CHAPTER – 5

CHAPTER -5

CONCLUSION

The present study is outcome of the intensive field study carried out among the Oraon tribe inhabiting in Bamongola Block, District Malda in West Bengal. The basic thrust of this enquiry is to delineate the health care practices of the Oraon community. The study has attempted to investigate the extent of acceptance and utilization of modern health services and facilities available in rural hospital and primary health centers by two groups of villages and analysed on a comparative perspective. The Oraons under study constitute a homogenous group, in terms of socio-economic background. The criteria adopted for dividing the entire seventeen villages into two groups were proximity to and distance from the rural hospital. Thus the impacts of modern health services on two sets of Oraon villages were analysed.

Further, this research paper also examines the nexus in terms of acceptance of a particular system of medicine: firstly, the perspective of village medicine or traditional medicine and treatment and secondly, the perspective of modern medicine and treatment. Further, the study makes an attempt to establish the relation between disease etiology and culture. It also seeks to identify various traditional medicine and health care practices, which has been in existence since age-old days and the changes therein under the impact of modern health services and facilities.

Review of literatures on this subject also shows the trend of research in this field of health care practices, socio-cultural dimensions have theoretical as well practical relevance for understanding tribal society and culture.

Health care practices form an integral part of social structure, religion and social organization of all tribal communities. Tribals have developed their own indigenous system of medicine for treatment and cure of various illness and disease, which persists even at the present time with varying degrees. Traditional medical practices of tribes include ritual healing, magico-religious methods of treatment, herbal medicine and so on. This study has made an attempt to explore as to why centuries old health care practices continue to exert its influence on the health behaviour of the Oraon tribe. With the help of intensive field study among the immigrant Oroan community of West Bengal, who inhabit in central region of India.

It is very difficult to find the records of Oraon migration into this part of Malda district of the state of West Bengal. The investigation among the respondents revealed that the first phase of migration from Chota Nagpur began approximately in 1860s. There was an acute shortage of agricultural labourers in this part of India during the British rule. The labour contractors brought the tribal labourers from Chota Nagpur region to work as agricultural labourers. The Oraons were well known for hard work and as agriculturists and earth workers. In course of time they were taken to Bangladesh. There local landlords also engaged them as earth workers in railway construction work as well as employed as agricultural labourers. They were also provided with some land for their livelihood. There was also vast forest area, which was free from human habitation. The Oraons cleared the forest areas and turned the land into agriculture land and settled down permanently there for almost a century, until they were forced to leave Bangladesh, during the ethnic problem that broke out during 1956-57. Compelled by the ethnic problem they migrated to India as refugees and settled down in the boarder districts of Malda and West Dinajpur. A large section of this Oraon immigrant population together with the 'native Oraons' is studied for the purpose of present investigation. The Oraons make some distinctions between those who did not move out to Bangladesh and remained in India are referred to as '*native Oraons,* or *sthania*, meaning original settlers and the immigrants from Bangladesh as refugees. Most of the immigrant Oraons had taken the title of *Sardar* in Bangladesh to which they still use, though they know it is not their title.

The present research on health care practices among the Oraons inhabiting in rural environment is of immense importance for analysing their health behaviour under the impact of modern medicine. The health care of the community under study has been analysed from the comparative perspective, following the criteria of proximity and distance from the rural hospital. Due consideration also has been given to discover reasons for continuity of their age-old or traditional health care practices. All the seventeen Oraon villages / hamlets located at different areas under Bamongola Block, PS. Bamongola, District Malda, in the state of West Bengal have been studied, which account for 494 households.

From the review of literatures it is observed that the trend of research in the field of health care practices, illness and diseases have theoretical as well as practical relevance.

II

The Oraon tribe is one of the major tribes, largely inhabit in the Central India. The main concentration of Oraon population in India is in the states of southern part Bihar, which at present forms the newly created state of Jharkhand, Madhya Pradesh, West Bengal, Orissa and Assam. Some Oraons are also found in Maharasthra state. According to 1991 Census of India, the total Oraon population is about 26, 50,939, excluding the Oraon population of Assam. The plateau of Chota Nagpur forms he principal center of Orisons.

