and epidemiology. No doubt these changes contributed to critical claims in the late 1980s and the 1990s, that medical sociology research had become fragmented. Today, there is greater understanding of the links between basic sociological theory and medical sociology (Gerhardt 1989). Medical sociology concepts such as “Medicalisation” have added to the broader understanding of social order and social control (Conrad 1992). Medicine and the other health care disciplines recognize sociology as a valuable discipline that can contribute much to the understanding and application of health care. Academic sociology has come to regard the sociology of medicine as a fruitful area of specialization

It is in their role of social critic that medical sociologists encounter the greatest resistance from mainstream medicine and health care. Critical medical sociology emerged from both Marxist and social constructionist traditions within the discipline (Waitzkin 1989; Brown 1995). Symbolic interactionists and labeling theorists in the 1960s saw that, despite the Parsonian notion of the sick role, many types of illness and disability were responded to socially as forms of deviance. Goffman’s concept of stigma (1963) explored the relationship between labeling and identity as a process of managing spoiled identity. One of the most powerful explanatory concepts in medical sociology, stigma has been used for decades to capture the experience of mental illness, alcoholism, physical disability, and many types of chronic illness.

Goffman (1961) and Zola (1972), among others, turned the standard notion of medical care as a service on its head by arguing that medicine functions as an institution of social control. Despite strong micro-sociological interest in the social construction and social consequences of medical labels (i.e., diagnoses), the professional power of

physicians made it exceedingly difficult for sociologists to study these processes until the 1980s. What could be studied, however, using the broader, cultural meaning of social construction, were processes of medicalisation. Building on the social control perspective of Zola and others, a number of studies examined the processes through which nonmedical phenomena such as childbirth, excessive drinking, children's active behaviour, and menstrual distress—became medical phenomena, with diagnostic criteria and specific medical treatments.

Gender analyses, especially those from a feminist perspective offered a critical, alternative perspective on the medical profession (Lorber 1984) and the health care system (Zimmerman and Hill 1999), as did research on the women's health movement (Ruzek 1978; Weisman 1998). This work examined the relationship between cultural ideas about gender, medical knowledge, and gender stratification systems; pointed out that the division of labor in medicine is also a gendered division of labor; and observed that the factors that often make women sick are linked to their social roles and disadvantaged social circumstances. Other critical perspectives were offered by disability researchers (Zola 1982) and by researchers focusing on the health and health care of racial and ethnic minorities (Hill 1992; Williams and Collins 1995).

A decisive event took place in medical sociology in 1951 that provided a theoretical direction to a formerly applied field. This was the appearance of Parsons' *The Social System*. This book, written to explain a complex structural functionalist model of society, contained Parsons' concept of the sick role. Parsons had become the best known sociologist in the world and having a theorist of his stature provide the first major theory in medical sociology called attention to the young sub discipline – particularly among academic sociologists. Anything he published attracted interest. Not only was Parsons' concept of the sick role a distinctly sociological analysis of sickness,

but it was widely believed by many sociologists at the time that Parsons was charting a future course for all of sociology through his theoretical approach. This did not happen. Nevertheless, Parsons brought medical sociology intellectual recognition that it needed in its early development by endowing it with theory. Moreover, following Parsons, other leading sociologists of the time such as Robert Merton and Erving Goffman published work in medical sociology that further promoted the academic legitimacy of the field.

The next major area of research after Parsons developed his sick role concept was medical education. Merton and his colleagues (1957) extended the structural functionalist mode of analysis to the socialisation of medical students, with René Fox's paper on training for uncertainty ranking as a major contribution.

During the 1960s, the symbolic interactionist perspective temporarily dominated a significant portion of the literature. One feature of this domination was the numerous studies conducted with reference to labeling theory and the mental patient experience. Sociologists expanded their work on mental health to include studies of stigma, stress, families coping with mental disorder, and other areas of practical and theoretical relevance. For example, Goffman's *Asylums* (1961), a study of life in a mental hospital, presented his concept of "total institutions" that stands as a significant sociological statement about social life in an externally controlled environment. An abundant literature emerged at this time that established the sociology of mental disorder as a major subfield within medical sociology (Cockerham 2006).

Between 1970 and 2000 medical sociology emerged as a mature sociological sub discipline. This period was marked by the publication of two especially important books, Eliot Friedson's *Professional Dominance* (1970) and Paul Starr's *The Social Transformation of American Medicine* (1982). Friedson formulated his influential "professional dominance" theory to account for an unprecedented level of professional

control by physicians over health care delivery that was true at the time but no longer exists. Starr's book won the Pulitzer Prize and countered Friedson's thesis by examining the decline in status and professional power of the medical profession as large corporate health care delivery systems oriented toward profit effectively entered an unregulated medical market. Donald Light (1993) subsequently used the term "countervailing power" to show how the medical profession was but one of many powerful groups in society – the state, employers, health insurance companies, patients, pharmaceutical and other companies providing medical products – maneuvering to fulfill its interests in health care.

Another major work was Bryan Turner's *Body and Society* (1984), which initiated the sociological debate on this topic. Theoretical developments concerning the sociological understanding of the control, use, and phenomenological experience of the body, including emotions, followed. Much of this work has been carried out in Great Britain and features social constructionism as its theoretical foundation. Social constructionism has its origins in the work of the French social theorist Michel Foucault and takes the view that knowledge about the body, health, and illness reflects subjective, historically specific human concerns and is subject to change and reinterpretation. Other areas in which British medical sociologists have excelled include studies of medical practice, emotions, and the experience of illness. Medical sociology also became a major sociological specialty in Finland, the Netherlands, Germany, Italy, Spain, and Israel, and began to emerge in Russia and Eastern Europe in the 1990s after the collapse of communism. In the meantime, the European Society for Health and Medical Sociology was formed in 1983 and hosts a biannual conference for European medical sociologists. In Japan, the Japanese Society for Medical Sociology was established in 1974 and, since 1990, has published an annual review of work in the field. Elsewhere in

Asia, medical sociology is especially active in Singapore, Thailand, and India, and is beginning to appear in China. In Africa, medical sociology is strongest in South Africa. Medical sociology is also an important field in Latin America, and because of its special Latin character, many practitioners prefer to publish their work in books and journals in Mexico, Brazil, Argentina, and Chile (Castro 2000). From the 1970s through the 1990s, medical sociology flourished as it attracted large numbers of practitioners in both academic and applied settings and sponsored an explosion of publications based upon empirical research. Major areas of investigation included stress, the medicalisation of deviance, mental health, inequality and class differences in health, health care utilization, managed care and other organisational changes, AIDS, and women's health and gender. Several books, edited collections of readings, and textbooks appeared. The leading reader was edited by Peter Conrad and Rochelle Kern in 1981 and is now in a seventh edition (2005), with Conrad the sole editor. The leading textbook was William Cockerham's *Medical Sociology*, first published in 1978 and due to appear in a tenth edition in 2007. Another major medical sociology journal, the *Sociology of Health and Illness*, was started in Britain in 1978, as was a new journal, *Health*, in 1999. However, the success of medical sociology also brought problems in the 1980s. Research funding opportunities lessened and the field faced serious competition for existing resources with health economics, health psychology, medical anthropology, health services research, and public health. Not only did these fields adopt sociological research methods in the forms of social surveys, participation observation, and focus groups, some also employed medical sociologists in large numbers. While these developments were positive in many ways, the distinctiveness of medical sociology as a unique sub discipline was nevertheless challenged as other fields moved into similar areas of research. Furthermore, some of the medical sociology programs at leading American universities had declined or disappeared over time as practitioners retired or were hired

away. Yet the overall situation for medical sociology was positive as the job market remained good, almost all graduate programs in sociology offered a specialisation in medical sociology, and sociologists were on the faculties of most medical schools in the United States, Canada, and Western Europe (Bloom 2002). The 1990s saw medical sociology move closer to its parent discipline of sociology. This was seen in a number of areas, with medical sociological work appearing more frequently in general sociology journals and the increasing application of sociological theory to the analysis of health problems. The American Journal of Sociology published a special issue on medical sociology in 1992, and papers on health related topics are not unusual in the American Sociological Review. While medical sociology drew closer to sociology, sociology in turn moved closer to medical sociology as the field remains one of the largest and most robust sociological specialties.

