

**THE CHANGING MEDICAL BEHAVIOUR OF THE TRIBAL
WORKERS OF TEA INDUSTRY : A STUDY OF MEDICAL
SOCIOLOGY IN SOME TEA PLANTATIONS OF THE TERAI
REGION OF WEST BENGAL**

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By

Shubhamanyu Chakravarty

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**DEPARTMENT OF SOCIOLOGY & SOCIAL ANTHROPOLOGY
UNIVERSITY OF NORTH BENGAL
Raja Rammohunpur, Darjeeling
INDIA**

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CHAPTER - I

INTRODUCTION

The term 'health' is a bi-polar conceptualization. It is opposed to 'disease' at the other pole. The term assumes a connotation in common parlance which refers to (desired) balanced state of body and mind. The World Health Organization has defined health as "A state of complete physical, mental and social well being and not merely the absence of disease or infirmity" (Lewis 1976:p.94). Health and disease are related to biological and cultural resources of a community in a specific environment. In simple as well as traditional societies health and disease, though biological are often culturally comprehended, because these have been connected with variations in socio-cultural circumstances and habit patterns. Authors have emphasized the need for scientific investigations of the impact of social and economic conditions of health and disease. Ackerknecht (1964) says that disease and its treatment are only in the abstract purely biological processes, but the fact that a person gets diseased and what kind of treatment he receives including diet and rest depend on social and cultural factors. Sociological knowledge, therefore, is imperative for the treatment and diagnosis of diseases (Behura, 1991).

Over the past few years, the social character of the phenomena connected with health and sickness is being increasingly

appreciated. Though throughout the history of mankind, attempts have been made to explain different aspects of medicine in terms of social variables, it is only since the past fifty years or so, that serious attempts are being made to systematically study the relation between the sub-culture of medicine and the wider society of which it is a part. The fact that every aspect of the sub-system of medicine is prone to influences from the wider social system is receiving greater attention.

Sociology is the study of human interaction, the social arrangement of human groups, and the latent and manifest consequences for the individuals and groups involved. Medicine is the application of technology and the knowledge to the prevention and amelioration of human damage and suffering.

The recognition of the complex relationship between social factors and the level of health has led to the development of Sociology of Health¹ as a substantive area within the general field of sociology. According to the Dictionary of Sociology, Medical Sociology covers a variety of topics: (1) the sociology of healing professions, (2) the sociology of illness, illness behaviour and help seeking behaviour, (3) medical institutions and health service organizations, (4) social factors in the

1. In the session of Medical Sociology in the World Congress in 1986 held in New Delhi, it has been decided upon to replace the term Medical Sociology/Medical Anthropology with Sociology of Health. Accordingly, in this study Sociology of Health has been used instead of Medical Sociology or Medical Anthropology wherever necessary.

aetiology of illness and disease; (5) social factors in fertility and mortality; (6) Social factors influencing the demand for and use of medical facilities; (7) the sociology of doctor patient interaction; (8) the social effects of different medical systems, such as between private and public provision of health care; (9) international patterns (Abercrombie, Hill and Turner, 1988: p238). The same Dictionary says that Sociology of Health and Illness is often preferred to the sociology of medicine and reflects theoretical interests of sociology rather than the professional interests of medicine. It has the following features:

- (1) It is critical of medical model and treats the concepts of health and illness as highly problematic and political;
- (2) it is concerned with the phenomenology of health and illness and gives a special attention to how patients experience and express their distress;
- (3) it has been significantly influenced by the concept of sick role but is also critical of ~~its~~ legacy;
- (4) it argues that modern societies have a residual conception of health, because the medical profession has been primarily concerned with illness;
- (5) it has been critical of the medicalisation of social problems.

Though the two have different orientations, in practice there is considerable overlapping between them.

Robert Strauss (1957:p200-204) has proposed two divisions of medical sociology, sociology in medicine and sociology of

medicine. The sociologist in medicine is a sociologist who collaborates with the physician in studying the social factors relevant to a particular health disorder. Some of their tasks are to analyse the etiology or causes of health disorders and differences of social attitudes as they relate to health and the way in which incidence and prevalence of a specific health disorder is related to such variables as age, sex, socio-economic status, racial group, identity, education and occupation. Such an identity is then intended to help health practitioners in treating health problems.

Sociology of medicine on the other hand has a different orientation. It deals with such factors as organization, role relationships, norms, values and beliefs of medical practitioners as forms of human behaviour. The emphasis is on the social process that occur in the medical setting and how this contributes to our understanding of medical sociology in particular and to our understanding of social life in general. The sociology of medicine share the same goal as all other areas of sociology.

While the development of modern medicine emphasized the biological and neglected the behavioral sciences, the development of sociology in turn originally spurned the influence of biological elements upon human social behaviour. Modern sociology developed largely in opposition to biological theories. Social behaviour must be explained from the standpoint of such social elements as norms, values and statuses that comprise the basis of human group life.

Sociology of health emerged as an area of sociological enquiry in its own right out of the realization that medical practice represented a distinct segment of society which has its own unique social institutions, social processes, occupations, problems and behavioural settings.

While the subject is a comparatively new development in India, it has made a considerable headway in the West. In 1955 it ranked sixth as an area of sociological research in the U.S.A. (Freeman and Reeder, 1957: pp73-81). In the latter period Hyman (1968) reported that the section of the subject was the largest speciality group in the American Sociological Association. The UNESCO's trend report and bibliography on the subject listed 622 published work in the field. Out of which only 4 or 5 studies were conducted in India (Freidson, 1961-62: 123-190). There is very little published research work in the field in India. A good deal is either unpublished or is in the process of being completed. But the bulk of the field remains untouched, including some aspects of vital importance for sociologists, medical scientists and policy makers. Some Indian scholars have collected materials on the field among the rural folk and tribes but the urban arena is completely neglected (Ahluwalia, 1974 : p402).

The subject has, of late, aroused considerable interest in non-sociological areas such as medical scientists and educators and agencies concerned with health programmes of governments.

Three important categories of persons have evinced a keen interest in the subject (a) sociologists themselves, (b) medical scientists and (c) health administrators (Ahluwalia, 1974 : p403).

The field of medicine is viewed by the sociologists in two main aspects, first, as a cultural complex, i.e., a complex of material objects, tools, techniques, knowledge, ideas and values and as a part of social structure and organisation i.e. a network of relations between groups, classes and categories of persons. Sociologists now realise that a knowledge of these two aspects of medicine, in itself and in relation to other fields of social life such as economy, religion, magic and law are becoming increasingly necessary for a comprehensive understanding of society (Ahluwalia, 1974 : p404).

In India there is immense heterogeneity of medical beliefs and practices and it is the main task of sociologists to explain this immense heterogeneity from the view point of sociology. A way of explaining would be in terms of the concepts of "spread", "sanskritization" and "parochialisation" used by Srinivas to explain that cultural items travel horizontally and vertically (Ahluwalia, 1974 : p404). This view has been supported by R.S. Khare (1963:pp36-40) in his work on village Gopalpur in Central Uttar Pradesh. Leslie (1967) too has proposed a similar approach. He focussed attention on the social settings and networks of communications within which health traditions are modified.