West Bengal is said to occupy third place in India with regard to Oraon population, first being the state of Bihar, (now the major tribal belt forms the part of Jharkhand), followed by Madhya Pradesh. Among the Scheduled Tribes, the Oraons constitute the second largest Scheduled Tribe population of West Bengal, who account for 11.48 per cent of the total Scheduled Tribe population. Verma (2000) mentioned the total Oraon population of West Bengal to be about 5, 36,010, out of which 2, 74,563 and 2.62,356 persons are males and females respectively. As per Census of India 1981, the major concentration of Oraon population in West Bengal is found in the Districts of Jalpaiguri (2, 56,972 persons) Darjeeling (47,322 persons), West Dinajpur (36,382 persons), 24 Parganas (31,855 persons), and Malda (8,953 persons). Out of the total Oraon population of the state 4, 22,178 and 15,396 persons inhabit in rural and urban areas respectively. It is very clear that the Oraon community, primarily, consists of rural population. At present not all the Oraons speak their own mother tongue, called *Oraon* or *Kurukh*

The principal occupation of the Oraons in the state is agriculture and many of them are agricultural labourers also. In other words, excepting unskilled labourers in the tea plantations of Jalpaiguri, Darjeeling and West Dinajpur Districts, the majority of the Oraons of West Bengal are engaged as cultivators, agricultural labourers and marginal farmers and other labourers.

In the District of Malda, the Santals form the largest Scheduled Tribe population. As per 1971 Census of India, The Santals constitute about 8.11 per cent of

the total population of the district and 5.16 per cent of the total Scheduled Tribe population of the state of West Bengal. The Oraons are the second largest Scheduled Tribe population of West Bengal as well as of Malda district. In Malda district the Oraons account for 10,325 persons (1981 Census) out of which 48.51 (5009) per cent and 51.49 (5316) per cent are males and females respectively. The literacy rate was very low among the Oraons. A vast majority of them, e.g. 93.56 (9660) per cent population is illiterate which comprises of 43.48 (4489) per cent and 50.08 (5171) per cent males and females respectively. The rate of illiteracy of all Scheduled Tribe also was very high e.g.92.42 percent as per the Census 1981(Table 8).

All the households in Oraon villages / hamlets of the present study area (Bamongola Block, District Malda) were surveyed. There are a total of 494 Oraon households in the block, which constitute a total population of 2274 persons, out of which 51.45 (1170) per cent are males while 48.55 (1104) per cent are females (Table 11). The literacy rate has just crossed the fifty per cent mark which accounted for 53.44 (1041) per cent, consisting of 33.11(645) per cent males and 20.33 (396) per cent female population (Table 12). So the literacy rate among the Oraons was very low, much lower than the average national literacy rate of 65.38 per cent according to census of India 2001. Further, the sex ratio literacy rate showed a very dismal picture. The ratio of males and female literacy was 33.11 per cent and 20.31 per cent respectively. On the other hand, illiteracy was much higher among the females, compared to males. Only 20.33 per cent female population was literate in comparison to 28.49 per cent males. Further, a vast disparity in the attainment of educational standard was recorded. Out of the 64.17 (668) per cent, only 28.53 (297) per cent and 35.64(371) per cent of the female and male population respectively, had attained primary level of education. On the other hand, only 10.57 (110) per cent of females had managed to reach up to junior high school level of education as against 18.06(188) per cent males, out of the total of 28.63 (298) per cent. High School level of education was very poor. Only a total of 6.05 (63) per cent of the people managed to attain high school level of education, of which 1.92 (20) per cent and 4.13 (43) per cent were females and males respectively. Not a single female was found to make up to Higher Secondary (HS) and graduate level of education. Among the males as well the per cent of population who attained HS and graduate level of education was very negligible. Only 0.96 per cent and 0.19 per cent could manage to make up to HS and graduate standard of education respectively (Table

13). Thus a vast disparity was found to prevail with regard to attainment of educational standard among males and females.

The patterns of land holdings revealed that 45.54 (225) per cent were poor marginal farmers and 24.29(120) per cent comprised of landless class, 17.41(86) per cent small farmers and only a small per cent, e.g. 0.40(2) per cent, 0.61(3) per cent and 0.81(4) per cent of the respondents possessed land between 12.1 - 15 bigha, 15.1-20 bigha and 0.81(4) per cent occupied land 20 bigha and above (Table 14) respectively. The land 15 bigha and above was considered sufficient to sustain their family.