Health, Illness and Medicine: A Global Perspective

According to Turner (1987), the global patterns of morbidity and mortality are converging, with cancer, strokes and heart disease pre-dominating whatever the national context. Similarly, there has been a globalization of the institutional responses to the demand for health care, that is, highly bureaucratic, 'rational' systems of medical delivery that go beyond national boundaries. Finally, as a feature of modernity common to all industrialized states, medicine is playing an important scientifically and professionally grounded role as a regulator of individual and collective bodies in all societies.

The globalisation of common forms of medical practice and their associated technologies – such as scanning devices, the paraphernalia of intensive care units and so on – reflects the existence of an international network of medical practitioners who share similar requirements and standards. It also reflects the way in which modernity has

encouraged the standardization of technologies and instruments (not only in medicine but also elsewhere). In addition, the communication and information technologies that are crucial to the globalisation process are playing a growing role in medical science and medical practice. In the field of medical research, access to international databases is important for keeping up with new developments and exchanging information quickly in standardized formats, as in the Human Genome Project. From practitioners' perspectives, the digitalization of patients' records allows doctors to discuss cases over the Internet without meeting the patient. Not only does this encourage greater international standardisation of symptomatology and diagnosis, it also opens up intriguing questions about doctor– patient relations and the continuing relevance of the bed-side manner.

At the same time, the globalisation process has prompted resistance at the local level. For example, transnational pharmaceutical companies have had their global dominance checked by small competitor companies in Southern states that are keen to cut their health care bills. Moreover, indigenous or traditional forms of medicine in Africa, Asia and the Pacific Rim countries are still popular and are often practiced alongside modern medicine: indeed, in China, this was openly advocated by the government until recently. Even in Western societies, alongside alternative medicine there are lay remedies for coping with illness – such as ‘feed a cold and starve a fever’ – and prescriptions for remaining healthy, such as ‘don't go out with your hair wet’. It is doubtful whether either of these are global injunctions.

Health Services in India:

The History of the health services in India provides an account of the influence of such forces in giving shape to it. Henry Seigerist (Marti-Ibanez, 1960) has drawn attention to this important aspect by contrasting the manifestly high standards of environmental

sanitation of the Indus Valley period with the level of sanitation that exists in India today.

Health Practices in India: Health Practices in Ancient India

Describing the five-thousand-year old planned city of Mohenjo Daro, (Marshall, 1931) has remarked that the public health facilities of the city were superior to those of all other communities of the ancient Orient. Almost all households had bathrooms, latrines, often water closets and carefully built wells. The elaborate nature of the Indus Valley public health organisation provides an indication of the extent of health consciousness among the ancient Indian people. The Vedic medicine that developed after the advent of Aryans to the Indus Valley (during the second millennium BC) had begun to show a tendency to develop rational methods of approaching health problems at quite an early stage.

Indian medicine is very ancient and the earliest concepts are spelled out in the Veda, especially the Atharvaveda which dates as far back as the 2nd millennium B.C. Use of magical practices and charms was common long before the Vedic period, Carak-samhita and Susruta-samitha, authored by physicians and a surgeon respectively, due to their antiquarian origins caused claims of superiority over the Greek counterpart which influenced western medical system. (Encycl.Brit., 1975:823-841). Underwood & Rhodes (2008) hold that this early phase of traditional Indian medicine identified 'fever (takman) cough, diarrhea, dropsy, abscesses, seizures, tumours, and skin diseases (including leprosy)'. The *Charaka Samhita* text is arguably the principal classic reference. It gives emphasis to the triune nature of each person: body care, mental regulation, and spiritual/consciousness refinement. The observance of religious beliefs Hindu society hygienic measure always received much importance. Religious observances were, and still are in consonance with general principles suggested in

Ayurvedic medicine. The Chinese pilgrim Fa Hsien (ca. 337–422 AD) wrote about the health care system of the Gupta Empire (320–550) and described the institutional approach of Indian medicine, also visible in the works of Charaka, who mentions a clinic and how it should be equipped. Madhava (fl. 700), Samgadhara (fl. 1300), and Bhavamisra (fl. 1500) compiled works on Indian medicine. The medical works of both Sushruta and Charaka were translated into the Arabic language during the Abbasid Caliphate (ca. 750). These Arabic works made their way into Europe via intermediaries. In Italy, the Branca family of Sicily and Gaspare Tagliacozzi (Bologna) became familiar with the techniques of Sushruta.

British physicians traveled to India to see rhinoplasty being performed by native methods. Reports on Indian rhinoplasty were published in the Gentleman's Magazine in 1794. Joseph Constantine Carpue spent 20 years in India studying local plastic surgery methods. Carpue was able to perform the first major surgery in the western world in 1815. Instruments described in the *Sushruta Samhita* were further modified in the Western World. Furthermore, there exists the famous decree of Emperor Ashoka Maurya in his second Rock Edict (257-236 BC) “celebrating the organisation of social medicine shaped by Emperor along the lines of Buddhist thought and kindred ethics (dharma)” (Zimmer, 1948). The works of the famous Chakra of the first century AD laid the foundation of the highly developed science of medicine which flourished in the tenth century after Christ—a period of all-round social and economic progress, often called the age of Indian Renaissance.

Yunani

Greek and Arabic, generally referred to as Mediterranean medicine which is based on the teachings of Greek physician Hippocrates, and Roman physician Galen, and developed into an elaborate medical System by Arab and Persian physicians, such

as Rhazes, Avicenna (Ibn Sena), Al-Zahrawi, and Ibn Nafis. Unani medicine is based around the concepts of the four humours: Phlegm (Balgham), Blood (Dam), Yellow bile (Şafra') and Black bile (Sauda'). It came to India late and its impact was conspicuous by 1200 A.D or the time of the Muslim rule. It was known as Yunani-Tibbia in Arabic (Greek medicine) and was initially confined to the Muslim population. Among the founder of this school of medicine were Hippocrates and Galen from Greece, Rhazes Avicenna from Persia, Abu al-Qasim (Albucasis Maimonides), a Jew from Arabic and Salerno from Southern Italy. Incidentally, all of these men advanced and used humoral theories composed of four humors: yellow bile, black bile, phlegm, and blood, which paralleled the three humors of Ayurveda. In India, Unani system of Medicine was introduced by Arabs and soon it took firm roots in the soil. When Mongols ravaged Persian and Central Asian cities like Shiraz, Tabrez and Galan, scholars and Physicians of Unani Medicine fled to India. The Delhi Sultan, the Khiljis, the Tughlaqs and the Mughal Emperors provided state patronage to the scholars and even enrolled some as state employees and court physicians. During Akbar's period the Unani medicine system spread all the way through the greater part of India. During the 13th and 17th Century Unani Medicine had its hey-day in India. Among those who made valuable contributions to this system into period where Abu Bakr Bin Ali Usman Ksahani, Sadruddin Damashqui, Bahwa bin Khwas khan, Ali Geelani, Akbal Arzani and Mohammad Hashim Alvi Khan.