Sociologists and anthropologists have made interesting observations on the variety of medical systems made use of by the people of small communities. Marriot (1955) has observed that members of a small village or family hold highly varied medical beliefs and follow widely divergent practices. O'Lewis (1958) has observed that traditional views about disease exist side by side with modern germ theory. This reflects the villagers' willingness to try anything that may work.

Traditional systems of medicine may be viewed as systems of values, beliefs, knowledge, objects, tools and techniques on the one hand and the organization of roles, activities and relationships on the other. These systems should, therefore, be studied with reference to their distinctive notions regarding different aspects of disease, health, food, human anatomy, physiology etc., their important differences in the institutionalization of norms and expectations, in medical techniques and in procedures for making diagnoses and prognoses and their organization of persons, roles, groups and categories.

Studies of the relationships between these systems of medicine and other spheres of social life is vital in improving our knowledge of these systems and other spheres of social life and also to make the knowledge more meaningful and complete. Sociologists and social anthropologists have underlined the importance of such studies. O'Lewis (1958:p263) has stated that the advantage in learning about indigenous beliefs and practices

of the community is the insight it gives into the world view of the people. Concepts of disease and its causation are part of a society's total world view, which is reflected in other spheres such as, agriculture, politics and interpersonal relations. Some sociologists and social anthropologists have provided descriptive analysis of these aspects of the traditional system and relationship that may exist between these systems and other spheres of society. Fuchs (1964), has described how two types of medicine men "Janka" who works through divination and 'Barwa' who works by calling supernatural powers into aid practise their respective arts. These practitioners and the subjects among whom the art is practised have common faith in the methods used. Elwin (1955) has described the role of male and female Shamans among the hill Saoras of Orissa. The services of the Shamans are solicited in disease treatments, protection of crops and death ceremonies. The Shamans are the most important figures among the Saoras. Carstairs (1955) pointed out the importance attached to "confident prognosis" as an attribute of the role of the healer. Traditional medicine establishes faith and assurance in the patient. Modern Medicine lack this aura of conviction and has to justify itself dramatically and without delay. Marriot (1955) has also emphasized the cultural definition of medical roles. Trust, responsibility, charity, power, respect are important aspects of interpersonal relations in the medical sphere. It is the spiritual power gained by the healer, more than his skill that gives him prestige.

The most distinguishing characteristic of traditional medicine is the notions regarding disease causation. Herein one will find a close relationship between medicine and such aspects as religion, morality and magic. Elwin (1955) has noted the various gods believed to be associated with diseases by the Saoras. For example there are gods associated with childrens diseases cough, cold, blindness, madness, disease of pregnant woman, of animals and so on. Most of these diseases can be cured by supplicating and propitiating the respective god associated with the disease either directly or through Shamans. Opler (1963;p35) has listed a few, most commonly believed causes for various diseases they are, (1) malfunctioning and imbalance of three humours (doshas); (2) faulty diet; (3) lack of harmony with supernatural world; (4) activities of ghosts; (5) displeasure of deities; (6) imbalance of forces which control health; and (7) immoderation or inappropriate behaviour in physical, social and economic matters.

Among the tribals and other backward communities, there are a group of specialists, the priest and/or magicians or medicine men whose services are sought depending on the cause of illness. Thus, the priests worship the deities and when epidemics or diseases are there in the village, he offers a sacrifice at a sacred place. He is entrusted with benevolent deities. The malevolent deities are controlled by magicians, often through magical performances. While some of the tribal groups have priests, magicians and medicine men there are others wherein the priest acts as magician and medicine man . Dutta Choudhury and Ghosh (1984 : p.31) in their study of the Idu Mishmis have shown that in

that society the priest (Bamni) is the medicine man.

The nature of treatment is closely related to the cause of illness. Choudhuri (1986: p6) has noted that among the Mundas such a relationship exist. Similar observation has been made by Valunjar and Chaturvedi (1967). Religious rites occupy a prominent place in the treatment of diseases which are attributed to super-natural agencies.

Traditional medical systems are undergoing a process of interaction. These systems have incorporated and continue to incorporate elements from each other and also from the modern system of medicine. While some of the elements of the modern medicine are accepted others are rejected. This is of interest for the sociologists and anthropologists. They are interested in the diffusion of items of culture and the rationale behind the acceptance and rejection of these items. Hasan (1967) in his study of the villagers of Chinaura in Uttar Pradesh observed that the people have developed their preferences for certain methods of diagnosis and treatment of modern medicine for example, the people like to be examined by stethoscope and have faith in the curative values of injections. Such preferences have influenced the 'modus operandi' of the traditional medicine men. Marriot (1955 : p259) writes : "Villagers' fascination with the diagnostic and predictive powers of thermometres and stethoscopes has already forced many indigenous physicians to add these to their kits, even though they may understand very little about the actual use of such instruments".

Brilliant et al (1982) have observed that the villagers believe in modern concepts of pathology or epidemiology and also accept vaccination, but, supernatural explanation of smallpox and corresponding treatments exist. Gould (1965:p207) has made a similar observation. He says that indigenous practitioners have adopted the paraphernalia of modern medicine in order to intensify their psychological impact on their patients. Newman, Bhatia, Andrews and Murthy have, in their study of two areas of India, reported that the successful among the indigenous practitioners make widespread use of modern medicine frequently in combination with indigenous remedies. Leslie (1968) mentions that, in the centres of British administration some 'vaidis' and 'hakims' claimed superior status to indigenous practitioners by virtue of their acquaintance with European medicine. Khare (1981) has talked of ethical overlaps and differences between indigenous and Western medicine in village therapeutic system. Karna (1976: p56) mentions of both conventional and scientific categories of etiology of diseases being present among the villagers.

While on the one hand the spread of modern medicine has forced the practitioners of indigenous medicine to incorporate modern ideas, values and techniques, there is on the other hand a decline of the traditional medical systems. Kurien and Bhanu (1980 : p74) have observed that with the spread of modern medicine the indigenous medicine of the Vaidus are on the decline. They write, "The medical profession today is regarded as one of the

most important professions enjoying a high social status. Till recently the Vaidus also enjoyed this elated ascribed status among the rural friends. However, with the explosion of knowledge during the 20th century and the establishment of mobile health units, primary health centres, government hospitals and dispensaries and clinics the present status of the Vaidus and their folk medicine are on the decline and may even disappear".