The largest per cent of the population, e.g. 45.15 (647) per cent belonged to owner cultivators, who also employed themselves as wage labourers in others' land, while 25.61 (367) per cent of the people were primarily agricultural labourers, and 1.88(27) belonged to the category of other wage labourers. The people, who owned sufficient amount of land, usually did not engage themselves in other than agricultural related occupations. They belonged to owner cultivators' category, which consisted of 25.26 (262) per cent of the population, who primarily cultivated their land with the help of agricultural labourers (Table15).

The economic condition of most of the people under study was very poor. They belong to underprivileged section of the society who derives their income primarily from agriculture and allied agriculture occupations. A great majority of the families were found to live on their meagre income. It was found that 2.83(14) per cent of the people earned their yearly family income below Rs. 5000 and 22.87 (113) per cent, 37.25 (184) per cent, and 17.61 (87) per cent belonged to the yearly income category between Rs.5,001-10,000, Rs.10,001-15,000, Rs.15,001- 20,000 respectively. Only 4.45 (22) per cent of the people earned up to Rs. 30,000 yearly. On the other hand, 6.88 (34) per cent of the people who earned their income more than Rs. 30,000(Table 16) were considered as well off people.

The analysis of the data (Table 17) on family structure revealed that 65.18 (322) per cent of the families consisted of nuclear families followed by joint families which accounted for 20.24 (100) per cent. On the other hand, the extended, broken,

conjugal and incomplete families consisted of 0.81(4) per cent, 6.28(31) per cent, 5.26 (26) per cent, and 2.23 (11) per cent respectively. The data revealed that nuclear family type was the most dominant type of family among the Oraons studied. Regarding family size, it was recorded that 45.54 (225) per cent of families composed of small family, with 2-3 members while 50.00 (247) per cent belonged to the category of large family size having 5-8 family members. It was also observed that 2.23 (11) per cent of the families consisted of more than 9 members (Table 18). It was very apparent that nuclear type of family was found to be a dominant type but in terms of the size of family, the nuclear families also composed of large members. The marital status of the population shows that 46.92(1067) per cent and 50.57 (1150) per cent were married and unmarried respectively. The number of widows, widower and divorcee consisted of 1.28 (29) per cent, 0.84(19) per cent and 0.40 (9) per cent respectively (Table 18). The marital status included 46.92 (1067) per cent married population consisting of 21.86 (497) per cent male and 25.07 (570) per cent females while total unmarried population comprised of 50.57(1150) per cent of which 27.53 (626) an 23.04 (524) per cent were males and females respectively (Table 19). All the households, accepting one Christian household, studied followed Hinduism.

III

Health of any community was profoundly influenced by prevailing general environment and sanitations. Therefore, it necessitated delineating the general environment and sanitation. It was found that general environment and sanitations were very poor. Housing condition was found to be in a very poor state. Disposal of household wastes and cow dung were dumped close to the houses in the open places or pits. Habits and practices of open air defecation also posed a threat to pollution of soil and sources of ground water which was used for practically all purposes, such as bathing, washing clothes, utensils etc. None of the Oraon households had sanitary latrines at home. So the general surroundings of the villages were found to be unhygienic and polluted which was a very serious cause of concern for causing various diseases and ailments during rainy season. Personal health and hygiene like daily bathing, teeth cleaning, washing and changing clothes etc. were of not very high order.

Habit of intoxication was another important element related to health hazard. Consumption of alcohol like *haria,* home made rice beer, *todi,* fermented palm juice and locally brewed liquor (*daru / chullu*) was rampant. Smoking *bidi* and chewing tobacco were very common among men. Smoking habit was also found among elderly women. When questions were asked about the effect of consumption of alcohol and smoking, most people were not aware of it or cared little about it.

The principal diet of the Oraons consisted of rice, pulse (*dal*) and some vegetables. Meat and fish was not taken on a regular basis. Neither the pregnant women take any additional nutritive food nor were the children given any special nutritive food items. Malnutrition was a serious problem among the children, which affected their health condition. Malnutrition also reflectd their poor economic condition.

