HEALTH CARE PRACTICES AMONG THE ORAONS OF BAMANGOLA BLOCK IN MALDA DISTRICT: A STUDY OF CONTINUITY AND CHANGE

A THESIS SUBMITTED FOR THE AWARD OF THE DEGREE IN DOCTOR OF PHILOSOPHY IN ARTS

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2009

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This is to certify that Sri John Breakmas Tirkey has completed writing of his thesis on "Health Care Practices among the Oraons of Bamangola Block, Malda District: A study ~~in~~ of Continuity and Change". This is based on an intensive field work among the tribes of Malda. As a researcher, he is found to be fully committed to achieve his goal. The thesis may be placed before the examiners for adjudication.

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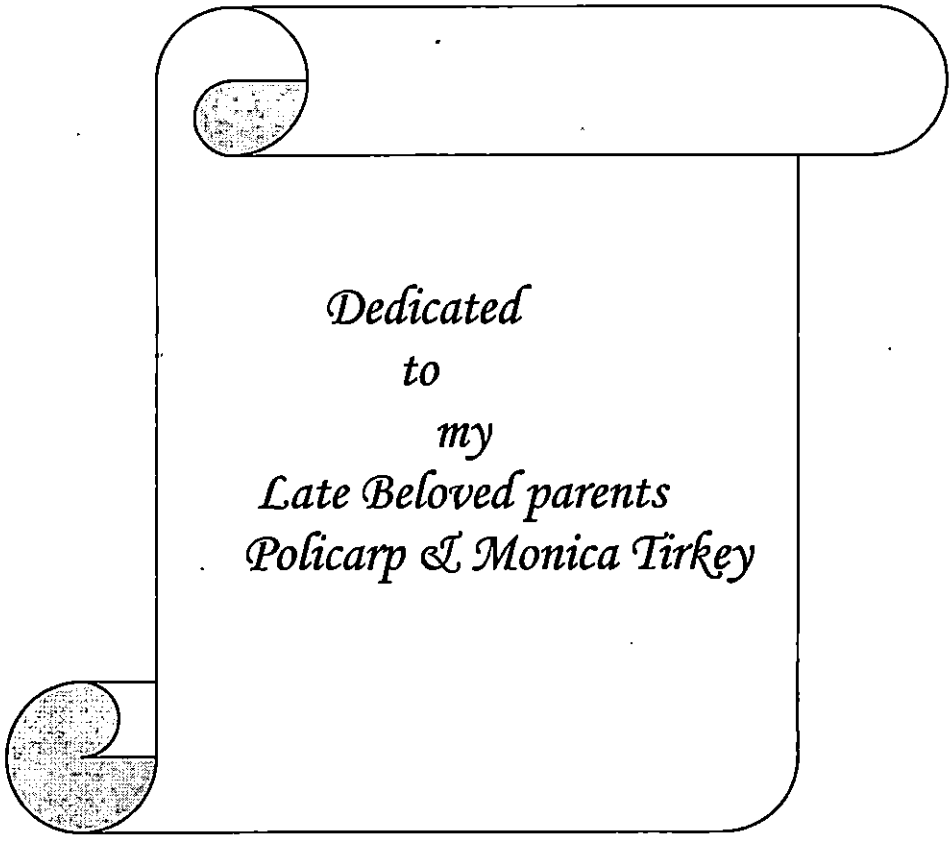
Dedicated
to
my
Late Beloved parents
Policarp & Monica Tirkey

ACKNOWLEDGEMENTS

This is the outcome for research, for my Doctoral Degree, on the health care practices on the Oraon tribal community, inhabiting in Bamangola Block, in the District Malda, West Bengal.

At the very outset, I express my sincere and deep gratitude to my guide, Prof. Ranjit Kumar Bhadra, Department of Sociology, University of North Bengal, for his scholarly and inspiring guidance all through my research work. Despite of his very busy schedule, he not only devoted time for my work, but also given constant encouragement, valuable advice and inspiration at various stages of this research.

I am also thankful to all my teachers and the faculty members, namely Prof. Rajat S. Mukhapadhya, Dr. Sanjay Roy, Reader, Dr. (Mrs.) Saswati Biswas, Reader, Dr. (Mrs) Mita Bhadra, Reader, of the Department of Sociology, University of North Bengal for their encouragement. I am specially grateful to Dr. (Mrs.) Mita Bhadra, Reader, for her constant inspirations and encouragement for completion of my research.

I also render my sincere thanks and gratitude to my Principal, Dr. Atin Bhattacharya, Pakuahat Degree College, Malda, for his support and encouragement and allowing me to do my research work. I am also very thankful to all my colleagues, of different disciplines, Pakuahat Degree College, for their support.

I am specially thankful to the President, Sri Jibendra Nath Bagchi., Governing Body Pakuahat Degree College. My specially thanks to Sri Sailen Sarkar, former President, Governing Body, Pakuahat Degree College, for allowing me to carry out this research. I am also thankful to all the members of the Governing Body, Pakuahat Degree College.

I extent my gratitude to the Director, Anthropological Survey of India, Kolkata for giving me permission to use ASI library. My sincere thanks to all the library staff of the ASI, Kolkata, who provided me with valuable study material for my work.

I am thankful to to the staff of the central library University of North Bengal for their co-operation and help in making available study materials for my research work.

My whole hearted thanks to my ex-student and assistant, Sri Paritosh Bhowmik for helping me all through the field work. I also extend thanks to Dipak Ekka, Telesphore Toppo and Pujanjali Sarkar for rendering help in various ways in connection with this research.

I also render thanks to Sri Gouranga Mandal, Clerk, Pakuahat Degree College, for doing the entire compilation of the thesis in the computer.

I extend my thanks to the B.M.H.O., Bamangola Block, for proving information regarding infrastructure facilities in the hospital and other information regarding health issues of the area. I am also thankful to all the Panchayat Members of the villages for their co-operation and help during my field work.

My thanks and gratitude to all the members of the Orion community. I always remember them with gratitude, their hospitality and co-operation extended to me during my field work, with out which it would have been impossible to complete my research. I am very indebted to them all.

I am also specially thankful to my friend Mr. Livinus Kujur and Mrs. Margaret Kujur, Bidhanpally, Shibmandir, for providing comfortable accommodation when ever, I went to the University of North Bengal for my research work.

I am also really thankful to all my family members, specially my wife Dipali and my daughter Michelle for their whole hearted help, co-operation and support who made a lot of sacrifices all through the research work.

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INTRODUCTION

Health care practices are integral part of any tribal social structure, religion and social organization. Practically all t4he tribal communities of the world have been practising their indigenous or traditional medical practices for centuries till today, with varying degrees depending upon the level of socio-economic development and influence of modern medicine. A large number of tribal communities still live in isolation from the mainstream of the country. Their isolated and secluded life prevents them from exploiting many of the advantages of modern civilization. They still depend on their own traditional medical practices, healing techniques and rituals when contacted by various ailments and disease. Methods of preparation and administration of folk or traditional method of treatment are still widely practised. Healing rituals and intervention of supernatural forces are integral component of the treatment procedure.

On the whole, traditional health care practices, traditional medicine, ritual and supernatural methods of treatment are integral part of tribal community. It is deep rooted in their religious belief system and cultural life, which is not completely and easily done away with, even with the impact of modern medicine. At the same time it must be kept in mind that tribals are not averse to accepting modern medicine. They are found to practise both traditional and modern medicines depending on the perception of the causes of diseases and ailments.

The objectives of this research is to investigate the health care practices among the Oraon community of Bamongola in the District of Malda in West Bengal to evaluate the continuity and changes occurring in the traditional medical system under the impact of modern medicine.

The Oraons are the second largest tribal community after the Santals in the state of West Bengal. The Oraons under study are one of the earliest inhabitants amongst the tribal groups. The Oraons under investigation are the migrant community in Malda District. The exact recorded information is not available, but the oral investigation reveals that they had arrived in the region from Chota Nagpur in Bihar (at present Jharkhand State) and adjoining districts of the states of Orissa and Madhya Pradesh in two phases. The first phase of migrant Oraons arrived in the region approximately, in the year 1860, which were brought by the British as agricultural labourers. The immigrants of the second phase were the refugees, who had migrated from Bangladesh in the year 1950-1951 and a few families in 1971. This group of Oraon refugees in course of time settled down in remote rural areas of Bamongola Block in Malda District of West Bengal.

Thus the research conducted on the traditional health practices among the early Oraon tribal inhabitants and the later arrival of the Oraons in Bamongola Block in Malda District of West Bengal. But the study on their traditional health care practices are investigated and analysed as a unit and not on a comparative basis between the two sets of immigrant communities. Hence the problem of the study is stated below.

STATEMENT OF PROBLEM

The problem proposed to be investigated in the present study is the traditional health care practices among the Oraons of Bamongola Block in Malda district and to analyse its continuity and change. It aims to study their traditional health care practices and the extent to which this system and health behaviours are influenced by various factors of change, mainly under the impact of modern medicine, e.g. Rural Hospital, Primary Health Centres (PHC) and PHC-Sub-Centres.

It will be of great significance to analyse and record the traditional health care practices of the Oraons from the point of view of modern perspective as to what extent and why they cling on to their traditional health care practices and to what extent they are utilizing the modern institutional health services and treatment available to them in Rural Hospital/ Primary Health Centers.

While studying the health problems of tribal communities, scholars often take a comparative perspective between Christian and non-Christians in their study. But the present study comprises of non- Christian Oraon population except a single Christian household.

At present the Oraons have adopted some Hindu culture, beliefs, festivals and other practices, yet they consider themselves as a separate ethnic group. Therefore, it is assumed that their culture may also have undergone changes to some extent. They also inhabit in a new ecological condition and social milieu different from that of Chota Nagpur. In the process of their migration to a distant alien land and culture and due to a long dissociation from their own larger culture and community, some of their cultural beliefs and practices may have undergone changes.

RELEVANCE OF STUDY

Tribal medicine, their health practices, namely, their traditional or indigenous health care practices and the changes taking place in it is the interest among sociologists and anthropologists. The study of health practices of tribal communities and their health problems is very relevant in modern times in view of acquiring knowledge of health care practices.The health behaviour and practices of the tribals are part of their social organization. The tribals more or less lead an isolated life from the mainstream of the population of the country. This isolation of their life and society prevents them from exploiting the advantages of modern health services and facilities. Many a times they are found to be rejecting the modern health services. On the other hand, they still depend upon their own traditional /indigenous health care practices during illness and disease. The traditional health practices of the Oraons, include-socio-magical aspects of diagnosis and healing practices, together with use of medicinal roots, barks, leaves, fruits etc. that are locally available.

This research is of great importance to analyse the causes and perception of diseases, to investigate the prevalence of traditional health care practices and to the extent it has changed under the impact of modern health services and facilities

provided by the Bamongola Rural Hospital / Primary Health Centres / Sub-centres, which are the primary institutional health care service providers.

The Oraons are the animistic tribe. But the Oraons under investigation have adopted some Hindu beliefs and practices. With regard to their health problems, they still depend very much on their traditional health care practices. Traditional practitioners or the village medicine men e.g. quacks, *ojhas, kabiraj* etc. play an important role in making diagnosis and providing treatment through both healing practices and herbal ingredients. But it is not free from the impact of modern medicine. Therefore, it is assumed that the Oraons living in proximity to Rural Hospital are utilizing modern health services more than those who comparatively, inhabit in villages far away from the Rural Hospital.

Therefore, the objectives of this research is to analyse and compare the existing indigenous health practices and changes taking place there upon among two sets of Oraon village –one located in the vicinity of rural hospital and the other group of villages situated comparatively far away from rural hospital. With this perspective relevant literatures have been reviewed in general tribal health and particularly, the Oraon tribal community.

REVIEW OF LITERATURE

In recent times, a good number of studies have come up on sociology of health, yet studies on medical beliefs and practices of tribal communities are few in India. Most of the studies in this field have been done during last two decades in India. Scholars of sociology of health have focused their researches on ethno-medicine, indigenous medical system, family planning, socio-cultural dimension and interaction between traditional and modern medical practices.

The studies associated with the field of indigenous medicine, ethno-medicine or traditional medical practices serve as an important theoretical background and broader conceptualization of this phenomenon.

The two established discipline - medical sociology and medical anthropology have made a very significant contribution in understanding the concept of health, illness, disease causation and their treatment. All these areas of studies are interlinked, yet for the purpose of convenience the various studies on health practices may be categorized into three groups; namely, ethno-medicine, interactional aspect between traditional and modern medical practices and the cultural aspect of medicine. The following reviews of literatures reflect the trend in research in ethno-medicine.

Subhabrata (2001) has analysed the health and economic status of the Santals in rural areas of Birbhum, Bankura, Burdwan, Midnapur and Purulia District in West Bengal. He pointed out that majority of the Santals under investigation were illiterate and living below poverty line and suffering from various diseases like tuberculosis, malaria, leprosy etc. Health services in the areas were poor. Whatever health facilities available were underutilized due to illiteracy and ignorance and a section of the sample household mainly dependent on local *kabiraj (*village quack doctor) for treatment. Again Troisi, (1978) also observes that the Santal religion consists of wide range of religious beliefs and practices, beliefs in supernatural powers, deities, spirits etc. The Santals also strongly believe in magic and witchcraft and supernatural powers which they believe as causing various sickness and illness. Hence appropriate sacrifices are made and propitiated to appease the spirits for treatment of illness and diseases.

Troisi (1998) has given a detailed presentation on tribal religion, religious beliefs and practices among the Santals. He describes various kinds of supernatural spirits and powers, some of which are considered benevolent while others malevolent. These spirits are believed to have a strong influence on the health of the tribals. The author illustrates, Hunter's classification of religious system as one of the terrors and depreciation and represents Santals as worshipers of malevolent spirits, whose sole aim is to cause drought, disease and death.

The Santals believe in a number of spirits and deities, each of which is believed to perform specific function. The Santals also believe strongly on magic and

witchcraft, which are associated with various sickness and diseases. Various supernatural spirits and powers are believed to be responsible for various diseases and illness and proper sacrifices are made or propitiated to appease the deities or spirits for treatment of illness and diseases.

Singh (1994) has summed up the report of the keynote address by Dr.Roy Burman of a seminar and emphasized that tribal health should be viewed holistically and in all perspective. Modern formal health system is inadequate to deal with tribal health because it touches only physiological aspects. On the other hand, tribal health system is a combination of herbal treatment acting physiologically, psychosomatics acting on the psyche and socio-psychology creating confidence in the individual and among the community, which may be described as health culture of tribes. The seminar also emphasized that tribal health system and the problem of health should be considered comprehensively and physical, psychological, socio-cultural, economic environment and concerned aspects should be taken into account. The author further says that system of health traditionally prevalent among tribal communities must be recognized and proper documentation of medicinal plants, herbs, roots, seeds etc. are to be made.

Srivastava and Saksena (1991) have examined the socio-cultural contours of the health and disease that existed in the primitive era and even continue to exist in 19th century. In primitive era treatment was not based on rationality but depended entirely on magic, spells, prayers, manual rites and dance. A religious preacher or a magician administered medicine. The religious beliefs and practices governed the diagnosis and cure of ailments. According to him the notion of disease depends rather on decision of the society than objective facts. In India disease has been attributed to extra-biological reasons such as disobedience to natural and religious laws, wrath of gods, sins and crimes committed by a person in present and as well as in previous life. The author stresses the point that diseases cannot be isolated from socio-cultural milieu. Diseases are not purely biophysical phenomena. Thus socio-cultural definition of disease is a dominant aspect of health and disease. So in modern era

preventive and social medicines are becoming integral part of every day medical practice.

Sujatha (2003) conducted fieldwork among a group of villagers in Persimmon Thevar in Thirumangan District of Tamil Nadu. In this field study, the author has tried to explore and unfurl the village folk medical knowledge, folk medical conception and health practices among the villagers. The author observed that though the villagers primarily attributed the causes of diseases to 'body constitution', quality of food, body system and diet, yet they also have a strong belief in supernatural causes of diseases and hence treatment of illness are given by folk practitioners, who administer medicine prepared from herbs, roots, leaves etc.

Basu (1994) has carried out a comprehensive health related studies among different tribal groups, namely, Muria, Maria, Bhattra, Halka, of Bastar District in Madhya Pradesh, Juansaris of Juansar of Bewar in Dehradun District of Uttar Pradesh, Kutia Khonds of Phulbani, Santal of Mayurbhunjh, Dudh Kharia of Sundergarh in Orissa. He used some parameters like female literacy, age of marriage, marriage practices, fertility, mortality, nutritional status of mothers, forest ecology, child bearing etc. His data analysis shows that mother-child malnutrition was a big problem of mother –child health resulting in high mortality.

Thakar (1997) has discussed about ethno medicine and tribal health – concept and cure of diseases, which are almost same among all tribes. They have a strong belief in supernatural causes of diseases e.g. spirits, anger of deities, magic, witchcraft and breach of taboo. The diagnosis of diseases is simple, done by shamans or ojhas or with the help of magicians.

Guha (1986) made a study on the folk medicine among the Boro-Kachris, a plain tribe of Assam. He states that folk medicine is a common practice among all communities and relates further that causation and cure of diseases are associated with religion and morality. On the other hand good health is a result of an honest and pious life while diseases and sufferings are the result of dishonesty, immorality and incest.

So the treatment of diseases is associated with religious rites. Boro-Kacharis have a strong faith in supernatural causes of diseases. Diagnosis of diseases follows divination and interrogation and treatment is sought accordingly, like prayers, propitiation, and sacrifices of animals to appease gods and to ward off evil spirits.

Bang (1973) has presented some current concept regarding small pox, *Sitala* in West Bengal. People believe that goddess *Sitala* is inside the patient when disease sets in and hence every wish of the patient must be fulfilled to keep the goddess appeased. The introduction of vaccination was considered violation of indigenous treatment and it was opposed for the fear that the wrath of goddess may be stronger and disease may be further aggravated. Therefore, herbal treatment and worshiping was favoured for treatment of small pox.

Srivastava (1974) in his study on folk medicine in some villages of Rajasthan an Uttar Pradesh has shown that the villagers generally use traditional knowledge and practices, habits, custom, magico-religious treatment as folk medicine in treatment of disease and illness.

Gupta (1986) has analyzed the tribal concept of health, disease and their treatment and pointed out that these concepts vary from one culture to another. Tribal community follows its traditional customs with regard to health, disease and treatment. He found that supernatural causes of diseases and supernatural means of cure was a common practice

Bhowmick (1980) highlights the concept of disease among primitive man and states that gods and goddesses are associated with various diseases. So the treatment of diseases follows certain sets of religious rituals, prayers and procedures.

Patnaik (1990) studied sociology of health, with a focus on the general sanitary conditions of Barpali village, which was found to be very low and poor.

Kar (1990) in his article, "Health and Sanitation Vs Culture" observes that social and cultural traditions significantly influence health of any community.

Kar and Gogoi (1993) studied health culture of the Noctes, major tribes of Arunachal Pradesh in the North East India. He pointed out that living condition of the people was responsible for most diseases. They also believe in supernatural causes of disease and treatment.

Joshi (1988) studied the traditional medical system among 'Khos', the Central Himalayan community. The 'Khos' usually do not differentiate between individual illness and other form of suffering. However, they relate illness and sufferings to natural and supernatural forces. They manifest the supernatural world in '*dos*' and the natural in '*bimari*'. The '*dos*'embraces all kinds of sufferings and misfortunes indicating illness of individuals and calamities of a larger group while '*bimari*'is indicative of bodily disturbances only. The author classified the healers into several categories as per this specialization such as i. *baman,* ii. mali-diviner, iii. *variyara,* iv. female specialist and v. doctor (non-traditional healer).

Behura (1991) made a study on the Koyas of Orissa. The author emphasizes that health and disease related to biological and cultural resources that of a community in a specific environment. In traditional societies these phenomena are rooted in social and cultural factors. They believe village medicine men and shamans posses a comprehensive knowledge about medicinal plants, herbs, wild fruits leaves etc. So they depend on a large extent on the indigenous medicine. Bagchi (1990) studied the health culture of the Munda tribe of Narayangarh, Midnapur District where he has highlighted the cultural factors influencing health status.

Sridevi (1989) discussed about the "Modern Women, Tribal Medicine and Social Change" among a nomadic tribe called Mundalavallu of Andhra Pradesh. Among this tribe both men and women healers play an important role in the society. A medicine man is conceived as specialist in preparing medicine and invoking the spirits, giving treatment to diseases caused by witchcraft or other evil spirits.

Gorer (1987) highlighted the role of Lama's faith in supernatural causes of illness and supernatural method of treatment. Lamas act as priests as well as diviners. To the Lepchas, the Lama is more a doctor than a priest.

Bhasin (1989) in his study presents that the Lepchas of Dzongu (Sikkim) had to trek a very long distance to avail hospital facilities upto Mangan. They also travel long distances to avail traditional treatment from a village medicine man. The Lepchas of Dzongu have indigenous system of medicine, based on herbs, other natural substance as well as supernatural forms of treatment. A local quack called 'Bongthing' or 'Jhankri' is widely employed in giving treatment of disease and illness.

Khare (1963) made a detail analysis of the concept of Jamoga (tetanus), which clearly reveals that the people of higher castes perceive the disease with the idea embodied in great traditions where as the people of lower castes seek explanations in supernatural forces.

Hasan (1965) brought out an important observation and stated that cultural factors affect the health of a community – like certain custom, practices, believes, values, religious taboos etc. may affect the health of community.

Kakar (1977) gave a picture of primitive folk and modern medicine. The history of the growth of Indian medicine to a great extent was mixed with theology and magico-religious conceptions. The origin of diseases was attributed to gods and goddesses and also believed to be caused by ghosts and evil deeds. Therefore, diseases were identified and the common notion held was that treatment or cure was possible both by herbs, charms, worships wearing of amulets etc. He was of the view that supernatural causes had a great influence on the health behaviour of people.

Foning (1987) in his book describes the Lepcha tribe, their culture, faith and belief in various malevolent as well as benevolent spirits. He discusses the institution of 'Mun' and 'Bonthings' which are ordained and have power to intercede and

appease different 'mungs' or 'bongthings' ward off unwanted malignant spirits by different religious rites, rituals and ceremonies. The author describes innumerable spirits that are responsible for various illness and disease.

Singh (1994) in his study reveals that indigenous medical system of the "great tradition and little tradition," predominantly prevails among rural and tribal population. Indigenous medical system has become part of their culture and life and continues to be an important source of medical relief to them. The tribes of Chota Nagpur e.g. the Hos, Mundas, Oraons, Kherias, Birhors etc. live in the "land of forest" (Jharkhand) and practise indigenous medical system completely. But it is in peril due to large-scale deforestation, devastating mining and massive industrialization in the heart of tribal land.

Gelner (1994) observes that shaman is known as a 'Jhankri' in Nepali Language. A shaman is usually a male who gives treatment to the patient and also performs priestly functions. Gelner (1994) in one of his studies observes that a large number of cases of diagnosis in one Kirtipur healers practice, a healer or a medium identifies 'spoiling action' as an action of a witch. The author points out that witchcraft and sorcery is widely prevalent in the Nepalese Society.

Levine (1987) made a study on the complex oracular possession and its importance in Hamla, a North Western District in Nepal. This study attempts to examine ethnic politics and ethnic interaction and tries to understand social inequalities in the region. His observation brings to light that the spirit possession finds the strongest support among the poor and the oppressed in every ethnic group. So the author emphasizes that the poor and the powerless have embraced the tradition mainly for the purpose to encounter exploitation from socially and economically superiors

Hitchcock and Johns (1976) have discussed elaborately about the spirit possession and shamanism among the Nepalese community of Nepal. The Nepalese believe in a number of supernatural beings. The authors have given four fold classification of spirit possession in the Nepal Himalayas –i.) Peripheral possession,

ii) Re-incarnate possession, iii.)Tutelary possession and iv) Oracular possession. The authors also discussed the concept of shamanism. A shaman is considered to be a specialist in healing, divination and allied social functions, allegedly by techniques of spirit possession and spirit control. A shaman is also a religious practitioner but primarily he is believed to be a curer or healer of illness and disease.

Rizvi (1991) made a study on the medical belief and practices of Juansaris. He has attempted to categorize the illness and disease believed to be caused by the intervention of supernatural beings (e.g. gods or deity,) or a non-human being (e.g.. ghosts, or evil spirit) and human being with a kind of supernatural power (witch or sorcerer|. These broad categories are further divided into sub-categories according to causative agent recognized by Juansaris: -

i. Divine wrath e.g. wrath gods and goddesses for sins and crimes and disobedience to religion.

ii. Wrath of non-divine sources: e.g. evil spirits and

iii. Ghosts.

Kannuri (2009) made a study on the Koya tribe of Andhra Pradesh, where the author has examined the koya's perception of health, illness and cure, illness behaviour and their health seeking behaviour. The author's finding was that Koya's concept of health was defined on functional perspective and be able to perform roles ascribed to individuals in their regular activities. The author has classified disease causing illness by natural or physical reasons which includes illness caused by humoral imbalance, injuries and animal bites. Sorcery was also attributed to be the major factor of disease and illness besides commission and omission of some certain activities that could cause illness to persons or entire village.

Kapoor and Kshatriya (2009) have studied the health cure practices of Dhodias of Valsad District of Gujrat in relation to demographic structure. The authors have observed that the Dhodias have their own traditional concept e.g. super natural, ancestor spirit etc. traditional way of treatment e.g. charm, animal sacrifice propitiation, worship and their preferences remain with traditional healing practices.

Of all other system of medicine Dhodias had preferred allopathic medicine. They consult private or Government Doctor at Primary health centres. The major problem of institutional health service providers was the lack of infrastructure availability of some basic facilities, other wise Dhodia community was well aware of modern system of medicine.

Karuna and Babu (2007) highlight issues of tribal health, Nagla (2007) also brings out the relation between culture and health care where as Seth and Dubey (2007) have used secondary sources to examine the health situation of tribal community and they have pointed out that poverty, malnutrition, intensified inequality, remote and secluded settlement, neglect of Government etc. responsible for poor health status of tribals in India.

Another area of studies gaining importance is the interactional aspect between traditional and modern system of medical practices. Some of the studies show the trend in this area.

Bhadra (1997) has made a study on social dimension of health of tea plantation workers in some tea estates of Terai region of North Bengal, (West Bengal). These tea estates primarily consisted of several tribal communities such as Oraon, Munda, Baraik, Gond, Mahali, Kheria, Santal, Sonwar, Nagesia, Nagbansi, Malpaharia, Kisan, Bhumihar Rabidas, Kharwar etc., besides some other caste like Nepalese and Biharis who are Hindus. The author has analysed the health culture of some major tribes e.g. Munda, Oraon, Baraik, Kheria, Ghasi, Mahali, Bhakata and Gond. He has taken a comparative perspective of health culture of tribal workers in tea estates—one having relatively good modern medical facilities and the other poor facilities.

His observation is that still tribal workers believe in supernatural causes of illness and disease but it is losing ground today. Generally, the study shows that with proper, adequate and easily available modern medical facilities the tribal workers accept modern medicine. And in tea plantations where medical facilities are better, acceptance of modern medicine is higher than the one with poorer facilities. Most

tribal workers are inclined to adopt and accept modern medical practices if easily available and accessible to them.

Basu and Mitra (2001) have made a general study on the health problems of the tribal communities in India in their article "Health Development Tribal Communities in India: Need for Action Research." They observe that the health culture of tribal community is closely linked with their health problems. They pointed out that the tribals have distinctive health problems, which are mainly governed by their habitat, difficult terrain and varying ecology. They say that among the primitive tribal community, insanitary condition, lack of personal hygiene, lack of health education and ignorance are the main factors responsible for ill health. Therefore, it is necessary for health functionaries to have proper knowledge about health culture of the tribes. They also pointed out that inadequate nature of health facilities, lack of respect of indigenous culture are mainly responsible for non-acceptance and distrust of the tribal people towards modern medicine. The poor health scenario is the result of widespread poverty, illiteracy, malnutrition, absence of safe drinking water, poor sanitary condition, poor maternal and child health and nutritional services.

Pokarana (1991) has carried out an empirical study in Jaipur District in Rajasthan in seventeen Panchayat Samitis area to examine the socio-cultural dimension of health and disease. The observations of his study were that most of the villagers believed sickness or disease to be the result of sin and fault in previous or present life. And so the villagers mostly consulted indigenous practitioners or traditional faith healers such as *ojhas*, priests and *bhopas* for diagnosis of various diseases. The personal hygiene and sanitary conditions of the villagers were found to be very low. The author puts forward his observation that the villagers rarely utilized the modern health services and facilities provided by the Government PHCs. But the villagers were not avers to visit private doctors and ayurvedic dispensary.

Thyagi (1997) has presented a descriptive account of his study on tribal health in anthropological perspective and puts forward hid view that the health of tribals depends on many interacting factors—such as poverty, malnutrition, poor sanitation, environmental factors and culture including life style, tradition, custom and culture

associated with health. The author observes that culture influences the health behaviour of a community and the methods of treatment. In case tribal community the treatment sought most was indigenous methods of treatment by village traditional medicine men rather than modern doctor/medicine.

Mahanta (2003) deals with folk treatment system of the tribal society in Eastern India. He observes that in the district of Orissa, West Bengal, Assam, Bihar, Madhya Pradesh and Jharkhand tribal groups still lack education and communication facilities and modern allopathic system of medicine and so the tribal people still have strong faith in folk medicine available in the areas. The author has pointed out three methods of treatment given by '*ojhas*'—medicinal method, sound method and divine method of treatment. Some tribals of these areas still prefer to use folk medicine prepared from herbs, plants, roots etc. by the '*ojha*' and he is considered as a rural doctor.

Carstairs (1977) made a study on the existing faith with regard to illness and disease and their remedies in two villages of Rajasthan and pointed out that the villagers had a strong faith in herbal and magical treatment and cure. The reasons for such type of attitude are that the traditional herbalist or magical curers gave assurances of cure to the patients while modern doctor did not. However it was pointed out that they were not totally averse to accept modern medicine. His important observation was that the people should be first made to accept the new and system and not introduce in a straightaway.

Carstairs (1983) in another study on the concept of illness and levels of prevailing hygiene, made a significant contribution by pointing out the reasons why modern (western) medicine has failed to improve upon the health of rural folk. His important observation was that the villagers attributed the causes of disease to supernatural forces or being, such as witches or sorcerer. The villagers had shown a strong faith on their traditional healers. He pointed out that modern medicine was accepted as an alternative method and used when traditional methods failed.

Sahu (1997) studied the health culture of the Oraons who live in different ecological, social and occupational background. He has made a comparative study of

the health behaviour of the Oraons-firstly those who live around Rourkela steel plant having access to rather sophisticated health facilities or Government health institution and some villages like Karbega and Hatibari having Government health facilities only. Some of the important observations of this study were –1.)Social, economic, religious and political factors do determine the access of the tribals to health institutions. 2.) Non-availability and non-accessibility to modern health facilities lead to relying on traditional method. 3.) Having opportunity of availability and accessibility the Oraons do accept modern medical practices and there are no strict traditional and cultural barriers to accept modern medicine.

Mital (1979) has analysed the interaction between modern and primitive medicine among the Santals. It was generally observed that the Santals do not avail modern medical health practices. On the other hand, they are heavily inclined towards primitive medicine. The traditional medicine man is known as '*ojha*' who also acts as a spiritual leader. They also have strong faith in witches. Modern health practice was not common among them.

Kumar (2008) carried out and intensive field work among the Kolam tribe in a village, named Junnapani under Jainath Mondal in Adilabad District of Andhra Pradesh. He followed traditional anthropological ethnographic approach both participant and non-participant observation for collecting primary data. The Kolam tribe attribute causes of illness to be both natural and super natural forces, active human agency like sorcery and non-human agencies like spirit (Daiyyam). So, ethno medicine and indigenous healers play an important role in the health care system with in the socio-cultural realm of kolam community. The author's observation was that the Kolam tribe still prefer ethno medical practice due to cultural acceptability and accessibility, cost effectiveness, and more efficacy. So, the Kolam have defferent categories of indigenous healers who provide medicines as well as mediated people and the spiritual world.

Maiti (2009) his study on ethonomedicine among the Bhotias, traditionally, a trading tribe of Chamoli District in the state of Uttarranchal found that they still have popular healing practices for curing of various ailments. The author stated that the

majority of Bhotias still prefer herbal to allopathic medicine. But the author's observation was that the health seeking behaviour of younger generation was shifting to modern allopathic medicine. Regarding concept of disease, he found that the Bhotias did not have clear concept related to disease or illness but all major ailments were attributed to supernatural forces.

Duarah and Pathak (1997) have discussed health practices among the Nishis, one of the major tribes of Arunachal Pradesh. Nishis practice animistic religion. The general health culture was reported to be poor. They attach least importance to health and hygiene during normal life. The Nishis have a wide range of indigenous method of treatment against various ailments. A strong faith in supernatural causes of illness and diseases are set to prevail among them. They also use local herbal medicine to a great extent. But it was observed that Nishis are becoming more conscious for better health under the impact of urban and semi urban areas.

The third aspect of studies emphasized is the studies on medical behaviour of people on general. Recently, several studies have been done in this area.

Xaxa (2008) has in his study, on the culture and ecology stated that knowledge of the treatment of diseases was very closely related to the Oraon community and its environment. The Oraons extensively used knowledge of herbal medicines found in the region for treatment of diseases, like headache, tooth ach, stomach pain, ear pain, fever wound dysentery diarrhoea etc.

Columbia and Wenzel (2000) give insight into the issue of health and culture. They stated that indigenous people all over the world – Scandinavian to Amazonian tribe, South Africa to American Nations, Australian aborigines etc., face problems due to traditional lands and life- ways being altered in the name of economic development. For indigenous people "health is linked to the health of the land, health of the culture and spiritual health. They stated that the World Health Organisation which defines concept of health as being physical, mental, social and spiritual wellbeing"(WHO 1946), does not cover the specific health habits and traditions of any culture, so it is difficult and more complicated to have general agreement on the cultural and social meaning on health practices.

The concept of health differs from tribe to tribe and nation to nation which is different for non-tribals. For indigenous people, knowledge of the land depends on contracts with other spirit world, which plays crucial part in ensuring health, reproduction of society, culture and the environment. For indigenous peoples, good health includes practising cultural ceremonies, speaking the language, applying the wisdom of the elders, beliefs, healing practices and values handed down in the community from generation to generation. So while diagnosing indigenous health, one must reflect the oral and behavioural traditions of the indigenous people who look at health wellbeing from a comprehensive perspective. Key player in indigenous culture are the elders, who play a crucial role in maintaining health of the community. So they reflect cultural context and values, which are not taken into account in health development. For indigenous people knowledge, beliefs, and cultural practices exists at many levels. But indigenous peoples all over the world including American Indians are faced with number of health related problems – old way of diagnosing and healing illness have not survived due to migration, changing ways of life. Skills have been lost. Modern health facilities are not always available for indigenous people.

Kar and Baruah (1997) have made their study on morbidity and health behaviour among the tea labourers, particularly the Munda tribe living in Chalkola and Athabari Division of Bokel tea estate in Dibrugarh District of Upper Assam. They have attempted to compare two divisions of tea garden—one Chalkola having better transport and communication facilities and the other Athabari having only rickshaws as means of transport from the National Highway. It was pointed out that health culture was very low and hence tea labourers suffered from several common diseases. There were three sources of health facilities available to them, namely plantation source, Government source and indigenous source. Despite of having modern health facilities, the Munda tribe had expressed strong faith in indigenous or traditional method of treatment. They were found to practise their own pre-existing health cultures.

Graham (1985) analysed sociological aspect of health and illness. He stated that an intimate relationship existed between biological and sociological responses during normal process of life cycles. He also envisions the possibility that social

behaviour may be related to status of health such as occupational behaviour, recreational pattern, dietary habits, and religious prescriptions. He discussed various sociological factors related to diseases.

Lieben (1973) discussed the field of medical anthropology. He stated that health and disease are measures of effectiveness with which human groups combine biological and cultural responses to their environment. He further pointed out that health and diseases are very closely related to cultural and biological factors. Anthropologists have made and interesting observation those health problems was related to cultural resources and social behaviour of the people.

The author said that indigenous medical system tends to be limited with cultural boundary and some variations are also found with regard to diseases and their treatment, preventive as well as therapeutical measures. Thus there is different ethno-medical therapist such as herbalist, diviners, shamans, midwife etc. So the author establishes a close relationship between medicine and culture of the people.

Hughes (1968) made a study on ethno-medicine. The term ethno-medicine is used to refer to those beliefs and practices related to diseases, which are the products of indigenous cultural development. He outlines five basic situations, which in folk etiology are believed to be responsible for various illness-i.) sorcery, ii) breach of taboo, iii) intrusion of disease objects, iv) intrusion of disease causing spirits and v) loss of soul.

He focuses more on the study of indigenous medical system. Therapeutical practices in ethno-medicine relate to both supernatural and empirical theories of disease causation. Many of the folk medicine, specially, preventive medicine is related to cultural practices, which have an important functional implications for health. He stated that folk medicine does not change easily under the impact of even sustained contact with the industrialized world or even as a result of deliberate attempt to introduce new concept of disease and hygiene.

Srinivasan (1987) has discussed the reasons for the failures and underutilization of Primary Health services by rural folk. His observation was that

factors for underutilization were inaccessibility, cultural beliefs, practices and prejudices.

Singh (2008) made a sample survey of two stage of North-East Region, namely Karbi and Rabha Tribes in Assam and Khasi and Jaintiya tribal community in Meghalaya and analysed socio-economic and cultural factors that influence health cure system. His finding was that distance factor had hindered utilizing public health facilities. The visit of Government run health centres, specially for vaccination, immunization and child delivery. Despite this they have a very strong faith in magic, deities, spirits etc. So they follow both magico-religious as well as allopathic system of medicine. His observation was that wide spread poverty, illiteracy, malnutrition, absence of safe drinking water, insanitary living condition, poor maternal and child cure services, ineffective health and nutritional services were the major factors for poor health status among the tribals.

Sachidananda (1986) has also highlighted social and cultural factors related to health of tribals which acted as impediments. The health of tribals to a great extent was dependent on their social organization, culture and religion.