Inspite of the fact that modern medicine has made its presence felt very much in the backward areas of our country and has influenced the health culture of societies one shall find persistence of traditional medicine. Mital (1979) reported that among the Santhals there is a strong aversion towards modern medicine. Modern medicine is viewed with suspicion. Bang (1973: pp 83-91) has observed that the people still believe in traditional concepts of smallpox and traditional methods of cure. They are opposed to vaccination. Mathur (1982) has reported strong influence of supernaturalism in the health culture of the tribals of North Wynad (Kerala). Gupta (1986: p161) opines that the tribal communities are guided by traditionally laid down customs. The faith of an individual and the society at large depends on their relation with unseen forces. Guha (1986), in her study of the Boro-Kacharis has observed influence of supernaturalism in etiology of disease and according treatments. She also observed the recognition of physical factors as to cause diseases. Joshi (1988: p78) mentions of division of the etiological world into supernatural

and natural among the Khos. Dash (1986 : p212) has reported that the Parjas believe in gods, goddesses, spirit intrusion, sorcery, evil eye and breach of taboo as to be responsible for all diseases except for a few diseases as cold, cough and headache.

In view of the tremendous strides of development of modern medicine and the all out effort by the government to reach the remotest areas this phenomenon seems unusual. How can it be explained? What are the factors responsible?

It is often alleged that there is present among the tribals and other backward communities an urge to preserve their traditional customs which is responsible for the non-acceptance of modern medicine. The ideas of modern medicine are often in clash with those of the traditional medicine. This has led to either passive rejection or violent upsurge. But this does not seem to hold good as an explanation for the persistence of traditional medicinal culture if viewed against the studies by Hasan (1967), Marriot (1955), Gould (1965), Leslie (1968) and Lewis (1958) all of which have shown that there has been acceptance of modern medicine. These studies have made another point clear that the people are not averse towards modern medicine. If then, conservatism is not a factor responsible for the persistence of traditional medicine and the consequent rejection of modern medicine, then what are the possible factors responsible?

Availability of modern medical facilities, structural facilities of the primary health centres, the failure of modern medicine to accommodate with the social milieu and the policy making have been pointed out by scholars as to be responsible for the acceptance of modern medicine.

The fact that availability of modern medicine is a factor in determining the acceptance of modern medical values and practices can be judged from the studies of Sahu (1980), Bhatnagar (1989) and Srinivasan (1987). Sahu (1980) in his study of the Oraons in two villages one with a Primary Health Centre and the other without any modern medical facilities has observed that the Oraons in the former village resort to modern medical treatment while those in latter village continue with their traditional methods of treatment which they are forced due to lack of modern medical facilities. The observation throws light on the facts that provided with modern medical facilities a population gradually gets inclined towards them and lack of modern medical facilities is a factor responsible for the persistence of traditional health practices.

Bhatnagar (1989) in his study of three villages in the Patiala district of Punjab State observed, that inaccessibility to centres of medical facilities, improper care, non availability of medicine, lack of education and exposure to outside world as factors which are responsible for the non utilization of the Primary Health Centres.

Srinivasan (1987: p30) has observed that one of the reasons why the health care delivery system in our villages has not been able to strike root is the inaccessibility to services by the majority of the population, specially women and children who cannot avail them due to transport and communication problems and time constraints. Location of Primary Health Centres therefore, is a vital factor.

Structural facilities have a direct relationship with the utilization of the Primary Health Centres. Inadequate structural facilities to a very great extent explain the under utilization of the Primary Health Centres in the backward areas. Klass Van Der Veen (1981) has pointed out that structural facilities of the Primary Health Centres in the country sides explain their under utilization, but he added that it is not the sole factor responsible.

One of the important factors pointed out by scholars to be responsible for the failure of modern medical practitioners in the country sides is their failure to take into consideration the traditional social structure. Klass Van Der Veen (1981) and Carstairs (1977, 1983) have such a view. They have mentioned of a clash of concepts and ideals of modern and traditional medicine. The authors have stressed the need for understanding the social milieu by the practitioners of modern medicine.

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The health policy adopted by the Government of India in the early post-independence period has been considered by scholars to be a reason for the failure of modern medicine in the rural sector. It has been alleged that the health policy was directed towards the urban upper class of the society. The rural masses received scant attention from the policy makers due to their prejudices in respect to the rural masses. Banerjee (1977:p352) writes: "The colonels did not appear to relish the prospects of dirtying their hands by getting involved in the problems which required mobilization of vast masses of people living in rural areas. The rural population raised in the minds of the decision makers the spectre of difficult accessibility, dirt, dust and superstitions".

It is also alleged that the national leaders were committed to building an egalitarian society and espousing such values as right to work, to health to special care for the weaker sections and to free and compulsory education to all children upto the age of fourteen but they were not prepared to bring about the necessary socio-political and administrative changes (Banerjee 1977 : pp350-351).

Moreover, the national leaders were alienated from the masses, they nursed westernised values, they lacked competence and were reluctant to come in grip with the urgent social problems. These along with pressures from vested interest groups induced them to westernized nations. The appeal of western conceptual

approach is fitted more to develop nations rather than developing nations like ours (Myrdal, 1968 : p20).

Added to these, the medical personnel were trained in colonial traditions and were not competent in meeting the emerging needs. Devotion to work was lacking.

Sanitation and personal hygiene have a direct or indirect relation to health. There are many diseases associated with improper sanitation and unhygienic practices. Lack of clean water supply, inefficient drainage, absence of awareness regarding animal borne diseases, unhygienic housing, improper defecation habits, unhygienic practices relating to teeth cleaning and other bodily cleanliness are responsible for many diseases. Rizvi (1986: pp222-229) has observed these factors to be responsible for many diseases those occur among the Jausaris. Kocher and others (1976: pp287-306) have observed defecation habits as a direct factors in hookworm infection. Choudhury et.al (1986 :p. 129) has attributed malaria to the unhygienic conditions in which the tribals of Purulia district of West Bengal live.

The level of sanitation and personal hygiene are believed to be very low among the rural and tribal folk. Dutta Choudhury and Ghosh (1984) in their study of the Idu Mishmis of Arunachal Pradesh have noticed a low level of sanitation and hygiene.

Hasan (1979), Rizvi (1986) and Basu (1990 : p22) have made similar observations on the societies they have studied. But against these observations there are those made by Bagchi and Ghosh (1987) and Guha (1990 : p215) all of which depict signs of hygienic behaviour among the tribal folk.

Intoxication and smoking also have strong bearing on health. Indulgences in such pleasures as cigarette smoking or alcohol have for long been known to influence health.

Food habits too have a strong bearing on health. The quality of food and also the quantity consumed determines directly the nutritional level of a community and thus the health status. Many diseases are directly connected with the level of nutrition.

The Problem of the study

In West Bengal the tea plantations are concentrated in the North Bengal districts of Darjeeling, Jalpaiguri, Cooch Behar and West Dinajpur², with Darjeeling having 147, Jalpaiguri having 187 and Cooch Behar and West Dinajpur² having one each tea plantation.