Social and religious lives of the Oraons were centered on religious worships and social gatherings. Important religious festivals of the Oraons are *Asadi puja. Sarhul* or *Khaddi* and *Karam or Karma.* Agriculture festivals include *Bichan puja* (Puja relate with sowing of seed), *Dhangar*i (festival related with paddy transplanting), *Nobanno* (festival related with eating of new rice) and *Khalihan puja* (festival of threshing paddy). Besides these there are festivals related with cattle, e.g. *Sohrai* or *Gowal puja.*

The religious life of the Oraons was centered on belief and worship of numerous gods, deities, household spirits, village deities, ancestoral worships and evil spirits. The Oraons were found to be very particular about observing religious rituals and rites in appointed times to keep appease those various deities, so as to protect themselves from their wrath that may bring disease or ailments. It was also considered as a part of spiritual activities

IV

The present study revealed that the concept and the causes of disease and illness were very much influenced by the culture, religion and beliefs in various supernatural forces and agents. The Oraons try to comprehend and explain various

causes of illness and human sufferings through various causative agents or forces, like wrath of gods, deities, evil spirits, witchcraft, sorcery, breach of taboo and some natural forces.

For the analysis of data regarding health care practices all the seventeen Oraon villages/hamlets were divided into two groups - one located in the vicinity of the rural hospital, within the area of 3kms approximately and the other group of villages situated at a distance more that 3kms from the hospital. The purpose of classifying these villages into two categories was to investigate what extent the modern medicine or health facilities and services had exerted influence on their traditional concept of disease causation. It also attempted to investigate the impact of modern health services and facilities on these two sets of villages. The investigation revealed that there was no significant difference between these two sets of villages with regard to concept of disease causation and its treatment. Magico-religious causes of disease were deeply rooted in the Oraon society and culture.

Oraons made a very clear distinction about natural and supernatural causes of diseases. Hence, they believed in and used traditional methods of treatment or healing practices, such as medicine prepared from ingredients of herbal items and other non-herbal items e.g. bones of animals and birds, and also adopted supernatural methods of treatments like propitiation, exorcism, ritual healing and so on. Indigenous medicine men still continue to play an important role in the Oraon society during illness and afflictions. The respondents held the view that the indigenous medicine men were needed and considered essential in their society and they could not do away with them. The Oraons under study constitute a homogenous group socially and culturally, and economically, therefore, no significant difference was found in their perception of disease etiology and their treatment. The people in both sets of villages still strongly believed in village medicine men like *ojha, kabiraj, gunin, baid* etc.

V

Data pertaining to modern health care practices of the Oraons has been analszed on a comparative perspective; from the perspective of proximity and distance from the hospital, with the objective of comparing the health care practices or health behaviour of the Oraon tribe. The study showed that the people inhabiting in villages adjacent to rural hospital were found to avail modern medicine and utilize facilities relatively more than those who lived in remote villages vary far from rural hospitals. The factors like easy availability and accessibility were observed to influence the health behaviour of those who lived in the vicinity of the rural hospital. This section of the population was found to avail and utilize modern medicine more than those who resided in remote villages away from the rural hospital. So to some extent distance factor did pose problem for adoption of modern health services but it was not the only factor

The Oraons of both sets of villages were not averse to modern medicine and treatment. The efficacy factor and the perception regarding causes of diseases were found to be important determinants for deciding the type of treatment/ medication to be adopted. Usually, the population of isolated villages or areas was more dependent on the traditional medicine men or the village doctors. The village medicine men were also not always opposed to modern medicine, but they did try to provide some form of treatment at the initial stage of illness. The data (Table. 33) revealed that 37.28 (85) per cent of the people in the villages close to rural hospital sought treatment first from indigenous medicine men while a very large section e.g. 62.78 (143) per cent of people directly sought modern treatment. On the other hand 70.68(188) per cent people of far away villages sought traditional treatment first while 39.32 (78) per cent directly sought or preferred modern medicine. Therefore, adoption of the type of treatment was dependent on their perception regarding causes of diseases. Of course, village medicine men like, the *kabiraj, ojha* or *gunin* also played a very deciding factor for the kind of treatment to be adopted. The lay people were in no position to decide for themselves the disease etiology. Modern medicine was preferred to traditional one with regard to natural causes of diseases. A very large section, e.g. 89.91(205) per cent and 74.06(136) per cent (Table34) of the population of the village adjacent to rural hospital and away from it respectively, preferred modern medicine

for the ailments perceived to be caused by natural forces or agents, where as a small number of the people were dependent on the *kabiraj or* village medicine man. Field inquiry regarding treatments of ailments in general revealed that despite having faith in modern medicine, they favoured the co-existence and continuity of both traditional and modern treatment.