Similar studies on tribal health care practices and tribal beliefs have been study by Medhi (2004) Jain & Agarwal (2005), Kumar (2003) and Joshi (2006)

Kujur (1989) has dealt about the health and hygiene among the Oraons of Chota Nagpur. She observes that health and hygiene condition are important cultural indices of the Oraons. These indices are influenced by not only geographical milieu but in fact by the entire set of socio-cultural fabric of the region. The attitude to and awareness of the people, of conditions of cleanliness, health and hygiene are shaped through a long span of time, depending upon the nature of interaction between natural and human constraints. The author remarks that the hygiene condition in an Oraon village is not conducive to a healthy environment. The general sanitation condition is low in Oraon villages. Cow dung pits are close to houses and there is practically no drainage system as a result the manure pits become breeding ground for mosquitoes and flies. The near by ponds or ditches are used for rearing ducks, washing domestic animals as well as cleaning household utensils, clothes and bathing lead to highly

polluted water and become cause for various skin diseases. The Oraons also still have the traditional practice of keeping the domestic animals inside one corner of the dwelling houses. As a community, Oraons have very low personal hygiene practices. They take bath only once a week. As a result they suffer from several common diseases like itches, scabies, typhoid, cholera, dysentery etc.

The Oraons also relate diseases with a number of causes such as religion; wrath of gods, spirits, physical, and natural causes e.g. wounds, accidental fall, sprains, and aches of various kinds. But at the same time these suspicious sicknesses or illness are believed to be the actions of some occult powers. Thus Oraons relate every sickness or illness to some spirit or wrath of gods. Therefore, the village doctor, locally known 'baid' is called upon for diagnosis and treatment of diseases. The 'baid' is believed to posses extensive knowledge of healing, herbs, roots and other ingredients needed for treatment. ..

In spite of faith in traditional healing or treatment, the author observes that the Oraons have more faith in hospitals and health centres run by Christian Missionaries than the Government hospitals. The reason pointed out is that doctors and nurses are more friendly, caring and dedicated in Christian Missionary run hospitals. Thus the Oraons are not averse to modern medicine in hospital.

OBJECTIVES

The objective of this research is to examine the traditional medical practices and various ritual healing practices existing among the Oraon tribal community and also to evaluate the changes occurring in their traditional health care practices due to the impact of modern medical services provided in rural areas through rural hospital.

This investigation aims to compare the traditional and modern health practices of two groups of Oraon villages from the perspective of proximity to and distance from rural hospital and the extent of impact it has on the two sets of Oraon villages.

The assumption put forward is the Oraons inhabiting in villages relatively closer to rural hospitals, utilize modern health services more than their counterparts who live in far away or in isolated villages from rural hospitals. Most of the Oraons

inhabiting in remote areas have very poor or no communication facilities as a result they face great difficulties during serious illness. Even during ordinary illness distance factor does affect them from utilizing the modern health services available in rural hospital. But it is not the only factor for underutilization of modern health services in rural hospital. There are multiple and complex factors attached with it, such as distance factor, easy availability, accessibility, affordability, doctor-patient interaction, and above all socio-cultural, magico-religious factors etc. have a great influence on their health care practices.

The Oraons still depend upon their traditional health practices during illness and disease. They follow certain age-old techniques and methods of preparing medicine from herbs, plants, etc. locally available. The village medicine man locally called as *ojha, baid, gunin and 'kabiraj.* A *kabiraj* is medicine man, who primarily herbal medicine but before preparation and administration of herbal drugs, observes some ritual observances. The laymen do not prepare any herbal medicine because they do not know all the ingredients of it. It is also because it involves intervention of some supernatural power, which only the village medicine men are believed to posses.

Together with herbal medicine, the village medicine man or a *kabiraj* employs healing rituals, by invoking the intervention of supernatural forces. On the whole the Oraons believe profoundly that traditional method of diagnosis, healing, and treatment. But many a times the Oraons follow both traditional and modern methods of health care practices.

Therefore, this study attempts to analyse socio-cultural phenomena of disease, culture and disease causation, concept and treatment and also investigate and present the recent changes taking place as well as its continuities with regard to traditional health care practices of the Oraons.

Hence the broad aims and objectives of this research are the following: -

1. To study the traditional health practices prevailing among the Oraons. It is assumed that the Oraons still widely practise traditional method of treatment of various diseases.

2. To investigate specific causes and concepts of etiology of disease or illness and to focus how far and to what extent aetiology are related to their culture, religion, faith etc.

3. To examine the value perception of traditional health practices. It is presumed that the Oraons still attach a great importance and value to their indigenous medical method of treatment. Therefore, it is important to record such values attached to it.

4. To asses the present health problems and record the common health problems faced by the Oraons.

5. To assess the extent to which traditional medical practices have come under the impact of modern medicine, e.g. impact of Rural Hospital, and Primary Health Centres.

6. To record the extent to which socio-cultural factors act as an impediments towards acceptance and utilization of modern health services and practices.

7. To find out the impact of economic and social factors with regard to practice and an adoption of modern medical services and facilities.

8. To assess the mother-child health care and to record their awareness about health care among the Oraons e.g. taking care expectant mothers, pre and postnatal care, immunization of children nutritional consciousness and habit.

9. To find out and record personal hygiene and general sanitation.

10. To record what extent indigenous health care practices have changed under the impact of modern medicine and facilities provided by the rural hospital and also to know the causes for underutilization of rural health services available through hospital sources.

11. It attempts to study and analyse traditional and modern health care practices of the Oraons in the present time. In particular, it tries to examine the health behaviour of the Oraons inhabiting in two sets of villages. Firstly, those who

live close to rural hospital and secondly, those who reside in remote villages away from the rural hospital.

METHODOLOGY

The study is based on the intensive fieldwork among the Oraons of Bamongola Block, District of Malda in West Bengal. Bearing a few isolated Oraon families inhabiting in remote areas, all the small and big Oraon villages have been selected for collection of data. Bamongola Block occupies a third place in terms numerical strength of Oraon population of Malda District after Gajol and Kharba Block. But the difference of Oraon population is not very big between these blocks. Information regarding socio-economic status collected through various secondary sources reveals homogeneous character of the population of the entire district. Hence the entire Oraon population inhabiting in several villages has been selected for this research.

All the seventeen Oraon villages / hamlets have been selected for the fieldwork. These villages have been divided into two groups / categories, taking into consideration of proximity and distance or isolation in terms of location from the Rural Hospital, situated at Modipukur village in Bamongola Block, about 50 KMs from the District Headquarter, Malda. The rural hospital plays an important role in influencing the health practices of rural population living close to it where as villages located at far away places in remote areas have less impact on rural population in general and particularly on the Oraon tribal population. Thus the villages under study located within the area of approximately 3 KMs from the rural hospital are treated as villages close to rural hospital, which comprises of villages, namely, Sindurmuchi, Durgapur, Mohunpur, Bintara, Gopalpur, Patul, Chandpur, and Belhharia. On the other hand, villages located at a distance of more than 3 KMs away are treated as villages far away from the rural hospital, which comprises of Kathuadanga Dhekurkuri, Titpur, Buridanga, Hanspukur Jogdala, Mirjapur, Anaharpara and Chotopathari.

There are a total of 494 Oraon households inhabiting in seventeen villages, out of which 266 households inhabit in villages far away from the rural hospital (RH)

where as 228 families reside in villages located close to rural hospital. Though some of the villages located just more that 3 KMs away from rural hospital might seem close to it, but due to isolation of villages in terms of lack of transport and communication, they are quite far away from rural hospital and serious patients have to be literally carried to hospital or taken by rickshaw van. Thus the Oraons inhabiting in remote villages face a lot of serious problems during sickness or ailments.

In the process of identification of Oraon villages the investigator had to face some difficulties because they were a little known tribe in this block. The people could hardly make difference between the major Santal tribes and the Oraons. Therefore, the field investigator had to visit all the Gram Panchayat Offices and collect necessary information regarding Oraon villages. The Gram Panchayat officials were very co-operative in providing necessary information. After identification of a few villages, the process of identification become easier, because they knew where about all the Oraon villages.. Some very remote villages posed some difficulties in approaching due to lack of proper road. In some villages there were no roads at all, so the researcher had to tread down to villages. In the initial stage the villagers were reluctant and unwilling to provide information thinking that it was useless to do so to Government officials. But once the investigator convinced them by explaining to them the purpose of his study and introduced himself as one being from his own community, a good rapport was easily established which helped to gather necessary information. Knowing of tribal language (Kuruk/Oraon) proved to be an additional advantage, to fill up the communication gap and clarify some questions to which they could not reply in Bengali language. At the same time they felt at ease to reply in their own mother tongue

The data for this study were collected mainly through primary sources but other relevant information on the subject was also collected through secondary sources. Other demographic information have been collected through published materials and census reports. The present study is outcome of intensive fieldwork carried out for a period of one and half years spreading over September 2001 to April 2003.

For the collection of data four conventional anthropological methods have been used – i) census method, ii.) Interview method, iii) observation method and IV) case study method.

After identification of Oraon villages, the information was collected through household census among all 494 families inhabiting in seventeen villages. The quantitative data collected through household census included – number of family members, age, sex, place of birth, year of migration, literacy, educational standards, agricultural land holdings, sex wise occupations, religion, mother tongue, languages spoken, marital status, agricultural implements, live stocks etc.

Census method was followed by interview method. It was an intensive study. Therefore, there was no sampling done. The head of the family or an adult member, either male or female of each family was interviewed with the help of prepared interview schedule, containing structured questions relating to interaction between traditional and modern medicine, housing, sources of drinking water, personal hygiene, food, mother-child health care, intoxication etc. Besides, interview schedule some key informants e.g. village medicine men were also interviewed in detail about their diagnosis and methods of treatment. Apart from this some doctors and health workers were also interviewed to collect data on health problems of the tribals and about utilization of modern medicine and facilities available in rural hospital and primary health centers.

Besides, interview method bulk of qualitative data for this research were collected through direct observation as well as case studies by interviewing selected informants with open ended questions relevant to this study. Information regarding causes, perceptions of diseases, and methods of diagnosis and treatment of some disease people had suffered or had been suffering from it were gathered through case studies. Such studies were very useful to understand wider notion of causes of diseases believed by Oraon community as a whole.

The data collected through various methods or tools of data collection have been analysed through qualitative and quantitative means. The qualitative data are mostly analysed on the basis of systematic and analytical descriptions of data

gathered, where as quantitative facts are analysed through tabulation and application of basic statistical method.

CHAPTER – 2

CHAPTER - 2

THE LAND AND THE PEOPLE

THE REGION

The District of Malda was a part of Jalpaiguri Division in the state of West Bengal. It is located in the northern sector of the state of West Bengal. The District is formed by northern sector of the river Ganges and included in the delta formed by river Ganges and Mahananda, the two most vital rivers of the district. It occupies a strategic position in the administrative map of West Bengal for its location and communication facilities.

It appears that in the District of Malda, there is a small town named "Old Malda" and it is commonly followed that the district has been derived from this town. The word "Old Malda" comes from the Arabic word 'Mal' which means 'capital' or 'wealth.' So Malda in Arabic indicates a place where financial transactions were performed and where wealth is concentrated in the hands of a large number of persons.

Malda has a very rich past of its own. The history of the district is interlinked with different periods of history. In 1813, Malda was created as a new District in Bengal , outlying portion of Purnea and Dinajpur district by the British authority. But it formally became an independent administrative unit only in 1859. In that year Malda District was formed with PS Sahibganj, Kaliachak, Bholahat and Gurguriabag of the district of Purnea in Bihar, Malda and Bamongola from the District of Dinajpur, and Rohanpur and Chhupi from Rajshahi District of the present Bangladesh. Afterward some more police stations were created out of those police station areas. It appears that immediately before the partition of Bengal Harishchandrapur, Kharba, Ratua, Manikchak, Malda, Gajole, Habibpur, Sahibganj, Bholahat, and Nachal police stations were included in Malda District. But after partition, five last named police stations were transferred to East Pakistan, now is a part of Rajshahi District of Bangladesh (Census of India 1991).

PHYSICAL FEATURE

Malda is located at the altitude from 25^0 32' 08" to 24^0 48' 20" in the north and the longitude from 88^0 28' 0" to 87^0 45' 50" in the east. The district covers an area of 3,773.0 sq KMs, with the total population of 2,637,032 (Census 1991) which increased to 32,90,160 (Census of India 2001).

Malda is bounded on the north by the West Dinajpur district and Bihar, on the South by Murshidabad district and Bangladesh, on the West by Bihar and the East by Bangladesh.

The district has been roughly divided into two equal parts by Mahananda river, flowing north and south, with some low lying plain without any hills and other has some high land areas, called barind corresponding by local tradition to the old boundary line of the Rarh and Barendra and to this day the eastern part is called "*barind*". The land of the district is slopping towards south. The soil of the area is alluvial formed by rivers of Ganga, Kalindi, Tangan, Punarbhba and Mahananda, the important rivers of the district.

The land of the district has been divided into three parts, namely, *barind* area at the eastern part, the characteristic features of which is the relatively high land formed by red clay soil of the old alluvium, the *tal* area in the northern part, the name of which applies to the land flood deeply as rivers rise, and the *diara* area in the southern part, the striking natural feature of which is the continuous line of islands formed in the bed of Ganges (District Gazetteer Malda & Census of India1991).

The economy of the district of Malda is rural in nature. The main source of livelihood of the people is agriculture. Cultivators and agricultural labourers together constitute about 74.30 percent of the total workers of the district according to 1981 census.

LOCALE OF STUDY

The present study is carried out in all the seventeen Oraon villages of Bamongola Block, PS Bamongola, and District Malda in the state of West Bengal. Bamongola Block lies in the eastern part of Malda District, which is approximately, 44KMs from the district headquarter. But the villages under study are located still further in the interior areas. On average Oraon villages are located 54 KMs from the district head quarter, Malda.

The important State Highway connecting Bamangola in Malda is the Malda-Nalagola bus route, which is recently extended up to Balurghat, the district town of South Dinajpur. It serves as an alternative State Highway to Balurghat.

Bamangola Block occupies an important place in the district for its location in the Indo-Bangladesh boarder area. Bamongola is surrounded by West Dinajpur District in the North, Gajole Block in the West, Habibpur Block in the South and the entire eastern part by Bangladesh.

Bamangola is the name of a tiny village after which the name of Bamangola Block has been derived. It is located at the bank of river Tangan. It used to be an administrative unit of the Block Development Office. But the administrative unit has been shifted to Pakuahat, which is located beside Malda-Nalagola State Highway about 44KMs away from district town. At present Pakuahat occupies an important place for all practical purposes of daily use for the entire inhabitants of the block.

CLIMATE

The climate of the district is divided into three usual season- monsoon(roughly lasts from mid- june to mid Oct.), the winter (lasts roughly from mid. Nov. to mid Feb) and the summer (lasts from mid March to mid June). Bamangola Block, like rest of the district of Malda, receives seasonal rainfall. The climate of Bamongola is same with that of entire District. But the temperature in summer is very dry and hot and extreme cold during winter. The region and the roads become very dusty during summer and extremely muddy during monsoon. The monsoon starts from mid June

and lasts up to September. The low lying areas, locally, called *duba / doba* remains practically, submerged during rainy season and the people have to use country boats to travel to reach the connecting roads and transport their goods to Pakuahat the main weekly market and other smaller *hats* (markets).

ECONOMY

Land in Bamongola Block is different from the rest of the land of the district. The land in the eastern part (Bamongola Block) is of two types. The first type of land is formed by uneven high land called, *barind* region formed by red clay soil and of old alluvium which is not fertile. The second type is lowland area formed by alluvial soil and is very fertile. This area remains flooded almost all through out the monsoon.

Economically, the region is very backward. The economy of the region is rural in nature. The region being *barind* area, the sole source of economy is agriculture. Hence, the principal occupation of the people of Bamongola Block is agriculture. The economic activities of the Oraons directly or indirectly centred on land. A large number e.g. 120 (24.29 %) of Oraon population is landless and hence their main occupation is agriculture labour. The largest numbers of families e.g. 225 (45.54 %) have land below three *bighas.* So they form a bulk of small and marginal farmers. The crop production from agriculture is hardly sufficient to sustain their families. The economic constraint forces them to work as daily wage labourers to supplement their family income. Those families having more or less sufficient agricultural land cultivate their land as self-cultivators, who produce food crops mainly for their own consumption. A few families owning land more than fifteen *bighas* employ agriculture labourers on daily wage basis to cultivate their land as well as for harvesting crops. Agricultural land is their permanent and precious possession along with some cattle and fowls.

Two main seasonal crops grown in the *barind* area.are- Kharif crops, rice being the principal crop, grown during monsoon in the high land areas, where as in lowland, locally called *duba/ doba* , winter crops are grown which is popularly known as high yielding crop.

Main occupation of the Oraons, both males and females is the agriculture. However, nowadays they are also taking up other works because agriculture is not sufficient to provide works for all. Most of them are employed as agricultural labourers only during agriculture seasons, which last at the most five to six months a year.

INFRASTRUCTURAL FACILITIES

The infrastructural facilities of any area are important for development and lack of these facilities leave the area backward. Hence the infrastructural facilities available in Oraon villages are discussed briefly:

TRANSPORT AND COMMUNICATION

Only some villages like Mirjapur, Titpur, Kamardanga, Bintara, Durgapur, and Jagdola are located besides *pucca* (tar) roads. The rest of the Oraon villages under study are located in the interior areas, some of which are connected by mud roads only while others do not even have proper mud roads. So lack of proper roads, transport and communication isolate the Oroan villages from the mainstream. The villages having mud roads become extremely muddy during rainy season, which make even difficult to walk. On such conditions one cannot even think of any transport during rainy season. In times of illness, people face great hardships to avail health services in hospital. The most common mode of transport for the people of interior areas is bicycle, rickshaw van and motor driven rickshaw van. Bullock carts and motor run vans are used for carrying goods to weekly main local *hat* (market), Pakuahat and other smaller hats. Also for carrying paddy from the field to the threshing ground bullock cart is used extensively.

SOURCES OF WATER

One of the major problems of Oraon villages is the lack of safe drinking water. There are two sources of drinking water in the village--wells and shallow tube wells provided by the Government but the shallow tube wells are highly inadequate and many of the villages don't have any of them. In such cases only sources of drinking

water available are the community wells. The surroundings of the sources of drinking water were not in sanitary condition. Dirt and leaves fall into the open wells, which contaminate the water. Over and above these wells are neither cleaned for years nor bleaching powder given periodically and due to which water become contaminated and lead to serious problem of health like diarrhoea, gastroenteritis etc., specially during monsoon. In summer also water become very unsafe and contaminated when water level goes down or dries up.

Sources of water for bathing and washing clothes and kitchen utensils were the ponds or rainwater collected in ditches. Even washing of animals was done in the same ponds, which made the water very unhygienic resulting in various skin diseases and other health problems. Only one village used river water bathing, washing etc.

EDUCATIONAL INSTITUTIONS

With regard to availability of educational institutions are, the Oraon villages are not very backward. Primary schools are situated near the Oraon villages. There are four high schools with higher secondary level of education, such as A.N.M. High School at Pakuahat, Bamongola High School at Bamongola, Maheshpur High School at Maheshpur and Nalagola High School at Nalagola. Besides these there are three high schools, namely, Balika Vidyala, Pakuahat, Jagdola High School, Jogdola and Nalagola Balika Vidyalaya, Nalagola. Of these Pakuahat and Maheshpur High Schools have hostel facilities for tribal boys fully supported by the Government. There is also a tribal hostel exclusively meant for tribal students with capacity of eighty beds, fully funded and supported by the Government. The boarders also receive Rs.300 per month as stipend. There is also a college situated at Pakuahat in Bamongola Block. Despite of having sufficient number of educational institutions and other facilities like hostel with stipends the Oraons are not availing high school education. At the most they study up to primary level of education and drop out. Therefore, educational institutions seem to have little impact upon the tribals, and more particularly upon the Oraon tribal community. Apathy towards education is due to very poor economic condition, negligence and lack of awareness on the part of the family and community as a whole.. Hence, the Oraons are still educationally very backward.

THE ORAONS

DEMOGRAPHIC PROFILE

The Oraon tribe is one of the major tribes of India inhabiting mainly in the Chota Nagpur plateau. The Oraons are spread over to vast areas in the central region; such as Bihar, Jharkhand, Orissa, Madhya Pradesh, and some districts of West Bengal. A sizable section of Oraons are also found in Assam, who is mainly engaged in tea plantations as unskilled labourers. In West Bengal too a major section of Oraon population is employed as unskilled labourers in various tea plantations of North Bengal. The Oraons are also found in Maharasthra state. Outside of India, a sizeable group of Oraons are also found in Bangladesh.

Numerically, the Oroan population is about 26.50 lakhs in India, presently inhabiting in different states, such as Bihar (at present the entire southern part of tribal belt forms the state of Jharkhand), which accounts for the total population of 12.14 lakhs, Madhya Pradesh 5.44 lakhs, West Bengal 5.36 lakhs, Orissa 1.65 lakhs and Maharasthra about 96 thousand (Verma 2002). The distribution of absolute number and the percentage of Oraon population in different states of India are given below.

Table: 1 Distribution of Oraon Population in Different states of India

States	POPULATION					
	Male	Percent	Female	percent	TOTAL	Percent
Bihar	618600	23.34	596108	22.49	1214708	45.82
Madhya Pradesh	272555	10.28	272404	10.28	544959	20.56
West Bengal	274563	10.36	262356	9.90	536919	20.25
Orissa	127820	4.82	130009	4.90	257829	9.73
Maharasthra	49495	1.87	47029	1.77	96524	3.64
Total=	1343033	50.66	1307906	49.34	2650939	100

** *Source: Compiled from Indian Tribes: Through the Ages, R.C.Verma, 2002, Publication Division, Ministry of Information and Broadcasting, Government of India.*

The table 1 shows that out of the total population, the largest percent of the Oraons inhabit in Bihar, followed by Madhya Pradesh, West Bengal, Orissa and Maharashtra respectively. Sex wise composition of population shows that there is very little difference between male and female population. The males and females constitute 50.66 percent and 49.34 percent respectively.

The plateau of Chota Nagpur forms the principle centres of Oraon tribal population. Of the various tribes inhabiting in Chota Nagpur, the Oraons are the most numerous. In Bihar the concentration of Oraon population is in the District of Ranchi (now the state capital of Jharkhand State), Hazaribag, Gumla, Palamau, Dhabad, Singbhum, Lohardaga and Simdega (at present all are District towns of Jharkhand) (Verma 2002).

In Madhya Pradesh, they are mainly found in the districts of Surguja, Raigarh and Jashpur. The main concentration of Oraon population in Orissa is in Sambalpur, Manbhum, Balasore and Sundergarh (Verma 2002). In West Bengal the district having Oraon tribal population are Jalpaiguri, Darjeeling, West Dinajpur, 24 Parganas, Hugly, and Birbhum (Census of India 1991). The Oraons also form a sizable section of tribal community in Assam. They inhabit mainly in the districts of Cachar, Darang, Nowgang, Sibsagar and Lakhimpur.

Besides these a good number of Oraon tribes also inhabit in the state of Maharasthra and also in Bangladesh in the districts of Rajshahi Division, Rajshahi, Dinajpur, Jessore, Rangpur, Pabna and Chitagong (Roy 2004 reprinted).

ORAONS OF WEST BENGAL

West Bengal occupies the third state in India with regard to Oraon population after Bihar (Now the main concentration of Oraons is in Jharkhand state) and Madhya Pradesh respectively.

According to Census of India, 1971, the total scheduled Tribes in West Bengal is about 25.9 lakhs (absolute figures 25,32,969 persons) who constitute about 3.72 percent of the total population of the state of West Bengal. Numerically, the most

dominant tribe is the Santals, who constitute about 54.35 percent of the total Scheduled Tribe population of the state (Bose, 1985).

The second largest tribe of West Bengal is the Oraon, the population of which is about 2.9 lakhs (absolute figure 2,91,173 persons), which accounts for 11.49 percent of the total population of West Bengal (Bose, 1985).

According to Verma 2002, the total Oraon population of the state is 5.36 lakhs (absolute figures 5, 36,919 persons) out of which 2.74 lakhs (2, 74,563 persons) and 2.62 lakhs (absolute figure 2, 62,356 persons) are males and females respectively.

As per the Census of India 1991 the districts of West Bengal having major Oraon population are Jalpaiguri, Darjeeling, West Dinajpur, Nadia, and Malda. Apart from the above practically all the districts of West Bengal have Oraon population in small numbers. The table below shows sex wise and rural urban distribution of Oraon population in various districts of West Bengal.

Table:2. District wise Rural –Urban Distribution of Oraon Population in West Bengal

STATE	I. RURAL			II. URBAN			T(1+2)
Total Oraon pop. in W.B./ Districs	M	F	T	M	F	TOTAL	T(I+II)
1	2	3	4	5	6	7	8
Total Pop. WB	216203	205975	422178	8333	7063	15396	437574
percent	49.41	47.07	96.48	1.90	1.61	3.51	100
Jalpaiguri	131673	125299	256972	1350	928	2278	259250
percent	30.09	28.63	39.03	0.31	0.21	0.52	60.63
Darjeeling	24429	22893	47322	335	256	591	47913
percent	5.58	5.23	10.81	0.08	0.06	0.14	10.99
West Dinajpur	18586	17796	36382	295	211	506	36888
percent	4.25	4.07	8.32	0.07	0.05	0.12	8.43
Nadia	8875	8804	17679	205	198	405	18084
percent	2.03	2.01	4.04	0.05	0.05	0.09	4.13
24 Parganas	16014	15841	31855	3413	3047	6460	38315
percent	3.66	3.62	7.20	0.08	0.70	1.48	8.76
Malda	4429	4524	8953	7	5	12	8965
percent	1.01	1.03	2.04	0.001	0.001	0.002	2.05
Murshidabad	2152	2150	4302	166	152	318	4620
percent	0.49	0.49	0.98	0.04	0.03	0.01	1.06
Burdwan	1698	1804	3502	808	715	1523	5025
percent	0.39	0.41	0,80	0.18	0.16	0.33	1.13

Table contd...

Table 2. contd.

	I. RURAL			II. URBAN			
Total Oraon Pop. in W.B.	M	F	T	M	F	TOTAL	Total (1+2)
1	2	3	4	5	6	7	8
Hugly	2578	1695	4273	677	629	1306	557
percent	0.59	0.39	0.98	0.15	0.14	0.30	1.21
Purulia	2231	2064	4295	113	103	216	4511
percent	0.51	0.47	0.98	0.03	0.02	0.05	1.03
Couch Bihar	2125	1890	4015	21	13	34	4049
percent	0.49	0.43	0.92	0.04	0.02	0.007	0.93
Birbhum	514	488	1002	131	116	247	1249
percent	0.11	0.11	0.22	0.03	0.03	0.06	0.29
Midnapur	424	413	837	112	123	235	1072
percent	0.10	0.09	0.19	0.03	0.030.05	0.94	0.34
Habra	337	182	519	471	422	893	1412
percent	0.08	0.04	0.19	0.11	0.10	0.20	0.32
Bankura	138	132	280	3	1	4	284
percent	0.03	0.03	0.06	--	--	--	0.064
Cal. District	--	--	--	216	144	360	366
percent	--	--	--	0.05	0.03	0.08	0.083
Total	216203	205975	2059758	8333	7063	15396	437574
percent	49.41	47.02	96..48	1.90	1.61	2.52	100

** Source: Compiled from Census of India 1981.*

The table 2 above shows the district wise rural-urban and sex wise distribution of Oraon population of West Bengal. It is clear from the table that the major concentration of Oraon population is found in the districts of Jalpaiguri, Darjeeling,

West Dinajpur, and 24 Parganas. According to the Census of India 1981, out of the total population, 96.48 percent live in rural areas whereas only a very small percent e.g. 2.59 percent belongs to urban population. Hence Oraon population is primarily rural in nature. Sex wise distribution of the population shows that the males are more than the females, though the difference is small.

Table 3. Total Oraon Population having Oraon/Kurukh as Main Language in West Bengal

W.B./Districts	Total Population	percent to total Population	Rural	Urban	Proportion in percent	
					Rural	Urban
West Bengal(Total)	1,90,612	0.282	1,84,083	6529	96.57	3.43
Jalpaiguri	1,01,265	3.620	99,520	1745	98.28	1.72
Darjeeling	33,709	2.590	33,259	450	98.61	1.32
West Dinajpur	30,408	0.970	30,246	162	99.47	0.53
Nadia	6016	0.310	5943	40	97.59	2.61
Malda	3925	0.50	1225	4	99.67	0.23
24 Parganas(North)	286	0.040	1384	1476	48.39	51.61
24 Parganas(South)	145	0.003		145		100
Birbhum	3146	0.120	2710	227	93.78	7.22
Howrah	372	0.010	16	366	4.19	95.81
Hugly	1847	0.040	1523	324	82.46	17.54
Bankura	337	0.010	43	294	12.76	87.24
Purulia	-	-	-	-	-	-
Midnapur	-	-	-	-	-	-
Murshidabad	1301	0.030	1298	3	99.77	0.23
Burdwan	3087	0.50	1734	1349	56.30	43.70
Calcutta	145	0.003		145		100

Source: Compiled from Census of India1991, West Bengal, and State District Profile.

Table 3 above shows the distribution of Oraon population having Oraon /Kurukh as their main language. In West Bengal only 190672 persons have Kurukh as their main language or mother tongue. Though all of them claim to be their mother tongue but they do not speak it as their main language. They speak *Sadri* (local language) as their main language, which is the language of other non tribals as well.

Table: 4. Total Oraon Population Speaking Oraon/Kurukh in West Bengal

State / District	Total Population	Percentage of Total Population	Population		Percentage of Rural & Urban	
			Rural	Urban	Rural	Urban
West Bengal	192833	0.280	185612	7221	96.26	3.74
Jalpaiguri	101423	3.620	99668	1755	98.27	1.73
Darjeeling	33761	2.600	33311	450	98.67	1.23
West. Dinajpur	30993	0.990	30831	162	99.48	0.52
Nadia	6016	0.160	5943	72	98.79	1.21
Malda	3979	0.160	3946	12	99.28	0.80
24-Parganas(N)	2964	0.040	1384	1580	46.69	53.31
24-Parganas(S)	20	--	19	1	95.00	5.00
Birbhum	4192	0.160	3606	536	87.06	12.94
Howrah	382	0.010	22	360	4.19	95.33
Hugly	1847	0.040	1523	324	72.03	27.97
Bankura	398	0.010	398	--	100	--
Purulia	--	--	--	--	--	--
Midnapur	--	--	--	--	--	--
Murshidabad	1305	0.030	1302	3	99.77	0.23
Calcutta	204	0.030	--	204	-	100

Source: Compiled from Census of India 1991, West Bengal State District Profile

The language / dialect of the Oraons is known as Oraon or *Kurukh* which still continues to be their common language. The Census of India *1991* reveals a surprising figure that not all of the Oraons of the state of West Bengal speak their language, *Kurukh.* Out of the total population (437574 persons}, only 192833 persons speak their mother tongue. The table 4 shows that the Oraon population in various districts of West Bengal the number of Oraons who speak *krupuk.*

ORAONS IN MALDA DISTRICT :

The District of Malda occupies a very important place among the districts of West Bengal, in terms of location, history, transport and communication. It is the gateway to northern part of North Bengal.

The first census of the district was taken in 1872, when the population recorded was 677,328, which increased to 884,030 (Census 1901) 1,004,159 (Census 1911), 2,44,0495 (Census of India 1971), 26, 37,032 (Census of India 1991) and 32, 90,468 persons (Census of India 2001). Out of the total population of Malda District ,the total Scheduled Tribe population accounts for 1,30,715 persons (Census of India 1971) who constitute about 8.11 of the total population of the district and 5.16 percent of the total Scheduled Tribe population of the state of West Bengal. According to census 2001, the total Scheduled Tribe population comprises of 227,047, which form 6.9 percent of the total population of the state. The majority e.g. 7.4 (224698) percent of the Scheduled Tribe population inhabits in rural area and merely 1.0 (2349) belong to urban population

Among the tribal community, the largest Scheduled tribe population of West Bengal is the Santals who constitute about 90,285 persons according to 1971 census of India. The total Scheduled Tribe population in Bamongola Block accounts for 25083 (Census 2001), all of whom inhabit in rural areas. In Malda district, as well as Bamongola Block under study, the Santals constitute the largest Scheduled tribe community.

The Oraon tribal community forms the second largest tribal population of the state of West Bengal as well as Malda District. In Malda District the total Oraon population is 10,325 persons(Census 1971). In Bamongola Block too the Oraons are

the second largest tribal group after Santals who account for 2274 persons according to the present survey. Some other demographic features of the Oraon population of Malda District are given below

Table: 5.Distribution of Scheduled Tribe Population of Malda Districts.

Police Stations	ST Population	Percent of S T Population to total Population of the District
Harishchandrapur	4370	3.29
Chorea	7250	5.46
Ratua	1535	1.16
Gajole	40989	30.88
Bamongola	18109	13.64
Habibpur	42460	31.99
Malda	12886	9.71
English Bazaar	5052	3.81
Manikchak	64	0.05
Kaliachak	2	0.01
Total =	132717	100.00

Source: Census of India 1971, W.B. District Census Handbook, Malda District.

The total Schedule Tribe population of Malda District is 1, 32,717 as enumerated in the Census of India 1971, who constitute about 8.11 percent of the total population of the district of Malda, who account for 5.16 percent of the total Scheduled Tribe population of the state of West Bengal. The table 5 above shows the largest concentration of Scheduled Tribe population in Habibpur e.g.31.99 percent followed by Gajol Block 30.88 percent and Bamongola Block and P S account for 13.64 percent of ST population.

Table: 6. Major Schedule Tribe populations and decadal growth

Schedule Tribe	Schedule Tribe Population		Decadal Growth in percent
	1961	1971	1961 – 71
Santals	84,207	90,285	7.22
Oraons	4783	10,325	115.97
Kora	2478	8378	238.10
Malpaharia	1182	4654	293.74
Munda	1583	5264	243.38

Source: Census of India, 1971, District Census Hand Book, Malda.

The table 6 shows that the two major tribes of Malda district are the Santals and the Oraons. It is apparent from the table that there is a sudden increase of population among all the tribal communities, bearing the Santals whose decadal growth is not very significant 7.22 percent. The decadal growths of various tribes were the Oraons 115.97 percent, The Koras 238.10 percent, and The Malpaharias 293.74 percent and for the Mundas it was 243.38 percent The influx of refugees from Bangladesh in the 1971 was one of the main reasons for sudden increase in percentage of tribal population in the district.

Table: 7. Literacy Status of Oraon Population of Malda District, 1971(PS wise)

Police Station	Total Population			Total Illiterate			Total Literate		
	M	F	T	M	F	T	M	F	T
H.C. Pur	706	518	1224	640	513	1153	66	5	71
Percent	6.83	5.02	11.85	6.18	5.97	11.18	0.64	0.048	0.69
Khabra	1606	1286	2890	1442	1257	2699	168	29	197
Percent	15.55	12.46	27.99	13.97	12.17	26.14	1.68	0.28	1.91
Ritual	98	141	239	91	141	232	7	--	7
Percent	0.95	1.37	2.31	0.88	1.37	2.25	0.067		0.067
Gajole	1544	2385	3917	1366	2283	3649	166	102	268
Percent	14.95	23.10	37.94	13.23	22.11	35.34	1.61	0.99	2.60
Bamon-gola	812	720	1532	737	714	1451	75	6	81
Percent	7.86	6.97	14.84	7.14	6.92	13.70	0.73	0.058	0.78
Habibpur	163	175	346	138	172	310	33	3	36
Percent	1.58	1.70	3.28	1.34	1.67	3.00	0.312	0.023	0.358
Malda Sadar	20	55	75	16	55	71	4	--	4
Percent	0.193	0.532	0.726	0.154	0.532	0.687	0.034		0.034
English Bazaar	58	35	98	57	35	92	1	--	1
Percent	0.56	0.43	0.95	0.55	0.37	0.89	.009		0.009
Manikch owk	2	1	3	2	1	3	--	--	--
Percent	0.0019	0.009	0.039	0.02	0.009	0.039			
TOTAL	5009	5316	10325	4489	5171	9660	520	145	665
Percent	48.51	51.49	100	43.48	50.08	93.56	5.04	1.40	6.44

- *Source: Census of India 1971, Series22, District Census Handbook, Malda.*

The table 7 shows the total literate and illiterate Oraon population. The sex wise distribution of Oraon population shows a big difference between the rate of literacy and illiteracy among males and females. The total Oraon population of the district is 10,325 persons, out of which 5009 (48.51 %) are males while 5316 (51.49

%) are females. Analysis of literacy status shows that a total of 9660 (93.56 %) are illiterates out of which 4489 (43.48 %) and 5171 (50.08 %) are males and females illiterates respectively. On the other hand a very small number e.g.665 (6.66 %) is literate, out of which 520 (5.04 %) are males while 145 (1.40 %) are females. It is apparent from the table that as per 1971 census a huge percent of the Oraons of Malda district was illiterate.

Table: 8. Educational Standards of all Schedule Tribe & Oraon population in Malda District.

Population	Scheduled Tribe Population			Oraon Population		
	Male	Female	Total	Male	Female	Total
	65936	64722	130658	5009	5316	10325
Percentage	50.46	49.54	100	48.51	51.49	100
Literacy Status						
Illiterate	57516	63267	120756	4489	5171	9660
Percentage	44.02	48.42	92.42	43.48	50.08	93.56
Lit. Without Ed.	2459	265	2724	127	76	203
Percentage	1.88	+0.20	2.08	1.97	0.74	2.71
Primary & Jr. High School	5734	1198	6932	379	67	446
Percentage	4.39	0.92	5.31	3.68	0.65	4.32
High School	207	18	225	13	02	15
Percentage	0.16	0.01	0.17	0.13	0.02	0.15
Graduation	20	01	21	1	--	I
Percentage	0.15	0.00	0.15	0.00	-	0.00
Total	65936	64722	130658	5009	5316	10325

Source: Census of India 1981, West Bengal Series 22, District Hand Book, Malda.

The table 9 presents a very abysmal state of educational status among Scheduled Tribe population in the district of Malda. It is very apparent from the table that a vast majority of the Schedule Tribes are illiterate. Out of the total Scheduled Tribe population of 130658, the males and the females respectively constitute 65936(50.46 %) and 64722(49.334 %) persons .It is apparent from the table that the tribals are very backward in terms of education of both males and females e.g. only 2724(2.25 %) are literate without education, 531(5.43 %) have up to primary / junior level high schooling, and very negligible, 0.174 percent and 0.015 percent have attained matriculation and graduate level of education respectively.