Homeopathy

European medicine, probably, found its way to India long before the English established the East India Company in 1500; there were Dutch, French and Spanish travelers and missionaries prior to the 5th century. Alexander the Great invaded India (Punjab) as early as 327-325 B.C. The ascent to paramountcy of the British at the turn of the 19th

century eventually resulted in, among several significant changes, creation of a class of professionals including physicians and surgeons who had to undergo training at approved institutions in India including some fortunate ones who were sent to England. Apart from allopath, another system of medicine of European origin, homeopathy, came to India sometime in the 17th century. Homeopathy deals with treatment of disease by the administration of tiny doses of a drug that in healthy persons causes symptoms resembling those of the disease treated. Paracelus (Encycl.Brit., 1975:982-984) is acknowledged to be the founder of homeopathy. Though homeopathy came to India with the advent of Europeans, it never gained much popularity for various reasons including the state of patronage, availability of drugs, exclusion of surgical procedures and tanning of medical personnel. Though in many ways it remained complementary and an alternative to Ayurveda, Yunani and Allopathy, it was never properly ingrained in the system like others and remained quite esoteric in its application and usage.

The history of western medicine in India dates back to 1600, when the first medical officer arrived in India along with the British East India Company's first fleet as ship's surgeons. In 1757, the East India Company established its rule in India, which leads to the development of civil and military services. A medical department was established in Bengal as far back as 1764, for rendering medical services to the troops and servants of the Company. Evolution of public health system during the colonial period followed the same path that was followed in Britain. Public health efforts were focused largely on protecting British civilians and army cantonments. Sanitation was given the top priority. Focus was also on early detection and control of contagious diseases – cholera and plague.

Restriction of public health efforts to British civilians and military established was a major constraint. Majority of Indian masses remained deprived of the dividends of

these efforts. At the time of Independence only 3 per cent households in India had toilets. Water, drainage and waste disposal services were utterly lacking. Although, public health efforts were restricted to British civilian and military establishment, they had impact on Indian masses. Mortality spikes were sharply reduced. Mortality from cholera and plague was sharply reduced. Diseases like malaria and gastro-enteritis continued to take heavy toll.

With more than one billion people, India is the second most populous country in the world accounting for 17% of the world's population. Following independence, India has pursued a policy of planned economic development until the early 1990s, when it shifted to structural adjustment policies and liberalisation. Subsequently, the Indian economy grew at a fast rate though concerns on equity and poverty persist. The country has recently become one of the world's fastest growing economies with an average growth rate of over eight percent in last three years. At the same time, new public health challenges have emerged in the form of changing demographics and environmental conditions; emerging infectious diseases and anti-microbial resistance, behavioral issues influencing health and the increasing focus on non-communicable diseases. Globalisation and trade agreements, technological advances in genetics and medicine, and health informatics hold forth the potential for more rational, evidence-based management in health care.

The health system in India has witnessed major changes in public health in the recent decades. Post independence, the country has made significant strides on many health fronts and these must be rightfully acknowledged such as increased life expectancy, reduction in maternal and infant mortality and eradication of smallpox. However, the country is still far from achieving its population health goals. Furthermore, extremely low levels of public health spending and low performance on

key health indicators places India at a considerable disadvantage in comparison with many of its Asian neighbours. High levels of maternal mortality, infant and child mortality and malnutrition continue to plague many parts of the country, coupled with significant variations across states. Together with maternal and newborn conditions, communicable diseases including HIV, TB, malaria, diarrhea and acute respiratory infections account for nearly half of India's disease burden. HIV surveillance indicates that around 5 million persons between the productive ages of 15 and 49 are currently infected. Even at modest growth projections, this figure is estimated to increase to 15-19 million by 2015, and 50 million by 2025 (GOI, NCMH, 2005). Non-communicable conditions like cancers, cardiovascular disease, diabetes, COPD and mental health conditions account for the second largest share of the disease burden, now and in the future. Blindness and oral health conditions are also expected to increase sharply over the next decade (GOI, NCMH, 2005). The pressure of a burgeoning population, 72% of which is rural, with widespread illiteracy and social deprivation, pose a formidable challenge for the health sector's functioning. Added to this is the response that is needed, in times of disaster and during sudden unexpected outbreaks of disease.

Evolution of public health care system in Independent India was shaped by two important factors: The Report of First Health Survey and Development Committee (*Bhore Committee*) constituted during the colonial rule; Emergence of modern medical technology for the prevention and control of diseases, especially communicable diseases. Appointed in 1943 the *Bhore Committee* recommended comprehensive remodeling of health services. The recommendations of Bhore Committee and the availability of preventive and curative medical technology resulted in the evolution of hospital-based public health system. The public health arrangements created during the colonial period were replaced by hospitals and health centres. Public health services

were merged with the medical services.

With the beginning of health planning in India and first five-year plan formulation (1951-55), Community Development Programme was launched in 1952 for the all-round development of rural areas, where 80% of the population lived. Community Development was defined as "a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance upon the community's initiative". The Community Development Programme was envisaged as a multipurpose programme covering health and sanitation (through the establishment of primary health centres and subcentres) and other related sectors including agriculture, education, transport, social welfare and industries. Each Community Development Block (CDB) comprised approximately 100 villages with a total population of one lakh. For one CDB, one Primary Health Centre was created. By the close of second five year plan (1956-61), "Health Survey and Planning Committee", The Mudaliar Committee, was appointed by the Government of India to review the progress made in the health sector after submission of Bhole committee report. The major recommendation of this committee report was to limit the population served by primary health centres to 40,000 with the improvement in the quality of health care provided by these centres. Also, Provision of one basic health worker per 10,000 populations was recommended. The Jungalwalla Committee in 1967 gave importance to integration of health services. Integrated health services were defined as "a service with a unified approach for all problems instead of a segmented approach for all different problems". The committee recommended integration from the highest to lowest level in the services, organisation and personnel. The Kartar Singh Committee on Multipurpose workers in 1973 laid down the norms about health workers. For ensuring proper coverage the committee recommended, one primary health centre to

be established for every 50,000 population. Each primary health centre to be divided into 16 sub-centres each for a population of 3,000 to 3,500. Each sub-centre to be staffed by a team of one male and one female health worker. The work of 3-4 health workers is to be supervised by one health assistant. The Shrivastav Committee on Medical Education and Support Manpower in 1975 suggested creation of bands of Para-professional and semi-professional health workers from within the community (e.g. school teachers, post masters etc.). It also recommended the development of a "Referral Service Complex" by establishing linkages between the primary health centre and higher level referral and service centres, viz taluka/ tehsil, district, regional and medical college hospitals. Following the suggestions of the Shrivastav committee report, Rural Health Scheme was launched in 1977, wherein training of community health workers, reorientation training of multipurpose workers, and linking medical colleges to rural health was initiated. Also to initiate community participation, the Community Health Volunteer-Village Health Guide (VHG) Scheme was launched. The VHG was to be a person from the village, mostly women, who was imparted short term training and small incentive for the work.

In 1978, together with 134 governments and 67 other agencies India signed the Alma Ata Declaration which launched the concept of Health for all by year 2000. The Report of the Study Group on "Health for All - An Alternate Strategy" commissioned by ICSSR and ICMR (1980) argued that most of the health problems of a majority of India's population were amenable to being solved at the primary health care level through community participation and ownership. The report recommended the formulation of a comprehensive national health policy through an inter-sectoral approach that includes environment, nutrition, and education, socio-economic, preventive, and curative dimensions. The Report of the Working Group on "Health for

All by 2000 AD", also examined the contextual issues in providing health care. The report set out health targets to be achieved by 2000 AD for which existing health services and manpower had to be increased substantially.

The responsibility of the state to provide comprehensive primary health care to its people as envisioned by the Alma Ata Declaration led to the formulation of India's 1st National Health Policy (NHP) in 1983. The major goal of policy was to provide of universal, comprehensive primary health services. The policy emphasised the role that could be played by private and voluntary organisations working in the country to support government for integration of health services.

The National Population Policy (NPP) was announced in the year 2000, the overarching policy framework for family planning and maternal and child health goals, objectives and strategies. The immediate Objective of NPP was to address the unmet needs of contraception, health care infrastructure, and health personnel, and to provide integrated delivery for basic reproductive and child care services. It envisaged development of one-stop integrated and coordinated service delivery at the village level for basic reproductive and child health services through a partnership of the government with voluntary and non-governmental organisations.