2. West Dinajpur is now divided into two North Dinajpur and South Dinajpur. The tea plantation falls in North Dinajpur.

The cultivation of tea in Darjeeling started long back before the formation of Darjeeling district. Its expansion was associated with the migration of a large number of tribal labourers to this district. Labour has a vital role in the tea industry. As such the tea industry is labour intensive. Assam was the first area in India to come under tea. From the very beginning of the industry there, shortage of labour was felt. Local peasants were not willing to work in the tea plantations. Moreover, epidemic and wars also contributed to the shortage of manpower. The sole source of local labour was the Kacharis of Darrang and small proportion of people^{of} adjacent areas. This only fulfilled marginal necessity. The Government tried forceful measures to draw local peasants to work on the plantations but failed. This made the authorities to think of recruiting labourers from outside and in 1853 recruitment of labourers from outside the state got underway. States like Bihar, Bengal, Uttar Pradesh, Orissa and Madhya Pradesh were the main suppliers of labour. The immigrant labourers belonged to the tribal communities like Santhal, Munda, Oraon, Khasi, Gond, Nagesia and Kisan (Roy Burman, 1968). The Chota Nagpur region of Bihar proved the bulk supplier of such labourers. This region is the homeland of the Oraon and Munda tribes. The tribes migrated as they were suffering from alienation from land. Non-tribal peasants, traders and money lenders who penetrated into tribal lands with the opening up of roads and communications cheated the tribals of their lands. Being eliminated from land and surmounted by indebtedness these hapless tribals were looking for

an outlet which they found in the form of work in the tea plantations.

Alike Assam, the opening up of the tea industry in Terai and Doars (Jalpaiguri), drew tribals to work as tea garden labourers from Bihar, Orissa and Madhya Pradesh. The state of turmoil in tribal society in Bihar was, as stated before, responsible for the migration of the tribals. There was large scale immigration to Jalpaiguri district in the period 1891 to 1941. The migration statement puts the total number of immigrants from Ranchi alone at 80,436. Santhal Parganas accounted for 10,562 immigrants. The Terai region of the district of Darjeeling too experienced heavy migration with the introduction of tea industry in the region. The Darjeeling hill areas did not experience tribal migration from Indian States as it did not have labour shortage. Cheap labour was obtained from Nepal.

It is evident from the above that bulk of the labour force in the tea plantations comprises of tribals who in quest of livelihood have immigrated to the plantations.

The migrated tribal population has landed up in an environment completely different from that of their native. Studies in migration has shown that a migrant population always accommodates itself to the new social and cultural milieu. In the process there is often a change in customs, tradition, norms and values. In short, the cultural patterns of which health forms an integral part changes.

Traditionally tribals believe in supernaturalism which pervades every aspect of their life. Belief in spirits, gods and goddesses is rampant. In the realm of health and disease, spirit, god, goddess, witchcraft and sorcery dominates and these in turn brings dominance of magico-religious and herbal treatments, metted out by traditional medicine men. Every tribal society has its own medicine man.

The belief in traditional ideas, customs are said to perpetuate in the absence of literacy and contact with new ideas and customs. The migrant tribal workers were illiterate and had little contact with the outside world in their native which otherwise would have helped in incorporation of new ideas and behaviour.

The migration to tea plantations provided circumstances both favourable and unfavourable for the continuity of traditional practices. In the case of dispersed migration wherein not many persons of a community settled in one place continuation of traditional practices becomes difficult. The case of the plantation workers was not so. They migrated in bulk and settled in one place together. This, therefore, was a factor conducive to carrying on traditional practices. Moreover, in the early stages of the growth of tea plantations there was little medical facilities available to the workers either in the form of plantation owned health unit or any alternative sources forcing them to rely on traditional ways of countering diseases. Added to these the isolated state in which

the workers were kept was very much conducive to continuity of original practices. It needs mention that prior to 1951 it was not compulsory for plantations to provide health facilities to workers. Some plantations during that period did provide health benefits but most of the plantations did not.

In 1951, the Plantation Labour Act was formulated according to which plantations should provide to their workers and maintain so as to be readily available such medical facilities for their workers and their families as may be prescribed by the State Government. Further, every plantation should have effective arrangements to provide and maintain at convenient places sufficient supply of wholesome drinking water for all workers and sufficient number of urinals and latrines of prescribed types.

The provision of facilities made by the PLA 1951 have made it compulsory for plantation to have a health unit to provide modern health facilities. This is likely to bring in change in the behavioural pattern of the people in terms of health.

It has been often alleged that there is a tendency among the tribals and the rural folk not to do away with their traditional customs and practices. Scholars like Mital (1979), Guha (1986) and Das (1986) have in their studies shown strong inclination of the tribals towards their traditional health customs and practices.

But this contention of strong inclination towards traditionalism does not seem convincing as a reason for non-acceptance of

modern health practices. Studies have shown that it is not this tendency which is solely responsible for the rejection of modern health concepts and practices. Sahu (1989) in his studies of the Oraons conducted from a comparative perspective taking into consideration two settings one with facilities of health and the other without facilities of health has observed that if provided with facilities the tribals are prepared to accept them. Reference may also be drawn of the studies by Marriot (1955), Gould (1965), Leslie (1968) and Carstairs (1977) also, all of which prove the point of acceptance of modern medicine among the rural and tribal folks.

The development of means of transport and communication have brought the remotest areas of our country in contact with the outside world. This has resulted in people coming in contact with new ideas and practices. This further, makes the argument of inclination of the tribal workers towards traditionalism and resultant non acceptance of modern medicine weak.

This brings us to the question as to what is the situation among the tribal tea garden workers. Are they changing in the environment with modern medical facilities?

Though the Plantation Labour Act (PLA) has made it compulsory for plantations to have medical facilities as prescribed

by the State Governments and also sanitation and drinking water facilities, most of the plantations do not maintain the standards. Kar (1990 : p34) reported that in Assam most of the plantations do not have satisfactory facilities. The situation in Terai is the same. Most of the plantation have health units just for the sake of it. Some even do not have the services of a resident doctor. Sanitation and drinking water facilities too are unsatisfactory.

With all these in mind, two types of tea plantations, one with better medical facilities and the other with minimum facilities of health have been taken to make a comparative analysis of the tribal people in terms of health. It may be mentioned that the plantations taken for the study are in varying degrees distant from the township of Siliguri and semi-urban agglomerations of Bagdogra and Bidhannagar and also from alternative sources of modern health facilities.

Food is a basic need of man and the type of food consumed and the quality as well as quantity of them have a direct relation to the health status of a community. The tribals have been reported to suffer from severe malnutrition which renders them suffering from various nutritional deficiency diseases. Their malnutrition is a direct result of their poverty. Their traditional food habits have also been reported to carry very less nutritive values.

The immigrant tribal labourers to the tea plantations find themselves in a new environment in terms of economy, flora and fauna. These along with contact with the outside world and other communities are likely to bring about changes in the food habits nutritional status and ultimately health status. Food habits, therefore, is an interesting and essential part of health culture which deserves investigation. However, this aspect does not require a comparative analysis.