The Oraon tribe also is very backward in education. Out of the total Oraon population of 10,325 persons, a huge majority of them e.g. 9660 (93.56 %) are illiterate, out of which male and female illiteracy accounts for 4489 (43.48 %) and 5171 (50.08 %) persons respectively. The Oraons having literacy without education account for 203 (2.71 %) of which male and female population constitutes 127 (1.97 %) and 67 (0.65 %) persons respectively. On the other hand, Oraons who have attained up to primary / junior level of education account for 446 (4.32 %) which includes 379 (3.68 %) and 67 (0.65 %) male and female population respectively. Only 13 (0.13 %) and 2 (0.02 %) males and females respectively have attained matriculation level of education and only one person had studied up to graduate level of education. Thus analysis of the educational standards of the tribals and particularly of the Oraon tribes presents a very dismal picture of education.

Table: 9. Distribution of all STs and Oraon Population of Malda District by Occupation (sex-wise)

Sex wise Occupation	SCHEDULED TRIBE POPULATION						ORAON POPULATION					
	Male	Percent	Female	Percent	Total	Percent	Male	Percent	Female	Percent	Total	Percent
Total STs in WB	65936	50.46	64722	49.54	130658	100	5009	48.51	5316	51.49	10325	100
Total Worker	33975	26.00	4596	3.52	3857	29.52	2464	23.83	358	3.47	2818	27.30
Cultivators	23284	17.78	389	0.30	23623	18.08	1575	15.28	70	0.68	1648	15.96
Agrl Labourers	8317	6..31	3808	2.91	12125	9..28	528	5.11	230	2.23	758	7.34
Livestock, Herding, Fishing	468	0.36	9	0.006	477	0.364	75	0.73	3	0.029	78	0.76
Mining/quarrying	15	0.011	12	0.009	27	0.020	2	0.019	1	0.009	3	0.028
House hold /industy	309	0..24	78	0.06	387	0..30	36	0..35	10	0.10	46	0.45
Other than House-hold industry	280	0..21	50	0.045	339	0.255	34	0.42	10	0.10	44	0.52
Construction	57	0.043	1	---	78	0.043	7	0.067	1	0.009	8	0.076
Trade /Commerce	185	0.141	14	0.010	199	0.151	23	0.22	2	0.019	25	0.24
Transport / Commu -nication	158	0.120	158	0.120	25	0.24	---	--	--	--	25	0.24
Other services	949	0.73	228	0.17	1177	0.90	125	1.21	32	0.31	157	1.52
Non-worker	31961	24.46	60126	46.01	64087	70.47	2549	24.69	4958	48.02	7507	72.71

Source: Census of India, 1981, West Bengal Series 22, District Handbook, Malda.

From the above table 9 it is clear that a very big section of all the Scheduled Tribes of Malda District are engaged as cultivators, agriculture labourers and other allied agriculture activities e.g. fishing, herding, livestock and household industry.

The principal occupation of the Oraons of Malda District is also the cultivation and agriculture labour and other allied agriculture activities. Some of the Oraons are also engaged in household industry and handicraft activities as their main or subsidiary occupation.

The Oraon tribe is one of the earliest immigrants to the region of North Bengal who inhabit in two different social and cultural milieu—one group is the inhabitant of tea gardens who are mainly engaged as unskilled labourers while the other group resides in rural areas or villages of North Bengal.

The Oraons under investigation are the inhabitants of villages or rural areas of Bamongola Block, P S Bamongola, in the district of Malda in the northern part of West Bengal. The Oraons are the largest immigrant community from Chota Nagpur region who settled down practically all over the state. The process of tribal migration from Chota Nagpur in Bihar (at present Jharkhand state) and its adjoining regions of neighbouring states, took place during the British colonial rule from about 1856 onwards which almost continued for a period of a century, that is from mid 19^{th} century to mid 20^{th} century. A large number of tribal labour force was recruited in various tea plantations of North Bengal, through well organized recruiting agencies, like Sardari System and Alkali (Licensed recruiters).

The Oraons of Bamongola Block under study were also a part of tribal labour migration during the British colonial rule. The exact record or information regarding the period of migration is not available but from the field investigation and interviews to elderly persons, it is estimated that they migrated to Malda district approximately during 1860s at the same time when the tea plantations of North Bengal and Assam recruited a large number of tribal labour force from Chota Nagpur in Bihar and the adjoining states of Orissa and Madhya Pradesh. But not all the immigrant labourers settled down in tea gardens of north Bengal. A good number of Oraons and other tribal communities did not find the new environment of tea gardens suitable to their traditional economic life of agriculture. Hence they inhabited in the sparsely populated rural areas and took agriculture as their occupation and also formed a large number of agriculture labour force. But the Oraons of these regions were recruited mainly as agriculture labourers by the British. On their arrivals, they were employed

as agricultural labour force by *local jotedars* and *zamindars* (landlords) as well. The British also recruitred them as railway construction works because they were known as good earth workers. They were recruited as labourers together with their families. They also worked as railway construction labourers for several years. After completion of railway construction works they did not return to their Original homeland, Chota Nagpur , for the reasons that acute poverty had forced them to migrate to other places in search of livelihood. They were used as cheap agricultural labour force in Bangladesh big *Jotedars* and *zamindars*. They were also used to clear vast forest areas for agriculture. In course of time they settled down in Bangladesh permanently. They gradually, spread out and inhabited sparsely populated forest areas cleared the forest land for agriculture and finally settled down as permanent agriculturists and also they formed a bulk of agricultural labour force in Bangladesh. But the problems started soon after independence of India.

The period 1946 -51 marked the beginning of ethnic problems in Bangladesh, the former East Pakistan (Gazetteer of India, West Bengal, 1965).Due to Hindu-Muslim ethnic problems, the minority group was forced to leave the country. The local Muslim community was very hostile and antagonistic towards the Hindus and other non-Muslims. Taking advantage of this situation, some land grabbing goons created terror by killing, burning and destroying their houses and property. Under such circumstances the Oraons were forced to leave the country over night and crossed over to Indian side of the boarder and entered the territory of West Bengal as refugees. The Oraon refugees settled mainly, in Police Station of Tapan , Balurghat, Gangarampur and Hilly in West Dinajpur district while the others settled in Malda district, mainly in Bamongola Block. It is this section of the Oraon population now comprises of the major landless agriculture labour force.

Thus research conducted on the health indigenous health care practices among the Oraons, the early settlers in Bamongola Block as well as amongst those who arrived later in this area as refugees. But the study on their health care practices are analysed as a unit and not a comparative perspective.

Like other tribal communities of India, the Oraons of northern region in West Bengal are mainly inhabitants of rural areas bearing those tribal populations living in

the tea gardens of North Bengal. The Oraon community under study in Bamongola Block in Malda District are the inhabitants of remote rural areas. They are still economically, socially and educationally very backward. Agriculture and agriculture labour is their main occupation. Literacy level is very low. The health condition of the Oraons under investigation is also in a very poor state. The modern health services and facilities are out of reach for the tribal people. It is also true in the case the Oraons of Bamongola block.

Due to socio-economic backwardness they are not sufficiently aware of the modern health services and facilities. Relatively, they live in isolated villages from the rural hospitals which are also one of the main reasons for not sufficiently utilizing and taking advantage of modern health services available in rural hospital. On the other hand, those Oraon populations who live close to rural hospital do utilize to some extent the modern health facilities available to them in rural hospital. But at the same time their great dependence on traditional or indigenous medical practices can not be denied and it can also be stated as the reason for underutilization of modern health services and facilities available to them.

ETHNIC PROFILE

The plateau of Chota Nagpur is the original homeland of the Oraons. But the history and the traditions of the Oraons say that their original home was the West of India before they came to Kaimur hills and to the plateau of Rohtas in Sahabad (Risley, 1998).

Some scholars of antique try to identify Vanara followers of Rama Chandra with the ancestors of the Oraons. Presuming this notion to be correct, then during their long association with the Aryan hero and the long journey in his company through the country of more civilized Dravidians of the plains, who had already taken to agriculture and reached higher civilization and their friendly visit to Rama Chandra's dominion in Northern India, the Oraons first learnt about cattle breeding and agriculture, use of metal implements and utensils (Roy 2002).

Still further, the folklore of the Oraons tells us that in course of their wandering an Oraon family did a good piece of service to the king of the land of their

sojourn and the Raja wanted to make a gift of five villages but they preferred to a herd of cattle. In course of time they settled down on fertile valleys of some great rivers like Narmada. But again due to some unknown reasons they moved forward from southern to northern India. After their wanderings, in northern India, they finally reached the district of Shahabad in Bihar. Here they settled down as agriculturists and land owners (Roy, 2004).It is here one of their chiefs known as Karakh is said to have established his suzerainty and named the country as Karus-des. Here in Karuk-des, some tribes, most probably the Kolarian tribe of the Cheros, became predominant and the ancestors of the Maler and the Oraons believed to have moved out from this land and taken shelter on the Rohtas plateau.(Roy,2004).

The tradition of the Oraons further tells us that "Mlechchhas" dislodged them from Rohtasgarh. It is said that these "Mlechchhas" were the Muhamadan conquerors of India, who drove them out from Rohtas (Roy 2004).

There is yet another tradition among the Oraons living in Shahabad district, that it was the Hindus who dislodged them from Rohtasgarh. The Bihar Census Report for 1911 also states that the Oraons held the fort of Rohtasgarh till they were ousted by the Hindus. Thus the Oraons assert that Rohtas originally belonged to their Chief, who was finally wrested from by the Hindus.

After being driven out from Rohtasgarh the Oraons split up in two branches : one branch known as Male proceeded northwards up to the valley of the Ganges and settled down on the Rajmahal Hills, and the other branch , the ancestor of the Kurukhs went down the Son and up the North Koel south-eastwards through Palamau into Chota Nagpur plateau. Finally, they took possession the North Western portion of Chota Nagpur plateau (Risley 1998).

When centuries ago the Oraons entered the Chota Nagpur plateau, these tribe's men of the ancient King Karakh found the country occupied by other tribes such as Korwas, Birhors and the Mundas. Of these the Munda tribes were the most predominant while the Korwas and the Birhors were till then the hunters and herdsmen. On the other hand the Mundas had taken to rudimentary method of agriculture, e.g. tilling the soil with pointed stick (Riseley 1998). According to one

tradition of the Oraons, it is said that they have lived in tolerable amenity with the Mundas for quite sometimes. But the Oraons were comparatively superior in terms of intelligence and civilization to Munda tribe. Later the Oraons drove the Mundas further and forced them to retire to their present settlement in the south of Lohardaga.

The Oraons also has comparatively superior equipment for the struggle for existence, better intelligence, and better knowledge of agriculture and cattle herding. In course of time, the Oraon population increased rapidly, may be due to better food secured through agriculture, they became predominant in the north western and the central regions of Chota Nagpur plateau. They cleared the forest areas and brought under plough cultivation (Roy 2004). But it appears that the later wave of Oraon immigration from Rohtas considerably increased their strength and importance in the Chota Nagpur plateau and from then onwards the Oraons settled permanently in the Chota Nagpur plateau.

The plateau of Chota Nagpur in the central region is one of the principal centres of many aboriginal and semi-aboriginal tribes of India of whom the Oraons are said to be one of the most important and numerous tribes. They appear to occupy the first rank in intelligence and social progress. It is believed that the Oraons had passed beyond savage, hunter and nomadic state before entering the Chota Nagpur plateau.

The Oraon tribe are said to have introduced the use of plough cultivation in Chota Nagpur plateau and displaced a "daha", a barbarous method of tillage such as burning jungles and sowing crops. The Oraons are believed to be one of the earliest settlers of the plateau of Chota Nagpur. Many of the Oraons still hold 'bhuinhari' tenure, in the right of being the first clearers of the soil. However, such rights are fast phasing out of their hand due to modern competition for land and a large section of the Oraons are reduced to the position of landless agriculture labourers (Riseley1981).

The Oraons call themselves *Kuruk*, in their own language. The origin of this name sometimes traced to one of their mythical hero-king called "karakh". This tradition ascribes the origin of the ancient name Karus-des. It is this region roughly comprised of and is known as the district of Shahabad, which was the former home of

the Oraons. Now the name of this country as 'Karus-des' is forgotten. But at the time when they entered the plateau of Chota Nagpur, they could remember their ancient king Karakh, the mythical king (Roy 1915). When the Oraons reached the plateau of Chota Nagpur, amongst the several other aboriginal tribes inhabiting in the plateau, they took great pride because of their superior equipment for the race of survival and also on their traditional rule in Karus country. So they assumed their distinguishing tribal name of the 'Kurkhar' which means the Oraon.

PHYSICAL CHARACTERISTICS

The Oraons have what is termed as "low" feature. They are short- stature, narrow-headed and broad nose people. The colour of most of the Oraons is the darkest brown, often approaching to black. Their hair is black and coarse and inclined to frizzy. They have projecting jaws and teeth, thick lips, low narrow foreheads, broad flat noses bright and full eyes are the characteristics of physical features of the Oraon tribes (Riseley1981).

LINGUISTIC AFFINITY

The Oraons call themselves Kurukh, which is their language. They are the Dravidian cultivating tribes. On the linguistic ground they are classified as Dravidian (Riseley 1981). Now they inhabit the North and Western part of Chota Nagpur, in the eastern part of Sirguja and Jashpur and spread over to Singbhum, Gangpur, Bonai Hazaribag and Shambalpur of the Central Province (Dalton 1960).

However, not all of the Oraons speak *Kurukh* /Oraon. The total number of Oraon population in Chota Nagpur in the census of 1901 and 1911 enumerate them to be 614501 and 868152 persons respectively including Christian converts and animist Oraons out of which not more than 800328 (395530 male and 404798 females) were found to be speaking Kurukh language { Roy 2004).

OCCUPATION

The Oraons are primarily a cultivating tribe, who claim to have introduced plough cultivation in Chota Nagpur. It is the Oraons who have displaced the barbarous 'daha' method of tillage, which was carried out by burning the jungles and

sowing crops of various types. They also claim to hold 'bhuinhari' tenures, on their ground that they were the first clearers of the soil (Risley 1981). So the primary occupation of Oraon is the agriculture. Both men and women participate in agricultural activities. However touching of plough is prohibited to women.

RELIGIOUS LIFE OF ORAONS

The religion of the Oraons is of Composite order (Dalton 1960). They have retained some portion of the beliefs they brought with them from Chota Nagpur. The Oraons always have some visible object of worship- it may be a stone or wooden post or a lump of earth. They acknowledge a supreme God adorned as Dharmi or Dharmesh, the holy one and Dharmesh is regarded as the perfect pure and benevolent being, whose designs are thwarted by malignant spirit, whose mortals must be propitiated because "Dharmesh" (Supreme God) can not or does not interfere with evil spirit (Risley 1981)The spiritual life of the Oraons is always made up of constant propitiation of the malevolent spirits. They also believe in Witchcraft. Nature spirits and dead ancestor's spirits beneficent and maleficent are recognized by the Oraons.

The sole object of Oraon religious ceremonies in the propitiation on the demons, which are ever thwarting the benevolent intentions of 'Dharmesh'. They have no notion of a service of thanks giving. When suffering and befall upon a man, he consults an augur or 'ojha' as to the cause of his afflictions and seeks his advice and service. The ojha has in his power to denounce a mortal or a particular devil (Risley 1981). Thus the religion and religious life of the Oraons consists of the beliefs in numerous deities, spirits, devils etc. and ceremonial observances are supervised by priests of their own tribe, called 'Naigas' (Risley 1981) .

MARRIAGE

According to Dalton, infant marriage is said to have been entirely unknown among the Oraon tribe. But a few wealthier men who affect to imitate Hindu customs and have taken to this practice and get their daughters married before they attain puberty. Polygamy is permitted, and in theory at least there is no limit to the number of wives a man may have. They are usually too poor to maintain many wives and so majority of them are content with one.(Risley1981)

Widow re-marriage is permitted and there is no restriction in selecting her second husband. In such cases marriage ceremony is not performed and it is deemed sufficient for the female relatives of the bridegroom to smear vermilion on the bride's forehead. But the children of the widow are recognized as holding equal rank with those women marrying for the first time with all ritual and ceremonies.

Divorce is readily effected at the will of the either husband or the wife. For divorce the consent of the Panchayet is not required. Divorced wives may remarry again on the same terms and by the same form as widows (Risley1981). The re-marriage of a widow is called 'sagai'(Roy1999).

Until lately young men and women among Oraons were allowed free sexual intercourse with each other before marriage, but with the restriction that the couple should not belong to the same totemic clan or 'gotra'. The sexual intercourse between boys and girls of the same totemic clan /gotra is not only severely condemned but also proper punishment is given. Marriage in the same totemic clan is regarded as a sin productive of dire calamity to the tribe, so it is totally prohibited (Roy1999).

DISPOSAL OF THE DEAD

Generally, dead among the Oraons is cremated. When a death occurs in Oraon family it is made known by lamentation of the women. The dead among the Oraons is laid on common colt, called "charpoy" and after washing it carefully, convey it to the appointed burning palace, and covered with narrow cloth and escorted by the villagers both by males and females. The body is placed on the pyre, anointed and then offerings of rice are made and finally the pyre is ignited by the father or mother, a wife or husband.

FESTIVALS OF THE ORAONS

The two most important festivals of the Oraons are the 'Karma' and 'Sarhul'. The Karma is celebrated at the season of planting out rice grown in seed beds. This festival is observed by the Hindus as well as Kols, Mundas and other tribes. On the

first day of the festival the villagers observe fast till certain ceremonies have been performed. In the evening a group of young people pf both sexes proceed to the forest and cut a branch of young *Karam* (Nuclei parvifolia) tree and bearing which they return in triumph-dancing and singing and beating drums and plant it in the middle of *akhra (*dancing arena) after performing certain rites and rituals. After the performance of sacrifice to *Karma Deota* (God of Karma) by the *Pahan* (Priest) the villagers feast and dance the whole night. In the morning festival closes with removal of the Karma tree. It is taken away by a merry throng and thrown into a stream or a tank.

The *Sarhul* or *Khaddi* is another major festival of the Oraons. It is observed at the end of March and the beginning of April. The notion of this festival that at this season the marriage of *Dharti* (the Earth) is celebrated and this cannot be done till the sal trees give flowers for ceremony. After sal trees blossom, a day is fixed by the villagers for celebration. On the day fixed by the villagers together with the *Pahan* (priest) go to *Sarna* (sacred grove) and worship the remnant of the old sal forest where their popular deity *Sarna Burhi*, the woman of the grove is believed to live there (Riseley1981&Roy2004).

Other minor festivals of the Orisons are – the *Phagu* festival,(hunting festival), *Phage Sandra* (celebrated in the month of *Phagun* or March), *Bison Sendra* (Summer hunting in the month of *Baisk* or March), festivals connected with cattle e.g. *Sohari* (celebrated on *amawas* or New Moon in the month of *(Kartick),* agriculture festivals e.g. *Hariari* (festival of green plant, celebrated in month of *Asarh* or mid June-July), *Kadoota* (festival connected with transplanting of paddy seedlings, celebrated in the month of *Bhado* or August), the *Jitia* festival (celebrated twelve days after the Karma festival)and *Kharra puja* or *Kharhani* (festival of threshing paddy, observed in *Aghan* or November) which is the last agriculture festival of the year.

SOCIAL ORGANIZATION

The exogamous septs are extremely numerous among the Oraons and all that can be identified are totemistic, the totem being taboo to the members of the septs (Riseley1981). Totemism, which was the basis for social and political organization of

the Oraons in what may be roughly called hunting and pastoral stage of Oraon culture, still forms fundamental features of their social organisation in so far as kinship, marriage and relations of sexes are concerned. For the purpose of exogamy the whole tribe is divided into a number of clans/ gotras (Roy 1999). The Oraons follow the simple rule of exogamy that is a man cannot marry a woman of his own sept. The sept name descends in the male line and so there is no objection to a man marrying a woman belonging to the same sept as his mother.

BACHELOR'S DORMITORY

One of the unique features of Oraon society and culture is the bachelor's dormitory, known as *jonk-erpa* or *Dhumkuria* in Oraon language or *Dhangar-kuria* in Hindi (Roy 2004). In the matters of domestic economy, the Oraon are a slovenly race and their badly built mud huts afford no sufficient accommodation for unmarried members of the family. Therefore, *dhumkuria* was provided separately for unmarried boys and girls where they all must sleep at night. In some villages a separate house under the charge of an elderly woman or a widow (Risley 1981). *Dhumkuria* was an important institution of the Oraons as well. It was an archaic form of economic, social and religious organization, a useful seminary for training young men and women in their social and other duties. But to some Oraons, e.g. Christian converts, the institution of *dhumkuria* appears to be a genuine and unadulterated product of 'primitive' Oraon culture, which is brought over by their ancestors from their ancient home on Rohtas plateau to their present home on the Chota Nagpur plateau. But at present in many villages of Chota Nagpur, the public *dhumkuria* house for some reasons or other ceased to exist but the institution itself is by no means extinct (Roy 2004)

RELIGION AND FESTIVALS

RELIGION

Traditionally the Oraons are animistic. Their religion and religious life centers on belief in numerous gods, goddesses, ancestor worship, deities, spirits and unseen forces.The religious life of the Oraons under study also consists of the worship of gods, deities and spirits belonging exclusively of the Oraon tribe. But they also participate in various social and religious festivals like Durga Puja, Laxmi Puja Saraswati Puja, and Kali Puja etc. of the Bengali Hindus.

The religion and the belief system belonging exclusively to the Oraon tribe is classified under four headings, namely, i. the village deity, ii. ancestor worship, iii. household deities and iv. the evil spirits

The Village Deity

The village deity is one of the important deities of the Oraons. It is popularly known as *Gaon Deota* or *Bahir Kali* by the Oraons in their own language. The term *Bahir kali* is used because this deity is believed to reside out side the house, in the village. It is popularly known and worshiped as *Basanti Debi* and *Mai Puja*, the term which is borrowed from Bengali Basanti Puja. But it must be noted that they worship their own clan deity. At present this term has become part of their religious and cultural tradition. The deity, *Basaanti* is considered the most important village deity worshiped by the Oraons of this locality. It is a community religious festival celebrated every year in the month of 'Asada' (Mid-June to Mid July). *Basanti puja* is also called *Asadi puma,* so named after the month of *Asada.* It is the worship of mother deity, locally called, *Mai puja,* The main purpose of observing this religious festival is to seek blessings of the deity so that the villagers may be protected from all kinds of diseases and illnesses, specially, chicken pox, cholera (*Mahamari)* as well as other kinds of misfortunes against human beings, cattle and crops. Therefore, *Mai deoti* or *Basanti deoti* is propitiated with at most care and reverence in the appointed time, every year in the beginning of the month of *Asada.*

The *Mai puja* or *Basanti* Puja is a community worship, which usually takes place at the house or the courtyard of the village headman, called *moral*. The worship or religious ceremony is officiated by the *moral* (village headman).

The Oraons have no idol worship. So they venerate and worship only through symbolic representation of the deity *Basanti* or *Mai* The entire courtyard of the village headman is cleaned by besmearing with diluted cow dung with water on the previous day or the early morning on the same day it is to be worshiped. The central position of the courtyard is specially marked for placing the object of worship. A new small symbolic earthen pot is kept at the center of the courtyard or a corner of a house. The earthen pot is covered with a piece of loin cloth called *gamcha* and then a *dab* (coconut), a mango leaf, some *arwa* rice (rice obtained without boiling the paddy) and *dubla* grass (cynodon doctylon) are placed near the earthen pot. After that a young black he goat *(patha)* and a pair of pigeon are sacrificed the blood of which are sprinkled by the village headman on all four directions – east, west, north and south so that no evil power could enter the village and attack the villagers.

The village headman conducts all the religious ceremonies. He enchants prayers for the well being of all the villagers, cattle and crops so that this protective deity of the village may protect them from all kinds of troubles, disease, illness and misfortune. The village headman as well as men and women observe fast until all religious ceremonies are completed. After completion of religious rituals all the villagers say prayers seeking blessings from the village deity. This religious ceremony is observed at a particular appointed time and if not propitiated properly the wrath of the deity may befall on them as well as other *bhuts* (malevolent spirits) may enter the village and bring disease and illness. Certain taboo is also observed before *Asadi* puja. Eating of any kind of fruits e.g. guava, jackfruit, mango papaya etc. are considered as taboo.

Khunt Puja

The *Khunt deota* (Ancestral god) exclusively belongs to the Oraon god or deity of the Oraons. The *Khunt puja* is also called *Mahis puja* (buffalo worship) or

Barka puja (worship of the supreme deity). The *Mahis* puja is so called because the sacrifice of a young buffalo is essential during *Khunt puja.* The Oraons also sacrifice a young sheep alternatively by the successive generations. But since *Khunt* puja takes place once in a new generation, they prefer to offer a sacrifice of a buffalo, though they consider it to be very expensive one. During *Khunt* puja all the clan members are invited well in advance so that all of them can join this ancestral worship. They consider the presence of all the clan members to be essential for this religious ceremony.

Rituals

The Oraons are very particular about following certain rites and ritual of *Mahis puja.* The preparations for it begin three to four months in advance. On the day of *Khunt puja,* the cattle shed where the sacrificial buffalo is kept, are cleaned properly. The sacrificial buffalo is decorated with flowers and some rituals are performed at the buffalo shed. The *kabiraj* /village headman/ *moral* enchants some mantras before leading the buffalo to the place where it is to be sacrificed. After completion of the rites and rituals the buffalo is taken to the place of sacrifice, usually, the central place in the nearby field close to the village. Some fodder is kept at the center of the field where religious rites are performed. There the buffalo is left free on the sacrificial ground. The sacrificial buffalo is believed to be ready for sacrifice when it comes itself at the center of the ground and starts eating fodder kept there. During this paraphernalia a special protective measure is taken by an experienced *kabiraj* from the attack of spoiling action or the intrusion of *bhut*or malevolent spirit or an action of a witch in the arena where the buffalo is to be sacrificed. It is believes that the kabiraj possesses the magico-religious power to keep away the spoiling action of all unseen evil forces or agent as well as evil powers of a witch.

Belief in *khunt* deity (the ancestor) forms a very important part of Oraon religion and religious belief system. Failure of propitiating in a proper manner may bring disaster, disease and even death of clan members, cattle or damage property. Hence the Oraons are very particular about worshiping *khunt* deota' or deity.

Household Deities

The Oraon tribe also believe in several *deotas* or deities that are believed to reside in the house. Hence they are called, *Bhitar Kali* meaning deities residing inside the house. Of the various household deities the important ones are the following:-

. **The Dangri/ Barka Deota**: The *Dangri*: or *Barka Deota* (deity) is the most important household deity of the Oraons. *Barka deoti, so* called because it is considered so sacred and important that the actual name can not be uttered without performing some rites and rituals. It is worshiped in the month of *Chaitra* (Mid March-Mid April). This deity is believed to be very active during marriage of a boy in the family. It is believed that when a bridegroom elect departs to the bride's house for marriage, the deity is believed to escort him up to the safe distance wherefrom the bridegroom will not be attacked by any kind of malevolent spirit or a witch and also when the bridegroom returns after marriage the deity escorts the newly wedded couple back home safely.

This deity is believed to protect the bridegroom as well as the other family members from all kinds of evil intrusion. No one dares to annoy the deity. So the Oraons are very particular about observing *Dangri puja* because if it is not propitiated properly at the appointed time it may bring disease, illness etc. to family members. The perception held by the villagers is that they can guess the cause of illness by observing certain symptoms in the patient but usually, they call a *gunin* or a 'kabiraj' for diagnosis and treatment of illness. The kabiraj is believed to diagnose the causes of illness by oil divination or just enchanting 'mantras'. The kabiraj after making diagnosis says that *bhut* (evil intrusion) has taken place in the house. It is believed that the evil spirit takes shelter in the house after driving the household deity out of the house. In such event human suffering and illness is bound to occur and so the kabiraj by his magico-religious power derives the evil spirit out of the house and brings the *dangri deota* (household deity) back home.

Rituals and Items of Worship: To propitiate *Dangri deota* a matured white he goat is sacrificed. The goat is decorated with flowers. Some rituals are performed at home. After that brother–in-low carries the sacrificial goat to the place of sacrifice, which is usually chosen in the open field near the village. After the goat has been sacrificed, the meat of it is cooked there itself and consumed by all because bringing the meat home is considered taboo.

Suryahi Deota (Worship of Five deities): This religious ceremony or puja takes place twice a year in the month of *Baisakh* (mid April- mid May) and *Agrahan*, (mid-Nov.-mid December). Five types of fowls- three cocks of different colours, namely, red cock, *mala murga* (cock with rings on the neck) and a spotless white cock and two hens of two different colours, namely, black and ' kesari'(spoted brown) hens are sacrificed in the name of five deities each symbolizing a particular deity – the red cock for *gaon deota* (village deity), cock with rings around its neck for *khunt deota a*(Ancestral god), white cock for *suryahi* deota, black hen for 'kali deota' and 'kesari' hen for *buda-budi*or all the dead men and women of the family including all the dead persons of the entire clan. The worship of *suryahi* deity is performed for the well being of all the family members as well as all the clan members of the village and other places.

Taboo : Eating of the meat of sacrificed black hen is considered taboo among the family and clan members. Hence eating of its meat is strictly forbidden. After sacrificial rituals are performed the meat is given to people belonging to other clans. Breach of this taboo is feared to cause misfortune, disease, illness etc. to family and clan members.

Manasa / Biswahari deity: The deity, or *Manasa* or *Biswahari* is considered as living *deota* (deity) among the Oraons over here. It is believed that both these terms -*Manasa* and *Biswahari* are borrowed from Bengali language which has become integral part of Oraon religious belief system but claim that they worship their own tribal deity. This deity is believed to protect the family members, or the entire villagers, especially, from misfortunes like snake bite to human beings as well as the cattle. The deity *Manasa* is worshiped individually and it is collectively worshiped during *Makar Sankranti* in the month of *Bhadro*(mid August

–mid September) while individual family worships *it Makar Sankranti* in the month of *Shraban* (mid July-mid August). The deity is worshiped as protective measures against snake bite. A very strong belief prevails even today that if the deity *Manasa* is not propitiated properly, the wrath of the deity befalls upon them which causes snake bites to people and cattle frequently. Therefore, the villagers venerate the deity with much care so as not to annoy the deity.

Kali Deota (Worship of Clan Ancestor): The deity, *Kali* is another important household deity. It is believed to be an ancestral clan deity, which is worshiped on the *Amawasya* (New Moon) in the month of *Kartick* (November) when Bengali Hindus observe *Kali Puja,* On this occasion each Oraon family worships its own clan deity. The head of the family offers puja by making sacrifice of a hen / cock on the day appointed. No Kabiraj is required for this puja.

Jaleswari Deoti : *Jaleswari* deoti is also considered a kind of clan deity which is believed to leave the dirty house of the clan member and looks for shelter in another family of the same clan which is clean. It is a minor deity and is considered harmless. It is worshiped only with some *batasa* and *sindur* (vermilion).

Bamini Deoti: It is also considered to be a minor household deity believed to help in household chores. It is also related with household clan deity which is venerated by 'batasa' only. Any kind of offering which is red is avoided during puja. This is also a harmless deity.

EVIL SPIRITS

Apart from various benevolent gods, goddesses and deities, the Oraons believe in numerous malevolent spirits or evil spirits which are believed to cause various disease, illness and human sufferings. The important malevolent evil spirits believed by the Oraons are the following:

Jal Masna (Evil spirit believed to reside in water) : It believed that when attacked the evil spirit called *Jal Masna* a tendency of jumping into the well or a pond is seen upon a person. People fear this evil spirit.

Bahir Masna: Intrusion of this evil spirit called *Bahir Masna* makes the patient or the victim run about here and there and he does not listen to anybody. He behaves abnormally as if he is mad.

Chandi Masna or Churail: It is an evil spirit which mostly attacks and harms the pregnant women. Therefore, amulets are worn by the pregnant women as precautionary measures.

Shasan kali: It is a malevolent spirit believed to intrude secretly upon a body of a person during sleep and makes a person shivering during sleep.

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Kandani Masna : The attack of *Kandani Masna* makes the patient or victim ceaselessly, the treatment of witch is possible only through warding of the action off evil spirit from victim's body.

Bandh Kanda (evil spirit of burning ghat or place) : It is a popular believe that the most malevolent called *Bandh Khanda* which resides around the cremation ground or *ghat*. It is to intrude upon a persons body when he or she passes by the *Shasan*, (burning *ghat*) alone at night. A person attacked by this malevolent spirit tents to run away towards the burning *ghat*. The *ojha or kabiraj* is called upon to exorcise this evil spirit.

FESTIVALS

Festivals of the Oraons are always connected with or centered on religion, ancestor worship, spirit worship, cattle and agriculture. Festivals of the Oraons are not purely a social gathering or an event but they are profoundly related with religious beliefs as well as well being of the community, cattle and crops and protection from various calamities, disease, illness and misfortune.

Before going into the details of Oraon festivals, the investigator would like to point out several types and aspects of socio-religious festivals / ceremonies / rituals described in many literatures on the Orisons of Chota Nagpur e.g. Roy,(2004) and Kujur(1989) that are not observed by the Oraons inhabiting in Bamongola Block, in Malda district, West Bengal. The study has revealed that non-

observance of certain festivals and religious rites and rituals connected with them are due to a very long, almost a century and half, dissociation from their original homeland, Chota Nagpur and also due to living in a different socio-cultural milieu. The detail discussion on their history of migration is already given earlier. During field survey the investigator asked about some festivals which were described by Roy,(1928) and Kujur (1989) to which the Oraons under study were unaware of or had no idea at all about them or some exists only as folk lore.

The people over here only know that their forefathers had migrated from Chote Nagpur. Many of them have even forgotten the area or region or very vaguely remember them from where their forefathers had migrated. They have never visited Chota Nagpur since their migration. The present generation of the Oraons inhabiting in Bamongola Block in the district of Malda was born either in Bangladesh or in the area where the study has been carried out. Not a single member of the present generation of the Oraons under investigation has ever visited their original homeland, Chota Nagpur. Since their migration they inhabit in a different socio-cultural milieu and ecological environment. Hence they have forgotten some of the festivals which were observed by the Oraons of Chota Nagpur.

Some of the important festivals not observed by the Oraons under study are related to festivals of hunting, like *Phagua Sendra* (Hunting festivals of young boys, called *Loddo sendra*), *Bisu Sendra* (biggest hunting expedition), *Jeth Sandra* (hunting festival held just before growing of paddy seeds in high lands or low lands), and *Jani Sikar* (hunting expedition of women folk, who dress up in male dress and go out for hunting from village to village). Apart from these various types of socio-religious gatherings, such as *Jatras – Jeth Jatra, Dasai* or *Dasara Jatra,* and *Pause Jatra* are not observed by the Oraons of this region.

The Oraons who inhabit in the area have completely dissociated themselves from their original homeland almost for more than a century and half but they still observe some important festivals which belong to the Oraon tribe. Though exclusive classification of the festival are not possible for each festival is associated with some religious beliefs, yet they are categorized into the following three categories:-

1. **Socio-religious festival**

   i. Asadi Puja

   ii. Bhelwa Phari Puja

   iii. Sarhul / Xaddi or Khaddi

   iv. Karam Festival

2. **Agriculture Festivals**

   i. Bichan festival

   ii. Dhangari festival

   iii. Nobano

   iv. Khalihan / kharihani festival

3. **Festival related to cattle**

   i. Sohrai / Gowal Puja

Socio-religious puja

The socio-religious festivals are discussed below in detail:

i.Asadi Puja: It is a religious festival celebrated in the beginning of the month of *Asada* (mid June-mid July) with the purpose of seeking blessings from the village deity for the well being of entire community. The village deity, called *Baraka Deota* is worshiped by the whole villagers (for detail ref. to the section on religious life).

ii. Bhelwa Phari Festival: Asadi puja is followed by *Bhekwa Phari* puja. It is celebrated just the next day of *Asadi puja*. Religious ceremony is held in honour of god, Narayan. Offerings of eggs and *arwa* rice (rice obtained without boiling the paddy) and a hen is sacrificed during puja.

iii. Sarhul / Xaddi /Khaddi: In Sadri language it is called *Sarhul* where as in Kuruk (Oraon language) it is known as *Xaddi / Khaddi*. It is an important festival of the Oraons celebrated in the month of *Chaitra* (mid March-mid April) after *Amawasya*, when the new moon appears. Usually the village head (*Morol)* and the elders of the village fix up the date of the festival to be observed. The day of *Sarhul / Xaddi* is fixed up on the date having uneven numbers such as third, fifth, seventh and so on. They also fix up the number of days the festival to be celebrated.

According to the tradition of the Oraons of Chota Nagpur, the original homeland of Oraons, the date for celebration of *Sarhul* festival is fixed up when *sal* tree is in full blooms. But since there are no *sal* tree is found in this region, they decide the any date for celebration of *Sarhul*. But they do know when about *sal* trees start flowering. So they do bring flower of *sal* tree from far away places.

The *Sarhul* festival has very deep inner meaning. The festival symbolize "the marriage of God" (*Dharmesh*, the supreme God) with the earth. The principal purpose of this festival is to venerate *Dharmesh* to ensure fertility of the mother earth, since the Oraons are primarily the agriculturist tribe. They pray for the good harvest on the occasion.

All grown up people observe fast on the day of the festival for the whole day. The village head man or the elderly person assigned the job or it is the kabiraj who officiates religious rites. The one who is entrusted with the job of worshiping must observe fast. Besides propitiatory sacrifice o a white cock , some fruits , namely, mango, drum stick, jack fruit, *neem* fruits, flower of *sal* tree with *dhup* (incense) and sindur (vermilion) are offered during puja. After the puja is over they break the fast and feast by eating and drinking of *handia* (rice-beer).

The Oraons over here do not follow all the rites and rituals as it used to be traditionally performed by the Oraons of Chota Nagpur. They have forgotten the idea of *sarna, naegas, pahan* etc. They also have no village priest to perform religious rites and rituals.

iv. Karma / Karam Festival: The *Karam / Karma* is the most important as well as the oldest of all festivals of the Oraons, believed to be adopted from the Hindus. The festival of *karam* is so named after the name of a tree called *karam*

(Nauclea Parvifolia). According to the tradition of the Oraons, the *karam* tree is sacred to *karam* deity who is believed to possess the power to give good autumn harvest. Thus the festival is celebrated in the month of Bhadra (mid September-mid October).