Nearly twenty years after the first health policy, the IInd National Health Policy (2002) was formulated. The NHP 2002 recognised the noteworthy successes in health since the enunciation of the first NHP in 1983. These successes included the eradication of small pox and guinea worm, the near eradication of polio, and progress towards the elimination of leprosy and neonatal tetanus. The NHP sets out a new policy framework to achieve public health goals in the socio-economic circumstances currently prevailing in the country. The approach aims at increasing access to the decentralised public health system by establishing new infrastructure in deficient areas and upgrading the

infrastructure of existing institutions. It sets out an increased sectoral share of allocation out of total health spending to primary health care. More recently (2005), the Government of India has launched the **National Rural Health Mission (NRHM)**, with the goal of improving the availability of and access to quality health care by people, particularly in rural areas.

Traditional System of Medicine

Studies of the relationship between these systems of medicine and other aspect of social life, such as religion, astrology, magic and morality, will make our knowledge, not only of these systems, but also of these other spheres of life more meaningful and complete. For example, S. Fuchs (1964) in his study of Balahis in central India has given a description of how two types of medicine men, Janka, who works through divination, and Barwa, who works by calling to his aid a superhuman force, practice their respective arts.

In a study of Shamanism in the Malnad region of Mysore, E.B. Harper describes “a Shaman in this south Indian setting is a man who has a familiar spirits that he can ask to posses him whenever he desires” (1966:344). When he goes into trance, the spirits speaks through him. “The purpose of the Shamanistic possession is to allow people in the human world to have advice and help from a super-human being who’s knowledge and ability to accomplish certain ends is superior to that of any human (1966:345).

V. Elwin (1955) has also described the role of male and female Shamans among the Hill Saoras of Orissa. The services of these Shamans are solicited in the rites for the dead. G.M.Cartairs refers to the importance attached to “confident prognosis” as an attribute of the role of the healer. Tradition medicine, establishes ‘faith’ and ‘assurance

in the patient. Modern medicine lacking this “aura of conviction” of traditional medicine is required to “justify itself dramatically, and without delay” (1955:122).

From the literature available it seems that the one most distinguishing characteristics of traditional medicine is the notion regarding disease causation. Herein one finds an extremely close relationship between medicine and such aspect as religion, morality and magic. M.E. Opler (1963) list the following as the most commonly believed causes of various diseases: 1) malfunctioning or imbalance of the three humors (doshas): 2) faulty diet 3) lack of harmony with the supernatural world, 4) activities of ghosts, 5) displeasure of deities, 6) imbalance of forces which controls health and sickness, 7) immoderation or inappropriate behaviour in physical, social and economic matters. T.N. Valunekar and H.R. Chaturvedi (1967), like Khare and others, have discussed how the nature of treatment varies with the type of cause identified. For example, religious rites occupy a prominent place in the treatment of diseases (such as small pox and plague) which are associated with supernatural causes to the exclusion of other factors.

When we study this traditional system in a process of interaction, our focus of interest shifts to the determination of how and in what manner these systems have incorporated and continue to incorporate, elements from each other, and also from the modern system of medicine. According to Hasan (1967), the people of village Chinaura in U.P., seems to have developed their preference for certain methods of diagnoses and treatment in the modern system of medicine. For example, they prefer to be examined with the help of stethoscope and to be asked question by the physician. They also attach greater curative value to injections. Gould has made similar observation in village Sherapur where indigenous practitioners adopt “the paraphernalia of modern medicine in order to intensify their psychological impact on their patient” (1965:207). Leslie

(1968) also mentions that, in the centre of British administration, some vaidis hakims claimed superior status to other indigenous practitioners by virtue of their acquaintance with European medicine.

Modern System of Medicine

It is already mentioned that India had fairly well developed indigenous system of medicine, in addition to tribal and folk medical beliefs and practices, when the powerful modern system of medicine appeared on the horizon. What response did it elicit from the people in the beginning? How do people respond to it now?

Khare mentions that the Kurmis of village Thakarpur, being more educated and economically better off resort more frequently to modern medicine, spray D.D.T. and get vaccinated in order to prove themselves to be more modern than their fellow villagers. However, Khare explains that “this tendency is only superficial in the sense that they readily fall back on their indigenous beliefs and practices” (1963:37). Gould (1965) on the other hand identified that modern medicine is chosen for critical incapacitating dysfunctions, diseases such as small-pox, cholera and severe. Madan (1969) has examined certain assumption regarding the influence of age, education and rural or urban upbringing, occupation, income and religion of a person on his acceptance of modern medicine for himself and for planned change. In Marriot’s (1955) paper, we find an interesting reference to the role of family members in preventing quinine pills from reaching a girl patient because old women in the family had voiced objection to it. Mintum and Hitchcock (1963) have indicated that parents’ greater eagerness to get medical aid for boys as compared to girls may be responsible for the differential death rate of boys and girls. Marriot (1955) observes that the traditional medical practitioners render medical help within the context of the family and thus win ready acceptance from the people. Carstairs (1955) has dwelt on the false expectation of doctors and their

village patients from one another, which arises out of different conception of the role of the doctor and create a barrier in communication between the two. Gould (1965) has emphasized the role of 'personal relationship' as against the 'professional relationships' which the villagers neither understand nor trust because they are not the members of the doctor's culture. Gould has referred to the 'aversion' the village people feel towards the institutional structures in which modern medicine is provided to them... "The peasants sees hospitals and clinics as places where he will be compelled to wait endless hours in congested ante-rooms, castigated and mocked by officious attendants, and finally examined and treated by a doctor who will show no personal interest in him whatsoever" (1965:208)

G.S. Aurora (1969) has rightly suggested that, as a first step in establishing sociology of food and nutrition, a national map showing systematic association of social categories with nutrition and food patterns should be prepared. In an extensive survey of the literature on the sociology of food consumption pattern in some Asian countries, M.O.L. Klein Hutheesing demonstrates how almost every aspect of food and nutrition is closely related to other aspects of society such as economy, religion, family and stratification. The literature also highlights the role of taboos and prejudices, likes and dislikes, in the preparation, distribution and consumption of food. 'Readings in Medical Sociology' edited by Sarah Cunningham-Burley and Neil P. Mckeganey (1990) bring together a range of papers based upon current or recent empirical work within the medical sociology field.

Neil Drummond and Christine Mason (1990), highlights another longstanding interest of medical sociologists: namely, in the patient's compliance with the medical practitioner's advice. Looking at the way in which diabetic patients manage their condition in terms of the shifting priorities within their everyday life, Neil Drummond

and Christine Mason are able to examine the basis for much of the disparity between the patients' account of their illness and those produced by medical practitioners. Sarah Cunningham Burley in her paper (1990), beliefs about and perceptions of their children's illnesses, provides an examination of beliefs and practices relating to children's illness within the family. The analysis draws on the concerns, beliefs, and practices of the mothers interviewed, in order to understand how they recognise, construct and explain illness in their children through a process of monitoring and interpretation. Illness was in fact only one explanation for a range of behaviours and states which the mother routinely noticed in their children. Health, illness and normality were closely related and the paper explores the concept of normality and normal illness as used by the mothers. Neil Mckeganey, focuses on issues which are potentially detrimental to health: namely drug and alcohol use (1990), he looks at it as one of the highest risk practices for contracting and spreading HIV infection; namely injecting drug use. The paper reports on a current ethnographic study of injecting drug use in the community, and associated risks. The author not only explores the extent of drug use within his study locale but looks specifically at the sharing of unsterile injecting equipment. Not only did he find an environment in which drugs were commonplace, he was also able to explore the social context of needle sharing: such activities have to be understood as part of a culture of sharing and mutual support- a culture that extends beyond drug users.