Objectives of the Study

While dealing with the problems of the study it has been stated that the labour shortage faced by the tea industry in the early period of its development in Assam, Doars and Terai of West Bengal resulted in importation of tribal labourers from outside mainly from the States of Bihar, Orissa and Madhya Pradesh. The bulk of the imported labour force was from Bihar and comprised mostly of Oraons and Mundas. The state of turmoil in the form of alienation from land and the resultant poverty in their native land facilitated the migration.

These tribals, as have been discussed earlier, have their own culture of which health is a part. Every facet of tribal life is dominated by supernaturalism. Diseases are attributed to the malign of spirits, gods, goddesses and the handiwork of witches and to counter them there are traditional medicine men in every society who work through magico-religious methods and herbal treatments. The lack of modern medical facilities in their native land ^{and} little

~~and~~ communication with the outside world facilitated the persistence of these beliefs and practices. Moreover, the concepts of hygiene, sanitation and nutrition and their level is not of very high order.

The migration to tea plantations had put the tribals in a situation both favourable and unfavourable for continuation of their traditional customs. The bulk migration of the tribals resulted in the formation of a homogenous society which was conducive to practice of their traditional customs. Their state of illiteracy and isolation from outside world in which they were kept also facilitated the continuation of traditionalism. Moreover, prior to 1951 it was not compulsory for plantations to provide modern health facilities and most gardens did not provide any health facilities to their workers. This perhaps was the most vital condition for the prevalence of traditionalism.

Though it has often been alleged that there is a tendency among tribals and rural folks not to accept new ideas, customs and practices and they generally continue with their traditional ones. Studies have shown that this is not always true. There are reports of acceptance of modern medical practices. Studies have revealed that if provided with facilities they are ready to shed their old practices for new ones. Sahu (1989), in his study showed acceptance of modern medical facilities by the Oraons. Bhatnagar (1989) and Srinivasan (1987) have shown that where there is availability of modern medical facilities there is acceptance.

Reference may also be drawn of studies by Marriot (1955), Gould (1965), Leslie (1968) and O'Lewis (1958).

The year 1951 saw the formulation of the Plantation Labour Act which made it compulsory for every plantation to maintain a health unit according to standards prescribed by the State Governments and also provide for sanitation facilities. Most of the the plantations it is reported, fail to maintain such facilities. Kar (1990 : p34) reported that in Assam most the plantations do not comply with the directives. The situation is not better in the Terai of West Bengal. Most of the plantations maintain a health unit just for the sake of it.

Food is a basic need of man. The quality and quantity of food consumed determined the nutritional level of an individual and therefore food has a direct relation to causation of diseases. The food habit of a community is determined by the physical environment fauna and flora of the region and contact with other communities. Over and above nature of food taken by a community has relation with its culture, and as such food is determined largely by the cultural habits of the community.

Keeping these in mind the present study seeks to find out the changes those have occurred in the health culture³ of the

3. By 'health culture' is meant all the concepts, ideas, customs, habits and practices related to countering diseases and maintaining health.

tribal tea garden workers as a result of migration to an environment which is new. In doing so the emphasis would be on the interaction between modern concepts of health and disease, modern medical systems and traditional concepts of health and disease and traditional medical systems. The investigation has been done from a comparative perspective taking into consideration two types of plantations one with better facilities of health and the other with minimum facilities of health.

It has been stated before that each tribal community has its own concepts, ideas, customs and practices in relation to health and diseases. Tea plantations provide the migrant tribal population with modern medical facilities minimum or better. Moreover, alternative sources of modern medical treatments may be available to the population. In this context there emerges a choice situation as to which system of treatment a person would choose in treating diseases. A person may adopt one medical system while ignoring the other. Factors like economic soundness of an individual, perceived effectiveness of a system of medicine, literacy and conservatism effect the decision making. Therefore, the choice of medical systems and the factors influencing it is the first objective of the study.

Concepts of diseases and etiology vary from community to community. They change in contact with new ideas. The presence of modern medicine may affect and change the traditional concepts

of the people and hence, the prevailing concepts of diseases and etiology and their analysis is another objective of the study. The prevailing concepts will throw light on the degree of penetration of modern medical ideas and concepts.

Each region has some diseases peculiar to it and each occupation has certain diseases directly or indirectly associated to it. It becomes, therefore, essential to investigate into the diseases prevalent among the people.

There has been allegation of under utilization of modern health facilities in the rural and tribal areas. The structural facilities of the health centres, accessibility to them, the quality of care disbursed and the tendency to cling to traditional customs have been cited as reasons for the occurrence of such phenomenon. A direct consequence of the under-utilization of the health centres is the prevalence of traditionalism in health practices. Consequently it becomes imperative to seek into the level of utilization of the health units of the plantations and the alternative sources of modern medicine. This would bring out the impact of traditionalism in the treatment of diseases. Also will be investigated the constraints in utilization.

Family Planning and its methods are believed to have very little impact on the life of the tribals. They are said to be resistant to the idea of family planning and its methods of practice. It should not be, however, taken for granted that the

tribals do not have any mechanisms for avoiding birth. There are indigenous methods like herbal contraceptives. What needs investigation is the awareness as to the concepts of family planning, their attitude towards it the methods used for prevention of birth and the degree of acceptance of modern methods of birth control.

Health of a mother is important in having a healthy child. It is essential that a mother during pregnancy gets nourishment to the required level. The tribals have been reported to be ignorant of the fact and take very little care and precaution during pregnancy. The care taken for a pregnant mother, therefore, is ~~an~~ important to be investigated.

Child health reflects and determines the human conditions. Improper child care has led to high level of infant mortality among the tribals. Therefore, the methods of child care adopted by the tribal workers needs to be looked into.

Delivery of child and post natal care are two issues related to mother and child care. It is reported the delivery cases are mostly attended by untrained midwives and the tribals usually avoid hospitals. Post natal care of both mother and child is also reported to be unscientific and improper. These two aspects need investigation.

Immunization campaigns, it is reported, have not gained the expected success in the tribal areas. The ~~suspicion~~ of the

people due to lack of clear conception of the thing has been cited as the reason. This fact has to be verified. In doing so the attitude of the people immunization and their level of acceptance have to be investigated.

The level of sanitation and personal hygiene has been reported to be at a all time low among the tribals. The two aspects have a direct bearing on health. The investigation into these two aspects therefore is essential to judge the health modernity of the people.

Alike sanitation and personal hygiene, intoxication and indulgence in narcotics have direct and indirect effect on health. Intoxication is reported to be high among the tribals. This phenomenon hence, has to be investigated. The awareness as to the bad effects of intoxication and narcotics and the degree of consumption are the information to be gathered in the process.

Food habits and the quality of food determines the nutritional level and thus the occurrence of many diseases. The level of nutrition among the tribals is very low and, therefore, an investigation into food habits is imperative. Points like amount of food and types of food consumed daily, the number of times food taken daily and the awareness regarding nutrition are to be covered in the process.