Kujur (1989), describes different names according to the place and time on which it is celebrated. These are *Dasai Karam* (performed on the night of Dasai feast), *Padda Karam* (performed in the court yard), *Raj Karam* (takes place on the dancing ground), *Jitia Karam* (it is so called when performed in imitation to the Hindus), *Pachcho Karam* '(It is meant for elderly women) and *Raji karam* (It is for the young girls).

Karam festival is celebrated with much religious fervour by the Oraons under study. But the Oraons over here use a branch of *Chakonda* tree in place of *karam* tree because *Karam* tree is not available in the region

The *jhumar* dance (community folk dance) is performed since fifteen days preceding the *karam.* Both young boys and girls perform *jhumar* dance every day in the evening which goes on till late at night. The *karam* festival is the culmination of this festive season. It is also coincides with the festival of Durga Puja a very important festival of the Bengali Hindus. The *karam* festival is celebrated on the *nabami* of Durga Puja.

On the day of festival young maidens and boys keep fast till the religious ceremonies are completed. Before noon in the same day a group of young maidens and boys who observe fast proceed to fetch a branch *of karam* tree, singing and dancing with traditional music instrument, *mandar* and *dholak.* After reaching the tree they dance around it, three or five rounds. Then a young boy or a girl fasting for the first time ties three or five strings upon the *karam* tree. Then after, a young boy climbs up the tree to cut a young branch of *karam* tree, which has not yet been flowered yet. The branch is cut with great care. After it is cut the branch is not allowed to fall on the ground or even touches the earth. The boys bring the branch down and hand over the branch to the girls waiting there. After the ceremony of cutting the *karam* branch, they all return singing and dancing in rhythm to *Akhara* (dancing arena located at the center of the village.) The *karam* branch is then

planted at the center of the *Akhara*. And after planting the branch, the boys and girls pay profound obeisance at the foot of the *karam* branch. The kabiraj or *mahan* performs the religious rites. He makes sacrifice of a hen, enchants mantras, while all other present at the *Akhara* listen to his mantras. While the kabiraj enchants mantras the maidens place the flower time to time at the foot of the *karam* branch. After completion of the religious rites they begin to dance to the tune of traditional musical instrument. They dance for the whole night. The next, that is on *Maha vijaya* or *Maha dasami* the *karam* branch is immersed in near by river or pond or stream.

Agricultural festivals

There are several festivals connected with agriculture. Since their life is directly or indirectly related to agriculture, they celebrate these festivals or *pujas* at different stages of agricultural crops. The important agricultural festivals are the following:-

i. Bichan puja (Puja related to sowing of seeds): The '*Bichan' puj*a is considered as the first agricultural festival of the season. It is celebrated before sowing of paddy seeds in the seed beds for growing seedlings. They pray for and seek blessings from god for good germination and healthy growth of seedling. The term '*Dhanbuni'* is used by Roy, 1999 for the same festival. The term '*bichan'* puja is believed to be borrowed from the local Bengali term "*bichan"* which means seed.

ii. Dhangari (Festival connected with planting of paddy seedling): *Dhangari* is an important agriculture festival is celebrated before transplanting paddy seedling. A puja is performed for the good crop. Transplanting of seedling begins after symbolic transplanting the seedling in the field. A puja is performed by the kabiraj with sindur (vermilion) '*urad*' (phaseolus roxburhi), banana, a handful of paddy grain and mustard seed. After completion of religious rites and rituals they drink rice-beer and feast.

iii.Nobano (Eating of new rice): The *Nobano* festival marks the eating of new rice grown in upland. No one eats new rice until this festival or ceremony is

held. *Nobano* is the equivalent term of *Tusgo or Nayakhani* used by Roy (1928) and Kuku (1989)

iv. Khalihan Puja (Festival of threshing paddy): The festival, *Khalihan* is the popular term used by the Oraons under study where as the Oraons in Chota Nagpur use the term *Khalihani*. The festival is celebrated in the month of Agrahan (the month starting from mid November) It marks the beginning of threshing of winter paddy on the threshing ground or floor, called *Khalihan* or *kharihan*, usually, prepares on the courtyard of near by field itself. The threshing floor is prepared in the open filed near the village by cleaning and besmearing with diluted cow dung in water and dried up; the Oraons under study mostly thresh their paddy on the courtyard. The practice threshing among the Oraons is done on the fixed threshing floor located close by in the village or on waste land or a rocky land (Roy) 1928, 1999 & Kujur (1989) The *Khalihan* festival is celebrated over here with some variations than that of the Oraons in Chota Nagpur. Among the Oraons under study, the *kabiraj* performs the puja where as among the Oraons in Chota Nagpur it is done by the village priest. After the puja is over they drink rice-beer and feast.

FESTIVAL CONNECTED WITH CATTLE

There is only one festival that is observed in connection with the cattle which is discussed below:

i. Sohrai / Gowal Puja: This festival is celebrated in the month of *Kartick* (November. It is the only festival connected with cattle. It is celebrated on the same day when Bengali Hindus celebrate *Kali Puja.* The festival, *Sohrai* is believed to be an original term of the Oraons where as *gowal puja* is derived from Bengali language.

The preparation of Sohrai starts the previous day by cleaning the cattle shed and lighting of small earthen lamps called *diya* at the entrance of the cattle. They also burn incense in the cattle shed. On the day of *gowal puja* or the Sohrai all the cattle are given washed in near by ponds or river and brought to the cattle shed. Then they tie a chain of flower around the neck and apply vermilion on the forehead of all the cattle. It is followed by some religious rites and then feeding with boiled bean seeds and rice.

On the occasion of *Sohrai /Gowal puja*, the Oraons worship their ancestors in the cattle shed itself. It is believed that the ancestor takes part in family sacrifice. The pray to the ancestor and seek blessings for the well being of the cattle. A red cock is sacrificed to propitiate the ancestral god and the blood of the cock is sprinkled in the cattle shed and at the door so that no malevolent spirit can intrude into the cattle shed and attack them with disease or any kind of misfortune.

THE PROFILE OF THE VILLAGE

The Oraon tribal villages under study have not grown out in a definite planned way. Houses and huts are built on high lands which are connected only by narrow village paths or foot tracts. The villages studied consist of multi-caste/ community groups, except some villages which are exclusively inhabited by the Oraons. The Oraons are a part of multi-caste /community in the village. But still they are found to inhabit in distinct clusters which are known as Oraon *para*. It was also found that the two tribal groups, the Santals and the Oraons live in separate cluster of hamlets or houses. The local people call or refer these tribals as *vanvasi* which bears some derogatory notion.

Mainly two types of houses are found among the Oraons of Bamongola Block. The native Oraons live mostly in big mud houses with thatched roofs or roof made of tin sheets. Some of the Oraon houses are very big, even two storied mud building with big court yard well plastered with mud or cow dung. Comparatively, the Oraons who migrated later as refugees in the region from Bangladesh live mostly in low thatched roof or poor quality of huts consisting of mostly one or two rooms.

Village Setting

The Oraon villages bearing a few are part of the larger village which are composed of other caste and communities of which the Namashudra and Rajbansis form the majority of the population in the villages studied but other castes and communities are not enumerated in this study. Before going into the brief description of the composition of caste and communities, the location of each village / hamlet is required. The villages studied have been divided into two categories which are presented in the chart with their respective administrative unit below.

Location of the Villages With Administrative Units

VillageCategory-I

Names of Villages	Approx Distance from RH (in K.M.)	Names of Mouza	J.L. No.
1. Dhekurkuri Gopalpur.	4	Maheshpur Palasbari	38
2. Mirjapur	8	Mirjapur	104
3. Kathuadanga	8	Sontara	64
4. Jogdola	7	Jogdola / Bhawanipur	75/77
5. Hanspukur	12	Pathar Jogdola	80
6. Titpur + Kamardanga Kamardanga.	8	Pakuahat / Titpur	99/101
7. Buridanga	4	Bamongola Khatil	42
8. Anaharpara	12	Madnabati Khoksan	
9. Chotopathari	6	Ailchora	54

Village Category-II

Name of Villages	Approx Distance from RH (in K.M.)	Names of Panchayat	Names of Mouza	J.L. No.
1. Sidurmuchi Gobindopur	3	Gobindapur-Maheshpur	Ramnagar	51
2. Belgharia Gobindopur	2	Gobindapur-Maheshpur	Maheshpur	40
3. Durgapur	1	Bamangola	Mohmmadpur	69
4. Mohunpur	1	Bamangola	Mohmmadpur	69
5. Bintara	1	Bamangola	Mohammadpur	69
6. Chandpur	3	Chandpur	Chandpur	57
7. Patul	3	Chandpur	Ailchora	55
8. Gopalpur	2	Chandpur	Gopalpur	53

The criteria adopted for categorizing the villages under study are based on the factor of proximity and distance from the Rural Hospital. The first category of villages are situated within the distance of 3 kms from Rural Hospital while second category of villages are located more than 3 kms away, are treated as far away villages Thus the health care practices of the Oraons have been investigated and analysed in two categories of villages. The first category of the village consists of the following villages / hamlets.

COMPOSITION OF CASTE/COMMUNITY

As said earlier that the villages under study is composed of people from several caste and communities. The Oraons are the part of the larger village yet they live in distinct *para,* (locality) known as Oraon *Para.* The composition of other caste and communities in each of the village is discussed in brief. At first the villages of category – I are described.

Sindurmuchi : This village consists of the Oraons and the Santals besides some Mohammadans. It is located quite interior from Dutta Para bus stop at Malda-Nalagola state highway.

Belkharia: It is about 2 KMs interior from Dutta Para bus stop at Malda-Nalagola state highway. The village is very big. It is composed of the Oraons who call themselves *sthania,* means the native settlers. It is the way they differentiate themselves between the native and the refugee Oraons who migrated from Bangladesh. Apart from this there is no difference. Most of the Oraons from this village are agriculturists.

Durgapur, Bintara, and Mohunpur: These three villages are located beside the Malda- Nalagola state highway, Mohunpur being the bus stop. These villages are situated adjacent to each other. They are also very close to the rural hospital. The village is composed of multi caste and communities, such as Rajbansis, Muslims, Bhuimali, Mahatos, and some Santals besides the Oraons.

Chandpur: This village is located about 3 KMs from Pakuahat, the administrative head quarter of the Block. The nearest important bust stop is Jamtala. The village is mainly inhabited by the Oraons but some Rajbansis and Muslims also inhabit there. It is the largest village in category-I type of village.

Patul: It is situated about 3KMs from Modipukur bus stand on Malda-Nalagola bus root and from RH. The Oraons form the largest community in the village. Besides the Oraons a couple of Muslim families also reside there.

Gopalpur: The village consists of the Rajbansis and the Oraons. The village is located about 1 KM from Modipukur bus stop on the Malda-Nalagola bus root as well as the Block Rural Hospital situated at Modipukur village.

The **village category-II** is located at a distance more than 3 KMs far from rural hospital. The caste / community composition of this group of villages is discussed below in brief.

Dhekukuri: It is a small hamlet surrounded by agricultural land. The inhabitants of this village are the earlier native settlers, who are mostly cultivators.

Mirjapur: Mirjapur is a very large village, adjacent to Pakuahat, the Block Headquarter. It is a multi-caste-community village which consists of the Oraons, Santals, Namashudra, Rajbansi, Bihari, Napit, Pal, Muchi Brahmins and a few Muslim families. The Oraons of this village are mostly immigrants from Bangladesh.

Kathuadanga: It is a multi caste/community village. Besides three tribal communities, namely, the Oraons, Santals and Mundas, the other communities inhabiting there are the Namashudra, **Bhumij**, Dhopa, Kapali and some Muslims.

Jagdola: The village is situated about 4 KMs from Jamtala bus stop on Malda-Nalagola bus route. It is connected by a good tar road. The village consists of multicasts and communities , such as the Oraons, Santals, Rajbansi, Mahato, Karmakar, Bairagi, Muchi and some Brahmins.

Hanspukur: The village is under Jogdola Gram Panchayat, located about 9 KMs interior from Jamtala bus stop on the Malda- Nalagola road. It is too connected by good pitch road, except the last stretch of 1 Km which is connected by mud road only. This stretch of the road gets flooded during monsoon and hence it is the boats that become common mode of transport for the people of the village. The two major communities of this village are the Oraons and the Santals besides some Rajbansis and Biharis who inhabit in the villages.

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Kamardanga & Titpur: This village is situated on the Pakuahat-Bamongola road, about 1 KM from Pakuahat. It is also a multi-caste-community village consisting of the Oraons, Santals, Mahatos, Rajbansis, Namashudra, Behari, Muchi, and some higher caste group. A good number of the men folk work as permanent and some of them as temporary wage labourer in the Agriculture Farm run by the West Bengal Government

Buridanga: It is under Bamongola Gram Panchayat, located in a very interior area, can be approached by badly built mud road. Besides the Oraons, other castes / communities are the Santal, mahato, Namashudra, Polia, Kamar, Napit, Teli and a few Brahmin households.

Anaharpara: It is under Madnabati Graam Panchayat. The village is located in a very interior area about 5 KMs from Nalagola bus stand and about 14 KMs from the rural hospital. The village consists mainly of two tribal communities- the Oraon and the Santal. The Oraons here are the natives , the early settlers and the later immigrants from Bangladesh. The of this village are both cultivators and agricultural labourers. It is the largest village in the category-II type of village.

Chhotapathari: It is situated about 6 Kms from Modipukur bus stop and rural hospital , at Malda-Nalagola bus route. The village consists of the Santal, Namashudra and the Rajbansi besides the Oraons.

DEMOGRAPHIC FEATURES OF THE VILLAGE

The study of the demographic characteristics of the village is important to gain insight into their way of life. Particularly, in this study the demographic features are very important because to a large extent it determines their indigenous system of medicine or health care practices. They are also socio-economic indicators of the level of development. Therefore, demographic characteristics of the village such as population by age and sex, literacy, educational level, land holdings, occupation, family income, family type, family size, religion and marital status have been taken into consideration while studying health care practices of the Oraons of Bamongola Block in Malda District.

Table: 10.Distribution of Oraon population in two categories of Villages.

Village Category-I **VillageCategory-II** **Total**

		Population					Population			
Villages Near Rural Hospital	No.of Fami-lies	M	F	T	Villages far from Rural Hospital	No.of Fami-lies	M	F	T	T (I+II)
1.Sindurmuchi	9	20	23	43	1.Kathuadanga	13	29	25	54	97
Percent		0.88	0.01	1.89	Percent		1.28	1.10	2.37	4.27
2.Durgapur	16	37	33	70	2.Dhekurkuri	40	88	85	173	243
Percent		1.63	1.45	3.08	Percent		3.87	3.74	7.61	10.69
3.Mohunpur	22	37	46	83	3.Titpur	45	114	101	215	298
Percent		1.63	2.20	3.63	Percent		5.01	4.44	9.45	13.10
4.Bintara	34	68	70	138	4.Buridanga	20	39	49	88	226
Percent		2.99	3.08	6.07	Percent		3.92	2.15	3.87	9.94
5.Gopalpur	27	65	63	128	5.Hanspukur	39	122	105	227	355
Percent		2.86	2.27	5.63	Percent		5.36	4.62	9.98	15.61
6.Patul	23	57	51	108	6.Jogdola	23	52	54	106	214
Percent		2.51	2.24	4.75	Percent		2.29	2.37	4.66	9.41
7.Chandpur	64	142	136	278	7.Mirjapur	25	53	50	103	381
Percent		6.24	5.93	12.23	Percent		2.33	2.20	4.53	16.75
8.Belkharia	33	93	86	179	8.Anaharpara	56	136	115	251	428
Percent		4.09	3.78	7.87	Percent		5.98	5.06	11.04	18.82
					9.Chhotopathar i	06	17	13	30	30
					Percent		0.75	0.57	1.32	1.32
TOTAL	228	519	508	1027	Total	266	650	597	1247	2274
PERCENT		22.82	22.34	45.16			28.58	26.25	54.84	100

The field work for the purpose of the study was carried out in all the seventeen Oraon villages, of which eight of them were located in the vicinity of the rural hospital, having 228 households, consisting of the total population of 1027 (45.16 %) ; of which 520 (22.82 %) and 507 (22.32 %) comprises of males and females respectively, where as 266 number of households in the category II type of villages consists of the total of 1247 persons of which 650 (28.58 %) and 597 (26.25 %) are males and females respectively.

Table:11. Distribution of total population in two categories of villages by age group and sex

Age Group	Male	Percentage (percent)	Female	percentage (percent)	Total	percentage (percent)
0—5	161	7.08	165	7.56	326	14.64
6—14	298	13.10	307	13.50	605	26.60
15—25	222	9.76	230	10.11	452	19.87
26—35	218	9.59	175	7.70	393	17.29
36—45	115	5.06	98	4.31	213	9.37
46—60	108	4.75	77	3.39	185	8.14
61 +	48	2.11	52	2.29	100	4.40
TOTAL	1170	51.45	1104	48.55	2274	100

The table11. Shows the distribution of population of the villages by age group and sex. It shows that out the total population of 2274 persons, male and female population which consist of 1170 (51.45 %) and1104 (48.55 %) persons respectively. The largest population of 605 (26.60 %) persons is found in the age group of 6-14 years, followed by 452 (19.87 %) and 393 (17.29 %) persons in the age groups 15-25 years and 26.35 years respectively. The child population in the age group of 0-5 years comes next in the order who constitute 326 (14.64 %) persons of which males population is 161 (7.08 %) and female population constitute 165 (7.56 %), persons followed by 213 (9.37 %) persons in the age group of 36-45 years. The males consists of 115(5.06 %) and female 98 (4.31 %) persons. A sizable population is also found in the age group of 36-45 years where male population is 108 (4.75 %) and

female 77 (4.75 %) persons, which account for the total of 185 (8.14 %) persons together. The people older age group that is 60 years and above accounts for 48 (2.11 %) and 52 (2.29 %) persons male and female respectively , which together constitute 100 (4.40 %) persons in the village.

Table: 12. Literacy Status of the Population in two sets of Village by Age Group and Sex.

1 Literate							2. Illiterate							
Age Group	M	percent	F	Per-cent	T	Per-cent	M	Per-cent	F	Per-cent	T	Per-cent	T(1+2)	Per-cent
6-14	282	14.48	268	13.76	550	28.23	24	1.23	28	1.44	52	2.67	602	30.90
5-25	132	6.78	90	4.62	222	11.40	85	4.36	150	7.70	235	12.06	457	23.46
26-35	114	5.85	26	1.33	140	7.19	95	4.88	151	7.75	246	12.61	386	19.82
36-45	55	2.82	10	0.51	65	3.34	63	3.23	82	4.21	145	7.44	210	10.78
46-60	44	2.26	1	0.05	45	2.31	60	3.08	98	5.03	158	8.11	203	10.42
61 +	18	0.92	1	0.05	19	0.97	25	1.28	4	2.36	71	3.64	90	4.62
TOTAL	645	33.11	396	20.33	1041	53.44	352	18.01	555	28.49	907	46.56	1948	100

The level of literacy is believed to have a strong influence on the health care practices or health behaviour of the rural folk. It influences the nature and concept of diseases to be suffered by the people as well as methods of treatments sought. Therefore, analysis of literacy of the population of the village deserve mention.

In the table 12, it is found that the population of age group 6 years and above constitute a total of 1948 persons, out of which a total of 1041 (53.44 %) % are literate , of which percentage of male and female literacy constitute 645 (33.11 %) and 396 (20.33 %) respectively. It is found from the table that the largest literate population e.g. 550 (28.23 %) belongs to the age group 6-14 years where male literacy is 282 (14.48 %) and female literacy is 268 (13.76 %). In the next age group 15-25 years male literates are 132 (6.78 %) and female literates are 90 (4.62 %) which together constitute a total of 222 (11.40 %) literate population. In the age group 26-35 years male and female literacy is 114(5.85 %) and 26 (1.33 %) respectively who constitute 151 (7.34 %) of the total literate population in the village. Similarly,

literacy status in the age group 36-45 years, male and female literacy is 55 (2.82 %) and 10 (0.51 %) which constitute a total of 65 (3.34 %) literates. Among the older age category, e.g. 46-60years literacy level is very low e.g. only 44 (2.26 %) and 01 (0.05 %) males and females are literate respectively who together account for a total of 45 (2.26 %) literate people in the village. On the other hand literacy rate among people 61 years and above accounts for very small number of literate persons e.g. only 19 (0.97 %) are literate out of which 18 (2.31 %) and 1 (0.05 %) are males and females respectively.

From the table it is obvious that a very large section of the Oraon population is illiterate. A total of 907 (46.56 %) persons are illiterate, of which 352 (18.07 %) and 555 (28.49 %) are males and females respectively. Among the lower age group that is 6-14 years, the % of illiteracy rate is very low, e.g. out of the total of 52 (2.67 %) illiterate persons 24(1.23 %) and 28 (1.44 %) are males and females respectively. In the next category of age group (15-25) years there are 235 (12.70 %) illiterate persons out of which males account for 85 (4.36 %) whereas females 150 (7.70 %). In 25-35 years of age group there is a total of 246 (12.61 %) illiterate people consisting of 95 (4.88 %) and 151 (7.75 %) male and female who are found to be illiterate respectively. In the subsequent age groups e.g. 36-45, 46-60 and 61 years and above total illiterate population is 210 (10.78 %), 203 (10.42 %) and 90 (4.62 %) respectively.

The observation on literacy status shows that rate of illiteracy is very high among the older age groups. The rate of illiteracy also increases with higher age groups for both male and females. But again it is noticeable that illiteracy among females is comparatively much higher than males. On the other hand, the table shows that literacy rate is found to be much higher among the lower age group or younger generation. Therefore, it may be said that literacy is increasing among the younger generation but at a very slow rate.

Table: 13. Distribution of Educational Level of Population in two sets of village by Age group and Sex

EDUCATIONAL LEVEL

Age group	Primary (Class I-IV)			Junior High (V-VIII)			High School (IX-X)			H.S (XI-XII)			B.A.			Grand Total
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	
6-14,	244	248	492	85	64	149	8	7	15	-	-	-	-	-	-	656
per cent	23.44	23.82	47.26	8.17	6.15	14.32	0.77	0.67	1.44	-	-	-	-	-	-	63.02
15-25	44	28	72	43	31	74	11	8	19	8	-	8	1	-	1	174
percent	4.23	2.69	6.92	4.13	2.98	7.11	1.06	0.78	1.84	0.78	-	0.78	0.10	-	0.10	16.71
26-35	34	12	46	35	12	47	14	3	17	2	-	2	1	-	1	113
percent	3.27	1.15	4.42	3.36	1.15	4.51	1.34	0.29	1.53	0.19	-	0.19	0.10	-	0.10	10.85
36-45	24	7	31	11	3	14	8	2	10	-	-	-	-	-	-	55
percent	2.31	0.67	2.98	1.06	0.29	1.34	0.78	0.19	0.96	-	-	-	-	-	-	5.28
46+	25	2	27	14	-	14	2	-	2	-	-	-	-	-	-	43
percent	2.40	0.19	2.59	1.34	-	1.34	0.19	-	0.19	-	-	-	-	-	-	4.13
T	371	297	668	188	110	298	43	20	63	10	-	10	2	-	2	1041
percent	35.64	28.53	64.17	18.06	10.57	28.63	4.13	1.92	6.05	0.96	-	0.96	0.19	-	0.19	100

The level of education is another important demographic feature that has a strong bearing on the health care practices of the population and hence it occupies an important significant place in the study of tribal health.

The table 13 presents the distribution of educational standard of the population studied. A total of 1041 persons have attained some education through formal means and a few of them through informal means who are categorized under primary

education. It is very obvious from the table that a very large percent of population, e.g. 656 (63.02 %) people in the age category of 6-14 years has attained only primary level education which includes people who have discontinued and continuing schooling at present. Taking the entire age group we find that the highest percent e.g. 668 (64.17 %) of population has attained primary education of which 371 (35.64 %) 297 (28.53 %) are males and females respectively. A total of 298 (28.63 %) have got their education up to junior high school level of education, out of which 188 (18.06 %) and 110 (10.57 %) are males and females respectively. On the other hand only 174 (16.71 %) have schooling up to junior level high school. The people having high school level of education is very low, e.g. only 63 (6.05 %) out of which males and females account for 43 (4.13 %) and 20 (1.92 %) respectively. On the other hand, a very small number e.g.10 (0.96 %) of them who are all males, have managed to reach higher secondary (HS) level of education. No female was recorded to have HS level of education. Similarly, at the time when the field work was conducted only 2 (0.19 %) males were found to be graduates.

It is very clear from the table that the level of education is very poor or low among the Oraons under study. The largest percent of the population has only primary level education. Again there is wide disparity of education between males and females. Comparatively, females still lag far behind with regard to education than males in the village.

Landholding

The land forms the integral part of the Oraon villages. The lives of rural people including the Oraons, directly and indirectly centred on agricultural land, yet a large section of them are landless. It is mainly because the Oraons, specially, the native Oraons have gradually lost their land to non-tribals especially after the influx of Hindu immigrants from Bangladesh in the area. Who were socially and economically far better off . The price of land suddenly soared up and the tribal were lured to sell off their land. Thus many of the Oraons have now left with very little amount of land and some have even become landless. Secondly, those who migrated from

Bangladesh as refugees comprised a large landless population. The pattern of land holding is shown in the table below

Table:14. Distribution of households by Pattern of Land Holdings in two sets of villages.

Land Holdings	No. of Families	Percentage
Landless	120	24.29
Upto 3 Bigha	225	45.54
More than 3-upto 6 Bigha	86	17.41
More than 6-upto 9 Bigha	27	5.47
More than 9-upto12 Bigha	27	5.47
More than 12-Upto15 Bigha	02	0.40
More than 15- upto20 Bigha	03	0.61
More than 20 Bighas	04	0.81
Total =	**494**	**100**

The table 14 shows the landholding patterns of the Oraon households in the village. All the 494 households studied have been distributed according to the size of their cultivable land holdings. It is very evident from the table that two large sections of the Oraon families belong to landless and marginal farmers. Out of the total of 494 families,120 (24.29 %) form the landless category where as families owning land upto 3 bigha constitute 225 (45.54 %) numbers. So the largest percent e.g. 45.54 percent of the families belong to marginal farmers. The families owning land more than 3 bighas upto 6 bighas are 86 (17.41 %) where as 27 (5.47 %) families which own land more than 6 bigha upto 9 bighas and more than 9 bighas upto 12 biogas each respectively. Only a very small percent of the families, e.g. 2 (0.40 %) and 3 (0.67 %) own land more than 12 bighas upto 15 bighas and more than 15 bighas upto 20 bighas respectively, where as more than 20 bighas of cultivable land is owned by 4 (0.81 %) families.

It is observed from the table that 45.54 percent of the families constitute marginal farmers and 24.20 percent families are landless. So it is obvious that the

Oraon population studied is basically poor landless, marginal and small farmers. They are economically backward.

Table:15. Occupation of the Population in two sets of villages by Sex

Occupations	Male	percent	Female	percent	Total	percent
Agriculture(Owner cultivator with hire in labour)	141	9.84	221	15.42	362	25.26
Owner cultivator + Hire outAgrl. wage labour	335	23.38	312	21.77	647	45.15
Agriculture labour	185	12.91	182	12.70	367	25.61
Service(Govt.,Non-Govt.,Pvt)	14	0.98	2	0.14	16	1.12
Business(small business, Tea stall,shop liquor vending)	6	0.42	2	0.14	8	0.56
Drivers, Rickshaw van pullers	6	0.42	--	--	6	0.42
TOTAL=	**710**	**49.55**	**723**	**50.45**	**1433**	**100**

i. Owner cultivator with hire labour: It refers to those who cultivate their land with their own labour and also employ hired labourers during agricultural season

ii. Owner cultivator hired out agriculture labour: This category of land owners usually engage their own family labours to cultivate and also work as agriculture wage labourers because the land they own is small and hence its production is insufficient for their livelihood.

iii) Agricultural labour: It refers to those categories of labourers whose primary occupation is agriculture but they also do other type of works on daily wages.

iv. Other wage labour : This category of wage labours are employed in works other than agriculture during major part of the year.

The occupation is one of the important indicators of socio-economic status of the people which has its impact on all aspects of their lives e.g., health, education, standard of living and so on.

The principal occupation of the Oraons studied is agriculture. The largest section of them is directly or indirectly dependent on agriculture. Table 15 presents the distribution of total working population of the village. Working population here have been defined as whole time workers, including self employed. There are a total of1433 working people, out of which the total male working population is 710 (49.55 %) female workers constitute 723 (50.45 %). The occupation of the population is primarily based on agriculture. Out of the total working force, 362 (25.26 %) persons are engaged in their own cultivation, who employ hired agricultural in the field during agricultural season. On the other hand Such population constitutes 647 (45.15 %) persons work on their own land as well as wage earners of which males are 335 (23.38 %) and females 312 (21.77 %). There are 367 (25.61 %) persons primarily engaged as agriculture labour, of which males and females constitute 185 (12.91 %) and 182 (12.70 %)persons respectively. A very small population is engaged in occupations other that agriculture, like small business, 8 (0.56 %), while drivers and rickshaw van pullers constitute 6 (0.42 %). Hence, occupation of the Oraon is rural and particularly agriculture in nature.

Family Income

The type of occupations and family income are interrelated. It reflects the general living standard of the people, which affects the other aspects of life. It is found in the present study that a very large section of the families earn their income less than fifteen thousand rupees. Hence majority of the Oraon families studied are very poor. The annual family income of households is presented in the table below.

Table: 16. Distribution of household by Annual Income (in Rs.)

ANNUAL INCOME								
Total No. of households	Up to Rs.5000	5001-10000	10001-15001	15001-20000	20001-25000	25001-30000	30001-above	Total
494	14	113	184	87	40	22	34	494
percent	2.83	22.88	37.25	17.61	8.10	4.45	6.88	100

The table 16 on family income of the population studied presents a very dismal picture of their economic condition. It is apparent from the table that a very large section of the families studied are very poor. Of the total of 494 households, 2.83 percent (14) earn their family income below Rs. 5000, which deprive them from even meeting their minimum standards of life. Further, a big majority of the population, e.g.(113) (22.88 %) and 184 (37.25 %) belong to very low income group of Rs. 5001-10,000 and 10,001-15,000 respectively. The families in the income bracket of Rs. 15,001-20,000 and 20,001-25,000 consists of 87 (17.61 %) and 40 (8.10 %) families respectively. The people who are relatively better off account for 22 (4.45 %) and 34 (6.68 %) households and belong to the income group of Rs. 25,001-30,000, but their percent age is very small.

The table reflects a poor economic condition of the people in the village. Most of the income comes from agriculture and allied sectors. Both males and females work in their own land or engage themselves as agriculture labourers. But the families having less amount of land also work as agriculture labourers because production from the land is hardly sufficient to sustain their family all through the year. Only those families having their yearly income of Rs.30000 or more have sufficient land to maintain their families. They do not engage themselves as labourers The wages paid for agricultural labourers is very low and it varies from season to season according to the demands for agricultural labourers. There is also disparity in payment of wages for males and females. During peak agriculture season male labourers get Rs. 40 to 45 while female labourers receive wages between Rs.30/- to

35/- The regular work available directly in agriculture is for about 5-6 months a year and the rest of the time they have to find other works.

Family

In the following sections, family structure, size, marital status of population and religion of the Oraon population have been analyzed.

Table: 17. Distribution of Family Structure.

FAMILY STRUCTURE							
Total Family	Nuclear	Joint	Extended	Broken	Conjugal	Incomplete	Total
494	322	100	4	31	26	11	494
percent	65.18	20.24	0.81	6.28	5.26	2.23	100

The analysis of the family structure in table 17 shows six types of families among the Oraons under study. They are:-

1. Nuclear Family: It includes married couples and their unmarried children living together.
2. Extended Family: It means family consisting of family members of close relatives.
3. Joint Family: It refers to a family with more than one generation or two or more nuclear family generally living together under one roof and sharing common hearth.
4. Broken Family: Broken family refers to a family that has been a nuclear family but due to death of either a couple resulting into such a family structure.
5. Conjugal Family: Conjugal family here refers to a family which consists of only a couple who has no children born yet or the elderly couples living separately after the marriage of their children.
6. Incomplete Family: It refers to a single member family which has been as a result of death of a spouse, divorce or an unmarried person residing alone.

From the table 17 above, it is very clear that the largest number of Oraon family consists of nuclear family which constitute of 222 (65.18 %) families followed by joint family which accounts for 100 (20.24 %) families out of the total of 494 families. The third largest family type recorded is the broken family which consists of 31 (6.28 %) families followed by conjugal and extended family types which comprises of 26 (6.28 %) and 26 (5.26 %) families. The incomplete family and extended family consists of 11(23 %) and 4 (0.81 %) households respectively.

The observation drawn from this table 17 is that the most common type of family found among the Oraons is the nuclear family. Due to several reasons they prefer to live in nuclear families, of which economic consideration is the most important one among the landless families who depend solely on daily wages for their livelihood. But it may be noted that they live in close proximity to other and often by partition of their parental house or making a small house or hut in the land owned their parent. It is mainly due to the scarcity of land. Joint families mainly consisted two generations, found among those who own more cultivable land. The broken family was recorded mainly, due to death of either of the spouse bearing a few desertion, divorce and separation.

Table: 18. Distribution of Family Size

SIZE OF FAMILY					
Family Size	Single	Small (2-4)	Large (5-8)	Very Large(9+)	Total
Total Family	11	225	247	11	494
percent	2.23	45.54	50.00	2.23	100

The size of family is another important demographic feature. It is found from the table that most of the families in the village are nuclear but the size of family is very big. Even in nuclear families the family size is big. The table 18 shows that half of the

families under investigation that is 247 (50.00 %) have large family size consisting of 5-8 members. The small size family comprising of 2to4 (45.54 %) members accounts for 225 (45.54 %) households. The single member family comprises of 11 (2.23 %) families and very large families numbering 11(2.23 %) consist of more than 9 members. Therefore, it can be said that even nuclear families the size of member is large e.g. 5-8 members.

Table :19. Distribution of Marital Status of Population by age and sex

MARITAL STATUS											
Age group	Married			Unmarried			Widow	Wido-wer	Diver-cee	Total	Grand Total
	M	F	T	M	F	T					
Below -14	--	--	--	626	524	1150	--	--	--	--	1150
Percent				27.53	23.53	50.57					50.57
15-Above	497	570	1067	--	--	--	29	19	9	57	1124
Percent	21.86	25.07	46.92				1.28	0.84	0.40	2.51	49.43
Total	497	570	1067	--	--	1150	29	19	9	57	2274
Percent	21.86	25.07	46.92	27.53	23.04	50.57	1.28	0.84	0.40	2.51	100

Table 19 shows the marital status of the population of the village. It is found from the table that a total of 1067 (46.92) persons are married out of which males and females constitute of 497 (21.86 %) and 570 (25.07 %) respectively. On the other hand 1150 (50.57 %) are unmarried, of which 626 (27.53 %) and 524 (23.04 %) are males and females. Further, there are 29 (1.28 %) widows 19(0.83 %) widowers and 9 (0.46 %) divorcee.

Table: 20. Distribution of household by Religion

Religion	No. of Families	Percent
Hinduism	493	99.80
Christianity	01	0.20
Total	**494**	**100**

The Oraon community under study still follows tribal religion, yet they call themselves Hindus and practice Hinduism as well. Bearing just 1 (0.20 percent) family which follows Christianity and the rest e.g. 493 (99.80 %) are Hindus.

CHAPTER – 3

CHAPTER – 3

CONCEPT OF DISEASE AND METHOD OF TREATMENT

HEALTH AND HYGIENE

The surroundings and general sanitation of any locality has an important bearing on health of a community. Poor environment and sanitation also reflect the cultural habits and practices of any community. Poorer the hygienic condition greater the health hazard involved. Therefore, a close look at the general environment and sanitation of a community is very important in understanding and explaining the health care practices. It has been pointed out by many sociologists, social anthropologists and anthropologists dealing with health related studies that environment and sanitation of rural people is very poor. Tribal people also form a part of rural community but their environment and the problem of sanitation is found to be still poorer and of low order than other communities, the reasons of which are many and complex in nature. From this back drop the environment and sanitation problem among the Oraon tribes of Bamongola, in the district of Malda has been discussed.

Data on general sanitation and environment has been obtained first hand through interview schedule and direct observation during field survey. Data pertaining to this aspect includes housing condition such as number of rooms, windows, ventilation, sanitary latrine facility and personal hygiene - food habits, habit of consuming alcoholic drinks, liquor, and other intoxicating items that have been collected through interview schedule and information on general hygiene such as drainage, surroundings around water sources of drinking, bathing, washing etc .has been collected through observation.

General living condition of the Oraons with regard to environmental sanitation and hygienic condition were found to be poor and deplorable during field survey. Socio-economic condition of the Oraons under study is also very poor. Poverty, illiteracy and ignorance forced them to remain unaware about the fatality of such poor environmental and sanitary condition. General apathy and cultural practices of the Oraons were also not less important causes of unhygienic condition.

HOUSING CONDITION

The Oraons like other tribal communities or other rural folk inhabit in natural environment where general environment is free from pollution. But cultural habits ands practices of the Oraons are the causes of poor housing condition. The housing conditions of most of the Oraons were found to be in the state of poor housing hygienic condition. All the Oraons in Bamongola Block live in mud – built houses with low thatched or tin roof. Most of the houses consisted of only one window. A small number of houses were found to with two small windows. Ventilation was not found in any of the houses. The houses remain dark even during the day time. During rainy season the floor of the house remain damp and in wet condition. They also have the habit of sleeping on the floor. In most of the houses kitchens were found to be located separate from the living rooms but very close to it. Dry cow dung cake, firewood, dry twigs and leaves are used as fuel for cooking which most often fills the house with smoke. Cattle sheds are also located at separate place but within one corner of the house or near the house. Goats and fowls are kept inside the house. All these habits and practices make the housing surroundings very unhygienic leading to various health hazards. The following data reveal the poor condition of living among the Oraons under study.