Public health raises fundamental issues and dilemmas for decision makers in the new millennium. In this succinct and timely analysis, Rob Baggott (2000), explores contemporary public health by adopting a public policy approach. The volume covers all major aspects of public health, including the historical context, the international dimension, the role of the NHS, health strategies and targets, health promotion and the

role of screening programs. In addition, broader public health policy issues such as environmental health, pollution, health and safety, sustainable development, transport, housing, food and diet, legal and illegal drugs, socio-economic inequalities and regeneration are explored and discussed. The book concludes by arguing that public health policy must be less dominated by commercial interests, more effectively coordinate across all sectors and at all levels of government, more inclusive and open, that it should be based on sound and independent research into the range of factors likely to affect health, and more sensitive to the perspectives of ordinary people.

Structural Adjustment Programs (SAP) as devised by World Bank and the I.M.F, were introduced in South Asia only in the early 90s. The first phase of these reforms in the health sector predicted differentiated effects for the regions. However, as their basic thrust became visible overtime, the negative consequences appeared to be much more uniform. This was particularly evident when the cut-backs in the welfare sectors began to impinge upon its growth. Imran Qadeer, Kasturi Sen, and K.R.Nayar (2001), studies the impact of SAP in South Asia and the numerous factors responsible for the state of public health in the region. The book is divided into six sections. The first provides a conceptual and historical background linking the ascendance of neo-liberal economic policies with the practice of public health. This section deals with the inter-relationship between politics, economics, and development of health system in the South Asian region, an issue that has been marginalised in much of contemporary social analysis and policy making. Debabar Banerji (2001), traces the evolution of Health Services in India within the political historiography of the region. He locates the current reforms in the desperate nature of health services and powerful policy interest of international capital that prevailed upon the political, bureaucratic, and professional elite of the region. Jennifer Bennett (2001) offers a harsh critique of the structural Adjustment

Policies in Pakistan. She argues that the costs of the failure to lift the economy out of recession are being borne disproportionately and unjustly by the poor in Pakistan. Farida Akhter (2001) illustrates an extreme case of verticalisation of health services in Bangladesh, where family planning, the most powerful and well funded program, subsumes all other programs. She argues that the cruel population control measures perpetuated by economic dependency are unstable. All the three papers emphasised the need for an autonomous and people-centered development in the health sector.

Indira Hettiarachchi's (2001) traces the transitions in the health sector in the tea plantations in Sri Lanka. Even though only this sector has been privatized, there is concern about the deterioration in health and social services for plantation workers, as reflected by substantial differences in the health indices of these workers compared to the rest of the population. Meri Koivusalo (2001) offers a detailed account of health sector reforms in Europe, their global imperatives, and their impact in the Organisation for Economic Cooperation and Development (OECD) countries, particularly Finland. Given the relatively agricultural and rural background and the centrality of equity in its social policies, Finland offers an interesting comparison for South Asia. Koivusalo also examines the growing disquiet in Europe over the social costs of the reforms and the largely negative experience in terms of cost savings. Marc De Bruycker (2001), examines the ethical mooring of the current paradigms in health systems development and research, and explores the implications of these for equity. These three papers points towards the negative consequences of decontextualised reforms. Imran Qadeer (2001) emphasizes the historical tension between science as practiced and the requirement of objectivity. It argues that power balances determine the patterns in the conceptual growth of science, as is evident in the paradigmatic shifts in public health.

Kasturi Sen's (2001) provides an overview of the global process of reforms. She shows that the advocates of reforms have ignored the mounting empirical evidence on the problems with the cost-benefit model in health services. It is being imposed with a heavy hand as part of debt-restructuring, despite lack of evaluation of its impact. Ritu Priya (2001) offers a critical appraisal of the methodology underlying the calculation of Disability Adjusted Life Years (DALYs). She argues that despite its intrinsic attractiveness to those who seek quantitative comparative models, the concept is unscientific. Shiela Zurbrigg (2001) illustrates the demographic and bio-medical biases in the debate. The explanations of the decline in mortality have been singularly overshadowed by the assumed role of medical science. Zurbrigg meticulously reveals the place of hunger and starvation in this debate. Lalita Charaborty (2001) reinforces Zurbrigg's argument; through her rigorous study of the four millet producing states of India between 1970-1993, she links evidence of biological stress to economic indicators over the period and proposes a consistent relationship between them. The evidence put forward by these researchers is unambiguous and deserves the close attention of the policy makers. Anwar Jafri (2001), states that the new Panchayati Raj bills enacted in the states have generated high expectations amongst those communities that were hitherto marginalised in the political process by focusing on the Panchayats in the Malwa region of the state of Madhya Pradesh in India. The paper reveals that the changes in the functioning and constitution of Panchayats have not resolved some basic conflicts that involve the poorer sections.

K.R.Nayar (2001), argues that the experience of decentralisation in other countries has not been encouraging, largely because of the type of decentralisation and the political context and social domain in which it was implemented. The paper analysis the unique experience of people's planning in the state of Kerala, wherein the state made

an effort to give power and resources to the people in order to enable them to collectively participate in shaping their future by identifying problems and evolving programs according to local needs. Nimal Attanayake (2001), argues that decentralisation in the country was largely reduced, with a narrow political objective of containing the ethnic conflict. In health, it largely represented a non-purposive direction of change, in which neither central level administrators nor politicians had the motivation to accelerate the process of decentralisation. Anurag Bhargav (2001) discusses the issues related to the implementation of the program in terms of contradiction between patient-centered and program-centered strategies. The paper states that patients are not given central importance in the program. Anand Zachariah (2001) argues that the resurgence of specific disease is related to social, economic, political, demographic, and ecological changes. By examining the experience with malaria and cholera, the paper illustrates that the epidemiology of these two diseases has changed in the Post-Structural Adjustment Period due to widening socio-economic differences, unplanned urbanisation, and lack of investment in the basic infrastructure.

Yogesh Jain (2001), states that given the inadequate understanding of chloroquine and quinine resistance in the country, the introduction of new drugs such as mefloquine and artemisinin in the open market is irrational. Anant R. Phadke (2001) contradicts the assumption regarding the efficiency of the private sector with respect to pharmaceuticals. A study conducted in Satara district in the state of Maharashtra in India shows that the use of medicine in the private sector was more irrational and more wasteful. Shyam Ashtekar's (2001) emphasizes the need to develop a rational curative package in the PHC system, which so far has been neglected due to an inherent bias against less trained healers. It proposes an alternative community health worker scheme, operationally managed by the people, who will also make a small financial contribution,

but supported largely by the state. Ghanshyam Shah (2001), studies the 1994 plague in Surat and points out the dangers of undermining public sector health care provisions and monitoring systems. He argues that propositions like the private sector being an “equal partner in development” and “efficiency through market mechanism” are clichés as private capital did not come forward to invest in infrastructure.

K.S. Sebastian’s (2001), narrates the experience of yet another Indian Town, Alleppey, in Kerala, which is experiencing the impact of SAP generated cuts in subsidies and the commercialisation of its agriculture and fisheries. These measures have aggravated the problems of the city’s working class population in terms of food availability, civic facilities, and re-emergence of communicable diseases. Meena Gopal (2001) study the organisation of female labor in the beedi industry of Tisunelveli district of Tamil Nadu reveals the double edge of patriarchy and its links with liberalisation. While women’s economic contributions are treated as secondary and marginal, patriarchal values help maximise exploitation of their labor and the denial of social security or dignity of labor. The rapidly growing population of the slums in Delhi is the subject of Alpana Sagar (2001), she vividly brings out the social dynamics of women’s health and their awareness and efforts to deal with the causes of ill health. The health care system, bound by its narrow vision, is unable to perceive the women’s dilemmas and remains indifferent.

Mohan Rao (2001) illustrates the danger of handing over research to individuals *and open markets, where neither its objectives nor its methodologies can be regulated.* He focuses on the clandestine use of quinacrine as a contraceptive for Indian Women to illustrate the indifference and callousness of the existing monitoring system and the health market to the needs of women.