To sum up, the methods of treatment adopted and the reasons behind them, the concepts of diseases and etiology, the diseases those occur in the population, the level of utilization of modern medical facilities and the constraints involved in it, family planning and its acceptance, mother and child care practices and the concepts involved, immunization facilities and the acceptance of them sanitation and personal hygiene, intoxication and indulgence in narcotics and food habits and nutrition are the salient aspects to be investigated in the study.

Methodology

The selection of field has important bearings on the generalizations of results of life and culture. A researcher selects his field according to suitability of his particular enquiry and several other factors. Tea plantations for this study were selected within a radius of 25 kilometers from the township of Siliguri keeping in mind the nature of facilities available at the health units of the plantations and nearness to the town and other semi-urban agglomerations with alternative sources of modern health facilities. Based on these criteria three plantations, two with better facilities of health, namely, Hansqua and Taipoo tea estates and one with minimum facilities of health, namely, Matigara tea estate have been selected. Hansqua tea plantation is 20 kilometers from the township of Siliguri and 7 kilometers from the semi-urban agglomeration of Bagdogra.

The Taipoo tea estate is 19 kilometers and 6 kilometers from the township of Siliguri and the semi-urban setting of Bagdogra respectively. The Matigara tea estate (which has two parts the eastern and western) has its eastern part 6 kilometers away from the Siliguri and 7 kilometers from Bagdogra. The western part of the plantation is 8 kilometers from Siliguri and 5 kilometers from Bagdogra. The Matigara tea estate is also located about 4 kilometers away from the North Bengal Medical College and Hospitals.

The various plantations were visited to gauge the quality of health services disbursed and to obtain permission. While from some managements the response was positive from others there was either denial or ambivalence. However, the above three plantations were selected from the study keeping in mind the various factors already discussed.

Several methods are used in sociological and anthropological investigations. Household census, observation, interview, questionnaires, case study, geneological method, bibliographical method, projective techniques, sociometric procedures, attitude scales and the available materials are to mention a few of them. For the present study, household census, structured schedule, observation and case study have been made use of.

Household census was taken at the initial stage of the survey to obtain primary information like the population figure, ethnic composition of the population, age and sex composition,

migration, occupation and a primary view on the method of treatment resorted to in disease treatment. Household census has been taken from all the families of the said plantations.

There are several types of information which a researcher cannot obtain through observation. For example if one wishes to know the behaviour of people in the event of an epidemic he will have to wait for one. The event may not coincide with the researcher's stay on the field. The best way of collecting such information is through interviews. For this study this method has been made use of extensively. The head of each family of the tribes considered for the study in the three plantations has been interviewed with the help of interview schedule containing structured questions. Moreover, special interviews have been taken of the staff of the health units of the three plantations and the traditional medicine men of the locality. The interview schedule contained questions covering aspects like diseases, etiology of diseases, treatments resorted to, the reasons for resorting to a particular type of treatment, utilization of modern health facilities, constraints involved in doing so, family planning and its practices among the people, mother and child care, immunization, sanitation, personal hygiene, intoxication and narcotics and food habits.

The interviews of the medical practitioners were focussed mainly on the interaction between traditional and modern systems of medicine.

Observation of two categories participant and simple observation are made use of by researchers. For this study the latter type has been made use of.

The last type of method used in the study is the case study method. Families wherein a member is suffering or have suffered from **disease** in the recent past were contacted with the help of records available at the health units or from information from the people. The patient if he or she is an adult or the head of the family if the patient is a minor have been interviewed for information ranging from treatments adopted, etiology of **diseases** and the problems faced in adopting methods of treatments.

Not all tribes residing in the plantations have been taken for the study. Eight tribes, selected on the basis of their numerical strength have been considered. Results of the numerically insignificant tribes may not be significant and thus have not been considered. All the households of the numerically dominant tribes have been covered under the interview. No sampling was done as the total number of households of the major tribes were 425 in the three plantations.

CHAPTER II

TEA GARDENS AND THEIR POPULATION IN NORTH EAST INDIA : A HISTORICAL PERSPECTIVE

Growth of the Industry

The Tea districts of North East India may be divided into five district regions, viz. (1) Brahmaputra Valley, (2) Barak Valley, (3) Darjeeling, (4) Dooars and Terai and (5) Tripura (Das, 1990).

The Development of tea industry in India was closely linked with the growth of the Western market for tea, and the colonial era in the East which encouraged, and in fact supported the tea plantations with foreign enterprise. Tea of international commerce grown outside of China, USSR and Japan had its origin in Upper Assam.

The tea plant was discovered growing wild in Assam in 1821 (Dash 1947, p113; Ghosh, 1987:p8). There was a bitter controversy as to who made the botanical discovery of tea for the first time. The two contestants were C.A. Bruce and Lieutenant Charlton. Griffiths gave his verdict in favour of the former. The first experimental cultivation of tea in India was undertaken by the British Government in India in 1834 (Edgar, J.W., 1873; Cited in Ghosh, 1987 : p8). Lord William Bentinck appointed the Tea Committee on February 1, 1834 with James Gordon of the firm of Mackintosh and Company as its Secretary. In 1832 Captain F. Jenkins,

an official, was deputed to report on the economic potentialities of Assam. Jenkins and his assistant Lieutenant Charlton sent some seeds and leaves of the tea plant in Assam and at last on 24 December, 1834, the tea committee reported to the Government about the indigenous tea plant of Assam and the possibility of its commercial success (Ghosh 1987 : p9). After being sure that tea could be grown in India the experts started exploring the sites for experimentation. The experts were divided on this issue. Some selected north western India, others the eastern area, while some favoured southern India. The Government wisely decided to try all the areas. The Sub-Himalayan areas were reasonably successful but it was in Assam that the most successful result was obtained. In the south the experiments were generally unsuccessful (Ghosh, 1987 : pp9-10).

In 1835 the Government of Assam started its first experimental plantation in Lakimpur (Ghosh, 1987 : p10; copy of the papers Received from India Related to the Measures Adopted for Introducing the Cultivation of the Tea Plant Within the British Possession in India, 1839). But the experiment failed. The plants were thereafter removed to Jaipur in Sibsagar district of Assam where a garden was established. The garden was later sold to the Assam Tea Company which was a private enterprise formed in 1839. The Company formed entirely with Private Britishers which was the first Tea Company in India, and is still one of the biggest.

There was a supposition that tea would not thrive in lower Assam. In 1854 cultivation of tea commenced in Kamroop Division where in 1859, 12,207 acres of land were granted for tea cultivation of which 297 acres were brought under tea. A good deal of tea grown in Kamroop had hitherto been planted in the low hills around Gauhati (Bengal Military Orphan Press, 1861).