Mother-child health care constitutes one of the very vital areas of modern health care practices. The field investigation revealed that the mothers were not much aware of the need of antenatal care yet 64.68(152) per cent and 55.74(136) per cent (Table 41) of the mothers living close to rural hospital and away from it had received antenatal services respectively from nearest health institution. The National Health Policy aims to provide total antenatal care for all mothers. But a sizable section of the rural people and particularly, tribal people still did not avail antenatal care services provided by Government health institutions, e.g. rural hospital/primary health centers /sub-centers. A total of 35.32 (83) per cent and 44.26(108) per cent of the mothers who lived adjacent to rural hospital and far from it, respectively, had not availed the antenatal services or had not completed the course or reported to be very casual in approach regarding antenatal care provided by the rural hospital / primary health centers / sub-centers. However, data has revealed positive aspect with regard to utilization of antenatal services by tribal women.

Though a very large section of the tribal mothers received or availed antenatal care / services from rural hospital/primary health centers / sub-centers, yet with regard to child delivery they were very tradition bound. All the normal cases of child deliveries, which accounted for a very high percentage e.g. 93.62 (220) per cent and 95.16 (236) per cent (Table 44) had taken place at home, attended by untrained mid-wife or *dai ma* or *kusrain* of the community. The practice of institutional delivery was not found in normal cases. The respondents, for this practice of child delivery at home provided several reasons. Adherence to their traditional practices was one of the important one, followed by economic constraints. They also asserted that they were not accustomed to child delivery at hospital, felt uncomfortable attended by male doctors, thought child delivery as a normal phenomenon and failed to understand the risks involved to the mother and the child.

Regarding immunization of children the Oraons were not very keen or interested or aware of the need for it, yet 93.75(210) per cent of the households near rural hospital and 86.67 (208) per cent (Table 46) far from it had got their children vaccinated/ immunized. This was possible due to propaganda and persuasion by health workers. Left to themselves they will not come forward for immunization of their children, for they are still unaware of the need for immunization. They fail to understand the implication of immunization of children.

The concept of family planning and birth control were also absent among the Oraons. Sterilization was the only birth control measure they were aware of. A total of 36.40 (166) percent of women had been reported to be sterilized, of which 39.81(86) per cent and 36.40(80) per cent of women respectively, were the inhabitants of villages near the rural hospital and the other away from it. This difference was not considered very important because proximity or distance factors had no direct relation to it.

Complex and multifaceted constraints have been found for adoption of modern health care practices among the Oraons community. The most crucial constraint was non- availability of adequate medical facilities and services at rural hospital/primary health centers. The common complaint made was that medicine free of cost was not available, excepting some cheap medicine. The most of the medicines prescribed by the doctors from rural hospital had to be purchased from out side medicine shops which were beyond their purchasing capacity since most of them were economically very backward. Diagnostic facility such as X-Ray, testing blood etc. was not available or did not function properly due to either lack of proper maintenance or lack of technicians. Except blood test for malarial virus and *kala-azar* and tuberculosis, no other blood testing facility was available. There were delays, some times a couple of days, due to procedural problems in the hospital for X-Ray and blood tests. All other tests had to be done out side which were very expensive for the poor tribals. The common notion also prevailed that doctors at the rural hospital neither examined the patient with proper care nor listened to their problems. Not caring attitude of the doctors also had discouraging impact for not availing services of the rural hospital. The infrastructure of the hospital was also very poor and inadequate. All the wards for