Sociologists and social anthropologists in India have been concerned with the tribal health since long time. Their researches included ethno medicine, health status particularly of women and children, health seeking behavior, impact of modern medicine etc. the health status of men and women in almost all countries and cultures without any exception. **World Development Report** (1993) says the female disability is especially high in Asia (Devi 1998:2). In Indian context, it is said that the story of indifferent attitude towards women starts from the moment it is known that the conceived baby is a girl and it runs throughout her childhood, adolescence, married life, old age and ends only with her death. In other words, 'the discrimination starts from womb and ends up in the tomb' (Nigam 1999:11)

Prof Mahapatra points out the paucity of data on the concept of health among the tribal populations groups of India. According to him, in the context of Indian 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 a functional one not a clinical one. **Prof Swain** examined in depth the aetiology of perception of health and perception of illness prevailing among the different tribal groups of India. It has been realized that disease are not only due to physical, chemical or biological processes but also due to a number of socially and culturally determined factors. It is found that the tribal, whether the most primitives or the relatively modern ones, are in the various stages of transition. The concept that the tribal are resistant to modern medical care system has not been found to be true.

Dr Bhupinder Singh in his thought provoking article examined in depth the complex interplay of several forces and factors influencing health of tribal communities namely, a) Physical environment, b) Socio-economic state, c) Nutritional availability and dietary habits, d) Psycho-socio culture, e) Health culture and health related

behavior, f) Mortality and morbidity patterns) Genetic diseases and disorders, h) Therapeutic system in vogue, and i) Health delivery systems. Dr. Singh pointed out that issues concerning tribal health, nutrition and genetic-environmental aspects are grossly under-researched.

Prof. Sachidananda referred the vicious circle of poverty, ignorance and ill health prevailing among the tribal population of India. He tried to view the field of tribal health into two main aspects a) as a cultural complex i.e. a complex of material objects, tools techniques, knowledge, idea and values and b) a part of social structure and organization i.e. network of relations between groups, classes and categories of persons.

Education and Communication:

Education is one of the basic activities of people in all human societies Sociologists are becoming more and more aware of the importance and role of educational institution and its structural changes in the modern industrialized and tribal society.

In India Educationists with development slant are few. A propitious beginning however, has been made with a useful collection of essays edited by M.S.Gore, I.P.Desai and S.Chitnis (1967) S.C.Dubey (1967) in his paper has suggested the possible contribution that education can make to modernization. M.S.A.Rao (1967) has contributed a useful essay on education, stratification and mobility. In a working paper, S.Shukla (1968) discussed the role of education in social change and development. The importance of formal education is greater, according to him, in those processes of development where there is less deliberate and forcible attempt to change existing properly relation is attempted. He also relates formal education to elite formation. The report of the Education Commission is a document of great value to the social scientist. Although it pays lip services to tradition and speaks of a synthesis between the traditional and the modern its principal focus is on the problem of gearing education effectively to the task of national development. In addition to this, M.S.Gore (1965)

spells out the needs to communicate the goals of modernization within the education system and B.V.Shah (1969) discusses some of the practical problems in adapting education to modernization. A.D.King has contributed two papers on this theme. In the first paper (1969a) he has analyzed professional education with respect to the needs of modernization. In the second (1969b) he has discussed higher technical education and the needs of socio-economic development. Writing on a similar topic, S.Shukla (1966) discusses education in contemporary Indian society and modernization. Taking up yet another aspect of the problem of education for modernization, Y.B.Damle (1966 b) has discussion for an unknown future. Damle (1969 a) also discusses education and identity formation.

According to Singh (1986:106), education is an institution by which society transmit its cultural traits and socialized its member for different roles. In developing societies like India education has been one of the most influential instruments of modernization. The education system has contributed to modernization by the growth of new forms of rationally organized structures in the shape of schools and university, which serve cultural networks for the diffusion of knowledge and cultural categories which are modern in ethos. In a tribal society which is passing through the process of transformation, secular education acts as an agent of modernization. Therefore, the expansion of education in tribal society can be taken as an indicator of development.

Education and Communication, mainly, the Mass media communication has positive relationship in a development process. **Schramm (1964:27)** recommended that “ the task of the mass media of information and the ‘new media of education, is to spread and ease the long, slow transformation required for economic development and in particular to speed and smooth the task of mobilizing resources entail behind the national effort.”

Right from Pre-Independence days, attempts have been made by both government and private groups to use mass media communication for educational purposes. The most ambitious attempt to exploit the mass media for education was of course, SITE (Satellite Instructional Television Experiment). It sought to educate rural people in six states of India about the need for family planning, improved agriculture, hygiene, nutrition and health care. Literate and educated people benefit much more educational media than the less literate and educated unless the education-oriented programmes are specifically geared to the needs, interests and levels of specific groups. Even before groups and regions can benefit from education through the print or the electronic media, they will need to become 'media literate'. Media literacy proceeds or is simultaneous with the skill to learn from the media. The folk media are perhaps much more effective in promoting the message of literacy than any of the mass media.

On a micro level, the modern mass media were used in one way and top-down communication models by leaders to disseminate modern innovations to the public. They were considered as magic multipliers of development benefits in third world nations. There were other contributory factors, as Rogers (1976:34) said, "Certainly the media were expanding during the (1950s) and (1960s). Literacy was becoming more widespread in most developing nations, leading to great print media exposure. Transistor penetrating every village.

Education and Health:

Education for health begins with people. It hopes to motivate them with whatever interests they may have in improving their living conditions. Its aim is to develop in them a sense of responsibility for health conditions for themselves as individuals, as members of families, and as communities. In communicable disease control, health education commonly includes an appraisal of what is known by a population about a disease, an assessment of habits and attitudes of the people as they relate to spread and

frequency of the disease, and the presentation of specific means to remedy observed deficiencies.

Health Education is the profession of educating people about health. Areas within this profession encompass environmental health, physical health, social health, emotional health, intellectual health, and spiritual health. It can be defined as the principle by which individuals and groups of people learn to behave in a manner conducive to the promotion, maintenance, or restoration of health. The Joint Committee on Health Education and Promotion Terminology of 2001 defined Health Education as "any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions." The World Health Organization defined Health Education as "comprising of consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health. Defining health education as "any combination of learning experiences designed to facilitate voluntary actions conducive to health" (**Green and Kreuter, 1999**) emphasizes the importance of multiple.

A health educator is "a professionally prepared individual who serves in a variety of roles and is specifically trained to use appropriate educational strategies and methods to facilitate the development of policies, procedures, interventions, and systems conducive to the health of individuals, groups, and communities" (Joint Committee on Terminology, 2001, p. 100). As a Health Educator you are here to help and enhance the health of others. In wanting to better understand the role of a health educator in January 1979 the Role Delineation Project was put into place. This made a basic role for the health educator. A Framework for the Development of Competency-Based Curricula for Entry Level Health Educators (NCHEC, 1985) and the revised version A Competency-

Based Framework for the Professional Development of Certified Health Education Specialists (NCHEC, 1996) resulted from the project and these documents made up the framework. Which were made into the seven areas of responsibilities? The eight-component model forms the basis of a coordinated school health program (CSHP), currently defined as "an integrated set of planned sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community based on community resources, standards and requirements. It is coordinated by a multidisciplinary team and accountable to the community for program quality and effectiveness" (Allensworth, 1997).

While no studies have evaluated the efficacy of the CSHP, there have been numerous studies that have evaluated the components individually and in combination with each other. These studies have shown that health education can improve the adoption of health-enhancing behaviors (Connell et al., 1985; Resnicow et al., 1991) and school achievement (Hawkins et al., 1999); and that nutrition services, and particularly school breakfast programs, have increased learning (Meyers et al., 1991; Powell et al., 1998). Health services have been associated with reduced absenteeism, academic achievement, and improved health status (U.S. General Accounting Office, 1983). Physical education has been shown to improve physical fitness, reduce stress, and enhanced student's self image (Dwyer, 1983; Pate et al., 1995). Involving family members and the community have been linked with improving health knowledge and behaviors (Pentz, 1997), and health promotion for faculty and staff have improved absenteeism rates for staff as well as improved their health status (Blair et al., 1984).