In the Lakhimpur Division of lower Assam where the cultivation of tea plant was first undertaken in 1835, a few indigenous plants, taken from the forest at "Ningroo" bordering "Singphoe", were put down on a strip of land at the "Koondil Mukh" at Suddujah. But the effort to grow tea there did not succeed. The plants were removed to Jaipore in Sibsagar Division where cultivation continued steadfastly till 1840. During this time the Government in view to promote enterprise and development of tea as a resource transferred two thirds of its tea establishment to the Assam Tea Company. The Government Operations after this were confined to a plantation at Muttock, on a spot where much indigenous tea had been discovered. The soil here was peculiarly favourable to the growth of the plant. The Government garden in the locality continued from 1840 to 1848 after which it was sold in April 1849 to a Chinaman named Among, as the affair proved unprofitable. But the Chinaman could make little of it and in 1851 the garden changed hands. It became the property of Messers

Warren Jenkins and Co. The period mentioned was one of depression as to the manufacture of tea. The works of the Assam Tea Company, as far as their operations in the district were concerned, were all but suspended. In 1852 a favourable turn took place which has since opened a prospect of wealth and prosperity for the district. Colonel Hanney who had a small garden close to Dibrugarh raised Cotton, sugarcane, tea, etc for experimental purposes. Having being successful in his experiment with the plantation of small patch of China tea, increased his cultivation area to about 10 acres. At the same time Messers Warren and Jenkins formed the Meejan Tea Barree, now a flourishing plantation. Following the examples first set by Colonel Hanney, an impetus was given to the extension of tea cultivation which led to tea in Lakhimpur inviting the attention of capitalists and to its promising fair to render the district as one of the most important division of Assam (Ghosh, 1987 : pp15-16). The total land taken up for tea cultivation for this division was 14,038 acres, the quantity of land cultivated from 1852 to 1859 was 1,700 acres. The total tea manufacture increased from 92,000 lb in 1852 to 282,000 lb in 1859 (Ghosh, 1987 : p 16). At present, there are approximately 725 gardens in Assam. In 1952 the number of gardens were 787. It increased to 789 in 1953 but decreased to 788 in 1954 and remained so till 1956. The year 1957 experienced an increase to 791, but the succeeding year experienced a decrease after which there had been a steady increase from 789 in 1959 to 799 in 1960. The number decreased to 744 in 1961 only to increase again to 746 in 1962-1963,

747 in 1964-65 and 765 in 1966. After 1966 there had been a decrease. The number was 755 in 1967 and 753 in 1969 (Tea Statistics 1966-67; 1969-70).

In West Bengal the tea gardens are exclusively in the North Bengal districts, 147 in Darjeeling, 187 in Jalpaiguri and one each in Cooch Behar and West Dinajpur districts (Ghosh, 1987 : p 3).

Before going into the development of tea in Darjeeling district it will not be out of the way to have a brief view on the early history and growth of the district. The whole of the Darjeeling district was part of the Dominion of the Raja of Sikkim. What is at present Kalimpong sub-division, was forcibly occupied by Bhutan in the year 1706. In 1780 the Gurkhas of Nepal invaded Sikkim and occupied the remaining areas of the district including Terai (Ghosh, 1987 : p 18).

In the beginning of the nineteenth century war broke out between the East India Company and the Nepalese. At the end of the war with the treaty of Titaliya in 1816 (now in Bangladesh) the entire area wrested by the Nepalese from the Raja of Sikkim was ceded to the East India Company which restored the entire area to Sikkim and guaranteed sovereignty (Ghosh, 1987 : p 18).

At the time of Lord William Bentinck, Governor General of India, it was reported to him that the small village of Darjeeling

could be developed as a sanatorium besides being utilized as a key military station. The proposal was initiated and was passed by the Directors of East India Company. On 1 February, 1835 an unconditional Cession of Darjeeling area to the East India Company was made by the Raja of Sikkim. The Company granted the Raja an allowance of Rupees 3,000 per annum as compensation in lieu which was raised to Rupees 6,000 per annum. During the Cession, the Darjeeling hill tract had a population of not more than 100 (Ghosh, 1987 : p 18).

In 1849, Dr Hooker along with Dr. Campbell, the Superintendent of Darjeeling with the sanction of the British Government and the permission of the Raja of Sikkim crossed the frontier into the State where they were seized and imprisoned by the authority of the Raja's diwan or minister. In February 1850, a punitive force was sent by the British Government. The grant of Rs. 6,000 was withdrawn and the remaining hill area and the Terai were annexed. There was break out of trouble in 1861 due to a military expedition. It ended with a treaty on March 28, 1861 between the British Government and the Raja of Sikkim which put an end to all frontier troubles. Freedom of commerce across the Sikkim frontier for British subjects was secured (Ghosh, 1987 : p 19).

Frontier trouble with Bhutan started around 1862. After various military expeditions a treaty was signed between Bhutan

and British India in 1865. Under the treaty Kalimpong sub-division and Bhutan Dooars (now parts of Jalpaiguri district and Assam) were ceded to the British in return for subsidy (Ghosh, 1987 : p 19). The Kalimpong area was first notified as a Sub-Division under the Western Dooars but in 1866 it was transferred to the district of Darjeeling. After Terai was annexed in 1850, it was placed under the Purnea district (in Bihar), but the dislike of the inhabitants compelled it to be attached to Darjeeling. After Kalimpong was brought under the British rule in 1865 and transferred to Darjeeling district in the same year, the district was divided into two sub-divisions, namely (I) the Headquarters Sub-Division including all the hills on both sides of Teesta and (II) the Terai Sub-Division which included the remaining area at the foothills. In 1891 Kurseong was made a Sub-Divisional Headquarter and Terai was merged with it. In the year 1907 Sili-guri was made a separate Sub-Division and in 1916 Kalimpong was separated from Darjeeling Sadar Sub-Division and made a separate Sub-Division (Ghosh, 1987 : pp 19-20).

Cultivation of Tea in Darjeeling started long back before the formation of Darjeeling district in 1866. But the rapid development of tea plantations in the district owed to a great extent to the consolidation of the British empire in the region and the active interest taken by the East India Company.

The discovery of tea in Bengal, according to Hunter (1876: p 165), dates back to 1826. The introduction of tea into Darjeeling is due to Captain James who persuaded the Government to obtain seed from China, which he distributed among the residents of the district to experiment with (Imperial Gazetteer of India 1908). In the year 1838, Dr. Campbell was posted as Superintendent of Darjeeling. This was an important event as far as the tea industry in Darjeeling is concerned. The development of tea industry in Darjeeling owes greatly to the enterprise of Dr. Campbell. Attempts to introduce the cultivation of tea in Darjeeling were first made sometime previously to 1853 when two or three gardens existed (Hunter, 1876 : p 165). In a report of Dr. Campbell dated 30th March, 1853, No. 123, it is mentioned that experimental planting of tea was started from 1841, but little headway could be made before 1853. The real date of the commencement of the industry may be taken at 1856-57. Of the existing gardens in the district only two date back as 1856, viz., that of the Karsiang and Darjeeling Tea Company and one owned by the Darjeeling Land Mortgage Bank. The two gardens were Alubari and Lebong Mineral Spring (Hunter, 1876 : p 165; Dash, 1947 : p 113). The Imperial Gazetteer (1908) mentions the names of tea gardens Alubari, Padam and Steinthal that were opened up in 1856 in the district. Since 1856, more and more gardens were opened, and more and more companies were registered. In 1859, the Dhuteria garden was started by Brongham (Dash, 1947 : p 113). The largest tea concern in

Darjeeling, that of the Darjeeling Company Limited owned four gardens Ambutia, Ging, Takda and Phubserang which were established between 1860 and 1864 (Hunger, 1876: pp 165-66; Ghosh, 1987 : p 24; O'Malley, 1907 : pp 73-74).