in-patients were very ill maintained. The hospital at the out door clinic/check ups were over crowded. Patients had to wait in queues for hours, which created problems. There was a shortage of doctors and other health personnel. The poor doctor-patient relationship was also not less constraining factor. The people who lived very isolated villages, especially, during monsoon, when the mud road became very muddy, when transport facility was not at all possible also reported the difficulty in accessibility. On the other hand people inhabiting in villages adjacent to the rural hospital had no such problems. So they were found to utilize services of the hospital comparatively more. On account of the above constraining factors the modern health institution has failed to impress upon the poor tribals. Majority of the respondents had expressed dissatisfaction over availability of health services, inadequate supply of medicine, blood testing facilities, poor infrastructure etc. Above all they have their own traditional beliefs and practices with regard to disease etiology and indigenous methods of treatments, which still have a great impact on their health care practices. All the above constraining factors together with their traditional beliefs and perceptions regarding causative agents and beliefs in magico-religious method of treatment acted as barriers for adoption of modern health care practices.

To sum up it must be said that the health status of the Oraons under study is very poor. It is not on account of the non-acceptance of modern medicine, rather it involved a multifaceted complex factors, ranging from cultural beliefs, values, norms, religion, orthodox values and tradition, superstition, ignorance and illiteracy, poor economic condition and isolated living. Analysis of the data shows that availability of doctors, availability of medicine, drugs free of cost, blood testing facility and other diagnostic facilities and easy access would help in promoting rural health in general and health of the tribal people in particular, who have been the victims of socio-economic marginalization due to isolated living.

Even in the phase of transition, considerable traditional medical beliefs and practices pertaining to health care continues to persist among the Oraon tribal community. But at the same time the Oraons are not averse to accepting modern medicine. Depending upon the nature of disease etiology the Oraon tribal community pragmatically avail the services of both traditional and modern system of medicine.

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Appendix:Names of Diseases,Medicinal Herbs with local names & methods of Preparation

Name of diseases with local names in brackets	Name of herbs /plans / Medicinal items with English / Botanical / terms given in the (where ever possible)	Methods of preparation of Medicine	Methods of application / administration	Remarks
Jar (Fever)	i) *Kalsola*, roots of *suli* tree, *golmarich* (pepper) roots of *bohera* (Beheric myrobalem). ii)Roots of choi (Piper chaba hunter)Chirata Andrographics Paniculata) Amla (Embelica officianalis) Bahera (Beleric myrobalam).	i) Paste prepared by grinding the ingredient with some water. ii) About 50 gm. Of each item is boiled in two liter of water, until the water reduced to about half a liter. Some black salt is added.	i)Dose: Taken two spoons thrice a day. ii) Dose: Two full spoon,2 / 3 times a day.	— —
Kala-azar	Golmarich (Piper nigrum), *sudhamochan, ishwar mul* (aristolochia indica).	Ingredients of these three items is crushed to prepare medicine	Taken daily, morning and evening.	
Kaula (Joundis)	i) *Halud* (Curcuma longa),leaf of *arhar* (Cajanus indicus0 and *akher-gur* (jaggery). ii)Cheng mach (A kind of small fish) and arhar (cajanus indicus). ii) Bark of mango tree (mangifera indica). iv) *Talmishri and takma.*	i)Raw turmeric, leaves of *arhar* and jaggery are mixed and crushed together and boiled. ii) Small fish and *arhar* is cooked together. ii) Juice extracted from bark of mango tree which bears very sour fruit.	i)Orally taken 2 /3 times a day. ii)Eaten with rice. iii) Takel / 2 spoon twice a day, in empty stomach in the morning and in the evening. iv)Applied externally on both palms of both the hands during night before sleep and palms are washed the next morning facing east ward while the Kabiraj faces west ward.	