Table: 21. Distribution of households by composition of rooms, windows, provision of sanitary latrine, sources of drinking water and location of kitchen

A. Composition of rooms	No. of households	Houses with one rooms	Houses with 2 /3 Rooms	More than 3 rooms	Total
	494	299	195	--	494
Percent		60.53	39.47		100
B. By provision For windows	No of households	Room with one window	Room with 2/3 windows	No window	Total
	494	212	74	208	494
Percent		42.91	14.98	42.11	100
C. By provision of Sanitary latrine	No. of Households	Pucca latrine/ Kachcha	No Latrine Facility	Community latrine	Total
	494	5	489	--	494
Percent		1.01	98.99		100
D. By provision for Drinking water	No. of Households	Community well	Hand pump	Others	Total
	494	400	94	--	494
Percent		80.97	19.03		100
E. Location of kitchen	No. of households	Within living room	Separate –close to Living room	Other	Total
	494	47	447	--	494
Percent		9.51	90.49		100

Table 21 shows the composition of rooms, windows, provision for sanitary latrines, provision or sources of drinking water and location kitchen in the house. Table clearly indicates that 299 (60.53%) of people live in houses with one room while a 195 (39.47%) of the houses have two or more small windows. Again table shows the distribution of houses with facilities for windows. It was found that out of the total of 494 houses, 212 (42.91%) of them consisted of only one window while 74 (14.98%) of the houses comprised of more than two or three windows. The most noticeable feature with regard to keeping windows is that 208 (42.11%) houses had no window at all, and neither did they feel necessity of keeping windows.

Under the prevailing condition and composition of the houses revealed that housing sanitation among the Oraons was found to be of very low order. Except a small number of houses, the rest had kitchens on a separate place but close to living room. The table indicates that 47 (9.51%) of the houses had their kitchen within the living room while most of them houses e.g. 447 (90.49%) had kitchens at a separate place but close to living room. All the families used dry cow dung cake, fire wood, dry twigs and leaves etc. as fuel for cooking. The volumes of smoke emitted fills the house with smoke daily which may have adverse effect on their health but they are little aware of it and also least concerned about it.

Defecation Habits and Pollution

Another aspect of poor sanitary condition among the Oraons relate to the habit and practices defecation in the open field. The entire Oraon population under study had the practice of going out into the field for attending the call of nature. This was also found to be one of the major causes of polluting the surroundings. But they were not aware of such pollution which results in several diseases like hookworms and other skin disease because human waste, specially, during rainy season pollutes the water sources of bathing and washing. But they were found to be least concerned about making sanitary latrine. This may make one think that poor economic condition does not permit them to make sanitary latrines. It is not the only reason. But it is more so with their habits and ignorance because it was found that even those who could

easily afford to make sanitary latrine but neither of them did so nor did they bother about it. So it reflects their level of cultural development.

Table 21, shows that a huge number e.g. 489 (98.99%) of houses, out of the total of 494, did not have sanitary latrine facilities. Only a very insignificant number e.g. 5 (1.01%) had *kachcha* latrine. It was found during field survey that poor economic condition was not directly related for having or not having sanitary latrine facilities but it was related more so with their cultural habit for generations. In fact they considered using sanitary latrines as a dirty place to use it every day which is used by many people. It was more so with the idea of community latrines. So they preferred defecation in the open field and were least concerned about pollution of the surroundings and unhygienic condition in the village.

Hygiene and Drinking Water

The Oraons of the study area had access to only two sources of drinking water – namely community wells and community hand pumps or shallow tube well which were very badly maintained. Table 21, shows that 400 (80.97%) of the household used community wells for drinking water where as only 94 (19.03%) families had access to drinking water from shallow tube wells provided by the Government.

It was observed during field survey that the condition of these sources of drinking water and surroundings were found to be in the state of very unhygienic condition. Sources of drinking water were also used for bathing, washing clothes, washing household utensils etc. Due to poor maintenances, lack of proper outlets, water gets stagnant around the water sources e.g. the tube wells. After washing utensils, food wastes are also thrown close to water sources. The filthy and dirty habits of the people lead to very unhygienic condition in and around the sources of drinking water. The tube wells were found to be surrounded by stagnant dirty water and full of mud. Some of them also reported leakages in pipes of hand pumps. Community ring wells also were found to be
no better condition than hand pump. In fact community water sources were the only sources of drinking water for most of the villagers but the wells were poorly maintained. All the well were found open, resulting in contamination of water, due to

dust, dirt, leaves etc that got collected into the wells. Leakages in the rings of the well also caused major serious problems, specially, during monsoon, because stagnant dirty water and ground water leak into the well in contaminating water meant for drinking. During the summer months too wells dry up and lead to severe contamination of water.

The Oraons under study seem to have no conception of germ and contamination of water. They do not take any precaution before drinking water even during rainy season as well as during summer when water level goes down and the water gets contaminated. Due this the Oraons reported to suffer from several disease and ailments like diarrhea, dysentery, gastroenteritis, cholera etc. every year during rainy and summer seasons. In this context the investigator would like to share his first hand experience that he had during the field.

The village, named Patul, inhabited mostly by the Oraons except a couple of Muslim families, was found to suffer from severe problem of dysentery and vomiting. The situation created panic among the villagers. Dozens of dysentery patients were admitted in the rural hospital .There were no beds left so patients were given treatment in the temporary makeshift. The enquiry revealed that the dysentery was caused by drinking of polluted and highly contaminated water from the community ring well that was the only available source of drinking water to them. Further enquiry brought to light some stunning fact that the water in the well was severely polluted. It was never cleaned since it was dug up, neither was bleaching powder given for years. The opening of the well was not covered as a result, dirt and dust and leaves had accumulated into it. It was also used for all purposes, like washing clothes and utensils, bathing etc. resulting in accumulation of dirty water around the well, leaking into the well through cracks in the joints of the rings. So the investigator, together with some villagers brought the matter to the notice of the Block Development Authority, who promptly responded and immediately directed the Block Medical Officer and the authority of the Panchayet concerned to take necessary step and the concerned authority did take immediate action to prevent further deterioration of the grave situation facing the village. This is not the isolated event. Every year a some of villagers of other villages too, including the tribals face this kind of problems, though it may not be that serious. This reveals that the Oraons have least conception of germ

and contamination. No precaution, such as boiling the water is taken even during rainy season. Thus the Oraons under study had very poor and low level of awareness regarding health and hygiene. At the same time, it is also true that there is lack of safe drinking water in the village

Sources of Bathing Water

The villagers usually take bath where ever water is available, be in ground water accumulated in ditches, pits, ponds or steams. These water sources are also used for all other purposes like washing clothes and household utensils as well as cattle. Rain water flowing into ponds, ditches and pits carry pollutants, like cow dung, excreta and other animal waste etc. which highly pollute the water. Bathing in such polluted water resulted in skin diseases.

Personal Hygiene

Personal hygiene and sanitation is directly related with the culture of a community. It also reflects the cultural development of community. Personal hygiene among the Oraons was also found to be of very low order. Data collected by the investigator revealed that they were not much aware of personal hygiene. Personal hygiene is understood to be the sum total of different habits and practices like defecation habit, bathing practices and habits, washing and cleaning clothes, cleaning of mouth, teeth etc. each of which will be dealt separately to gain better knowledge. So personal hygiene is a product of the cultural habit.

Bathing Habits

Regarding bathing habits, it was found that some people were in the habit of taking bath daily. But in general, the Oraons under study were not very particular about taking bath daily. Habits of bathing were also found to vary in different seasons. In summer most of them took bath daily but in the winter months it was done on weekly basis. During rainy season too they took bath once or twice a week. Only those who worked in their own fields usually took bath daily and those working as wage labourers twice or thrice a week. Children were left for themselves to take care of their own bath. So due to negligence on the part the parents in giving proper bath to

children, many were found to be suffering from skin diseases, like scabies on their body and wounds on their heads.

Regarding use of detergent, necessary for cleanliness, it was found that most of them were using soaps for bathing but not daily. After bathing they do not change their clothes daily. Even the inner wears were not changed regularly according to the report provided by the respondents; neither did the feel necessity for change. Same clothes are used for several days. Washing clothes is also a weekly affair. Normally, women members wash clothes on week ends. Earlier they used to boil the clothes with burnt ash

before washing them. But nowadays they use soaps and other detergent for washing clothes. As said earlier, that they have no habit of changing clothes regularly after bath, they were more prone to skin disease.

Teeth Cleaning

Teeth cleaning and washing mouths form another important aspect of personal hygiene. The Oraons under study used two items for cleaning teeth – one tooth paste and brush and the other twigs of neem (Azadirachitra indica) and *karanj* (pongomia globra), locally called *datoon* in Sadri language and *kairka* in Oraon / Kuruk language. But the use of twig for cleaning teeth is found to be more common among the Oraons. They also use burnt ash or a piece of charcoal with twig for cleaning teeth, infact, they preferred to use of twigs or 'datoon' of neem and karanj tree to toothpaste saying they have medicinal value because twigs both trees are very bitter. Children at the age of about eight or nine years or more were found not in a habit of cleaning their teeth regularly. Those who go out for work, wash their mouth quite late in the morning, usually, before their meal.

It was observed that the Oraons were not much aware of proper cleaning or brushing of teeth which result in foul breath of mouth and tooth decay.

Intoxication

Consumption of alcoholic drink like liquor, taking various narcotics is very common problem of any tribal community in India. The Oraons are no exception to this. Life of the Oraons under study, without consumption of various types of

alcoholic drinks or liquor can hardly be imagined. The Oraons seem to have little awareness about the impact of alcohol, liquor and other narcotics on health. Consumption of home made alcoholic drink called, ***haria*** (rice-beer) or locally prepared ***todi*** (alcoholic drink prepared from the juice of palm tree) and ***daru*** or ***chullu*** (country liquor brewed from either ***mahua*** flower or jhagri or fermented rice) is very rampant among the Oraons. Three types of alcohol or liquor namely ***haria, daru*** or ***chull*** and ***todi*** are consumed by all, men, women young boys. However young girls normally abstain from taking any of these alcoholic drinks. Even the pregnant women do not abstain from taking home made or country liquor which may be very risky for the health of the mother and the child.

Alcoholic drink or liquor is prepared by the following method: i. *Harai* (rice-beer), is prepared by fermenting of rice in earthen pots for about three to four days and then brewed. ii. *Todi* (juice of palm tree) prepared by fermentation of the juice obtained from palm trees. iii. *Daru* or *chullu* (country liquor) is prepared by distillation of fermented *mahua* flower (Basia Latfolia), jhagri and fermented rice. All these items are fermented and distilled to obtain liquor. For early fermentation they use chemical like urea which may involved high risk of serious health hazard and even risks of lives. But the tribals under study seem to have little aware of it.

In all social occasions like festivals, marriages, religious occasions, social gatherings as well as to entertain guests all these alcoholic drinks and liquor are commonly used. In fact it has become part of their culture and ritual during all social occasions and events. Alcohols are also consumed rampantly on weekly *hat* (bazzar /market) and smaller *hats* which take place twice or thrice in a week nearby. Table 22 below clearly indicates that out of the total 494 respondents, 454 (91.90%) consume alcohols while only 40 (8.10%) reported that they did not.

Habits of smoking and chewing tobacco

Apart from consumption of alcohol or liquor as discussed above, habits of taking other intoxicating items is also very common. Smoking of *bidi* is very rampant among men folk. Elderly women also had the habit of smoking *bidi* but in lesser frequency than men. However, cigarette smoking is not very common which is mainly

due to economic factor. A good section of the respondents reported that they smoke two to three packets of *bidi* daily.

Table 22: Distribution of Population by habits of smoking, Consumption of alcohol and chewing tobacco

Respondents' Response				
Habits of respondents	**No. of households**	**Smoke**	**Do not smoke**	**Total**
A. Smoking	494	361	133	494
Percent		73.08	26.92	100%
B. Consuming alcohol/liquor	494	**Consume**	**Do not consume**	**Total**
		454	40	494
Percent		91.90%	8.10%	100%
C. Chewing tobacco	494	**Daily(Frequently)**	**Do not chew**	**Total**
		295	199	494
Percent		59.72	40.28	100

Table 22 : shows that out of the total of 494 respondents, 361 (73.08%) had smoking habit of *bidi* while 133 (26.92%) did not. Some of the men folk also reported that they had the habit of smoking *ganja*. Discussion with the respondents revealed that they were not all aware of the consequences of smoking or even if they were they did not bother about it. Again we find from the table 21 that majority of the respondent e.g. 295 (59.72%) were in the habit of chewing tobacco while 199 (40.28%) of them did not. Discussion revealed that majority of them were not aware of the possible impact of chewing tobacco and some were aware of it, but cared little about it.

Observations made through discussion with the respondents about consumption alcohol or liquor etc. that most of them were not aware of the health problems that could result from excessive drinking habits of alcohol. Only small section of them reported that chewing tobacco leads to the problem of teeth decay and infection of gum while excessive smoking could lead to breathing problems. But majority of the respondents had no idea about possible disease or health hazard that

could result due to excessive consumption of various kinds of home made alcohol and country made liquor.

NUTRITION AND DIETARY HABITS

Malnutrition is one of the main causes for various diseases and ailments and in general, poor state of health in rural India. In particular, malnutrition is the major concerns for the poor status of health of tribal communities. It is due their poor economic condition. But at the same time nutrition and dietary habits have direct relation on the health of tribal communities

The Oraons of Bamongola, under study are economically very backward. A large section of them forms landless class, agricultural labourers, small and marginal farmers. The family income is very low. Poor economic condition does not permit to have access to nutritious food for most of them. They also can not afford to provide any additional nutritious food for children. Mothers are also not given any additional nutritious food during pre-natal and post-natal period. The take normal food- rice, dal and some vegetable like other family members. A large section of the Oraons of Bamongola, under study is poor hence their diet is of very poor quality and deficient in nutrition. The diet of the Oraons consists of rice, dal and some vegetables. But vegetables are not consumed regularly. But they also take rice with some addition of salt, onion and a few chilies. Vegetables are collected from near by fields, plants or trees and sometime bought from local *hat* (markets). Those who own some land produce vegetables in their own land or garden.

The Oraons are non-vegetarians. As such they do not observe any taboo with regard to food items, like beef, pork, mutton, fish, eggs, rats, and fowls of all kinds. But in most cases their food is poor and deficient in nutrition. The economic condition of majority of the Oraons is so poor that it hardly allows access to nutritive food needed for minimum standard of living in terms of diet. But with regard to consuming fruits, some strict taboo is observed, e.g. they do not eat any fruit until the ceremony of *Ashadi* or *Mai puja* is performed in the month of *Ashada* (mid June-mid July).

Items of Diet

Normal daily diet of the Oraons consists of rice and pulse (dal). They consume vegetables as and when available and not regularly. Meat, fish, eggs etc. are not taken on a regular basis. They also collect and eat roots, tuber, leaves, fruits and flowers of trees and plants available in the locality. But collection of food items is disappearing fast due to non availability of trees and plants in the area. Eating of fruits also mainly consisted of seasonal fruits only, either locally available or bought from local hat (market).

Table: 23. Distribution of the Respondents by Frequency of consumption of diet : meat, fish, and milk.

No. of Respondents	Food items	Daily	Weekly	1/2 times a month	Not Consume	When produced at home	Total
494	Meat	--	9	471	14	--	494
Percent		--	1.82	95.34	2.83	--	100
494	Fish	--	73	411	10	--	494
Percent		--	14.78	83.20	2.02	--	100
494	Milk(children)	--	--	--	450	44	494
Percent		--	--	--	91.09	8.91	100

The table 23 : shows the frequency of consuming some food items by the population studied. It is apparent from the table that none of the families found to consume meat, fish eggs etc. on regular basis. Only 9 (1.82%) people could afford to eat meat once in a week while the largest section, e.g. 472 (95.34%) households eat meat once or twice only and 14 (2.83%) can not afford to consume it. Even fish is not consumed regularly. It is the same per cent of people e.g. 73 (14.78%) take fish at least once a week on the day of weekly hat or market. On the other hand, 411 (83.20%) people somehow manage to eat fish once or twice a month while 10 (2.02%) people can not afford to buy fish even once a month. Milk is also not given to children in 450 (91.09%) households while a small section, e.g. 44 (8.91%) household provided some milk for children only when it was available or produced at home and the major portion of the milk was sold. The fowls like, pigeon, hens, ducks, birds etc. are raised mainly to sell in the local market. The food items such as meat, fish, milk etc. are not consumed by the people in the village mainly due to economic constraints and partly by their food habits. It was observed that a small section of the

people who could afford to eat meat / fish etc. at least once a week was economically better off. Daily habits of taking food for most people are twice or thrice a day and their staple food items consisted of rice, pulse and some vegetables. Usually, they take *kanji* (rice cooked on the previous night) in the morning, with salt onion and hot chilies. Meals during noon and night are taken with *dal* (pulse) and some vegetable. But the poorer families take meals only twice a day - late in the morning and evening. During agricultural season all the people working in the field take their lunch in the field itself.

Observation made from the food items they take is that their diet is imbalance, deficient in protein, vitamins calcium etc. necessary for hard and prolonged physical labour.

CONCEPT OF DISEASE / ILLNESS

A very little difference is found between two sets of villages regarding their perception about disease causation by evil spirits. The Oraons, who lived close to Rural Hospital, relatively had easy access to modern medicine and services from Rural hospital sources, due their proximity, yet they held a strong notion about evil spirits causing illness or disease. Therefore, method of treatment to be followed was found to be dependent on the diagnosis or explanation about the causes of disease by a traditional healer or medicine man. It was the traditional village medicine man whose advice was sought first by the villagers who had strong faith on him. It was very clear that the tribals who lived close to Rural Hospital did not want to compromise with their belief. Disease is not only purely a bio-physical phenomenon. It can not be isolated from socio – cultural milieu. The perception of disease and its cure assumes different dimensions in different societies – cultural pattern and typical ways of living give substances to the manner in which disease is perceived, expressed and reacted (Nagla 1997).

Etiology of diseases of any community depends on the motives, perception of the pathogenetic agents or force responsible for the causes. But the perception of diseases depend not only on pathogenetic agents or forces, rather it involves complex cultural and social phenomena – cultural situation, beliefs and practices of a given community. Therefore, it is imperative to understand the perception of disease etiology. Chaudhuri (1986) also emphasizes that every culture, irrespective of simplicity and complexity

has its own beliefs and practices regarding health and disease and it does not work in meaningless fashion always. Every system of culture tries to give treatment of disease in its own way. So the treatment of diseases and illness varies from one community to another.

Interpretation of and the causes of disease starts at the family level, with initial diagnosis to search for meanings, perception, suggestion suspection regarding possible origin and cause of disease by family, relatives, village elders and the community as a whole (Tribhuvan,1998). So the perception of belief held by a community also to a large extent influence and act as determining factor regarding causes of diseases. It is for this reason the pattern of health care practices and health institutions differ from society to society and from time to time. The differences depend to a large extent upon cultural views and norms regarding disease.

Tribal perception of causes of diseases like other non-tribal communities is also rooted in their socio- culture and religious dimensions of tribal life. Tribal people are usually very much conscious about their religion. Beliefs in supernatural forces or being occupy an integral part of their society and culture. Most of the tribal people have been living in backward regions or in remote rural areas, in hills, close to forest areas in natural environment since ages away from modern civilization. Naturally, inhabiting in isolation too has direct relation to their health care practices. So they hold their own conception of disease and methods of treatment which involves supernatural and ritual healing together with herbal medicine prepared from roots, barks, leaves, fruits etc. available in nature.

Concept of Disease/Illness

The Oraons are the animistic tribal group. They believe in numerous gods, deities and spirits that surround them. Practically, every aspect of the Oraon life is related to their belief system. The causes of diseases and illness are one important aspect of tribal life which is related to their belief system, religion and supernatural world. The Oraons believe in numerous spirits, gods, goddesses and deities both beneficent and maleficent of different classes and categories.

The highest divinity recognized by the Oraons is *Dharmesh* or the Supreme Being or God who is the creator of the universe. The spirit of the dead ancestor, called *pachbalar* is also and important deity. Similarly, there are many other deities and

spirits believed by the Oraons such as *Pat Raja, Chala Pachcho, Chanddi, Khunt Bhut* (tutelary spirit of founders of the village), *Barndo* and *Chigrinad* (household spirits worshiped at least once in year) and so on (Roy,1999). These spirits and deities are worshiped at an appropriate time and sacrifices are offered as traditionally practised. If the spirits are not worshiped at an appointed time, it is believed to bring the most terrible epidemics and even death to the villagers.

The present paper seeks to investigate and examine the concept and causes of disease and illness and their treatment among the Oraon tribes inhabiting in scattered hamlets or villages of Bamangola Block, in Malda district in West Bengal. Analysis of the concept of disease and illness is based on an intensive study. The field survey was conducted in all the seventeen Oraon villages / hamlets covering 494 Oraon households inhabiting in the Block.

As said earlier that the Oraons are the animistic tribal group, they have their own deities and spirits. But at present they also worship Hindu goddess e.g. *Kali, Laksmi, Durga* and so on which may be due to a very long association with local Bengali culture.

Data collected through field survey reveals that the Oraons related causes of diseases and illness with their belief system, religion and supernatural world. The Oraons of Bamangola like those of Chota Nagpur still believe in numerous deities and spirits, both benevolent and malevolent. Besides evil spirits, deities and spirits are believed to cause various diseases and illness if not worshiped properly in the appointed time. Thus it was found that the Oraons under study very strongly believe in natural, supernatural and human agency that cause disease and human suffering.

NATURAL CAUSES OF DISEASES

It is not easy to make a distinct classification of the causes and perception of illness held by the Oraons because same disease is sometimes believed to be caused by supernatural forces an at times the natural agents. Therefore, it is the symptoms

and the nature of disease or illness that are taken into consideration for attributing the causative agents

The Oraons do not always attribute each and every disease to some mysterious forces. Many of the causes of illness are attributed to natural forces as well which include environmental factors such as excessive exposure to heat, cold or rain during work in the fields. They also believe that many diseases; like gastric, diarrhea, dysentery are attributed to intake of adulterated food stuff or too spicy food, over eating and drinking of contaminated water which was frequently found during summer and rainy season. Excessive stress, strain, fatigue etc. due to a very long and heavy physical work in inclement weather are also responsible for many ailments, which are considered natural causes by both sets of Oraon villages under study, the detail discussion of which is given below.

Table: 24. Respondents' belief in causes of disease / Perception of disease held in two sets of villages.

		Village close to Rural Hospital Causes/Perception Held					Village far from Rural Hospital, Causes/Perception Held			
Names of diseases/ Illness Reported	No. of Respondents	Natural	Super-Natural	Don't Know	Total	No. of Respondents	Natural	Super-Natural	Don't Know	Total
1. Fever, cold, cough, head ach, body pain, joint pain, ear pain, nose bleeding, eye problems, gastric, diarRural hospitalea, swelling of body, scabies.	228	163	16	49	228	266	184	20	62	100
Percent		71.49	7.02	21.49	100		69.17	7.52	23.31	100
2. Leprosy, paralysis, pox, tuberculosis, tetanus, cholera, chronic chest pain, joint pain, epilepsy, mental disorder.	228	37	147	44	228	266	45	165	56	266
Percent		16.23	64.47	19.30	100		16.92	62.03	21.05	100

The table 24 : shows the perception of causes held by two groups of Oraon illages- firstly those living close to Rural Hospital and secondly those living away

from it. Comparative analysis the responses of the respondents show that 163 (71.49% and 184 (69.17 %) of the people who inhabit close to and away from Rural Hospital respectively ascribe diseases like fever, cold, head ach, body pain, gastric, diarrhea, dysentery etc. to natural causes which include an adverse effect of inclement weather, intake of adulterated food, drinking of contaminated water and excessive fatigue due to hard physical labour in extreme cold or hot weather. Small per cent of people that is 16 (7.02%) and 20 (7.52%) villagers living near and far from the Rural Hospital attributed to supernatural causes while 49 (21.45%) and 662 (23.31%) who inhabit close to and away from the Rural Hospital respectively had no idea at all about causes of diseases.

In the other category of diseases namely, leprosy, paralysis, chicken pox, cholera, epilepsy, mental disorder etc, a large section of respondents attributed to supernatural causes. It was very clear from the table that 147 (64.67%) and 165 (62.03%) people residing in the vicinity of Rural Hospital and away from it respectively ascribed to unseen forces as their causes while a small per cent e.g. 44 (19.30%) and 45 (16.92%) respondents respectively attributed to natural causes.

The data above clearly indicates that there is no significant variation or differences with regard to their perception of natural and supernatural diseases causation between these two sets of villages which can be clearly associated with their socio- economic and cultural homogeneity.

SUPERNATURAL CAUSES OF DISEASES

Tribal concept of health, disease and treatment is as varied as their culture. Accordingly, tribal society is guided by traditionally laid down customs and every member of the society is expected to conform to it. They believe that the fate of an individual and the community at large depends on their relationship with unseen forces or spirit world which intervene human affairs. If men offend them, the mystical power afflicts them by sickness, disease, death and other natural calamities (Chaudhuri 1986:161).

Tribals all over the world as well as in India have always attributed causes of various diseases and human suffering to supernatural forces or agents, like wrath of deities, gods, spirit intrusion and human power like evil eyes, witchcraft and sorcery. The belief in supernatural causes of disease is an integral part of tribal society which has been in existence since primitive times. Every tribal society tries to relate and explain various causes of illness and disease through unseen supernatural forces which can not be done away with easily, for it is an integral part of their culture and religious life.

The Oraons have a long tradition of belief in numerous unseen forces or agents through which they try to comprehend or perceive disease etiology. The Oraons under study also trace the causative agents of disease and other afflictions to be the harassment of deities, spirits, wrath of gods and witches.

The Oraons of Bamangola Block are much conscious about their belief in supernatural being. It is ingrained in their culture and society. Many of the diseases and illness are conceived as caused by supernatural forces – gods, goddesses, deities, and spirits as well as evil human power of a witch.

The concept of causation of illness and disease among the Oraons of Bamangola Block can be classified into the following categories:-

Classification of Perception of Causes of illness and Disease held by the Oraons

Natural	Supernatural	Human Agency/witchcraft
Intake of adulterated food contaminated water	Wrath of gods/deities	Witchcraft
Inclement weather /climate	Evil spirit	Sorcery
Excess exposure to heat, Cold, fever, exhaustion	Wrath of ancestral deities	Evil eyes and evil mouth

It must be kept in mind that the researcher has made an attempt to classify these causes of illness but feels that such categorization is not an exhaustive or an

exclusive one. The villagers were found to believe and attributed causes of illness to more than one causative agent – natural, super natural or human agency.

It is very apparent from the preceding table 24 that the each of these above causes of diseases as believed by the Oraons has been discussed separately. But large section, e.g. 147 (64.47%) out of the 228 respondents and 165 (62.03%) out of the total of 266 respondents who inhabit in two sets of villages- one in the vicinity to Rural Hospital and the other far away from it respectively have strong faith in supernatural causes of disease, particularly, wrath of gods and deities for some diseases like leprosy (kodi /kustho rog), paralysis (sitali / basoli), tuberculosis, tetanus, cholera (Mahamari) pox (chechak / ham), epilepsy (mrigi), chronic chest pain, joint pain, mental problems etc. Therefore, an important observation made was that inhabiting in close proximity to Rural Hospital had very insignificant impact on the Oraon community regarding causes and perception of diseases stated above. This is directly related to their culture which does not change easily even with introduction of modern medicine and facilities. Thus cultural beliefs and practices are considered vital determinants of health care practices among the Oroan community

CONCEPT OF EVIL SPIRIT

Another category of supernatural forces responsible for the cause of human suffering, disease and illness believed by the Oraons is a host of spirits of various categories – benevolent or malevolent Roy (1999), also has also illustrated the Oraon world of spirits which consists of different spirits – *pachbalar* (spirit of the dead ancestor), tutelary deities of the village such as *Pat Raja, Chala Pachcho or Sarna* but Rural Hospital, *devi mai, Darha, Desauli, Chandi* (spirit of hunting), *Achrael or Joda* (special spirit worshiped by women), *khunt bhut* (tutelary spirit of the dead ancestor),*Barndo* household deity)and other groups of spirits believed to be residing in certain objects and symbols such as babies, beautiful young girls, newly wed couples etc. are believed to be more susceptible to evil eyes. Besides these well fed and healthy cattle and luxuriant crops also are attacked by evil eyes and the cattle stops eating fodder and the crops turn pale and start drying. Thus harm is caused to human beings and damage to cattle and crops.

Thus the Oraons believe in numerous deities and spirits which when not propitiated properly may caste their wrath causing human suffering, disease and suffering. The table below reflects the respondents perception regarding illness / disease caused by evil spirit.

Table: 25. Respondents' Beliefs in Causes of Diseases / Illness by Evil Spirit

RESPONDENTS' RESPONSES							
Groups of Villages	No. of respon dents	Believe in evil spirit	Percent	Don't believe in evil spirit	percent	Total	Percent
Villages near Rural Hospital	228	175	76.75	53	23.25	228	100
Villages far from Rural Hospital	266	206	77.44	60	22.56	266	100
Total	494	381	77.13	113	22.87	494	100

The Oraons of Bamangola have strong faith on evil spirits responsible for causing diseases. Table 25 shows responses of the respondents of two sets of villages regarding disease caused by evil spirits. A group of villagers inhabit close to Rural Hospital while the other group lives far away from Rural Hospital. It is apparent from the table that 175(76.75%) and 206 (77.44%) people living close to and far away from Rural Hospital respectively attributed the causes of disease to evil spirits while only a small percent of people that is 53 (23.25%) and 60 (22.56%) living close to Rural Hospital and away from it respectively did not believe in evil spirits causing diseases.

It is obvious from the table that people from both groups of villages had expressed their strong faith or belief in evil spirits causing various diseases. There is system. Wrath of gods and deities were greatly feared and practically it was impossible to do away with such beliefs. No amount of modern medicine and facilities could change their belief in disease causing evil spirits. Such perception on the nature of disease causation was integral part of their culture.

Evil Eyes (*Najair*) & Disease causation

Of the various maleficent occult influence believed by the Oraons is the evil eyes (Najair). It is the common notion that some persons are born with an evil potency to their eyes. It is believed that whenever *najair* falls on other people, their food, drink, cattle, and even crops, harm is sure to befall on them. Children in general and particularly healthy children, babies, beautiful young girls, newly wed couples etc. are believed to be more susceptible to evil eyes. Well fed and healthy cattle and luxuriant crops are also attacked by evil eyes by evil eyes. It is believed that cattle stop eating fodder and the crops turn pale and start drying. Thus harm is caused to human beings and damage to cattle and crops.

It was found during field survey that some people expressed their views that they did not believe in evil eyes yet they fear. The belief in evil eyes has been found to be in existence for centuries among all tribal communities. The Oraons are no exception to this. Though the respondents of Bamangola Block could not explain the reasons for existence of evil eyes, yet this belief was found to be very common among the Oraons and they still hold a strong view that those evil eyes do bring disease and sufferings in various forms to men, cattle, and crops. The table below presents the belief of the respondents regarding evil eyes responsible for causing human sufferings.

Table :26. Distribution of respondents' beliefs in causes of disease / illness by evil eyes and method of treatment

Groups of villages	Response of Respondents				Method of Treatment		
	No.of respond-ents	Believe in evil eyes	Don't Believe in evil eyes	Total	Only Traditio-nal	Only Modern (Doc/hosp)	Total
Village Near Rural Hospital	228	180	48	228	180	--	180
Percent		78.95	21.05	100	100	--	100
Village Far from Rural Hospital	266	204	62	266	204	--	266
Percent		76.69	23.31	100	100	--	204
Total		384	110	494	384	--	384
Percent	494	77.73	22.27	100	100	--	100

It will be very imperative to discuss further who are responsible for casting evil eyes. It is believed among the Oraons that the power of evil eyes emanates on some persons from birth. Generally, women and specially, elderly women, barren women, old widows and *dains* (witches) are believed to possess power of casting evil eyes. Men folk however are not much feared with regard to evil eyes. A witch is considered to possess power of casting evil spell just by a look or gaze or uttering some remarks upon some persons without their knowledge. It is also believed that casting of evil eyes is not always intentionally done to harm a person. So a person, cattle or crops may also be attacked unintentionally by evil eyes, But evil eyes is not limited to witches, even the *najair* of elderly men or women may affect the person but in that case illness is not considered very serious in nature.

The table 26 : presents the respondents beliefs in the causes of diseases or illness by evil eyes and their methods of treatment. It is apparent from the table that a very large section of the respondents of both groups of village – situated near and far away from the Rural Hospital believe in evil eyes causing various ailments and human sufferings.

Of the total of 494 respondents 228 live in the vicinity of the Rural Hospital while 266 of them are the inhabitants of remote villages, away from Rural Hospital. A very large section of respondents from both categories of villages, e.g. 180 (78.75%) living close to Rural Hospital and 204 (76.69%) who inhabit in villages located away from Rural Hospital believe strongly in evil eyes causing diseases, while only a small section of the people did not believe in it, accounted for 48 (21.05%) and 62 (23.31%) from villages living in the vicinity of the Rural Hospital and far away from it respectively.

The observation from this table is that the impact of Rural Hospital upon the Oraon community residing close to it was not found in respect to evil eyes causing various illnesses. This belief among the Oraons is in prevalence since generations without any significant change to which they could not rationalize or explain. Their simple response recorded was that this belief was coming down from generations in

their community and it did affect them. The enquiry further revealed that modern medicines were futile in cases of diseases or ailments caused by evil eyes.

Further the investigator sought the views of the respondents who believed in disease causation by evil eyes regarding methods of treatment and recorded the information that cent per cent of the respondents of both set of villages believed in traditional method of treatment from local village medicine men called, *ojha* or *baid.* Modern medicine is sought only if advised by the village medicine man or when traditional medicine proved inefficacious.

WITCHCRAFT AND SORCERY

The perception of witchcraft, called *dain,daini or bishahi*, is still very strongly held in Oraon society. Witches are feared very much. The spells of witches are believed to bring different types of human sufferings as well as sufferings of domestic cattle and also damage crops. Certain people are more susceptible to spell of a witch, like young children, beautiful young girls, pregnant women, newly wed couples and well dressed girl or a woman. Even a good and
healthy crop is also believed to attacked by just a gaze or uttering a few words
like "how good it is looking!"

Usually a woman is branded as a witch who is always an elderly lady, and elderly widow and a barren woman but never a young girl. However, it is shrouded in mystery why women alone are labeled as witches. A witch is believed to possess mysterious supernatural power of casting evil eyes and evil spells with disastrous results. Therefore, a witch is considered to be a very dreadful one and feared by all. She is believed to possess an evil power which can cause a great physical harm or illness, suffering, and even death. So the Oraons attribute many of the ailments and diseases to witchcraft. The field survey revealed that belief in witchcraft was very common among the Oraons of Bamangola Block. For the analysis on belief in witchcraft the villages have been divided into two sets – one located at the vicinity of the Rural Hospital and the other away from it and to examine if there is any difference between two sets of villages under the impact modern medicine. The responses of the respondents who believe in witchcraft is presented in the following table.

Table:27. Belief of respondents in witchcraft causing illness / disease

Responses of the Respondents				
Group of Villages	No.of Respondents	Believe in witchcraft	Don't Believe in witchcraft	Total
Village Near Rural Hospital	228	159	69	228
Percent		69.74	30.26	100
Villages Far From Rural Hospital	266	191	75	266
Percent		71.80	28.20	100
Total	494	350	144	494
Percent		70.85	29.15	100

From the table 27 it is apparent that the people of both set of villages have a very strong faith in witchcraft causing different kinds of illness and sufferings. Out of the total respondents of 228 who inhabit in villages close to Rural Hospital, 159 (69.74%) and 191 (71.80%) out of the 266 respondents living in villages far away from Hospital believe strongly in witchcraft causing illness. On the other hand 69 (30.26%) and 75 (28.20%) of people from villages located close to Rural Hospital and away from it respectively did not believe in witchcraft.

The observation made from this table is that the people irrespective of their proximity and distance from Rural Hospital, have a very strong belief in witchcraft. Only a small difference is found regarding belief in witchcraft between these two sets of villages, which is not very significant. The important finding is that availability of modern health facilities have hardly any impact upon the people living in the vicinity of the Rural Hospital with regard to causes of diseases by witchcraft.

Training of Witches:

The Oraons call a witch *dain or daini or bishahi* in their mother tongue. Some witches are believed to be born with "evil eyes" and "evil mouth", while most of the witches are believed to acquire their art by rigorous course of training in a secret or secluded place from human habitation such as cremation ground or cemetery. Usually the art of witchcraft is believed to learn at the dead of the night and specially, during the new moon (*Amawasya*) in the month of 'Kartik'when novices are initiated into

the techniques and other mysteries. Trained witches are also believed to be more active during the month of *Kartik* and cause harm to the people, property and cattle. Reasons for acquiring the art of witchcraft are shrouded in mystery. But it is believed that some women learn this art with the intention of harming people when they don't like or with the intention of taking revenge against some persons.

Bishhi / Bishaha: The Oraons also commonly believe in *bishahi* and *bishaha. Like a dain or daini a'bishahi or bishaha* is a person who is said to have acquired a familiar spirit to which he or she uses to harm others. They are also believed to have credited with evil eyes. Some *bishahi* are said to learn the magical arts like *dains or daini* But a witch is believed to possess superior magical spells. The Oraons believe that witches can change their shape and form and can take the form of a cat usually a black cat.

Modus Operandi of Witches:

The Oraons under study believe that there are various ways and methods by which a witch can inflict harm to an individual, a family or the entire village. The common methods of harming people are the following:

i. Use of B*an* (arrow - shot):

The common notion held by the Oraons is that witches employ *ban* (magical arrow or an arrow-shot to the person intended to harm. So *ban* is most feared by all. This magical spell or arrow is believed to travel a long distance and silently hit or attack the victim causing severe physical harm to a person and sometimes believed to make the victim permanently incapacitated.

ii. Extraction of Heart:

One of the most dreadful acts of a witch, believed by the Oraons is the magical extraction of the heart. A witch is believed to possess the power of extracting the heart of a victim through magical spell when a person is in deep sleep at night. In such cases the victim is sure to die.

iii. Inflicting Harm in the Guise of a black Cat:

It is also a popular method of causing harm upon the intended victim by 'over shadowing' in the name of a black cat (chardewa). A witch always uses this method to attack or harm the intended person. Therefore, entering of an unknown black cat into the house is considered as very inauspicious and a sign of imminent calamity or suffering in the family.

iv. Sucking out Blood from Human Body:

This belief is also very common amongst the Oraons that a witch possesses a power or magical spell by which she sucks out the blood of the victim in course of time and makes the victim very weak and feeble.

v. Use of *San / Najair*:

Use of *sans* or *nasan* is yet another method of harming the intended person. The *sans / nasan* consists of a small parcel or a torn rag on one earthen ware – small pot or a jar, with all sorts of head horn, bone of animals and human beings etc. is buried secretly at night on the way or near the door of the of the house of the intended person or victim. When contacted by *sans* or *nasan* or the person will suffer physically and mentally.

vi. Attacking Domestic Cattle and Crops:

A witch not only attacks human beings, but also attacks cattle and crops of a person, mainly, due to jealousy. It is believed by the Oraons that just uttering of few words with evil intention may affect harm to cattle and crops.