Communication and Health:

Communication is a medium of information, concepts and ideas to both general specific audiences. They are important tools in advancing public health goals. Communicating about health through mass media is complex and however, challenges professionals in diverse discipline. **Liana Winett and Lawrence Wallack (1996)** wrote that “using the mass media to improve public health can be like navigating a vast network of roads without any street signs- if you are not sure where you are going why, chances are you will not reach your destination”

Sophisticated societies are dependent on mass media to deliver health information. **Marshall McLuhan** calls media “extension of men”. G.L.Kreps and B.C.Thronton (1992) believe media extend “people’s ability to communicate, to speak to others far away, to hear messages, and to see images that would be unavailable without media”. It follows that employment of mass media to disseminate health news has, in effect, reduced the world’s size. The value of health news is related to what gets reported. According to **Ray Moynihan and colleagues (1999)** “The news media are an important source of information about health and medical therapies, and there is widespread interest in the quality of reporting. Previous studies have identified inaccurate coverage of published scientific papers, overstatement of adverse effects or risks, and evidence of sensationalism. The media can also have a positive public health role, as they did in communicating simple warnings about the connection between Reye's syndrome and the use of aspirin in children.” Despite the potential of news media to perform valuable health-education functions, **Moynihan et al.** conclude that media stories about medications continue to be incomplete in their coverage of benefits, risks, and costs of drugs, as well as in reporting financial ties between clinical trial investigators and pharmaceutical manufacturers. The mass media are capable of facilitating short-term, intermediate-term, and long-term effects on audiences. Short-term objectives include exposing audiences to health concepts; creating awareness and

knowledge; altering outdated or incorrect knowledge; and enhancing audience recall of particular advertisements or public service announcements (PSAs), promotions, or program names. Intermediate-term objectives include all of the above, as well as changes in attitudes, behaviors, and perceptions of social norms. Finally, long-term objectives incorporate all of the aforementioned tasks, in addition to focused restructuring of perceived social norms, and maintenance of behavior change. Evidence of achieving these three tiers of objectives is useful in evaluating the effectiveness of mass media.

Diana Hackbarth and her colleagues (1994) in their Chicago-based study, revealed how billboards promoting tobacco and alcohol were concentrated in poor neighborhoods. Similar themes were seen in other urban centers (Baltimore, Detroit, St. Louis, New Orleans, Washington, D.C., and San Francisco) where alcohol and tobacco billboards were much more concentrated in African-American neighborhoods than in white neighborhoods. The tobacco industry now pursues the same strategy in developing countries.

Decades of studies on the consequences of mass media exposure demonstrate that effects are varied and reciprocal—the media impact audiences and audiences also impact media by the intensity and frequency of their usage. The results of mass media for promoting social change, especially in developing countries, have become important for public health.

J. R. Finnegan Jr. and K. Viswanath (1997) have identified three effects, or functions, of media: (1) the knowledge gap, (2) agenda setting, and (3) cultivation of shared public perceptions. Health knowledge is differentially distributed in the population, resulting in knowledge gaps. Unfortunately, mass media are insufficient for distributing information in an egalitarian fashion—changes in social structure and institutions are also necessary for this to occur. Thus, the impact of mass media on

audience knowledge gaps is influenced by such factors as the extent to which the content is appealing, the degree to which information channels are accessible and desirable, and the amount of social conflict and diversity there is in a community. Hence, public health media campaigns are more effective when structural factors that impede the distribution of knowledge are addressed. A related theme is the extent to which the media set the public's perception of health risks. According to **J. J. Davis**, when risks are highlighted in the media, particularly in great detail, the extent of agenda setting is likely to be based on the degree to which a public sense of outrage and threat is provoked. Where mass media can be especially valuable is in the framing of issues. "Framing" means taking a leadership role in the organization of public discourse about an issue. Media, of course, are influenced by pressures to offer balance in coverage, and these pressures may come from persons and groups with particular political action and advocacy positions. **According to Finnegan and Viswanath**, "groups, institutions, and advocates compete to identify problems, to move them onto the public agenda, *and* to define the issues symbolically" (1997, p. 324). Thus, persons who desire to access mass media's agenda-setting potential must be aware of the competition.

On the basis of the above discussion we could say there is a positive relationship between education, communication and health. Mass media communication has an effect on individual health. However, using mass media can be counterproductive if the channels are not audience-appropriate, or if the message being delivered too emotional, fear arousing, or controversial. Undesirable side effects usually can be avoided through proper formative research, knowledge of the audience, experience in linking media channels to audiences, and message testing. On the other hand, Health Education plays a crucial role in the development of a healthy, inclusive, and equitable social, psychological, and physical environment. It has undergone radical change in recent years, and modern approaches now use an empowering, multi-dimensional, multi-

professional approach which relates to all settings, organizations, and parts and levels of society, including schools, colleges, the community, and the workplace. In terms of the relation between education and various health risk factors - smoking, drinking, diet/exercise, use of illegal drugs, household safety, use of preventive medical care, and care for hypertension and diabetes - overall the results suggest very strong gradients where the better educated have healthier behaviors along virtually every margin, although some of these behaviors may also reflect differential access to care. Those with more years of schooling are less likely to smoke, to drink heavily, to be overweight or obese, or to use illegal drugs. Interestingly, the better educated report having tried illegal drugs more frequently, but they gave them up more readily. Thus, the study is an attempt to examine the relation between education, communication and patterns of Health Care in the context of a tribal community, namely, Barmans in Cachar District of Assam.

Objectives of the Study:

The study has the following objectives:

- (i) To understand the relationship between level of education and health care practices in tribal society.
- (ii) To understand the relationship between communication and health care practices in tribal society.
- (iii) To understand the relationship between level of education and level of mass media exposure in tribal society.
- (iv) To understand the level of health awareness in tribal society.
- (v) To understand the types of health practices in tribal society.

Hypotheses:

The major hypotheses of the study are as follows:

- (i) There is a positive relationship between the level of education and mass media exposure.
- (ii) There is a positive relationship between the level of education and awareness of health care.
- (iii) There is a positive relationship between mass media *exposure* and health care

Methodology:

The study is located in Silchar town of Cachar District and a village namely, Bijoypur of Borkhola Circle of Cachar District. As the study is confined to the Barman tribe only, the interplay between education, communication and patterns of health care can be analyzed more directly. It helps in controlling background factors to a great extent, covering both rural and urban setting. The data collected from all about 300 the adult family member of the village household (N= 125), of which 81 Respondents are from lower level of education, 36 Respondents have higher secondary level of education and 8 Respondents have higher level of education. The data covered three generation of the village, 41 of the Respondents belong to the age group from 18-30 years, 50 Respondents belong to the age group of 30-50 years and 30 generation belong to the age group of 60 and above. The mass media exposure of the respondents is analyzed in terms of frequency of reading/listening/watching different forms of media. To understand the patterns of health care practices and awareness the data collected covering every generation and education level of the tribe. However, in the Silchar town a list of Barman household is prepared with the help of some knowledgeable person of the Barman community of Silchar town. An appropriate sample of 115 adult members drawn from this list during the course of the study. The data is collected by observation, informal discussion and administering a highly structured interview schedule on a purposive sampling.

Measurement:

A) Patterns of Consumption and Styles of Living:

Social Strategy related to the economy of the Barman Families can be seen through an analysis of Patterns of Consumption and Relations of Production.