Name of diseases with local names in brackets	Name of herbs /plans / Medicinal items with English / Botanical / terms given in the (where ever possible)	Methods of preparation of Medicine	Methods of application / administration	Remarks
Sitali / Basoli (Paralysis)	i) Roots of konark dhatura,ada (ginger) golmarich(Piper nigrum)akonda (calotropis gigantia). ii) Pure Ghee	i) About 50 gms of each ingredient with five pieces of golmarich is ground to obtain paste.	i) After enchanting mantras /Jhar phunk(divination) by the kabiraj, the paste is externally applied on the affected part of the body. ii) After ritual of divination ghee is applied on the affec-ted part of the hand/leg	
Jakkaka (Tubaerculosis)	Doi (curd), leaves of jamun (syzygium cumini) ek-barna dudh (Milk of one coloured cow)	Juice extracted from jamun tree is mixed and diluted with milk.	Dose: Orally taken 1st day five times 2nd day four times 3rd day three times	
Typhoid	Leaf / bark of *bakos* tree (justicia Gandrussa), *soma* leaf, chirata (andrographics paniculata)	Juice extacted from leaves / barks of theses planta/ tree.	Orally taken: about two spoons twice in the morning and evening	

Name of diseases with local names in brackets	Name of herbs /plans / Medicinal items with English / Botanical / terms given in the (where ever possible)	Methods of preparation of Medicine	Methods of application / administration	Remarks
Kasi (Cough & Cold)	i) Bosak (justicia gandrussa) pipal tree (ficus religiosa)	i)leaf of bosak tree (about100gm) and fruit of pipal tree are crushed to make a paste.	Orally taken	Given only f adults .
	ii)Garlic (allium sativum)	ii)Garlic about 100 gm) is fried in apprx. 250 gms of mustard oil	Externally applied all over the body	
	iii)Grain of rice, ginger (piper nigrum), turmeric and dry chilli.	iii)Mixture of ginger, turmeric, chili and fried grain of rice crushed together	Orally taken three times a day—morning, noon and night.	
	iv) Pat sindur, salt	iv)Sufficient amount of leaves of Pat sindur plant is steamed a bit to obtain juice and the juice is mixed with salt	Orally taken once only in the morning.	
Sukna Kasi (Dry Cough)	i) Tobacco leaf, golmarich (black pepper)	i)Tobacco leaves are boiled in some water, until the water is steamed out. After it cools down *talmisri* is added and crushed to make paste / powder.	Orally taken 3/ 4 times a day about one spoon.	
	ii)Gulancg, golmarich (black pepper)	i)Juice of gulanch, black pepper and talmisri is boiled in about 100gms of water.	Taken thrice a day.	

Name of diseases with local names in brackets	Name of herbs /plans / Medicinal items with English / Botanical / terms given in the (where ever possible)	Methods of preparation of Medicine	Methods of application / administration	Remarks
Gastric	i)Beal fruit (aegle Sutki fish(dry fish) ada / ginger (zinbiber officinale) Orange (Citrus reticulata blanca),bedona (pomegranate) padda (lotus) ii) Mango tree (Mangifera indica),jamun tree(syzygium cumini), golmarich (pepper nigrum), tulsi leaf (ocimun sanctum) & talmisri.	i)Dry beal fruit, dry fish, ginger, dry peal skin of orange, dry seeds of pomegranate and seeds of lotus are crushed together to make bhori(tablets) ii) Barks of mango tree, jamun tree,are soaked in about 200 gms of water for some times and then filtered by loin cloth and talmisri and juice of tulsi leaf is added to make syrup.	day Orally administered 3 / 4 times a day. Taking in empty stomach in the morning is must, followed by noon and at night	
Rakta Amsa (Blood dysentery)	i)Fruit of *bot gach* (banyan tree-Ficus Benghalensis), *Babul gach* (Babul tree-Ficacia Arabia),guava tree(Psidium Guava) better gourd (Momordica charantia) and Kalmegh (Andrografsaphis paniculata). ii)*Kul* tree (Tizyphus jujuba) leaves of patherkuchi (Aromatic medicinal herb)	i) Tender fruit of banyan, guava, bark of Babul tree and Chireta and bitter gourd are ground together to make paste. ii) Cashew of *kul* tree and leaves of aromatic medicinal herbs ground together and paste is prepared	i) Taken three times a day-morning, evening and night. ii) Taken three times a day.	i) Taking Row oil, Small fish, and all Kinds of sour food items is avoided.
Sada Amasa (White Blood Dysentery)	i)Tender fruit of guava(pisidium guajava), roots of kul tree (tyzyphus jujuba granatum), black pepper (piper nigrum)	i)Tender guava fruit and roots of tyzyphus jujuba and promagrate and black pepper are mixed amd ground to prepare tablets	i)Dose: One tablet is taken three times a day.	