METHOD OF TREATMENT

Treatment for Illness Caused by a Witch

As it is said earlier that ailments or diseases caused by magical spell of a witch is considered to be a very dreadful one which may result in a death of a person or make one permanently incapacitated. Disease caused by the spell of a witch can be cured by an *ojha* only who is considered to be superior to all other village medicine man or a *baid*. It is believed that only an experienced or a superior ojha is capable of driving away the magical spell of a witch. Therefore, ordinary ojhas decline to give treatment because the magical spell is considered far more superior and powerful one

which may even attack the ojha himself if fails to drive away the magical spell properly. Hence an experienced ojha alone could give treatment to the victim. An elaborate counter – magical paraphernalia is used to treat the victim before administering any other herbal medicine. The *ojha* observes certain rites and rituals such as fasting, abstaining from drinking all sorts of alcohol and offers puja (prayer) to his guardian deity / bhut in order to get himself empowered to caste away the magical spell of a witch successfully, if not the most dreaded magical spell, the magical arrow, called *ban* may be directed to hit the *ojha*. The three *ojhas* interviewed for the purpose said that they use counter *agni ban* (magical spell or fire arrow) to ward off the *ban* (magical spell) of a witch in the desired direction so that it may not hit any one else. Sacrifice of a black hen is essential.

Traditional Methods of Treatment

It has been discussed in chapter two that the Oraons under investigation are the immigrants from Chota Nagpur, the original homeland. Now they inhabit in a different social milieu and ecological conditions. But in terms of their economic activity and occupation they still follow their traditional occupation the agriculture. Most of the Oraons population of Bamangola block is agricultural labourers, small and marginal farmers. Their economic condition is very deplorable which has a direct relation with the poor health status. The immigrant Oraons have also brought with them their religion and culture. This investigation shows that some religious, social and cultural elements have undergone changes in course of their long habitation in different social environment. They also have adopted some local Bengali Hindu culture. But in the context of health care practices and perception of the causes of diseases and ailments and their methods of treatment have been retained. Their health care practices are very much ingrained in religious beliefs and cultural practices.

In the preceding section it has been discussed in detail that the Oraons of Bamangola Block in Malda district in West Bengal continue to explain various causes of ailments and diseases to supernatural agents or forces. Thus they trace the causes of diseases to harassment of various gods, goddesses, deities, evil spirits and spells of witches. So the causation of disease etiology perceived and believed by the Oraons is-

i.Natural agent ii. Supernatural force iii.Evil spirits iv. Witchcraft and sorcery and 5.Evil eyes.

Therefore, it is natural that to get rid of themselves from all physical miseries and mental problems, they turn to their traditional healers, village priests, diviners, witch doctors and traditional herbal specialists for treatment and cure. The Oraons employ different methods of treatment of diseases depending upon the perception held regarding their causes. The traditional modus-operandi of therapeutic has been discussed under two headings – natural and supernatural

Treatment for Naturally Caused Diseases

The type of treatment depends first and foremost on the nature and causes of illness perceived by the people. But the common people were neither in a position to decide for themselves the type of medication required nor possessed any knowledge of herbal medicine. Therefore they totally depend on the village medicine men known by different names such as *kabiraj, baid, mati , ojha or gunin.* However, services of not all these traditional medicine men are sought for naturally caused disease because it is believed that each of them has expertise in certain areas, e.g. *ojha, mati and gunin* mainly resort to supernatural and ritual healing. So generally, *kabiraj* provide medication of herbal ingredient for naturally caused diseases which is serious in nature while for minor ailments herbal medicines are provided by *ojha.* Diseases and illness believed to be caused by natural agents are ordinary fever, cold, cough, gastric, diarrhea Rural hospital, swelling of body, scabies, body pain, head ache, nose bleeding ear and eye pain etc. Usually the *kabiraj* after making diagnosis provides mainly herbal medicine for naturally caused diseases, though to make it more effective enchants some mantras. Amongst different village medicine men the *kabiraj* is considered to be most effective in giving treatment of diseases. He is considered as specialist in herbal medicine. He does not employ supernatural methods of healing though enchants *mantras* to his guardian deity before preparing of herbal medicine. During field survey one *kabiraj* was interviewed who was found to make herbal medicine by using ingredient prescribed in ayurvedic books. He administered only herbal only herbal medicine. He was a very popular *kabiraj* the services of whom were sought after by the villagers. On the other hand local *baid* prescribed herbal

medicine mainly from locally available herbs, roots, barks, plants, grass etc. through the knowledge gained by traditional method of learning and experience.

Even in naturally caused diseases influence of supernatural forces was not ruled out. Hence the village *baid* does enchant *mantras* to caste away the influence of supernatural agents before administering herbal medicine.

Supernatural Method of Treatment:

Causes of many diseases are related and explained by the Oraons to magic-religious beliefs. Beliefs in supernatural causes of illness occupy an important place in the Oraon society. Accordingly, most of the Oraons under study found to employ magico-religious methods of treatment and cure for many of the diseases and illness. Usually, traditional medicine man, such as *ojha, gunin, baid* and *mati* make diagnosis of illness and resort to supernatural healing. The Oraons of Bamangola Block attributed several diseases, such as leprosy (kustho rog), paralysis (sitali / basoli), pox (chechak) epilepsy (mrigi rog), cholera (Mahamari), mental problems , chronic chest pain, acute pain, sudden abnormal behaviour, mental disorder etc. are believed to be caused by the wrath of gods, goddesses, evil spirits or magical spell of a witch or supernatural agents or forces.

It was found that in cases of diseases like, leprosy, paralysis and tuberculosis, they were taking medicine from the Rural hospital but discontinued after sometimes because they believe that only modern medicine can not cure such diseases. It is because leprosy and paralysis were caused due to wrath of gods for the sins or misdeed committed by the patient himself or the sins or bad deed committed by their forefathers in the past life. Therefore, they consult village medicine men or the *ojha* who employ magico-religious method of treatment to propitiate gods or deities the followed by prescription of herbal medicine. The *ojha* also offers prayers, puja, makes sacrifices of fowls as required to appease the disease causing gods or deities and thus claim to restore, first of all, the man-spirit relationship. Thus propitiation to deities is a common method of treatment of illness believed and employed by the Oraons.

Various supernatural methods of treatment adopted by the Oraons under investigation may be discussed in the following categories:-

i. Treatment for wrath of gods and deities

ii. Treatment for evil spirits

iii. Treatment for witchcraft and sorcery

Treatment for diseases caused by wrath of gods / deities

The Oraons believe in a number of gods, deities and spirits which are not only the means of attaining spiritual end but also to keep them appease so that their wrath may not befall on them and bring misfortune, disease, epidemics and all sorts of sufferings.

Therefore, the Oraons take a great care in observing certain rites, rituals and make sacrifices periodically and at the appointed time.

Pox is the disease strongly believed to be caused by goddess *sitala*, which is commonly known as *mayer-rog*, the term probably adopted from Bengali language. Therefore, when the pox appear in any person, it is not only the person attacked by pox or the family concerned but is the whole villagers who observe certain rites and rituals so that goddess *sitala* may not get further infuriated causing greater suffering to the people. So when pox appears, certain taboo is observed such as eating of fish, meat, spicy food, use of cooking oil etc. is avoided by the concerned family. Taking modern medicine is totally avoided for the fear that the disease may be further aggravated . It is only the *ojha* who performs puja for three days in order to appease the disease causing deity. Herbal medicines are also not administered.

Paralysis (sitali / basoli) and *mahamari* (epidemic) is believed to be caused by infuriated *gaon debota* (village deity). The *barka bhut* an ancestral god is also feared most if not worshiped periodically and at appointed time. It was disclosed that the ancestral god may cast terrible sufferings and even to death to any of the clan member or their cattle.

Treatments for illness believed to be caused by supernatural forces may be cured only by a village medicine man, popularly called an *ojha or kabiraj*, by making proper propitiation and sacrifice. The *ojha* or *kabiraj* is believed to possess the

mysterious power to restore the man-deity/gods relationship necessary for the well being of the entire community.

Treatment for Illness Caused by evil spirit

The Oraons under investigation believe in numerous evil spirits, commonly known as *bhut,* which are believed to be responsible for causing various diseases and illnesses. Illness such as mental disorder, madness, hallucination, abnormal behaviour, wandering at night alone, and being frightened during sleep are believed to be caused by evil spirit. It is believed that even the common people may guess the causes of illness by reading and observing certain symptoms and behaviour of the patient but it is the *ojha / baid* who makes diagnosis and decides the causes of illness and prescribes the method of treatment to be followed.

With regard to diagnosis, the *ojha* usually employs three methods: (a) divination, (b) feeling the pulse of the patient and (c) enquiry method which includes asking questions or enquiring about the places the patient has visited and approximate time when the illness started. Of these three methods of diagnosis, divination and feeling pulse is the most common. But the divination method is employed only when illness is serious in nature otherwise *ojhas* claim that they are capable of making diagnosis just be feeling pulse and even observing the face and eyes of the patient. After making diagnosis of illness the *ojha* resorts to different paraphernalia to ward off the evil spirits. In case of ordinary illness or ailments only incantation (jhar phunk) of mantras is required to be performed. But if patient is suffering from some serious mental disorder, hallucination, talking and behaving very abruptly, the *ojha* makes sacrifice of either a hen or a pigeon to ward off the evil spirit. He also prescribes some amulets to be tied around the neck, are or waist to keep away and protect from the influence of the evil spirits.

Treatment for Evil Eyes

One of the other etiologies of ailments believed by the Oraons is the spells of eyes which may befall on any person. But the common prevailing perception among the Oraons is that children specially, good looking ones, young boys, well dressed beautiful girls, newly wed couples and pregnant women are believed to be more

susceptible to the attack of evil eyes. Even just a look or a gaze or a remark made by a witch can cause

physical or mental harm or disorder. Treatment of ailments caused by evil eyes belongs exclusively to the domain of an *ojha* or a *baid.* The Oraons strongly believe that illness caused by evil eyes can be cured by *ojha* or *baid* through incantation of 'mantras' or ' *jhar phunk.* Specialist (*kabiraj*) in herbal medicine is not called upon to give treatment and normally herbal medicine is not administered. When the respondents were asked about modern method of treatment by the investigator, it was reported that modern medicine was futile in cases of illness caused by evil eyes. Thus as special protective measures like amulets and other herbal ingredients are worn on neck or tied on arms.

In this study, information was collected from the respondents of two sets of villages, one located in the vicinity of Rural hospital and the other away from it, regarding their beliefs in causes of ailment by evil eyes and their treatment which are given in the table below:

Table: 28. Belief of respondents in causes of illness / disease by evil spirit and adoption of method of treatment,

RESPONSES OF THE RESPONDENTS							
Categories of villages	No of respondents	CAUSES OF ILLNESS			METHODS OF TREATMENTS		
		Believe in evil eyes	Don't believe	Total	Traditional	Modern/ Doctor	Total
Village Near Rural Hospital	228	210	18	228	210	_	210
Percent		92.11	7.89	100	100		100
Village Far From Rural Hospital	266	252	14	266	252		252
Percent		94.74	5.26	100	100		100
Total	494	462	32	494	462	_	462
Percent		93.52	6.48	100	100		100

The belief regarding causes of illness due evil eyes has been discussed earlier Hence in table 28 above, only the methods of treatment have been discussed. All of the 210 (92.11%) and 252 (94.74%) respondents from both sets of villages located

near and far away from the hospital respectively, who believed in causes of illness by evil eyes sought or preferred treatment from traditional medicine man. They believe that such causes of illness can be cured only through village medicine man called *ojha* or baid.

Treatment for Broken/Fractured bones:

Normal cases or incident of broken or fractured bones are usually not related with any supernatural causes. But the severity and type of pain experienced by the victim is sometimes believed to be the attack of a witch or having the influence of evil agents. The place of an accident is also attached due importance Hence, before seeking herbal treatment from *kabiraj* or traditional bone specialist or seeking modern treatment from doctors in the hospital, some form of supernatural treatment *(jhar phunk)* is considered necessary to free the victim from the influence of a witch or evil agents. But in most cases fractured or broken bone is considered a natural incident.

The common practice for treatment for broken bones or fractures is herbal treatment by village medicine man. There are also specialist in giving massages for minor fractures and dislocation of joints. There is also a bone setter specialist, called *harbhanga kabiraj*. The bone setter specialist is believed to be competent to diagnose the problems of bones by just checking the affected part of the bones. After examination he prepares herbal medicine, mainly for external application. The *harbhanga kabiraj* also places three or four leaves of *harbhanga* plant on the affected area and gives bandages as well. There was no exclusive bone setter specialist or kabiraj among the Oraons under study. For ordinary fractures of bones and sprains they sought treatment from the only kabiraj available among the Oraons. Therefore, they were dependent on non-tribal bone setters.

Table: 29. Method of Treatment used / preferred by respondents of two sets of villages for broken / fractured bones

		Responses of the respondents			
Categories of villages	No of respondents	Traditional medicine	Modern/medicine	Both Traditional &Modern	Total
Village Near Rural Hospital	228	163	48	17	228
Percent		71.49	21.05	7.46	100
Village Far From Rural Hospital	266	212	42	12	266
Percent		79.70	15.79	4.52	100
Total	494	375	90	92	494
Percent		75.60	18.41	5.99	100

Table 29 : shows the methods of treatment normally adopted by two sets of Oraon villages for broken or fractured bones and ordinary dislocations of joints. Both groups of villages – close to Rural Hospital and away from it preferred and were found to be practising traditional method of treatment from the village medicine man (*kabiraj*), for almost all minor cases of broken or fractured of bones. Out of the total of 228 respondents residing close to Rural Hospital, 163 (71.49%) preferred traditional method of treatment while out of the total of 266 respondents inhabiting in villages away from Rural Hospital, 212 (79.70%) of them preferred traditional method of treatment. The respondents living in the vicinity of the Rural Hospital and away from it, who preferred or sought modern treatment from Rural Hospital constituted 48 (21.05%) and 42 (15.70%) respectively. There was small number of respondents who considered that both traditional modern methods of treatments were required. They accounted for 17 (7.46%) and 12 (4.51%) from the villages living close to Rural Hospital and away from it respectively.

Observation made regarding methods of treatment for fractured or broken bones is that a large percent of the Oraons in both sets of villages believed in traditional methods of treatment and cure from *kabiraj* or *harbhanga* specialist. Comparative analysis shows that those living in the interior areas, away from Rural Hospital sought more or were dependent more on traditional treatment than those

Oraons inhabiting close to Rural Hospital, though the difference recorded was not very big. The important point to be made here is that traditional mode of treatment from bone setter specialist as well as kabiraj in both sets of villages continues to be the common methods of treatment among the Oraons.

Treatment for Snake Bite:

Cases of snake bites and treatment of them have brought important revelation in Oraon society. The snake bite was not merely an unfortunate incident but the causes behind it was perceived and related beyond. It was directly related with wrath of a deity, called *Manasa*. They strongly believe that misdeed committed or some acts of the victim were believed to have offended the deity which resulted in snake bites. It was also brought to light that if the deity was offended, the incident of snake bite would occur among human beings as well as domestic animals. But the more interesting thing was that whether snake bite was the result of the wrath of deity or not, most sought and preferred method of treatment followed was *jhar phunk*(incantation of mantras) by an *ojha*. Specialist in herbal medicine, called *kabiraj*, was generally not called upon for treatment of snake bite. It was not only the Oraons but other tribal communities as well as non-tribal communities also strongly believe in *jhar phunk* (incantation of mantras) - a supernatural and traditional method of treatment. So the first preference for treatment of snake bite was sought from the *ojha or gunin.*

The *ojha or gunin* makes diagnosis by feeling pulse or by a method called *ganana*, (a method by which an *ojha* takes some mustard seed or rice on a plate and enchants mantras to determine the spread of poison in the victim's body) and then after he takes a bunch of *neem* leaves and sways it up and down on the spot of snake bite and also enchants mantras as long as he feels necessary. By doing so the *ojha* tries to arrest spread of poison on the body. The people also believe that the *ojha* can suck out the poison as well as can remove it by enchanting mantras. This magical method of treatment goes on for hours. If the *ojha* is unsuccessful, the superior *ojhas* from far away places are also called upon for treatment. Such is the faith the people have on *ojhas* for treatment for snake bite. It is only when all the treatment by *ojhas* fails they take the victim to the hospital. Thus it was found that traditional method of

treatment for cases of snake bites was very popular among the Oraon community. The table below shows their responses regarding treatments for snake bites.

Table:30 Faith /preference of the respondents on the Methods of treatments in two groups of villages for snake bite.

		Responses of the respondents			
Categories of village	No. of Repondents	Traditional Medicine man(*Ojha*)	Modern Treatment (Doc/Hosp.)	Both Traditional & Modern	Total
Village Near Rural Hospital	228	116	13	99	228
Percent		50.88	5.70	43.42	100
Village Far From Rural Hospital	266	174	12	80	266
Percent		65.41	4.51	30.08	100

The table 30 : shows the faith or preference of the respondents for treatment for snake bite. It was found from their responses that traditional method of treatment was very common among the Oraons and it dominated their psyche. The data reveals that majority of the Oraons believed that snake bites can be cured only by *jhar phunk* by *ojhas*. A very large per cent of the respondents, e.g. 116 (50.88%) and 174 (65.41%) people residing close to Rural Hospital and away from it respectively have strong faith in the traditional, *jhar phunk* method of treatment. On the other hand only a very small per cent of the respondents e.g.13 (5.70%) and 12 (4.51%) from village located in the vicinity of Rural Hospital and far from it respectively preferred or had faith and emphasized only in modern treatment from hospital. Hence, the respondents, living close to and away from Rural Hospital, who said that the existence of both traditional and modern methods of treatments were necessary, accounted for 99 (43.42%) and 80 (30.08%) respectively.

It is apparent clear from the data that people from both sets of villages still have a very strong belief in *jhar phunk*, a traditional method of treatment for snake bite. They believe that it is absolutely necessary. There was only a small difference in the percentage of respondents regarding faith in the method of treatment between two sets of villages. Comparatively, people residing close to Rural Hospital had more faith in modern treatment while those living in very interior villages away from Rural Hospital believed more on traditional method of treatment from *ojhas*. Further a good number of the people said that both traditional and modern methods of treatments were absolutely necessary. Further enquiry revealed that the *ojhas* in the earlier days used to be more effective. They believe that the *ojhas* of the modern times are less competent to deal with the cases because they have not been able to acquire proper knowledge after the death of older *ojhas*. So the age old beliefs and methods of treatments of snake bites continue to be very dominant even in the modern times among the Oraons under study.

TREATMENT FOR DOG BITE

The '*jhar phunk*', a traditional method pf treatment by village doctor (ojha) is also very commonly employed for treatment of dog bites among the Oraon community of Bamangola. A very large section of the Oraons studied employed this method of treatment. The common perception prevails among the Oraons is that treatment given by *ojha* is more efficacious than modern medicine in case of dog bite. The data below show faith of the respondents regarding types of treatments

Table:31. Faith / preference of the respondents in methods of of treatments for villages for dog bite in two groups of villages

Responses of the respondents					
Categories of villages	No. of Respondents	Traditional treatment(*ojha/baid*)	Modern treatment(doc/hosp)	Both traditional and modern treatment	Total
Village near Rural Hospital	228	149	33	46	228
Percentage		65.35	14.47	20.18	100
Village far from Rural Hospital	266	202	28	36	266
Percentage		75.94	10.53	13.53	100

The table 31 reveals that out of the total of 228 and 266 respondents, 149 (65.35%) and 202 (75.94%), who inhabited in villages close to and far from the Rural Hospital respectively, reported to have a strong faith supernatural method of 'jhar *phunk* by a village *baid or ojhas*. They reported that treatment by an *ojha* was very necessary for the cure of dog bite. On the other hand a small section of the people e.g.46 (20.18%) and 36 (13.53%) from both sets of villages inhabiting close to and away from Rural Hospital respectively said both traditional and modern medicine was absolutely necessary. Again a very small per cent of the respondents that is 33 (14.47%) living close to Rural Hospital and 28 (10.33%) inhabiting in villages away from Rural Hospital, said that they had no faith in traditional method of treatment. They emphasized more on treatment from hospital.

The analysis of the data shows that the difference in the method of treatment between two sets of villages was not very big. Still the data reveals that the per cent of people inhabiting close to Rural Hospital preferred less on traditional method of treatment than those living far from the Rural Hospital. Further, the people living within the easy reach of hospital sought or preferred modern treatment from hospital more than those living in the interior areas, though the difference was not very big. The enquiry made by the investigator regarding treatment from Rural Hospital for dog bite brought to light that that it was mainly because the Rural Hospital was close by. and it was easy approach In this regard it was also disclosed that unavailability of vaccine against rabies also posed a major problem at the hospital because outside the hospital it was beyond the purchasing capacity of the poor tribals. But the point to be emphasized here is that perception of traditional method of treatment still persists very much. They also expressed the need for both methods of treatment simultaneously.

Treatment for cuts and wounds

With regard to cuts and wounds two types of health behaviour were found. For the wounds and skin related diseases they rely upon herbal medicine. But it was also noted that they neither use any medicine nor take proper care to protect from further infection for ordinary wounds and cuts. They were also found not taking any tetanus vaccine for any type of cuts. During field survey many children were found with

wounds on their heads and legs who had neither taken any medicine nor precaution against dirt and dust from getting further infected. The table below will shows their treatment of wound and cuts.

Table 32. Treatment used /preferred by respondents for cut and wounds

RESPONSES OF THE RESPONDENTS				
Groupsof villages	Traditional Medicinemen	Modern/Doctor/ Hospital	Both Traditional/Modern	Total
Village Near Rural Hospital	37	178	13	228
Percent	7.49	36.03	2.63	46.15
Village far from Rural Hospital	48	199	19	266
Percent	9.78	40.28	3.85	53.85
Total	85	377	32	494
Percent	17.21	76.31	6.48	100

It is very clear from the table 32 that trend of availing modern treatment is seen very clearly for cuts and wounds. But it may be noted that only major wounds and cuts are treated in the hospital. Minor wounds are left to be healed by itself or some herbal medicines prepared by traditional medicine men are used. The largest section of the people irrespective of proximity and distance e.g. 178 (36.03%) and 199 (40.28%) respectively seek modern treatment while small section of them e.g. 37(07.49%) and 48 (9.78%) people relied on local medicine men. While those who favoured both traditional and modern method constituted 13 (2.63 %) and 32 (6.48%) living closed to rural hospital and away from it respectively.

Traditional Medicine Men and their Role

Traditional village medicine men are considered very vital in Oraon society even today. It is they who make clear distinction between two categories of causes of diseases or ailments. The first category of the causes is related to supernatural forces

or agents for which treatment can be given by the village medicine man only. They believe that treatment of supernatural causes of ailments falls under the exclusive domain of traditional healers. The second category of causes of diseases or illness identified by them is the natural causes for which herbal medicine is prepared by village medicine man or modern medicine is used.

The village medicine man besides taking care of various diseases, they also officiate some religious rites and rituals. So village medicine men of different categories and statuses are found. The experience and extensive knowledge of herbal medicine and other form of supernatural healing is very important for medicine man. In the study area medicine men are known by different names like, *ojha, baid, mati gunin and kabiraj*. But the kabiraj is the most popular term and is considered to be specialist in herbal medicine while others combine both herbal medicine and supernatural method (*jhar-phunk*) of treatment. Not all of these medicine men enjoy same status. Among the *ojhas, baids* and *gunin* some are considered superior depending upon their experience and efficacy in giving treatment and enjoy better social status in the society.

The villagers consider that village medicine men are very necessary even today and can not be done away with them To them supernatural causes of diseases can be cured by village medicine men only and in this case the modern doctors are considered futile. Religious functions of the medicine men the other important aspect.

Among the Oraons the office of the ojhas, baids or kabiraj is not hereditary. A person interested in acquiring the art of traditional medicine gets initiation and rigorous training from an experienced *guru* (Teacher) of his village or from neighboring village. But ultimately, the *guru* will decide whether the person will be eligible for training as medicine man or not.

Generally, remuneration is not demanded by the traditional medicine man. But they do accept whatever is given to them as gift. They are not full-time practioners. Villager medicine men consider their role as social responsibility to give treatment to not only the villagers but also to other people of his own community and usually they never refuse when called upon to give treatment..

Two case studies have been given to show their perception of the causes of deseases / illness and their method of treatment

Case Studies

Case- 1. Respondent Arati Oraon, aged 35, educational qualifiucation class V, an agricultural labourer by profession, is a resident of the village Patul, reported " my husband late Bijoy Orion was suffering from the illness, *mrigi* (epilepsy) for the last ten years. When the symptom of this illness was observed / attacked for the first time, we took him to the a *kabiraj* in the neighbouring district of West Dinajpur for treatment. The *kabiraj* gave some medicine, e.g. amulets to tie around the arm and also medicine to inhale. There was no improvement .Then we took him to a kabiraj at Bangladesh for treatment who provided some herbal medicine and also tried to cure by supernatural (jhar-phuk) means. He was well for about seven months. Again he was attacked by this illness. We took him to local kabiraj once every month. He was not cured. The patient died." The investigator asked if the patient was taken to hospital any time. The respondent replied " we never took the patient to hospital. It can not be cured in the hospital, since the illness is caused by wrath of gods." The fatality of this behaviour was that the patient died just three weeks ago when this field work was being carried out.

Case.2. Soma Oraon aged 65, is illiterate and resident of the village Patul. His main occupation was agriculture. The respondent, Rabia Oraon, aged 30, the son of Soma Oraon said " my father has been suffering from the illness *sitali* (paralysis) since four years. When the symptom was first observed or first attacked by the illness, we took him to the rural hospital at Modipukur, the very next day. He was admitted in the hospital and was released after three days. There was no improvement. So we took him to the kabiraj of the village, named Biswanath Orion. He gave treatment by *jhar-phuk* and also provided some medicine from herbal ingredients to apply externally. The was not much improvement. After that we took him to another *kabiraj* at Chotapathari who tried to cure through *jhar-phuk* and performedother rituals for three days in the morning. It was not cured. Then again they called in another kabiraj from the village who also tried to cure by *jhar-phuk* and also gave some herbal medicine. He continuously performed jhar-phuk and other rituals for fifteen days. Now the patient is all right." The enquiry by the field investigator revealed that *sitali* can not be cured by modern doctor/ medicine. On the contrary, they hold a strong perception that injection if administered in to the patient will increase the problem, by further weakening the affected paralysed portion of the body.

CHAPTER – 4

CHAPTER – 4

HEALTH CARE PRACTICES

For the purpose of analysis of modern health care practices among the Oraons of Bamongola Block, the entire Oraon population inhabiting in seventeen villages or hamlets have been divided into two groups of villages – one group was located close to Rural Hospital and the other situated far from Rural Hospital. A group of villages located within the distance of approximately 3 KMs is treated as villages close to Rural Hospital while the other villages situated more than 3 Kms away are considered as villages away from Rural Hospital.

The objective of dividing these Oraon tribal villages into two sets, following the criteria of proximity and distance was to investigate and record the impact of modern health services and facilities provided through Block Rural Hospital upon the Oraon tribal community. It also seeks to examine the extent of utilization of modern health services and facilities by the Oraon community. It would also examine and record the factors availability and accessibility for proper and better utilization as well causes for underutilization and constraining factor for adoption of modern health services at Rural Hospital /Primary Health Centres.

The study on the health care practices or health behaviour of the Oraons revealed that they were not totally averse to modern medicine and treatment. The people from both set of villages were found to be accepting modern medicines. But acceptance and utilization of it to a great extent were influenced by their perception regarding disease etiology. The simple village folk could not decide for themselves what method of treatment to be adopted for the patient. Diagnosis of diseases and their treatment was left entirely to the village medicine man known by different names, such as *kabiraj, baid, ojha,* and *gunin.* The perception of the Oraon community regarding causes of diseases also influences the method of treatment. Decision of the community and tremendous social pressure, together with cultural practices and religious beliefs continue to exert strong influence on the health care practices of the Oraon community.

Village medicine men are also not totally against the use of modern medicine but at the same time they do try to give treatment first. It is because the village medicine men live close to their village or in neighbouring village and are available whenever they are called upon to give treatment. When no other medical facilities are available in the villages, which are situated very far from Rural Hospital, it is the village medicine men who provide the treatment first specially at night. Their diagnosis of illness and treatment mainly consists of supernatural method together with some herbal medicine. In fact in most cases of diseases or illness the village medicine men attributed the causes to supernatural forces, mainly, to evil spirits. Therefore, it was felt necessary to have some kind of ritual healing first and then after taking the patient to rural hospital for treatment.

The important and interesting belief found to prevail among the Oraons is that some magico-religious and ritual healings which were considered very necessary before taking the patient to hospital. The reason provided was that it required warding off the influence of malevolent spirits if not modern medicine may not be effective. Another strong perception prevailed among the Oraons was that magico-religious treatment by an ojha was very necessary before taking the patient to hospital so that *bhuts* (evil spirits) do not attack the patient on the way. Therefore some rituals were performed before leaving home for hospital. This was considered a very important protective measure against evil spirits or evil eyes of a witch. Thus both traditional and modern methods of treatment were considered necessary by the Oraons.

Thus, the interaction of modern and traditional methods of treatments is discussed below:

The first appearance of symptoms of diseases is not only the problem of physical or mental suffering according to the Oraons. They believe that either the man-spirit relationship with gods or deities has been disturbed or the evil spirits must have attacked. Therefore, the usual practice is to call upon the village medicine man, e.g. *kabiraj, ojha, baid* or *gunin* for diagnosis and treatment first. The respondents inhabiting in interior villages far from the Rural Hospital also reported that at the time of illness only treatment available was from that of *ojha* or *kabiraj* or *baid* who

attended the patient at any time called upon to do so. But the deeper investigation revealed that whatever amount of modern medicine or health facilities made available, their indigenous system of treatment can not be completely done away with. They asserted that treatment of some diseases and illness fell exclusively under the domain of traditional healers. On the other hand, modern medicines were preferred for the diseases or illness they believed to be caused by natural agents. The table below shows the behaviour of the respondents regarding health care practices when diseases or illness appear.

Table:33. Responses of respondents regarding adoption of first contact for treatment of diseases / illness

RESPONSES OF RESPONDENTS				
Categories of villages	No of respondents	Use / believe in traditional treatment first	Use / believe in modern treatment at the very first time.	Total
Village near Rural Hospital	228	85	143	228
Percent		37.28	62.72	100
Village far from Rural Hospital	266	188	78	266
Percent		70.68	39.32	100

Table 33 : shows the responses of the respondents of two sets of villages regarding methods of treatment adopted first when the symptoms of illness or diseases appear. The data clearly show two distinct pattern of health behaviour regarding first time treatment in two sets of Oraon villages under investigation. It was found that the largest section of people living close to Rural Hospital used and preferred modern treatment from hospital first. On the other hand the respondents who resided in interior villages away from Rural Hospital. used or believed in traditional form of treatment first. Out of the total number of 228 respondents only 85 (37.28%) and 143 (62.72%) people had used or believed in traditional and modern treatment first

respectively. In the second set of village, that is located far from Rural Hospital 188 (70.68%) and 78 (39.32%) people had used or preferred traditional and modern treatment first respectively. It is very apparent that a small percent (e.g. 37.28%) of people who live close to Rural Hospital used or preferred traditional form of treatment. On the other hand the largest percent, (e.g. 70.68%) of the respondents who inhabited in far away villages from the Rural Hospital, were dependent more on traditional method of treatment. Again a very large section of the respondents that is 62.72% of them residing close to Rural Hospital used or preferred treatment from hospital while only 39.32% of people who inhabited in far away villages from the Rural Hospital preferred modern medicine first.

It is apparent from the table that two different pattern of health behaviour are observed among the Oraons inhabiting in two sets of villages. The people who resided in villages far from the Rural Hospital used or believed more in indigenous treatment by village medicine man that *kabiraj* or baid or *ojha* or gunin before starting modern treatment. So they were dependent more on traditional healers. These medicine men try to give treatment at the initial stage for practically every case of disease and illness and when fail to cure, advises the patient to be taken to hospital which sometimes results in a fatal death of a patient. It is because the Oraons start treatment of illness at a very late stage and the treatment by village medicine man further delays the proper modern treatment resulting in fatality of a patient. The respondents who live close to the Rural Hospital also start treatment at later stage but prefer and go for modern treatment directly due easy accessibility.

At the same time it was revealed through discussion with the respondents that their choice regarding methods of treatment was directly influenced by two main factors firstly perception regarding causes of illness and disease and secondly the accessibility and availability. So the Oraon community has no suspicion or problem in accepting modern medicine. They also accept the efficacy of modern medicine. The following table will show the method of treatment for diseases and illness believed to be caused by natural agent or forces.

Table:34. Methods of treatment used at the first appearance/Symptoms of disease / illness believed to be caused by natural causes

RESPONSE OF RESPONDENTS				
Category of villages	No of respondents	Follow traditional treatment	Follow modern treatment	Total
Village near Rural Hospital	228	23	205	228
Percent		10.09	89.91	100
Village far from Rural Hospital	266	69	197	266
Percent		25.94	74.06	100
Total	494	92	402	494
Percent		18.62	81.38	100

Table 34 : shows the health behaviour of the Oraons in two sets of villages, in case of diseases / illness believed to be caused by natural forces or agents. Therapy for ailments is determined by their perception of disease etiology. Therefore, the Oraons though believe very much on supernatural causes of illness, yet for natural causes they use or prefer modern medicine or treatments. It was found that out of the total respondents inhabiting in the vicinity of Rural Hospital, 23 (10.09%) and 205 (89.91%) of them used or preferred traditional and modern methods of treatments respectively. On the other hand 69 (25.94%) and 197 (74.06%) people who lived in villages located away from Rural Hospital used or preferred treatment from indigenous sources and modern medicine from hospital sources respectively, out of the total of 266 respondents.

The data analysis on the table above clearly shows that the largest percentage of the inhabitants from both sets of villages used or sought modern treatment in case of natural causes of illness. But comparatively, the percentage of people seeking treatment from hospital sources was found to be higher among those who lived in villages close to Rural Hospital than those who inhabited in remote villages from Rural Hospital. Therefore, the perception of the people regarding disease etiology and

accessibility were considered important factors for adoption of treatment method either indigenous or modern.

Table:35. Types of treatment method used/preferred for diseases and illness in two sets of villages.

Responses of the respondents					
Category of villages	No.of respon-dents	Use//prefer only tradition-al medicine	Use / prefer Only modern Medicine	Use /prefer both tradition-al medicine	Total
Village near Rural Hospital	228	5	81	142	228
Percent		2.19	35.53	62.28	100
Village far from Rural Hospital	266	16	66	184	266
Percent		6.02	(24.81)	69.81	100
Total	494	21	147	326	494
Percent		4.25	29.76	65.99	100

Table 35 shows that the Oraons used or preferred to use three types of treatment for various kinds of diseases and illness, namely traditional, modern and combination of both traditional and modern. The data clearly shows that a very large percent, e.g. 142 (62.28%) and 184 (69.81%) respondents from the village situated near the Rural Hospital and the other far from Rural Hospital, still used or preferred to use combination of both traditional and modern medicine. On the other hand a small percent, e.g. 81 (35.53%) and 66 (24.81%) of the inhabitants of the village close to Rural Hospital and away from it respectively had faith in modern medicine. Those who exclusively believed in indigenous medicine accounted for only 5 (2.19%) and 16 (24.81%) from the both categories of villages near and far from Rural Hospital respectively.

The most important revelation of this data was that both sets of villages were found to be using combination of both indigenous and modern medicine. The reasons provided as discussed earlier that most of the diseases and illness, even if caused by natural forces or agents, the influence of evil spirits, evil eyes etc. were not ruled out. Hence it was believed by the Oraon community that any one method of treatment may not be effective. So both methods of treatments were used simultaneously and were considered important for cure of illness and disease.

Rural Health Facilities at Bamongola Rural Hospital

Promotion & Provision of rural health care is the major concern for the policy makers and the Government. To promote better rural health care the first land mark in official health policy of independent India was the acceptance of Bhore Committee recommendation of 1946, which laid the foundation of comprehensive rural health services through the concept of primary health centres. The 1978 Declaration of Alma-Ata also received full fledged commitment from Indian Government in relation to the health care and development. This declaration was important for laying broad philosophy towards strategy secured in primary health care approach. The National Health Policy (NHP) 1983 also set the primary objective to attain the goal of health for all by AD 2000, by establishing an effective and efficient health care system for all the citizen and particularly, the most vulnerable groups like women, children and under privileged groups such as Scheduled tribes and Scheduled Caste. The NHP emphatically stressed in creation of primary health centres. Besides this other major priorities were –co-ordination of health related services and activities such as drinking water supply, sanitation and nutrition. In 1980s a massive infrastructure expansion and programmes for providing family health care was under taken. It set the goal of achieving one primary health centre for 30,000 people and one sub-centre for 5000 people and one primary health centre for 20,000 population and one sub-centre for 3,000 people in tribal areas. However, despite of the vast expansion in infrastructure remained grossly under utilized due to poor facilities and inadequate supplies and lack of effective man power. Therefore, problem of health in rural areas, particularly, in tribal areas remains a complex problem.

Provision for and availability of modern health services and facilities has an crucial role in influencing the health behaviour of the rural people. Since rural people in general and in particular tribal communities are economically backward, it is very difficult for them to afford expensive allopathic medicine. Hence availability of modern medicine free of cost and other facilities are very important in influencing the health behaviour of the tribal communities. The Oraon tribal community under investigation is also educationally and economically very backward. The cost factor of modern allopathic medicine and other services and facilities were found to have direct relation with the poor response to adoption of modern health care practices by the Oraon community.

Before going into the detail analysis of the health care practices among the Oraons, it is necessary to discuss the health facilities and other services available in Bamongola Rural Hospital at Bamongola Block.