Consumption Patterns:

The Level of Consumption of the Barman Families is measured on a Five Point Consumption Pattern Ranking Scale (developed during the study) based on the presence of a number of Household Items in the Families concerned. The main features of the scale are the following:

- i. A Total Number of Thirty (30) Items are equally distributed into five unit continuum; each unit includes six items
- ii. Different Score Values are assigned to the items in each unit. However, each items of a unit has similar score value.
- iii. The Score Values of Items included in the scale are as follows:

Unit	Items	Score Value
I	Air Conditioner, Car, Computer, Washing Machine, Water Purifier (Aqua Guard/Cooler), Cordless phone, Greaser, Refrigerator, VCD player, Electric Pressure Cooker	5
II	Inverter. Electric Oven, Scooter/Motor Cycle,	4

	Colour T.V.,Mixture/Juicer/Grinder Dining Table	
	Cooking Gas, Immersion rod, Dinner Set, Washing basin	
III	Camera, Moped, Dressing Table, Television (B&W), Telephone, Tape Recorder, Carpet Air Cooler, Sofa Set, Cable Connection	3
IV	Radio, Emergency Light, Water filter, Shower Sewing Machine, Binocular, Steel Almirah Good Night Coil /All Out, Show Case, Pressure Cooker.	2
V	Wall Clock, Iron, Bicycle, Torch, Kerosene Stove, Table/Harmonium, Electric Heater, Calculator, Electric Fan, Thermos Flask.	1

The Consumption Pattern of a Family was measured on the basis of its score on this scale. Four Strata were formed on the basis of the scores attained by different families. Four Strata were: i. High ii. Upper Medium iii. Medium iv. Low

B) Level of Mass Media Exposure, Education and Health Awareness of the Barman Families are measured on a Five Point Ranking Scale (developed during the Present Study).

The Level of Mass Media Exposure:

It is measured on the basis of the following Five Media Items:

- i. Newspaper Reading
- ii. Radio Listening
- iii. Television Viewing
- iv. Mobile Phone Usage.
- v. Magazine Reading (No. of Magazine)

These items are assigned Score values. The score values of assigned to the items included in the scale are as follows:

Sl. No	Items	Frequency	Score Value
1	Magazine Reading	i. Daily	5
		ii. 5 Hr. Or more	4
		iii. 3-4 Hr.	3
		iv. 1-2 Hr.	2
		v. Less than 1 Hr.	1
2	Radio Listening	i. Daily	4
		ii. More than 2 Hr.	3
		iii. 1-2 Hr.	2
		iv. Less than 1 Hr.	1
3.	Television Viewing	i. Daily	3
		ii. 3-4 Days	2
		iii. 2-3 Days	1

4.	No. of Outgoing Mobile Calls in a Day	i. 30-40	3
		ii. 10-20	2
		iii. 5-10	1
5.	Reading Magazine	i. Five Magazine	5
		ii. Four Magazine	4
		iii. Three Magazine	3
		iv. Two Magazine	2
		v. One Magazine	1

Education:

Similarly, the Level of Education is measured on the basis of the Year of Schooling.

They are categorized as follows:

Sl. No	Education	Frequency	Score Value
1	Class I-IV	Very Low	1
2	Class V-VIII	Low	2
3	Class X-XII	Average	3
4	Graduate	High	4
5	Post-Graduate	Very High	5

Health Awareness:

Likewise, the Level of Health Awareness also measured on following items, with an assigned ranking score value. It is measured on the basis of the following Items:

Items for Bijoypur Village:

- a. Source and Ownership of Drinking Water
Pond ---0, Well--- 1, P.H.E water supply ---- 2
- 2. Purification of Drinking Water
No ---- 0, Yes --- 1
- b. Ownership of Drinking Water
No --- 0, Yes --- 1
- c. Mode of Purifying Water
Cotton Net ---- 1, Alum ---- 1, Filter --- 2, , Boil --- 2
- d. Brushing Teeth
No ---- 0, Yes ---- 1
- e. Tools for Brushing Teeth
Coal --- 1, Tree Branch ---- 2, Toothbrush ---- 2, Salt --- 1
- f. Frequency of Brushing Teeth
Once ---- 1, Twice ---- 2
- g. Mosquito Protection Measure
No ---- 0, Yes ---- 1
- h. Types of Using Mosquito Protection Measure
Mosquito Net --- 1, .Coil ---- 2, Hit Spray ----- 3, All Out --- 4
- i. Drainage Connectivity
No Drainage --- 0, Open Drainage --- 1, Closed Drainage ----- 2
- j. Disposal of Wastage
Do Not Maintain any specific place --- 0, Pit at the back of the House --- 1
Garbage System --- 2
- k. Cleaning of Cattle shed :

Daily --- 2, Weekly --- 1

l. Use of Cattle Excreta:

Throw it outside ---1, Use it as Fertilizer --- 2

m. Awareness about village Health and Sanitary Committee

No --- 0, Yes --- 1

n. Know about member of Committee :

No --- 0, Yes --- 1

o. Attend meeting on village health and sanitary :

No --- 0, Yes --- 1

p. Physical Exercise

No --- 0, Yes --- 1

q. Smoking

No ---- 0, Yes ---- 0, Quit ---- 1

r. Frequency of Smoking

Rarely ---- 2, Moderately ---- 1, Often ---- 0

s. Skip Breakfast

No ---- 0, Yes ---- 1

t. Drinks

Never --- 2, Quit ---- 1, Yes ---- 0

u. Frequency of Drinking

Rarely ---- 2, Moderately ---- 1, Often ---- 0

v. Physical Activities

No ---- 0, Yes ---- 1

w. Physical Activities :

No --- 1, Yes ---- 1

x. Information on Health Related Facilities Available

No --- 0, Yes --- 1

y. Awareness about Janani Suraksha Programme.

No --- 0, Yes --- 1

z. Awareness about Aasha Programme.

No --- 0, Yes --- 1

<u>Frequency</u>	<u>Score Value</u>
Very Low (1-12)	1
Low (13-24)	2
Average (25-36)	3
High (37-48)	4
Very High (49-60)	5

Items for Silchar Town

a. Source and Ownership of Drinking Water

Tube Well --- 1, P.H.E water supply ---- 2

b. Purification of Drinking Water

No ---- 0, Yes --- 1

c. Ownership of Drinking Water

No --- 0, Yes --- 1

d. Mode of Purifying Water

Filter --- 2, Aqua Guard --- 2, Boil --- 2

e. Brushing Teeth

No ---- 0, Yes ---- 1

f. Tools for Brushing Teeth

Coal --- 1, Tree Branch ---- 2, Toothbrush ---- 2

g. Frequency of Brushing Teeth

- Once ---- 1, Twice ---- 2
- h. Mosquito Protection Measure
No ---- 1, Yes ---- 2
- i. Types of Using Mosquito Protection Measure
Mosquito Net --- 1, .Coil ---- 2, Hit Spray ----- 3, All Out --- 4
- j. Drainage Connectivity
No Drainage --- 0, Open Drainage --- 1, Closed Drainage ----- 2
- k. Disposal of Wastage
Do Not Maintain any specific place --- 0, Pit at the back of the House --- 1
Garbage System --- 2
- l. Physical Exercise
No --- 0, Yes --- 1
- m. Smoking
No ---- 0, Yes ---- 0, Quit ---- 1
- n. Frequency of Smoking
Rarely ---- 2, Moderately ---- 1, Often ---- 0
- o. Skip Breakfast
No ---- 0, Yes ----- 1
- p. Drinks
Never --- 2, Quit ---- 1, Yes ----- 0
- q. Frequency of Drinking
Rarely ---- 2, Moderately ---- 1, Often ---- 0
- r. Physical Activities
No ---- 0, Yes ----- 1
- s. Information on Health Related Facilities Available
No --- 0, Yes --- 1

t. Awareness about Janani Suraksha Programme.

No --- 0, Yes --- 1

u. Awareness about Aasha Programme.

No --- 0, Yes --- 1

<u>Frequency</u>	<u>Score Value</u>
Very Low (1-11)	1
Low (12-22)	2
Average (23-33)	3
High (34-44)	4
Very High (45-55)	5