Names of diseases with local names and English term in brackets.	Names of herbs/plants/ medicinal items used for preparation of medicine with English/botanical terms give in brackets wherever possible	Methods of preparation of medicine.	Methods of Administration/ Application	Remark
Jakka/yak (tuberculosis)	Doi (curd), leaves of jammun (syzygium cumini) ek- barna dudh (milk of one coloured cow)	Juice extracted from jammun tree is mixed and diluted with milk.	Dose: orally taken 1st day five times 2nd day four times 3rd day three times.	
Typhoid Kasi (cough&cold)	Leaf/bark of *bakos tree* (justiciaGandrussa),soma,leaf, chirata (andrographics paniculata) i.Bosak (juisticia gandrussa)papal tree (ficus religiosa) ii.Garlic (allium sativum) iii.Grain of rice, ginger (piper nigurm),turmeric and chilli. iv.Pat sindur, salt.	Juice extacted from leaves/barks of theses planta/tree i.leaf of bosak tree (about 100gm) and fruit of papal tree are crushed to make a past. ii. Garlic(about 100gm) is fried in apprx. 250gms of mustard oil. iii.Mixture of ginger, turmeric, chili and fried grain of rice crushed iv.Sufficient amount of leaves of pat sindur plant is steamed a bit to obtain juice and the juice is mixed with salt.	Orally taken: about two spoon twice in the morning and evening. Orally taken Externally applied all over the body. Orally taken three times a day. Orally taken once only in the morning.	 Given only to adult. Given to children only.
Sukna kasi(Dry cough)	i.Tobaccoleaf,golmarich(black papper) ii.Gulanch,golmarich(black papper)	i. Tobacco leaves are boiled in some water until the water is steamed out. After it cools down *talmisri* is added and crushed to make paste/powder ii. Juice of gulangh, black pepper and talmisri is boiled in about 100gms of water.	Orally taken ¾ times a day about a spoon. Taken thrice a day.	

Names of diseases with local names and English term in brackets.	Names of herbs/plants/ medicinal items used for preparation of medicine with English/botanical terms give in brackets wherever possible	Methods of preparation of medicine.	Methods of Administration/ Application	Remark
Gastric	i.Beal fruit (aegle marmelos) Sutki fish (small fish dried in theSun), ada (ginger (Zinbiber officinale) orange (Citrus reticulate blanca), bedona (pomegranate),padda(lotus) ii. Mango Tree(Mangifera Indica), jamun tree(syzygium cumini), golmarich(pepper nigrum), tulsi leal(ocimin sanctum) & talmisri(sugar candy).	i. Dry beal fruit, dry fish,ginger, dry peal/skin of orange, dry seeds of pomegranate and seeds of lotus are crushed together to make bori(tablets). ii.Barks of Mango tree, jamun tree are soaked in about 200gms. of water for sometime and then filtered in loin cloth and talmisri and juice of tulsi leaf is added to make syrup.	i. Orally taken one spoon, 3 / 4 times a day. ii.Orally administered 3 / 4 times a day, in empty stomach followed by noon and night.	
RaktaAmasa (Blood dysentery)	i.Fruit of bot gach(banynan tree/ficus benghalensis), babul gach(ficacia arabia),guava tree(psidium guava), bitter gourd(momordica charantia) & Kalmegh(andro grsaphis paniculata) ii. Leaves / Bark of kul tree (Tizyphus jujube) and patharkuchi (Aromatic medicinal herbs)	i.Tender fruit of banyan tree, guava,bark of babul tree and crireta and bitteer gourd are mixed and ground together to make paste. ii. Cashew of kul tree and leaves of aromatic medicinal herbs ground together and paste is prepared.	i.Taken three times a day morning, evening and night.	i.Taking raw oil, small fish and all kinds of sour food items ii.Taken three times a day.
Sada Amasa (White blood dysentery)	i.Tender guava fruit (pisidium guava) roots of kul tree (Tyzyphus jujube granatum), black pepper (piper nigrum).	ii. Tender guava fruit and roots of tyzyphus jujube and pomegranate and black pepper are mixed and ground to prepare tablets.	Dose: One tablet taken three times.	