As a part of the health policy of the state, the Government of West Bengal makes provision for setting up a Rural Hospital at every block of the district to cater to the health need of rural population. The structure of health services of the District of Malda, consists of *Sadar* Hospital (District Hospital), located in the District Headquarter, Malda, which serves as referral hospital for all the rural hospitals at the block level. At the district, *Sadar* Hospital is headed by a Chief Medical Health Officer, who in turn is responsible for policy-making, implementing and evaluating various health projects and programmes in different block of the districts. Health care in rural areas at the Block level has been developed in three tier structure – Rural Hospital, Primary Health Centre & Sub-centre. The sub-centre is the most peripheral health institution and the first contact point between rural hospital and primary health centre. The sub-centre is manned by one trained Multi Purpose Worker (MPW) who is entrusted with providing basic drug for minor illness and provide services relating to maternal and child health e.g. nutrition, immunization, diarrhea control etc.

The primary health centre is the second tier and rural hospital the upper most tier in rural health structure which envisage to provide integrative and preventive health care to rural population. These health institutions emphasize on preventive and promotional aspect of health, e.g. promotion of better health and hygiene.

The present study has been conducted in Bamongola Block, in Malda District, in the state of West Bengal. This block is one of the most backward blocks of the districts, inhabited mostly by Scheduled Tribes and Scheduled Caste, who are socially and educationally very backward. The health status of the tribals in general and particularly, of the Oraons, is at a very low level. The only health services and facilities available for the entire population of the block, is the Bamongola Rural Hospital, located at Modipukur village, about 50 KMs. from the district headquarter, Malda. Prior to setting up of Bamongola Rural Hospital, the people of the block had to depend on the *Sadar* Hospital, Malda for their health need. The Bamongola Rural Hospital was set up in the year 1957. In the same year (1957), the Primary Health Centre (Primary Health Centre) was also set up at Kasimpur village, known as Kasimpur Health Centre, located at a distance of about 15 Kms from the rural hospital, Modipukur.

Bamongola Rural Hospital is headed by Block Medical Health Officer (BMHO). The rural hospital is staffed with five qualified MBBS general physicians, six general nurses, one pharmacist, one laboratory technician for X-Ray and some non-technician office staff. The health facilities available in rural hospital are: 30 general beds for patients, one labour room, one laboratory for testing blood and sputum, one X-Ray room with one X-Ray machine and one ECG machine. There are separate male and female wards available. Though a laboratory is available for testing blood and sputum, yet only two tests are done there- one blood test for malaria and *kala-azar* virus. The other test done is for tuberculosis. There is also one ambulance for carrying patients to *sadar* hospital at a nominal charge.

The BMHO is the administrative head of the hospital as well as all the Primary Health Centres, and sub-centers of the block. He is also responsible for carrying out other health education programmes and propaganda such as polio, immunization of children, mother –child health awareness programmes, family planning education etc. The rural hospital serves as referral hospital for all Primary Health Centres and Primary Health Centre -Sub Centers at the block level.

Besides the rural hospital, there are two Primary Health Centres, namely Uttarpara at Nalagola and the other Kasimpur Primary Health Centre at Kasimpur

village. The Uttarpara Primary Health Centre is situated at Nalagola, on the Malda – Nalagola, state high way, about 60 KMs from the district town, Malda. It is staffed with one doctor (general physician), one pharmacist, three general nurses and four non-technical office staff. The Uttarpara Primary Health Centers is provided with ten beds for in-patients. But it is very poorly maintained. The Kasimpur Primary Health Centre is located in the very interior area. It is also provided with one doctor (general physician), one pharmacist, two general nurses and five non-technical office staffs. There is no provision for beds at Kasimpur Primary Health Centre. The Primary Health Centers do not have facilities for blood testing, X-Ray etc. The Primary Health Centers besides, providing curative medicines, also promote preventive health education

The Primary Health sub-centers take care of the health need and requirements of rural population of every 5000 persons in rural areas. In Bamongola block, there are 27 Primary Health Centre sub-centers. Each sub-center is provided with one trained Multi-Purpose Worker (MPW), called health assistant. The MPW is normally a female but there are some male MPWs as well. Of the 27 multi-purpose - workers in Bamongola block eight are males while the rest females. The MPWs are recruited by Panchayet samity. The MPWs under go a training course at the sadar hospital for eighteen months, before being posted at Primary Health Centre, sub-centers.

The MPW scheme envisages at controlling or eradicating communicable diseases, to provide mother –child health services, to health education, health awareness, family planning etc. among the rural population. A health assistant is given the responsibility of providing medical needs of specially the mother and child. Pregnant mothers are given iron tonic, tablets etc. Children are given BCG, polio dose, immunization etc. and maintain all these records. Medicines are also provided for mother and child for ordinary fever or illness. Besides these, a health assistant maintains all records of births and deaths. She also reports the cases of leprosy to the Rural Hospital.

Thus there is a vertical structure of health services- S*adar* hospital at the district level, which is the referral hospital of the district followed by rural hospital at the block level, which also serves as referral hospital of all Primary Health Centres and sub-centers at the block level. At the third and fourth level, we find Primary Health Centres and sub-centers respectively.

Satisfaction / Dissatisfaction Regarding Hospital Facilities

Availability of modern health services and facilities from the hospital sources and awareness about them are important for successful promotion of health among the rural population and particularly among the tribal people. But mere awareness will not have much impact unless adequate facilities are provided free of cost to rural including the tribal people. Therefore, provision of medicine and other facilities free of cost were found to be very crucial among the tribal community in particular. In this regard satisfaction and dissatisfaction of the respondents of two sets of villages have been analysed.

Table: 36. Distribution of respondents in two sets of villages as per satisfaction an dissatisfaction regarding Health facilities / Services at the hospital.

Responses of respondent and category of village						
Availability of facilities at Rural Hospital	Village near Rural Hospital			Village far from Rural Hospital		
	Satisfied (some how)	Not satisfied	Total	Satisfied	Not satisfied	Total
Doctors facility	155	73	228	168	98	266
Percent	67.98	32.02	100	63.16	38.84	100
Medicine free of cost	78	150	228	84	182	266
Percent	34.21	65.79	100	31.58	68.42	100
X-Ray facility	66	162	228	70	196	266
Percent	28.95	71.05	100	26.32	73.68	100
Blood, sputum testing	44	184	228	64	202	266
Percent	19.30	80.70	100	24.06	75.94	100

Some questions were asked to the respondents about their experiences and views regarding their satisfaction and dissatisfaction with the availability of medical facilities at the rural hospital and their responses were recorded.

Table 36 shows that the Oraon respondents varied in their responses with regarding availability of different services and facilities in the hospital. It is very clear from the table that a large percent of the respondents residing close to Rural Hospital, e.g.155 (67.98%) of the people were found to be satisfied while only 73 (32.02%) did not. Similarly a large section of the respondents living in villages far from Rural Hospital also said that they were satisfied with availability of doctors at the hospital. Thus the respondents living in remote villages who expressed their satisfaction and dissatisfaction accounted for 168 (63.16%) and 98 (38.84%) respectively. So it was found that majority of the respondents were found to be satisfied with availability of doctors at the hospital. Only a small section of the respondents from the village near the Rural Hospital and away from it were dissatisfied with availability of doctors. The reason cited for their discontent was that frequent transfers and changes did pose problems for the villagers. Vacant posts take time to fill up by new doctors. And also lack of sufficient number of doctors also create problems for the patients coming from far-flung interior areas. They have to wait for hours in a queue to be treated. As a result the patients face immense problems. The BMHO also has admitted to the investigator that it was very difficult to manage a large number of patients every day. The number of doctors was hardly sufficient to cater to the needs of the patients.

Availability of medicine free of cost was the very important and crucial point that was discussed with the respondents. It was found that the Oraons were not totally against accepting modern medicine. The main problem faced by the Oraons was that medicines which are supplied free of cost to the patients was not adequately available. People from both categories of villages were not at all satisfied with supply of medicine. A very large section of the respondents, e.g. 150 (65.79%) and 182 (68.42%) from the village situated close to and away from the Rural Hospital respectively were highly dissatisfied with availability of medicine free of cost. Only a small number of people, e.g. 78 (43.21%) 84 (31.58%) from the village located near the hospital and away from it, expressed their satisfaction respectively.

Diagnostic facility, e.g. X-ray, was also very poor. The respondents were highly dissatisfied X-ray facility in the hospital because this facility was not always available and also involved a long process to get the X-ray done. So the poor people had to get the X-ray done out side which was very expensive for them. So naturally, they were quite discontent about it. It is clear from the table that a very large percent, e.g. 162 (71.05%) of the respondents living close to the Rural Hospital while 196 (73.68%) of them who inhabited in remote villages from the Rural Hospital were dissatisfied very much with X-ray facility at the hospital. Again people were not happy at all with another diagnostic facility like blood testing. A very large percent of the respondents e.g. 184 (80.70%) who lived in the proximity to the Rural Hospital and the other 202 (75.94%) people who lived in remote areas from the Rural Hospital were dissatisfied with blood and sputum testing facility. In fact there is no other diagnostic facility at the hospital. Some blood test were made only for malarial virus and kala-azar fever and sputum test for tuberculosis. So all the other test have to be done out side in private clinics, which was very difficult, and at times impossible for the poor lot of the tribals due to economic constraints.

The crucial point that figured during discussion with the respondents was that of the lack of adequately availability of medicine and services in the hospital free of cost. Other diagnostic facilities such as X-ray, blood testing etc. were poorly maintained and most of the time they were not available for the poor patients for one petty reason or the other. The process and procedures to get the diagnosis done at the hospital was also very long. The patients have to come to the hospital several days to get diagnostic facility which is very frustrating and even difficult, they claimed. It took several days to get the report of the diagnosis. Further not all the diagnosis are done at Rural Hospital so the blood samples are sent to the Sadar hospital for examination, which further delays the process of treatment. Bearing malarial and kala-azar virus, no other facility for blood test is available at the hospital. So the people have to depend on private clinics and laboratories and private diagnostic centers to get blood, urine etc. tested which is very expensive. The tribal can not afford it. The respondents claimed that only some cheap medicines were available such as medicine for ordinary fever, cold cough, paracetamol, iron tablets, vitamins etc. free of cost and the rest of the medicines have to be bought from near by medicine

shops. The respondents also expressed their dissatisfaction regarding the quality of medicine supplied to them free of cost in the hospital. They consider this medicine given to them from hospital sources as cheap and not very effective in comparison to the medicine bought from the medicine shop.

The over all general observation made from this table as well as discussion with the respondents that given their poor economic condition, lack of adequately available medicine, health services, lack of adequate diagnostic facilities etc. had a very discouraging impact on adoption of modern health care practices among the Oraons.

Awareness of Health Services / Facilities in Rural Hospital

Promotion of tribal health in rural areas depends on several factors, like literacy, educational level, economic condition and culture of the tribals. Awareness about the provision of medical services and facilities in rural hospital is also very important for better utilization of the same and making available of such facilities alone is not enough for bringing greater impact on prevailing poor health condition of the locality and particularly of the tribals. Rural folk must be made aware of and oriented to accept theses facilities, else they will remain underutilized. In particular, it is more important to make tribal communities ware of these facilities of modern medicine and facilities and motivate them to accept the same because illiteracy, ignorance, superstitious etc. still exists among the tribals. It is also true in the case of Oraon tribal community of Bamongola Block. So the awareness of the Oraons regarding health facilities provided by hospital sources has been discussed.

The analysis of the modern health practices among the Oraons of Bamongola revealed that the awareness regarding medical facilities in two sets of villages differed. Two different levels of awareness about modern health services in the hospital and general orientations were found among the Oraons. For the purpose of discussion and analysis the entire Oraon villages or hamlets of Bamongola block have been divided into two sets. A group of village that is located approximately within the distance of 3 KMs is considered as village near the hospital while those villages which are situated more than 3 KMs are termed as village far from hospital.

The Oraon community inhabiting in two groups of villages were homogeneous in terms of literacy, occupation, and economic condition. The Oraons living in village close to hospital were found to be comparatively more aware of the kinds of services and facilities available in the hospital. They also had more contact with the hospital due to its proximity. On the other hand the Oraons living in villages far from hospital were found to be less aware of the health facilities that were provided by the hospital. The people who lived in interior and remote villages from the hospital were found to be less in contact with the hospital and due to lack of awareness as well as distance factor. Hence they were not sufficiently utilizing health services available in the hospital.

The respondents from both groups of villages had faith in modern medicine. They were not suspicious about this either. Beside hospital, some were found to consult quack allopathic doctors available in the locality. But economic constraint was the main obstacle in consulting doctors at private chambers.

Besides awareness factor; perception of people towards the system of modern medicine, its efficacy, availability, easy accessibility, distance factor, doctor-patient relationship, proper care and treatment, faith in it etc. were found to be important factors among the Oraon community for accepting and utilizing health services and facilities adequately in the hospital.

DOCTOR-PATIENT RELATIONSHIP

Doctor-patient relationship is considered another very important and crucial factor for promoting rural health among the rural folk. Several scholars dealing with health studies have emphasized doctor-patient relationship for better adoption and utilization of modern health care practices among the rural people. The doctor- patient relationship is further emphasized by the investigator in this particular study on health care practices among the Oraon tribal community of Bamongola block. Like other tribal communities, the Oraons lead a very simple life. They mostly earn their livelihood from agriculture and agricultural labour. Economically, they are the disadvantageous lot. Illiteracy and ignorance prevails among them. The very important revelation came out during field survey that the simple Oraon tribal

consider the doctors as urban people who belonged to other higher class and community. So they do not feel comfortable to consult the doctors. They felt very uneasy and were reluctant to go to the hospital. The Oraon community has faith in modern system of medicine and treatment but do not feel at ease with the doctors. The common perception prevailed among the Oraon tribes that the doctors at the hospital neither did listen to the patient properly nor gave treatment with care. They felt that the doctors did not examine the patient properly. They also consider the doctors, who belonged to other community of higher status, who were not caring towards their health problems. So they felt very uneasy and inferior to consult them. The tribal women were found to have more problems with approaching the doctors. Thus not caring attitude and behaviour of doctors was one of the principal factors for not motivating the tribals for adopting modern medicine adequately. Above all most of the medicine prescribed was also not available in the hospital. So they had to buy the prescribed medicine from near by medicine shops to which they could not afford.

In order to substantiate the above claims and argument of the Oraon respondents, the researcher considers appropriate to discuss the doctor-patient relationship that has a greater impact on the tribal health behaviour. There is one Oraon allopathic quack doctor in the study area. Being from the same community, he was most sought after by the Oraons. It was reported that he (Oraon quack doctor) treated the patient with much care, gave enough time and listened to the problems of the patients properly. They also felt quite at ease and comfortable to consult this particular doctor in their own mother tongue. Therefore, the Oraons, from far away villages also consulted and sought treatment from him He was known to all the Oraon villages. So the Oraons of nearby villages consulted him for all ordinary cases of ailments. The point the investigator wants to make is that proper and friendly doctor patient-relationship is absolutely necessary for promotion of rural health and better utilization of health services and facilities provided by the hospital.

Perception of Modern Diagnosis and Medicine

The field survey reveals that the Oraons have their own perception modern methods of diagnosis and medicine. They do accept modern doctors are better equipped to make better diagnosis and provide medicine. Modern diagnosis is done with the help of superior technology, hence capable of making proper and correct

diagnosis. Proper diagnosis and prescription bring quick relief to the patient. So the Oraons have no difficulty in accepting modern medicine but at the same time they also follow their traditional method of treatment.

In this study the respondents were asked questions about the reasons for their belief in modern system of medicine. The two main reasons provided were; modern machines / technology used by doctors for diagnosis is far superior in making correct diagnosis and medicines are also more effective in bringing quick relief to the victim.

Table: 37. Reasons held by respondents for having faith in modern method of diagnosis and medicine.

No. of respondents in two groups of villages		
Reasons	Village near Hospital	Village far from Hospital
Makes proper diagnosis with the help of modern diagnostic tools (Machines)	109	120
Percent	47.81	45.11
Proper medicine is more effective/brings quick relief	199	146
Percent	52.19	54.89
Total	228	266
Percent	100	100

Of the 228 respondents, (table 37) from the village who live in proximity to the Rural Hospital, 109 (47.81%) said that doctors at the hospital make better diagnosis with the help of modern technology while 119 (52.19%) opined that prescription of proper medicine is more effective and bring quick relief to the patient. Similarly, out of 266 respondents from a group of village located in remote areas,120 (45.11%) also expressed their opinion that doctors use modern equipment for diagnosis of ailments which is capable making correct diagnosis and 146 (54.89%) said that modern medicine was more effective in bringing quick relief of diseases. Therefore, the observation from the data analysis of Oraons show that though they are illiterate and tradition bound in many cases of diseases yet are aware that modern

methods of diagnosis is more accurate and medicine is more efficacious. Comparative analysis of the data shows that there is no significant difference regarding reasons provided for having faith in modern methods of diagnosis through technology and efficacy of medicine.

Discouraging Factors for Adoption of Modern Medicine

It has been earlier said that the Oraons are not totally averse to modern medicine. They do accept modern n medicine without any hesitation or difficulties or suspicion, though they follow certain traditional medicine from the village medicine man. There are multiple factors for under-utilization modern health services and facilities available at rural hospital. The major discouraging factors are categorized into four types, namely, economic constraints, lack of proper examination by doctors, time-distance factors and poor doctor – patient relationship.

Table:38. Discouraging factors for adoption of modern medicine at the rural hospital

NO OF RESPONDENTS				
Discouraging factors	Respondents in village near Rural Hospital	Percent	Respondents in village far from the Rural Hospital	Percent
Economic constraints:. Most prescribed medicines are not available at the hospital, hence very expensive to purchase medicine from medicine shops	76	33.33	104	39.10
Doctors neither examine with care nor give time to listen to their problems	64	28.08	56	21.05
Patients have to wait for hours to get examined as a result lose a day's work and earnings / wages	68	29.82	71	26.69
Doctors / Nurses behave rudely	20	8.77	35	13.16
TOTAL	228	100	266	100

Table 38 : shows the percent of people of two sets of villages who have held different factors for discouraging or factors of under-utilization of modern health services and facilities at the rural hospitals and primary health centers. It is apparent from the table that 76 (33.33%) and 104 (39.10%) of the villagers living in proximity to the Rural Hospital and away from it respectively attributed the economic constraints since most of them are economically very backward and the medicine prescribed by doctors are not available in the hospital free of cost. So they could not afford to purchase prescribed medicine from medicine shops. Therefore, free examination or check up by doctors made little impact on the health behaviour of tribal people. Secondly, 64 (28.08%) and 56 (21.05%) people living close to and away from the Rural Hospital said that doctors at the hospital did not examine the patients with proper care and also gave very little time for check up. The doctors did not listen to the problems of the patients; hence they feel discouraged to go to the hospital. The third discouraging factor recorded was the time-distance factor which was applicable for mostly the respondents living in remote villages away from the Rural Hosapital, while the people living close to Rural Hospital had complains of long wait in queues, who accounted for 68 (29.82%) and 56 (26.69%) respectively. Regarding the fourth factor, 20 (8.77%) and 35(13.16%) respondents from the set of village close to and away from it respectively said that rude and harsh behaviour of some doctors also discourages them from going to the hospital. The doctors in the out door clinics are not at all sympathetic, caring. They said that said that the doctors merely perform their routine job.

The investigator had an interview with the Block Medical Health Officer (BMHO) who gave his own explanation regarding the problems of the hospital. Some of his version of the availability of medical facilities directly contradicts to that of the respondents. He said that medicines are provided to the patients sufficiently. Other facilities were also adequate. The hospital is more or less well equipped to meet the need of the rural masses. But he agreed that sometimes delay in supplying and short supply of medicines do create problems for the patients. Another major problem cited was the lack of sufficient man power to meet the very large number, almost 300 outdoor patients every day. But he agreed that the hospital needed to be improved in many areas.

Co-existence of Traditional and Modern Medicine

Co-existence of traditional and modern system if medicine is considered to be another important area of interest among the sociologists dealing with health issues in rural society, particularly, among the tribal society. In this context the Oraon tribals were asked to give their views and opinion regarding the need for simultaneous existence of traditional and modern system of treatment between two groups of Oraon villages – one set of village located in the vicinity of the Rural Hospital while the other away from Rural Hospital, and to find out the impact of Rural Hospital / Primary Health Centre on the health behaviour of the tribals from the perspective of proximity and distance. It has also been attempted to find out why and what per cent of respondents favour or disfavour simultaneous existence both system of medicine and treatment.

Table 39: Responses of respondents favouring / disfavouring co-existence of both traditional medicine men and modern medicine.

		RESPONSES OF RESPONDENTS					
Category of villages	No.of respon-dents	Favour existence of TM*& Modern doctors simultaneously	Percent	Disfavour existence of TM* & Doctors simultaneously	Percent	Total	Percent
Village near Rural Hospital	228	176	77.19	52	22.81	228	100
Village far from Rural Hospital	266	234	87.97	32	12.03	266	100
TOTAL	494	410	83.00	84	17.00	494	100

**TM= Traditional Medicine men.*

It is apparent from the table 39 - that a very large section of the Oraon tribals, e.g. 410 (83.00%) favoured the co-existence of both traditional medicine men and modern doctors, while only a very small section of them e.g. 84 (17.00%) did not. Comparative data regarding co-existence of traditional medicine men and modern doctors in two sets of village, near and far from Rural Hospital, respectively, does not show or reflect any significant difference. A very large section of the people of both set of villages was in favour of simultaneous existence of traditional medicine and modern doctors. Out of the total of 228 and 266 respondents, 176 (77.19%) and 234 (87.97%) living in the vicinity of the Rural Hospital and the other far from it

respectively, strongly favour both system of medicine side by side, because they consider that either system is useful for treatment of particular disease or ailments. They believe that both system of medicine is necessary. It is because treatment of some diseases or ailments falls, exclusively, under the domain of traditional medicine and in such case modern doctor is considered futile. On the other hand, there was only a small section, e.g. 52(22.81%) and 32 (12.03%) of the people living close to Rural Hospital and away from it respectively, did not believe in simultaneous existence of both system of medicine. Actually the people disfavouring co-existence of both system of medicine attached greater importance and efficacy of modern system of medicine. According to them the traditional medicine of modern day is not honest and well trained in the traditional art of healing and providing herbal medicine.

Table 40: Reasons provided by respondents for continuing /favouring the existence of traditional medicine man in two sets of villages.

NO. OF RESPONDENTS				
Reasons/Reports	Village near Rural Hospital	Percent	Village far from Rural Hospital	Percent
Diseases/ailments caused by supernatural forces-wrath of gods/goddesses, evil eyes, evil spirit, witchcraft can be cured by Traditional medicine only	149	84.65	194	82.91
Traditional medicine's service available at any time at home, less expensive, provides good medicine, mantra (incantations)also necessary	27	15.34	40	17.09
TOTAL	176	100	234	100

In the above table 40, reports / reasons are provided for continuing indigenous medicine and method of treatment by the respondents of two sets of village have been analysed. The reasons provided by the respondents have been categorized into two categories- one supernatural perception of disease causation and the other service provided by the indigenous medicine man. According to them, there are two areas of the causes of disease and illness which require different system of treatment. All the ailments or human sufferings which fall under supernatural causative agents or forces, requires supernatural method of treatment by traditional medicine. But sometimes one

system is followed by either system so as to become more effective. For example, respondents 149 (84.66%) and 194 (82.91%) of both groups of villages- near and far from Rural Hospital, respectively, believed that in case of supernatural causes of diseases, traditional medicine was considered more effective. On the other hand 27 (15.34%) and 40 (17.09%) of the people said that traditional medicine was always available at home and provides medicine at a nominal price. And for supernatural healing he does not charge any money. At the same time they follow both system of medicine side by side.

MOTHER - CHILD HEALTH CARE

Survival, growth and development of a child is dependent on maternal health. And nutritional status.Mother-child health care is determined by a number of factors such as nutrition, marriage, fertility behaviour, use of antenatal and postnatal care as well as medical care and services provided at the time of delivery. But it is also influence by in socio economic determinants- nutrition, education, environmental. Sanitation and hygiene.

Mother-child health care forms an important aspect of health care practices among the Oraons. Mother-child health care is determined by interaction of traditional health care practices and modern health services as well as social environment they live in. In particular, the factors that influence mother-child health of the Oraons under study area are - social, cultural, economic, availability of medicine, accessibility and acceptability, motivation and awareness. Both traditional and modern health care practices have been found to prevail among the Oraons.

Therefore, mother – child health care practices among the Oraons have been discussed and the data collected by the investigator through field survey in two groups of Oraon villages at Bamongola Block in Malda District have been analysed. An attempt has been made to analyze the impact of modern health services through rural hospital upon the health behaviour or health care practices of the Oraons, who live close to Rural Hospital and the others who inhabit in very interior villages, far away from the Rural Hospital.

In this section on mother – child health care has been discussed under the following headings:

1. Ante-natal services.
2. Post-natal health care of mother and child.
3. Immunization.
4. Nutrition of children.
5. Family planning practices.

Antenatal health care practices

Antenatal health care is very important for pregnant women right from conception. The health of the mother and child depends on proper care right from the womb of the mother. From this perspective the investigator has tried to understand and analyse their concept and practices regarding ante-natal care. The study conducted on the Oraon tribes of Bamongola, revealed that the level of ante-natal care of pregnant women was very low, the reasons of which lie in multiple factors. But before going into the details of these factors it is important to note that a total of 288 (60.13%) of pregnant women / mothers in last ten years who had gone through routine modern medical health check up during pregnancy while the rest had not. But it was also revealed that those who had gone through routine medical check up did so only when advised or persuaded by health workers, otherwise they had general apathy towards it. They do not give much importance to routine medical check up of pregnant women.

There were multiple factors recorded for the poor antenatal care of mothers of which poor socio-economic condition is the important one. The economic condition of the Oraons studied was found to be very deplorable. A large section of them belonged to landless, small and marginal farmers. Malnutrition during pregnancy was one of the important factors affecting the health of the pregnant mother and the child. It was found that neither they took any extra nutritious food nor considered it important to do so. Above all they could not afford to have extra-nutritious food. Therefore, they had to be content with taking normal staple food- rice, pulse and some vegetable only as an when available. No additional nutritive food items were available for expectant mothers due to economic constraints. A large section of the Oraons belonged to economically very backward community. Therefore, deficiency in

nutritive food did affect the mother-child health. It was further revealed through discussion that economic constraints forced the pregnant women to do hard labour. They carry on daily physical work at the field as long as they could. At the same time it was also reported that the Oraons were not very particular about the notion of fatigue that may have an adverse effect on health of expectant mothers.

As a prenatal care, regular medical check up of pregnant women / mother mothers is necessary. But not all of the Oraon pregnant women had gone through health check ups either at Rural Hospital or Primary Health Centre. It was observed during field survey and also it was also reported by the health workers that ignorance and apathy still prevails among the Oraons regarding prenatal health care. They were not in a habit of coming to the Rural Hospital / Primary Health Centre for medical check ups by themselves during pregnancy, unless they were repeatedly persuaded to do so. It was also revealed during interview with the respondents that those pregnant women who had gone for medical check up, did not consider taking iron tablets, folic acid, supplement vitamin, tetanus injections etc. necessary. Still further those who lived in interior villages care very little to take these prenatal care during normal condition. In fact they were found to be ignorant about prenatal care. Some reservations and reluctance were also reported due to the fear that the medicine may harm the baby. Therefore, all ordinary cases or problems relating to pregnancy were treated by *kabiraj*.

Table: 41. Respondents' responses regarding regular health check up by pregnant Women / Mothers in two set of villages.

NO. OF WOMEN						
Category of village	Women having regular medical check ups	Percent	Women having no regular check up/ no check up at all	Percent	Total	Percent
Village near Rural Hospital	152	64.68	83	35.32	235	100
Village far from Rural Hospital	136	55.74	108	44.26	244	100
Total	288	60.13	191	39.87	479	100

Table 41 shows prenatal care taken by of the Oraon women of two set of villages during their pregnancy. The first contact point available for medical check ups for pregnant mothers were Rural Hospital /Primary Health Centre or sub-centers. The data show that a sizable section of the Oraon women had not taken any medical check up at all or were very irregular about it. It is apparent from the table that 152 (64.68%) pregnant living in villages close Rural Hospital / Primary Health Centers had availed themselves for prenatal medical check as against 136 (55.74%) of women who live in remote villages, far away from the Rural Hospital /Primary Health Centers . There fore it is clear that per cent of pregnant women attending to prenatal health check were more that those who resided in remote areas. The women of two sets of villages – near Rural Hospital and away from it who had not availed themselves for prenatal health check up accounted for 83 (35.32%) and 108 (44.26%) respectively.

Some observations drawn from this table enquiry during interview revealed that those women of the villages situated close to Rural Hospital / Primary Health Centers were more aware and were in the practice of health check up during pregnancy than those women who live in far away villages but could not explain the necessity for it. They simple reply was that they were advised by the health workers to do so. They also reported that it was convenient to avail themselves because of the proximity of their villages to Rural Hospital / Primary Health Centers. On the contrary, women of living in interior areas, away from Rural Hospital /Primary Health Centers did emphasize distance factor for not attending to prenatal health check ups. But awareness level was also found to be lower among the women living in isolated villages. Besides distance factor, some other crucial factors reported were lack of proper roads, transport and communication, compounded with poor economic condition of the respondent families. It was difficult to meet cost of transport to the hospital. Loss of daily wage was another concern because one adult family member had to accompany the pregnant woman to the hospital. Non-availability of prescribed medicine free of cost sometimes played a major factor for not attending to prenatal health check up services provided by the hospital or Primary Health Centers. But above all their ignorance, apathy and their traditional attitude were no less important causes for not having regular prenatal health check at Rural Hospital /Primary Health Centers.

Places of Antenatal Immunization

Antenatal care is very vital to survival and good health of the child as well as safe motherhood. Therefore, antenatal care has been recommended for pregnant women under public health care system that include three or more antenatal check ups, two or more tetanus toxoid injection and iron and folic acid tablets or syrups for three or four months. But in rural areas antenatal care is in dismal state for various reasons.Receiving antenatal immunization is found to be influenced by its availability and easy accessibility. In this study, care has been taken to record the places of immunization available for two groups of Oraon tribal villages. Interview and discussion with the respondents revealed that the Oraon pregnant mother, her husband and elderly members of the family were not much interested in receiving such antenatal health care services unless advised and some times almost compelled to do so specially, by multi-purpose lady health workers and *Anganbari* (Integrated Child Development Scheme worker) workers in the village. Mere propaganda through various media, posters, print media, televisions, radios etc. alone did not have much impact on them. On the other hand direct persuasion and motivation by health workers were found to have greater impact and acceptability on antenatal health care services. Availability of antenatal services within the easy reach of the pregnant women also found to have greater on impact on them. The table below will show the per cent of women receiving immunization at various places.

Table : 42. Places of antenatal immunization/ services received by women / Mothers of respondent families

		PLACES OF IMMUNIZATION					
Category of villages	No. of respon-dents	Rural hospital	Percent	Primary Health Centre/Sub-centers/villages	Percent	Total	Percent
Village near Rural Hospital	152	81	53.29	71	46.71	152	100
Village far from Rural Hospital	132	26	19.70	106	80.30	132	100
Total	284	107	37.68	177	62.32	284	100

Table 42: shows that the pregnant mothers had received antenatal immunization primarily from two sources or places; one the Rural Hospital and the other Primary Health Centre Sub –Centers. A large section of the women, e.g. 81 (53.29%) residing in the vicinity of the Rural Hospital availed antenatal services from Rural Hospital while 71(46.71%) of them were given prenatal care services by Primary Health Centre sub-centers or in the village itself by the health workers. On the other hand out of the 132 women residing in very interior villages, 26 (19.70%) 106 (80.30%) had taken prenatal care services in Rural Hospital and Primary Health Centre / sub- centers/in village itself respectively. Comparatively tribal women were availing antenatal care services more from Primary Health Centre and its sub-centers. Of the total 284 women 107 (37.68%) and 177 (62.32%) availed for antenatal services at Rural Hospital and Primary Health Centre /sub centers respectively.

It is obvious from the table that Oraon women had mostly availed antenatal services from Primary Health Centre and its sub-centers due to the proximity to their villages. They attributed a great importance to easy accessibility. It was also found that women from those Oraon villages located close to Rural Hospital or Primary Health Centre or its sub-centers were availing antenatal services more.

The women who had not availed for antenatal services had their own reasons to give. Of the total of 479 women, a total of 191(39.87%) had not received antenatal services (Table 37). The reasons given by the women for not availing the prenatal care services are more or less categorized into four headings as shown in the table below.

Table 43. Reasons provided by respondents for not receiving antenatal care services / immunization from Rural Hospital /Primary Health Centre

NO OF RESPONDENTS						
Reasons /reports provided by respondents	Respon-dents in village near Rural Hospital	Percent	Respond – dents in village far from Rural Hospital	Perce -nt	Total	Perce -nt
Medical check up not required / necessary during normal case of pregnancy	48	57.83	50	46.30	100	51.31
Loss of work and wages and pro-blems of accessibility due to dis-tence factor / long wait in queue	12	14.46	24	22.22	38	18.89
Feel shy/ uneasy	15	18.07	20	18. 52	35	18.32
Take medicine from local village medicine man during minor cases of problems	8	9.64	14	12.96	14	12.96
Total	83	100	108	100	191	100

In the previous table 41, it has been shown that a total of 83 (35.32%) and 108 (46.77%) of the pregnant women living in villages relatively close to Rural Hospital and in a group of villages away from it respectively had not received antenatal immunization. It is this section of the women or the respondent families whose response or reasons have been recorded and analysed for not attending to prenatal health services provided by health institutions. It is obvious that a section of the Oraon tribal community form both sets of villages did not receive antenatal care services. In the table 43 reasons provided for not attending to prenatal care by them have been classified into three categories but they are not exclusive but interrelated. By doing so the investigator has tried to analyze their attitude towards prenatal health care services. A big majority of the women who had not received any antenatal services were found to be unaware of pregnancy related complications that could arise. A total of 48 (57.83%) and 50 (46.30%), out of the total of 83 and 108 women who live in proximity to the Rural Hospital and away from it, respectively, said that prenatal health check ups were not required or necessary during normal cases of

pregnancy. On the other hand12 (14.46%) and 24 (22.22%) women from both groups of villages, near and far from Rural Hospital respectively, ascribed to loss of work and wage because another adult member had to accompany the pregnant woman to the hospital. In addition to that those who live remote villages far from Rural Hospital attributed to distance factor and the problems of roads, transport and communication, especially during monsoon. The third reason attributed to feeling of uneasiness and shyness, particularly to be checked by male doctors, who accounted for 15 (18.07%) and 20 (18 .52%) of women living near and far from Rural Hospital respectively. It was also found out that the pregnant women even feel uncomfortable to talk about pregnancy related matters in the presence of male members of the family. A small section of the mothers said that medicine provided by the Kabiraj or village medicine man was sufficient for minor case of pregnancy related problems hence they avoid going to long distance.

Postnatal Care

It is not only the antenatal care but also the health of the mother and the child depends very much on the postnatal care administered to both the mother and the child in the first few weeks after delivery. But in rural areas and particularly, in tribal areas, the postnatal care is very poor or is of very low level. With regard to child birth the Oraons are tradition bound. They still follow the age old traditional custom of delivery of a child at home, bearing complicated case of delivery. The untrained midwife continues to look after the mother and the child. It was observed among the Oraons that until some problems arise, they never take the mother and the child to hospital or a doctor. No additional nutritive food item is given to the mother.

Practice of Delivery

A very important component of safe motherhood is delivery in a safe and hygienic condition under the supervision of a trained health professional. The National Family Health Survey, 1989-89 indicates that despite of trying to make provisions for Primary Health Centres and maternal homes for safe deliveries but on an average only one third of the deliveries were held in health institutions and 64.5% in the home, attended by untrained traditional birth attendant. Delivery of a child among the Oraon tribal community is usually assisted by untrained midwife, called

dai- ma who continues to look after the mother and the child until purification ritual is performed. But in case of Scheduled Caste mothers in rural areas, practice was far less.

Table:44. Preference of Place for delivery by women in respondents Oraon families

Response /preference						
Category of village	At home (attended by untrained mid-wife)	Percent	Rural Hospital / Primary Health Centre (attended doctors/nurses)	Percent	Total	Percent
Village near Rural Hospital	220	93.62	15	6.38	235	100
Village far from Rural Hospital	236	95.16	12	4.84	248	100
Total	456	94.41	27	5.59	483	100

The table 44 gives the picture about the practice and preference of child delivery in Oraon families of two groups of villages- one close to Rural Hospital and the other away from it. A total 456 (94.41%) child births had taken place at home out of the total of 483 mothers, and the delivery was attended by untrained mid- wife, called *dai-ma.* Separate analysis of the practice of delivery shows that there was little difference between mothers inhabiting in two set of villages. The most noticeable figure is that a very high per cent of child deliveries take place at home among the Oraons of Bamongola. It is recorded that 220 (93.62%) and 236 (95.96%) deliveries, had taken place at home from the village categories one and two respectively, They also preferred home to hospital for child deliveries. Only a very small per cent e.g. 15 (6.38%) and 12 (4.84%) complicated cases deliveries had taken place in the hospital among the Oraon families of two groups of villages. Therefore, institutional deliveries are not a common practice among the Oraons.

From the analysis of the above data it is very clear that there were hardly any difference in the practice and preference of child deliveries between two sets of villages, located in proximity to the Rural Hospital and the other groups at far-flung

areas from Rural Hospital. A very little impact of modern health institution was found among the Oraon tribal community of two sets of villages with regard to child delivery practices. The investigator observes that rural health institution has failed to have much impact due to a strong traditional custom and practices still prevailing among the illiterate tribal community. At the same time a very poorly maintained and ill equipped infrastructure of the hospital also has failed to put any impact upon the rural tribal folk.

Table: 45. Reasons /provided by respondents for delivery at home

RESPONSES								
Category of village	Traditional custom to have delivery Rural Hospital /Primary Health Centre not required	Percent	Find no problem/ Convenient at home/ get support of other family members relatives	Per-cent	Only complicated cases of delivery need to be attended in hospital	Percent	Total	Percent
Village near Rural Hospital	200	85.11	20	8.51	15	6.38	235	100
Village far from Rural Hospital	196	79.03	37	14.92	15	6.05	248	100
TOTAL	396	81.99	57	11.80	30	6.21	483	100

The table 45 : shows the reasons provided by the respondent families with regard to practice of child delivery. Though the investigator has tried to categorize the reasons or responses given by the respondents' families yet they are not exclusive ones but are inter-related. It is obvious that a very large per cent, e.g. 200 (85.11%) and 196(79.03%) of the people, living in vicinity to Rural Hospital and far from it, who were interviewed also emphasized on traditional custom that has been in practice since generations. They have become accustomed to child deliveries at home. The mid-wife called, *dai ma or kusrain,* who is normally from own community, is considered experienced enough to attend a delivery and take care of the mother and

the child. On the other hand a small percent, e.g. 20(8.51%) and 37 14.92%) of the respondent families ascribed to convenient factor where they get support from other family members, relatives and people of their own community. It also involves no cost. It is learnt that the concept of safe motherhood has not found its place among the tribal communities. The people inhabiting in villages near Rural Hospital also do not take the expectant mothers to Primary Health Centre or Rural Hospital for delivery. The services of the rural health institutions are vastly underutilized due to manifold and multifaceted factors. The child delivery is considered a natural phenomena, hence, generally avoid institutional delivery.

From the foregoing analysis the investigator has made certain observation that the Oraons have no inhibition regarding acceptance of modern antenatal health services and medicine. But at the same time the Oraons are very tradition bound with regard to the custom of child delivery at home. They do not venture to break the tradition that transcended from generations. It was also revealed through discussion and interview with the respondents that illiteracy, ignorance, poverty, superstition and taboo also had to some extent influenced the age old practice of child birth at home. Expectant mothers are not taken to hospital for delivery, except some complicated cases, that to as the last resort, which many a times results in a fatal death of both the mother and the child. The simple and illiterate Oraon folk fail to understand the risk of death involved to both the mother and the chilled and several delivery related deaths were reported in the village. They also avoid going to hospital for delivery for the fear of operation. The expectant women also do not like the deliveries to be attended by male doctors. Discussion with the respondents further revealed that the Oraons follow ineffective and a kind of primitive method of home deliveries of babies. The child birth takes place in a poor and unhygienic condition. The umbilical cord is detached by sharp bamboo silt which is not properly washed with water and immunized. But nowadays, a mid-wife uses a new blade also for this purpose.

Rituals of Child Birth

The Oraons follow some religious rites and rituals after the birth of a baby. The Oraons believe that newly born babies are amenable to be easily attacked by evil spirits or evil yes. Therefore, certain religious rites are conducted as preventive or

precautionary measures. Goddess *Kali* is considered to be their protective deity, hence *pujas* are performed and sacrifices of either a gray or red or a black hen is made to this village deity, known as *goan deota* by the Oraons.

The prevailing custom of the Oraons is that the practice of observing a period of pollution of impurity after child birth. Therefore, after the birth the mother and the new born baby is secluded in a lying room. Not only the mother and the child but also the entire house is considered ceremonially unclean until the purification ceremony is performed. At the secluded room mid-wife continues to look after the mother and the child. No medicine is administered to the mother except massages. She also applies fomentation to the baby. Usually on the fourth or fifth day after delivery a house considered ceremonially purified by besmearing the court yard and the floor of the house with diluted cow dung in water. All clothes of the mother since delivery and also clothes used for new -born baby are washed. After purification ceremony they start normal life.

Immunization of Children

In order to protect children from vaccine preventable diseases, immunization schemes have been launched, starting with BCG in 1962, when it was included in the programmes of maternal and child services. Gradually, other diseases were included and six vaccines (BCG measles three doses each of DPT and polio vaccines) are now covered. Pregnant women for tetanus toxid vaccine were included in Universal Immunization Programmes (UIP). According to Social Development Report, India 2006, there was a marked rural urban difference in coverage of full vaccination. In 1989-89 60.5 per cent of children aged 12-13 months old were fully immunized in urban areas as compared to only 36.6 per cent in rural areas. Among the tribals in rural areas immunization was still much less. Immunization of children among the tribals remains a big concern even today. Though immunization programmes has made some progress in rural areas, yet in general it is neglected, particularly, among the tribals. The simple and illiterate tribal folk are not much aware about immunization of children and fail to understand the implication of immunization of children. It is found in the present study that a good progress has been achieved with regard to immunization of children among the Oraons.

Table: 46. Distribution of children in respondents households having received immunization and places of immunization

Category of village	Number of Children			Places of Immunization		
	Immunization received	Immunization not received	Total	RURAL HOSPITAL	PRIMARY HEALTH CENTRE/Sub-centers	Total
Village near Rural Hospital	210	14	224	124	86	210
Percent	93.75	6.25	100	59.05	40.95	100
Village far from Rural Hospital	208	32	240	58	150	208
Percent	86.67	13.33	100	27.88	72.12	100
Total	418	46	464	182	236	418
Percent	90.09	9.91	100	43.54	56.46	100

The table 46 shows the immunization of children in two sets of villages. It was found that 418 (90.09%) of children out of the total of 464 children below the age of 5 years have received immunization, like BCG and DPT, in both sets of villages combined. They also have received polio doses. Of the total of 418 children 210 (93.75%) and 208 (86.67%) from a group of village situated near Rural Hospital / Primary Health Centre and the other group located away from it have received immunization while 14 (6.25%) and 32 (13.33%) have not received it respectively. Therefore, it is apparent from the table that that the Oraons are not averse to receiving immunization. But still awareness about the need of it needs to be created since most of them are illiterate and often fail to understand the need of it and its implications. They do not come forward themselves to get their children immunized at the health institutions. They reported that they were advised by health workers mainly, the Multi-Purpose Health workers to do so. The important point to be made here is that they are nor rejecting immunization.

Places of immunization also considered a very important factor for making a good progress in far-flung rural areas, particularly in very isolated tribal villages. It is obvious from the table above that closer the health institutions to the rural-folk, higher is the rate of immunization received among children. It is no exception to the tribals as well. The people living in villages close to Rural Hospital had got their children immunized from Rural Hospital while the rest either from Primary Health Centre or Sub-centers, whichever was easily accessible, who accounted for 124(59.05%0 and 86(40.95) respectively. On the other hand people inhabiting in remote villages far from Rural Hospital had utilized more the services of either Primary Health Centre or sub-centers for getting their children immunized. It is apparent that 72.12 % (150) received immunization services from Primary Health Centre / sub-centers while only 27.88% (58) went to Rural Hospital. The analysis of this table lead us to some important observations that easy accessibility, together with better delivery system will play a major role if cent per cent immunization has to be achieved in rural areas, especially among the disadvantageous section of population.

Nutrition of Children

Food of children among the Oraons is very deficient in nutrition. Neonates and infants are usually suckled by mothers and breast feeding continues up to the age of two or three years or even more. Breast feeding is considered sufficient for infants. The infants are given semi-solid food, normally rice, as early as at the age of six to seven months. But the poor economic condition does not permit them to provide for additional nutritive food like 'canned food'. At the same time they do not consider additional nutritive food necessary. After one year of age the children are given practically all kinds of solid food. No special food is cooked for children and so whatever food cooked for adults is served for children. The people under study were found to be satisfied with the diet of children. Like adults, adequate diet of children tends to be thought of in terms of quantity and not quality of sufficient staple food. Consequently, malnutrition may exist due to a lack of adequate balanced diet.

Family Planning

Family planning is an important aspect of health, specially, the mother-child health. The concept of family planning was found to be absent, though a small percent of women have gone through contraceptive surgery. As far as modern family planning methods are concerned sterilization is the most preferred one. Birth spacing and other conventional contraceptives like condoms, pills, tablets etc. are not in vogue.

Table : 47 Traditional / Modern Methods of Family Planning practised by respondents of two sets of villages.

RESPONSES OF THE RESPONDENTS				
Groups of villages	Modern Method sterilization	Traditional Method	Do not practised any Method	Total
Village located near Rural Hospital	86	16	114	216
Percent	39.81	7.41	52.78	100
Village located far from Rural Hospital	80	49	241	456
Percent	36.40	10.75	52.85	100
Total	166	49	241	456
Percent	36.40	10.75	52.85	100

Table 47 present the type of family planning practiced by the respondent couples of two sets of villages, it is found that 86 (39.81) and 80 (33.33%) women from both sets of villages living close to and away from Rural Hospital respectively had gone though sterilization but not before the family size had become big. On the other hand, 16 (7.41%) and 33 (13.75%) of couples from villages near Rural Hospital and away from it were reported to practise traditional methods of birth control. Again, majority of the eligible couples numbering 114 (52.78%) and 127 (52.92%) from both categories of villages reported that they were not practising any family planning methods. The concept of family planning had no relevance to them.

Health Care Practices: Continuity and change

Health care practices of the Oraon tribe like any other tribal community is found to be deeply ingrained in their culture and hence it is an integral part of their society and culture. Health care practices among the Oraons are an important component of their broader culture which has been in existence since centuries. This holistic aspect of health care practices provide a valuable framework for analysing the interaction of their traditional method of health care practices with that of modern health services provided by modern health institutions e.g. rural hospital, and primary health centers, in rural setting.

Some conventional studies have rightly pointed out that unified culture and its components constitute are unified health culture. It implies that health care practices which is a part of the integral culture that does not change easily with the introduction of various modern health services and access to them by the rural people, particularly the tribal community. In this context the health care practices of the Oraons have been analysed from the perspective of proximity and distance from the rural hospital and primary health centers and the findings have been recorded.

For the analysis of the health care practices the Oraon villages are divided into two categories based on the criteria of contiguity and distance from the rural hospital / primary health centers and to find out its impact in the health care practices on a comparative perspective.

The study shows that the Oraons in both set of villages are found to be practising both traditional methods of treatment as well as modern medicine for various diseases and illnesses. The introduction of rural hospital and primary health centers and sub-

centers seems to have not much impact on the health care practices of the Oraons. But certainly there are areas of changes taking place in their health behaviour.

With regard to health care practices, the Oraons are not totally averse to modern medicine yet traditional mode of treatment to a large extent still persists. The

concept of disease causation is highly influenced by their culture – religious faith and magic. The Oraon community under study led a very simple life. They were found to relate and explain most of the diseases to some supernatural forces and agents.

The health behaviour of the Oraons was found to be clearly influenced by four causative agents of disease and illness: - i) supernatural, e.g. wrath of gods, deities, and spirits, ii) natural forces, iii) evil spirits and v) witchcraft. A vast majority, e.g. 71.05 per cent and 69.17 per cent of the respondents who inhabited in a group of village adjacent to the Rural Hospital and the other away from it respectively, attributed some of the ailments, such as fever, cold, cough, headache, body pains to natural forces like inclement weather, while gastric, ordinary diarrhea etc. were ascribed to excessive intake of adulterated food items and contaminated and polluted water.

A very strong perception prevails among the Oraons is that diseases like paralysis, leprosy, small pox tetanus, cholera, epilepsy, mental disorder etc. were attributed to supernatural causative agents or forces. A vast majority, e.g. 64.47 per cent and 62.03 per cent (table 24) of the people from both groups of village living in contiguity to the Rural Hospital and the other fare away from it respectively, ascribed the above diseases and illness to supernatural forces. The belief in evil spirits as causes of disease and illness were also found to be very strong. A very large section, e.g. 76.75 per cent and 77.44 per cent (Table 25) of the respondents believed that hosts of evil spirits, commonly known as *bhuts,* were behind many of the illnesses and diseases. Further, 78.95 per cent who inhabited in villages adjacent to RH and 76.69 per cent (Table 26) who resided in remote villages also had a very strong faith in evil eyes, locally known as *najair* as diseases causative agents. A strong perception of witchcraft still persists in the Oraon society which is believed to cause many kinds of diseases, ailments and sufferings, not only to human beings, but also to domestic cattle and good looking and healthy crops.

Witchcraft is a superstitious belief found to prevail in different tribal societies in India and elsewhere varied in nature, forms and patterns. It is very difficult to determine the origin of this phenomenon of witchcraft or this belief system. Belief in supernaturalism is one of the main causes of this superstitious belief in witchcraft. It

is one of the traits of primitive society. Witches are believed to possess magical power or some supernatural power with the ability to cast black magic upon a person, crop or cattle as and when intended to harm them. Normally, a woman is branded as a witch, locally called *dain, daini* or *bishahi.* But some men are also believed to possess this magical power of a witch in Oraon society who is known as *bishaha* locally. Belief in a witch exists till today in Oraon society. In order to ascertain the impact of modern health institutions, e.g. rural hospital, upon the traditional belief system relating to disease causative agents and their treatment, the Oraon villages were divided into two groups- one living in the vicinity of Rural Hospital and the other away from it. But the data (table 27) clearly shows 69.74 per cent who resided close to Rural Hospital and 71.80 per cent of the Oraons who inhabited in very isolated villages strongly believed in witchcraft causing various illnesses and diseases and sufferings. The modern health institutions, medicines etc. are still far from making much impact upon this indigenous belief on witchcraft. So the Oraons still continue to explain the etiology of diseases in magical power of a witch. Poverty, illiteracy, ignorance and poor health condition compel the Oraon tribals to seek advice and treatment from traditional medicine man, called by different names, such as *ojha, kabiraj, baid, mahan* and *gunin* in times of adversary. Beliefs in numerous evil spirits causing illness are also found to be widely prevalent among the Oraons inhabiting in both sets of villages. A large per cent e.g. 76.75 per cent and 77.44 per cent (Table 25) of the people living in the vicinity to the RH and away from it strongly believe in evil spirits of different types, as causative agents of diseases and illnesses.

Indigenous methods of treatment are sought after for practically every cases of disease of disease and illness. Magico-religious form of treatment by village medicine men is very common feature in Oraon society under study. In fact a *kabiraj* is called upon to perform some religious rites and rituals even if diseases are not attributed to supernatural causative agents. By doing so, they believe that herbal medicine or modern medicine become more effective. The most popular methods of diagnosis of indigenous medicine men include – divination, reading the pulse of the patient, making queries and observing symptoms.

Three types of indigenous methods of treatments found among the Oraons are : herbal ingredients, religious propitiation with an elaborate rites and rituals and

exorcism. Firstly, diseases believed to be caused by wrath of deities or gods like leprosy, epilepsy, cholera (*Mahamari)* etc., offerings and sacrifices of fowls are made to appease the concerned deity. Secondly, medicine prepared from different herbal ingredients by *kabiraj* as well as modern medicine from hospital is administered for diseases believed to be caused by natural agents or forces. Normally, in such cases of illness religious rite and rituals are not performed. Thirdly, treatment of all the ailments or diseases diagnosed by kabiraj to be caused by witchcraft or spell of evil spirits requires exorcism or warding off evil spirits. But in case human sufferings is caused by the magical spell of a witch only an experienced *ojha* is capable of or empowered to exorcise the magical spell of a witch. Elaborate magical paraphernalia is followed by the *Ojha* in casting out the evil spell of a witch, if not it is feared that it may attack the *ojha* himself or if not directed properly it many attack any other person or cattle.

It was revealed during field work that the Oraons consulted the village medicine man first for most of the diseases. The village medicine man lives in the village or the in the neighboring village who is contacted first attends to the patient, gives initial treatment and then advises the patient to be taken to rural hospital for modern medicine. Home treatment or remedy is not done because laymen posses little knowledge of herbal medicine. So they are greatly dependent on traditional medicine men even today. Many of the respondents expressed their anxieties and fear that they are not getting the services of good village medicine men nowadays due to the death of some old and experienced indigenous medicine men. They also opined that not all the medicine men of the present day are very effective. The field investigation revealed that the Oraons even after they have started using modern medicine, indigenous method of treatment and cure continues to play a significant role in their health care practices. The traditional method of treatment can not be done away with, they claimed. Therefore, they favoured co-existence of both systems of medicine– traditional and modern. The Oraons used both system of medicine simultaneously according to the nature of disease etiology.

The age old medicinal combinations and healing techniques, e.g. through incantation of mantras, ritual healing, magico-religious methods etc. inherited from their forefathers persist in the modern times among the Oraons.

Besides, certain diseases and illness, in the event of dog bite and snake bite, traditional method of treatment, e.g. treatment mantra, called *jhar phunk* was a very common practice among the Oraons. For snake bite and dog bite the most preferred treatment was *jhar phunk* that is through incantation of mantras. Majority of the respondents, in both groups of villages, e.g. 50.88 per cent and 65.41 per cent (Table 27.1) located in the vicinity of Rural Hospital and away from it respectively sought or preferred treatment from *ojha / kabiraj* who is believed as specialist in snake bite and dog bite curer. A majority of the respondents e.g. 50.88% and 65.41% (Table 30) from both sets of villagers favoured treatment from traditional medicine A sizable section of the people e.g. 43.42 per cent and 30.08 per cent (Table 30) who inhabited adjacent to Rural Hospital and while others way from it respectively preferred both traditional and modern treatment for snake bites and only a very small per cent of the, e.g. 5.70 per cent and 4.52 per cent preferred only modern treatment from hospital. In case of dog bite a huge number that is 65.35 per cent and 75.94 per cent (Table 31) from the village close to Rural Hospital and away from it respectively believed in traditional *jhar phunk* method of treatment, 20.18 per cent and 13.53 per cent respectively said that traditional and modern treatment were necessary and 14.47 per cent and 10.33 per cent respectively preferred only modern methods of treatment from hospital. This section of the people did not believe ritual healing through *jhar phunk.* The most common form of treatment for both snake and bites was mantras. Though it may seem a very superstitious belief to any rational mind but the fact is indigenous method of healing with incantation is sought after even today in the study area not only among Oraons but also among the non-tribals. The introduction of modern medicine through hospital has very little impact among the tribals in case of dog and snake bite. They go to hospital only as a last resort after failure of all traditional method of treatment, which many a times resulted in a fatal death of the victim. Thus we find that traditional method of healing practices is widely prevalent even today in Oraon society.

However, village medicine men of the present age are considered to be much less competent than their predecessors. The Oraons claimed that the village medicine men of olden days were more effective in giving treatment of all kinds of diseases. They reported that with the death of old medicine men, considerable amount of

knowledge about herbal medicine and other healing techniques have been lost because they could not pass on the indigenous knowledge to their disciples or the medicine men of younger generation. In addition to this due to deforestation, depleting forest resources medicinal flora and fauna also have disappeared. So now they are increasingly becoming dependent o herbal properties or items bought from local market or *hats*. So the scarcity of medicinal herbs, plant etc. are posing difficulties in preparing essential ingredients of herbal medicine

Impact of Modern Health Institutions

In the preceding sections it has been discussed that the Oraons are following age-old methods of treatment, yet it can not be concluded that their health care practices are totally tradition bound. They are found to be using modern medicine for detain illness only. The introduction of modern medicine certainly has some impact upon the Oraon community. The respondents said that in the initial stage of the introduction of Rural Hospital in 1957 they were not bothered to avail its facilities. But nowadays, modern medicine is changing the health behaviour- perception of disease etiology and their treatment.

The data collected revealed that the Oraon tribal community has no hesitation or suspicion in accepting modern medicine. After evaluating the over all impact of rural health institution upon Oraon community, it was found that both traditional and modern systems of medicine co- exist. The other objective of this research was to record the impact of rural hospital upon two sets of Oraon village, one located in the vicinity of Rural Hospital and the other away from it. The data show that the percentage people inhabiting in the villages adjacent to Rural Hospital were found to be utilizing the services of Rural Hospital more than those people who resided in isolated villages, very far from the Rural Hospital, though the difference recorded was not very significant. But still it is worth recording that if good modern health services are made easily available the tribals would utilize these services more and more. Actually the poor delivery system of health services acted as discouraging factor for not utilizing the services provided by the Rural Hospital.

Regarding treatment after first appearance of the symptoms of disease, it was found that a very large percent of respondents, e.g. 62.72% from a group of village adjacent to Rural Hospital sought modern treatment directly while only a small per cent e.g. 37.28% (Table 33)of people preferred indigenous treatment first, followed by modern medicine. On the other hand 70.68 per cent of people who inhabited in remote villages from Rural Hospital were found to be using more and were dependent on traditional method of treatment, as no alternative mode of treatment was available at hand, while only 39.32 per cent directly sought modern medicine.

The decision about the choice of treatment among the respondents of two sets of villages was fundamentally determined by their socio-cultural perception of disease etiology. A very large per cent of the villagers of both group of village e.g. 89.91 per cent and 74.06 per cent living close to Rural Hospital and far away from it respectively sought modern medicine while only 10.09 per cent and 25.94 per cent (Table 34) people respectively favoured traditional medicine for the diseases believed to be caused by natural agents for forces. But at the same time lack of good delivery system and accessibility factor also had a major discouraging factor for utilization of modern health services.

The important revelation regarding modern health behaviour of the Oraons is that a trend of utilization of modern medicine is observed among both sets of villagers. But comparatively, people inhabiting in the vicinity of the Rural Hospital were found to utilize modern health services more than those who lived in far away villages from the Rural Hospital though the difference recorded was not very significant. Again questions were asked regarding their preference for treatment, a great majority, e.g. 62.28 per cent and 69.81 per cent (Table 35) of the people from the village near Rural Hospital and far away from it expressed their strong views that that both system of medicine to co-exist.

Impact on Mother Child Health Care Practices

One of the crucial areas where utilization of modern health services by the Oraons clearly seen was the mother –child health care. The present study revealed that the Oraons were availing modern medicine or services, especially, antenatal services

or care provided by the hospital sources. The practice of availing antenatal services were found to slightly higher amongst women living in the vicinity of the Rural Hospital than the ones who reside in remote villages away from the Rural Hospital. The total 64.68 per cent and 55.74 per cent of the mothers from the village close to Rural Hospital and from remote villages had availed antenatal services from Rural Hospital respectively, while 35. 32 per cent and 44.26 per cent (Table 41) respectively did not receive the same. The mothers living adjacent to the Rural Hospital reported that they had no difficulty in approaching the Rural Hospital or Primary Health Centre as they live close to Rural Hospital /Primary Health Centre. But the mothers are still unaware of the necessity of receiving antenatal immunization. They themselves do not come forward to avail these services. Constant propaganda, persuasion and motivation by health workers are done. But the researcher was told by the health workers that in earlier days the tribals as a whole, including the Oraons were very rigid in not accepting antenatal services, like taking folic acid, iron tablets or tonic, vitamins etc. for the fear that it may affect the child in the womb which may result in deformity. But at present this perception has been changing at present. But the progress in this matter is very slow. Still general apathy towards antenatal services continues to persist even in modern times mainly due to illiteracy, ignorance and also due to traditional attitude and practices.

Despite availing antenatal services fro Rural Hospital/ Primary Health Centres the Oraons were very tradition bound with regard to delivery of a child. Almost cent per cent deliveries had taken place at home, attended by an experienced but untrained mid-wife called *dai ma* or *kusrain*. Only a small per cent of the complicated cases of deliveries had taken place in the rural hospital. There was no difference found in the practice of deliveries in the two sets of villages. The data revealed that 93.62 per cent and 95.16 per cent of deliveries in the group of villages near and far away from Rural Hospital had taken place at home respectively. Reasons provided for such practices were that it was their prevailing customs since generations and they find no problem in it. Also they feel shy and uncomfortable to be attended by male doctors. The economic constraints was also reported by many since taking the pregnant mother to hospital involved some expenditure to which they find difficult to meet.

Regarding immunization of children, the Oraons were not averse to it. 93.75 per cent and 86.67 per cent of children from the village close to and away from Rural Hospital respectively had received immunization while only a small per cent e.g. 6.25 and 13.33 per cent (Table 46) of the children either did not receive or did not complete the course of immunization in both sets of village respectively. Here again the parents got their children immunized but the discussion and interview to the parents revealed that they were quite ignorant of the need for such immunization. They do not come forward to get their children immunized. Neither do all of them follow the exact course of immunization reported the health workers. Left to themselves they would not get their children immunized. The concept of immunization and need for it is lacking.

Constraints of Acceptance of Modern Medicine

The present study, among the Oraons reveals multifarious and complex constraints related with regard to acceptance of modern medicine. It has been discussed earlier that the Oraons are accepting modern medicine but in a selective way, for example, they are accepting modern medicine more for diseases believed to be caused by natural forces or agents. Among the preventive measures antenatal care and immunization are being utilized more. At the same time there are diseases and illnesses where indigenous methods of treatments are given preference to modern medicine or treatment.

Socio-cultural constraint is considered to be one of the important constraints for adoption and acceptance of modern medicine and modern health care practices. Socio-cultural constraints include perception of disease and illness, notion of causative agents, e.g. faith in supernatural agents, witchcraft, religious beliefs, faith in rites and rituals, and attachment to traditional methods of healing and treatment. The tribals still hold the notion that most of the diseases are directly or indirectly caused by supernatural forces or agents, hence, accordingly traditional form of treatment are preferred to modern medicine and many a times they follow simultaneously both system of medicine side by side. The Oraons still attach a great value to traditional form of treatment-ritual and magical healing, herbal medicine and in no way it can be given up, they claimed. They strongly believe that existence of traditional medicine

men or healers were absolutely essential for the well being of their society and modern medicine can not replace it, though they do not deny the greater efficacy of modern medicine.

Economic constraint is another major obstacle for adopting modern health care practices since most medicines prescribed by the doctors at Rural Hospital were not available free of cost. Only the doctor's fee was free of cost. Except a very few cheap medicine, the rest were not available in the hospital. Other diagnostic facilities, such as blood test for malarial virus, kala-azar and sputum for tuberculosis, supposed to be done in the hospital free of cost but they are not done properly. X-Ray and ECG facilities are available but very poorly maintained and many a time do not function at all. ECG facility was not always available. Over crowding and long queues for check up at the out door clinic as well as waiting in queues in various diagnostic centers is common feature. Inadequate diagnostic facilities at the Rural Hospital forces the poor patients to get the medical tests to be done out side which prove to be very costly. Patients coming from very interior areas where no proper roads and communication facilities are available face great hardships. Non-availability of medicines and the problem of accessibility, in the absence of proper road for the people inhabiting in remote village was also a major constraining factor for adoption of modern health care practices. So the poor economic condition of the tribals leads to great dependency on their indigenous methods of treatment.

A common notion also prevails among the people that doctors in the hospital do not examine the patients with care. The Medical Officer of the hospital also admitted that overcrowding of patients was one of the main concerns. It was very difficult to manage a very large number of patients every day. There was shortage of medical personnel. Lack of inadequate infrastructural facilities was also a major problem.

Ill-equipped and poor infrastructure of the rural hospital was also a major concern for underutilization of health services provided from the hospital. Poor delivery system of health services also posed no less problems. Doctor- patient relationship was also reported as one of the constraining factors. It was a very

common notion among the people studied that the doctors in hospital neither examine the patients with care nor give treatment with care.

Besides socio-cultural constraint, economic constraint, inadequate provision of health services, the other very crucial constraining factors for adoption of modern health practices were illiteracy and ignorance. Illiteracy is very high among the Oraon tribes. Due to illiteracy and ignorance high degree of superstitious beliefs are found to prevail regarding causative factors of disease and illness. Though the Oraons accept modern medicine in a selective way yet the notion of modern medicine has failed to gain much ground in Oraon society.

The present research on the health care practices among the Oraons brings out some striking features. The study establishes the fact that contemporary indigenous medicine men or local healers continue to carry out various methods of treatment. The treatment given by local medicine men include combination of religious or spiritual healing and other forms of healing, besides herbal medicine, which had been in existence in Oraon society since generation. The role of traditional medicine men or local practitioners is considered very essential even today for the well being of their society. So the faith in village medicine men also considered to act as hindrance for accepting modern medicine.

In nut-shell major constraining factors for adoption of modern health practices include socio-cultural beliefs and practices, superstition, religious faith, inadequate provision of health facilities, of which non-availability of medicine free of cost is the important one, a very poor economic condition, illiteracy and ignorance are considered to be important constraints for adoption of modern health care practices among the Oraons under study.

After evaluating over all effect of modern medicine upon the Oraon community, it may give the impression that modern medicine has taken over the traditional or indigenous system of medicine among the Oraon tribal community. But this assumption is far from reality. The Oraon tribes are accepting modern medicine without any hesitation or suspicion but it does not mean that they have lost their traditional system of medicine and healthcare practices. The choice of medicine varies

according to the etiology of disease they conceive. They also decide the type of medicine which they think would be of greater efficacy and bring quick relief to the patient. So their traditional health care practices continue to persist.

Various socio-cultural and religious factors continue to be deciding factors for disease and illness etiology and their treatment. The influences of local healers, practitioners, or medicine men are considered to be very significant even in the modern time. Even in the age of transition and modernization the Oraon tribe believes in archaic forms of supernatural causes of diseases and illness, like evil eyes, sorcery, witchcraft, wrath of deities and gods, ancestral spirits and breach of taboo.

In fact the Oraons hold the perception that they can not completely do away with the traditional methods of treatment. They further expressed their view that both traditional and modern medicines were absolutely necessary because two dimensions of disease and illness exist: - one falls under the domain of traditional medicine men or practitioners, e.g. ailments or sufferings caused by witchcraft, other supernatural agents, cases of dog bites and snake bites etc., while the other area under modern medicine or the modern doctors. The present investigation has revealed that the Oraons have no doubt on the efficacy of modern medicine. They accept modern medicine more for diseases or ailments believed to be caused by natural agents.

The age old medicinal combinations and healing techniques; e.g. through incantations mantras, magico- religious rite and rituals etc. inherited from their forefathers still persist among the Oraons of Bamongola, in the district of Malda in West Bengal, even after their immigration from their original home land, Chota Nagpur, almost a century and half ago. At the same time they are also adopting modern medicines and modern health care practices but the progress is very slow.

CHAPTER – 5

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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.	

1. CIRRIGENDUM

A List of Typing Error/ Omission	A list of corrigendum in the text /reference to be read / referred as:	Page
Subhabrata(2001)	Dutta, Subhabrata (2001)	5
Troisi (1998)	1998 be ignored	5
Srivastava and Saksena (1991)	Srivastava and Saxena (1991)	6
Thakar (1997)	Thakur (1997)	7
Khare (1963)	Khare (1981)	10
Hasan (1965)	Hasan (1967)	10
Kakar(1977)	Kakar (1995)	10
Hitchcock and Johns (1976)	Hitchcock and Jones (1976)	11
Karuna and Babu (2007)	Kusuma and Babu (2007)	13
Pokarana (1991)	Pokarna (1991)	14
Thyagi (1997)	Tyagi (1997)	14
Sahu (1991)	Sahu (1991)	15
Krupuk	Kuruk	41
Orion	Oraon	130
Page 135 (Double insertion)	A sheet of page 135 be ignored	135
medine	medicine	193
Dalal, A.K. & Roy, S. (Ed.)	Dalal, A.K. & Ray,S. (Ed.)	193

2. CORRIGENDUM

A list of corrigendum in the reference to be read / referred as: **Page**

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* Omission included in the reference.

3. CORRIGENDUM

NAME OF DISEASES WITH LOCAL NAMES AND MEDICINAL HERBS / ITEMS(Page201-206)

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 (Cassia occidenfael* linn.),** roots of ***suli(*Nyctanthes *arbrtristis linn.)*** tree, ***golmarich*** (pepper/ Piper Nigrum Linn) roots of ***Bahera*** (Beheric myrobalem). ii)Roots of ***choi*** (Piper Chaba Hunter) ***Chirata*** (Swertia chirata) ***Amla*** (Embelica Officianalis) ***Bahera*** (Terminalia belerica).	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, Sadasimul(Ciba pentandra Linn)*** Ishwarmul (Aristolochia indica).	Ingredients of these three items is crushed to prepare medicine	- Taken daily, morning and evening.	
Kaula (Jaundice)	i) ***Halud*** (Curcuma longa), leaf of ***arhar*** (Cajanus indicus) and ***akher-gur*** (jaggery / Saccbarum officinarum linn). ii)***Cheng mach*** (A kind of small fish) and ***Arhar*** (Cajanus indicus). iii) Bark of mango tree (Mangifera indica). iv) *Talmishri(Suga candy 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) Taken 1 / 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*** **Datura metel. Linn).**, ***Ada*** (Gingiber officinale Rose) ***golmarich*** (Piper nigrum) ***akonda*** (Aalotropis 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 (Tuberculosis)	***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),***som /sona (*****Oroxylum indicum).**leaf,***Chirata*** (Swertia chirata)	Juice extracted from leaves / barks of theses plants/ 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) ***Bakos*** (Justicia gandrussa) ***pipal*** tree (Ficus religiosa)	i) Leaf of *bakos* tree (about100gm) and fruit of ***pipal*** tree are crushed to make a paste.	i) Orally taken	Given only t adults
	ii)***Lahsun(***Garlic/Allium sativum)	ii) Garlic about 100 gm) is fried in apprx. 250 gms of mustard oil	ii)Externally applied all over the body	
	iii)Grain of rice, ginger (Piper nigrum), **turmeric(Tarmarindus indica)** and dry chilli (Capsicum longa)	iii) Mixture of ginger, turmeric, chili and fried grain of rice crushed together	iii) Orally taken three times a day—morning, noon and night.	
	iv) ***Pata- sinduri*** **(Bixa orellana Linn)** , salt	iv) Sufficient amount of leaves of ***Pat sindur*** plant is steamed a bit to obtain juice and the juice is mixed with salt	iv) Orally taken once only in the morning.	
Sukna Kasi (Dry Cough)	i) **Tobacco (Nicotiana tobacum linn.)**leaf, ***golmarich*** (Piper nigrum)	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.	i) Orally taken 3/ 4 times a day about one spoon.	
	ii)***Gulancg(*****Tinotora cordifolia)** ***golmarich*** (Piper nigrum)	ii) Juice of ***gulanch***, black pepper and ***talmisri*** is boiled in about 100gms of water.	ii) 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 marmelos) ***Sutki fish***(dry fish) **ada** / *ginger* (zinbiber officinale) Orange (Citrus reticulata blanca),*bedona* (Punica granatum) *padda* (Hibicus mutabilis) 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.	i) 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*** (Acacia nilotica),guava tree(Psidium Guajava) bitter gourd (Momordica charantia) and ***Kalmegh*** (Androgrsaphiscs paniculata). ii)***Kul*** tree (Tizyphus jujuba) leaves of **patherkuchi** (Coleus aromaticus)	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(Tyzyphus jujube)* 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 prom grate and black pepper are mixed and 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),*sona*(Oxylum indicum)leaf, ***chirata***(Swertia chirata) i) ***Bakos*** (Juisticia gandrussa) ***pipal*** tree(Ficus religiosa) ii) Garlic (allium sativum) iii) Grain of rice, ginger (Piper nigurm),**turmeric**(Tarmarindus indica) and **chilli** (Capsicum annum). iv) ***Pata- sinduri*** (Bixa orellana) and salt.	Juice extracted from leaves/barks of theses plants/tree i) Leaf of *bakos* 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)**Tobacco** leaf Nicotina labucum linn),*golmarich*(Piper nigrum linn)) ii) ***Gulanch*** (Tinotora cordifolia),***golmarich*** (Piper nigrum)	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 *gulanch*, black pepper and *talmisri* is boiled in about 100gms of water.	-Orally taken about a spoon ¾ times a day. -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 the Sun), ***ada*** /ginger (Zinbiber officinale) orange (Citrus reticulate blanca***), bedona*** (pomegranate/ Punica granatum),paddahibicus mutabilis) ii) Mango tree (Mangifera Indica), ***jamun*** tree (Syzygium cumini), ***golmarich*** (Pipper nigrum), ***tulsi*** leal (Ocimum 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 t*usk* leaf is added to make syrup.	i) Orally taken a 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*** (Acacia nilotica),guava tree(Psidium guajava), bitter gourd(Momordica charantia) & ***Kalmegh*** (Androgrsaphis paniculata) ii) Leaves / Bark of ***kul*** tree (Tizyphus jujuba) and ***patharkuchi*** (Celeus aromaticus)	i) Tender fruit of banyan tree, guava, and bark of *babul* tree and *chrireta* 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 guajava) roots of ***kul*** tree (Tyzyphus jujube La.), black pepper (Piper nigrum).	ii) Tender guava fruit and roots of tyzyphus jujuba and pomegranate and black pepper are mixed and ground to prepare tablets.	Dose: One tablet taken three times.	

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Some photographs of medicinal herbs/plants/items used by the villagers of the study area:

Bahera (Terminalia belerica)
(Seed used to prepare medicine for fever)

Amla (Phyllanthus embelica)
(Used for preparing medicine for treatment of fever

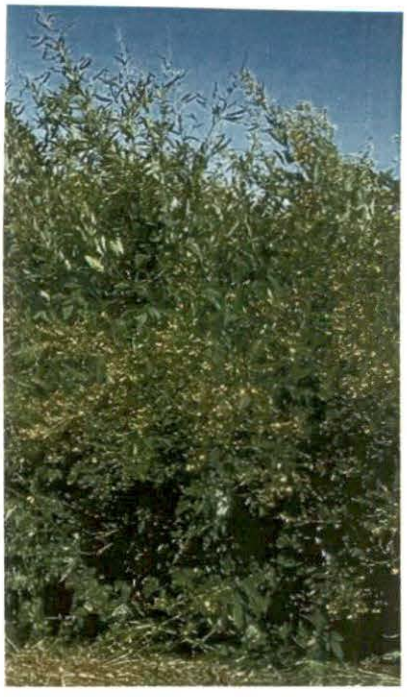
Kul /Bair (Ziziphus (zizyphus) jujube)
(Leaf forms one of the ingredients of medicine for treating Rakta Amasa).

Kalmegh (Andrographis paniculata)
(used in the treatment of blood dysentery and fever)

Guava (Psidium Guajava)
(Tender fruit used to treat white blood dysentery)

Tulsi (Osimum sanctum)
(used in the treatment of gastric, caugh and cold)

Ishwarmul(Aristolochia indica)
(used in the treatment of kala-azar)



Arhar (Cajanus indicus spreng)
(used in the treatment of jaundice)

Datura Innoxia, Datura suaveolens
(Juice extract of bark of is used as one of the ingredients for preparing medicine for treatment of Tuberculosis)

Jamun (*Syzygium cumini*)
Use as ingredient for preparing medicine for treating *sitoli* (paralysis)

Babul (Acacia nilotica (L.)
(Juice extract from bark used for treating dysentery)

Chirata (Swertia Chirata)
(It forms one of the very important Medicinal plants used for treatment of fever and typhoid)

Harbhabga
(Cissus quadrangularis, Vitis quadrangularis)
(One of the very common bone setter plants)

Oraon youth erecting a signboard of youth club.

Children working together with their father to pluck the paddy seedling for transplanting In village Mirjapur.

Some photographs of the villages of study area :

A view of Titpur village.

A view of two dilapidated houses in Mohunpur village.