In Terai, the first garden was started at Champta near Khaprail in 1862 by James White (Dash, 1947 : p 113; Ghosh, 1987 : p 25; O'Malley, 1907 : p. 74). James White previously had opened up one of the largest garden in the district and Singell near Kurseong. Prior to 1864, the Lebong Tea Company opened Takvar and Badamtam tea gardens. The Makaibari tea garden was also opened in this period (O'Malley, 1907 : p 74; Ghosh, 1987 : p 25). Others gardens opened up in Terai by 1866. Since 1866 till 1874 there was a steady increase in tea cultivation in the district. In 1866 there were 39 gardens and the extent of land under cultivation was 10,392 acres¹. In 1867, there were 40 gardens with 9,214 acres of land under cultivation. In 1868, the number of gardens was 44 and the land under cultivation was 10,067 acres. The figure of 1869 showed 55 gardens with 10,769 acres of land under cultivation. In the year 1870 there were 56 gardens and the land under cultivation was 11,046 acres². In 1872, 1873 and 1874 there were

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1. O'Malley (1907 : p 74) mentioned that the extent of land **under** cultivation was 10,000 acres.
 2. In O'Malley (1907 : p 74) it is mentioned that the land under cultivation in 1870 was 11,000 acres.

74, 87 and 113 gardens respectively and the corresponding amount of land under cultivation was 14,503 acres, 15,695 acres and 18,888 acres (Hunter, 1876 : p 165). It was thus seen that within a period of nine years between 1866 and 1874 the number of gardens had almost trebled and the area under cultivation increased by 82 percent. In the Kalimpong Sub-Division land was withheld from tea cultivation. The Government policy was to reserve the area for forest and ordinary cultivation. According to the Settlement Report of C.A. Bell, I.C.S. (1901-1903) there were only four tea estates in the Sub-Division, Sama Beong, Ambiak, Phagu and Kumai. The position had not changed even by 1975. At present there are six tea estates Sama Beong, Ambiak, Kumai, Upper Phagu, Lower Phagu and Mission Hill (Ghosh, 1987 : p 27).

To trace the growth of gardens in Darjeeling upto recent times. In 1881 there were 155 gardens with 28,367 acres of land under cultivation. The figure rose to 175 in 1885 with 38,499 acres of land under cultivation, 177 in 1891 with 45,585 acres of land under cultivation and 186 in 1895 with 48,692 acres of land under cultivation. Thereafter there had been decrease in the number of gardens. In 1901 there were 170 gardens and 51,724 acres of land under tea. In 1910 there were 148 gardens and the land under tea was 51,281 acres. The number of gardens remained the same till 1935 with increases in 1911 to 156, 1921 to 168 and 1931 to 169 and corresponding increases in area under tea to 51488 acres in 1911, 59,005 acres in 1921 and 61,178 acres in 1931. After 1935 there was decline in the numbers to 142 in 1940

with 63,059 acres of land under cultivation, 138 in 1951 with 62,580 acres of land under cultivation and 135 in 1952 with 67,526 acres of land under cultivation. It may be noted that though there had been a decrease in the number of gardens the acreage under tea increased (Government of India, 1951).

From the list of tea plantations published by the District Census Handbook, Darjeeling, in the 1961 Census, on the basis of All India Tea Directory, 1960, names of 139 tea gardens were found. The list of villages and towns published in the 1971 Census District Handbook, Darjeeling revealed the names of only 119 tea gardens. It should be mentioned here that it had been a convention since long to treat a tea garden as a separate mouza or village. It was probably that in the 1971 alphabetical list a number of mouzas had not been shown as tea gardens. According to the tea Statistics in 1962 and 1963 there were 144 gardens in the district which increased to 145 in 1964 (Tea Statistics 1966-67).

To resolve the controversy over the total number of tea gardens in the district, records of the Land Utilization and Reforms ~~and Land~~ and Land Revenue Department, Government of West Bengal may be consulted. According to the list of tea gardens as maintained by the Revenue Department the total number of tea gardens of the district is 147 (Ghosh, 1987 : p 32).

Before we study the growth of tea industry in the district of Jalpaiguri let us have a look into the history of the district. The present district of Jalpaiguri was born on 1 January, 1869 by the amalgamation of the Western Dooars district and the Sub-Division of Rangpur district. The Western Duars was wrested by the British Government from Bhutan at the end of Bhutan War of 1864-65. The Western Duars was mostly waste and jungle not subject to any settlement. Though the area was suitable for tea cultivation much progress could not be made before the district assumed some sort of political and administrative stability.

The tea industry in Jalpaiguri did not begin commercially before 1874-75. The first tea garden that was established in the district was Gazilduba in 1874 (Grinnings, 1911). The credit of establishing this garden goes to one named R. Haughton. In 1875, L.W. Barantee brought 500 acres of land under cultivation of tea. In the same year two gardens Phulbari and Bagrakote were established. From 1874 to 1878 thirteen tea estates with a gross acreage of 11, 984 acres were set up by the British planters in the Mal sector : Gazaldoba (1874), Phulbari (1875), Bagrakote (1876), Dalimkota (1876), Kumlai (1877), Damdim (1877), Washabari (1877), Baintbari (1877), Ellenberry (1877), Manabari (1877), Moneyhope (1878), Patabari (1878) and Ranicherra (1878) (Mukherjee, 1978).

In 1881 the number of gardens were 55 with 6,230 acres of land under tea. The number increased to 182 in 1892. The growth of the industry was very rapid in the 80s. This can be gauged from the fact that the area under tea in 1892 was over 6 times than in 1881. But the rapid expansion continued till 1901. During 1901 the number of gardens was 235 and the acreage under cultivation was 76,403 acres. After 1901 there had been a check in the expansion and in 1907 the number of gardens came down to 180 and the acreage under cultivation increased by a mere 4,935 acres (Ghosh, 1987 : p 34). The check in the expansion has been attributed by Mr. C.J. Donnell (1888) to lack of water. But this did not stop the expansion of tea gardens. Gardens obtained water from springs in Bhutan and brought them down in pipes. All the tea gardens in the district are situated in the Western Duars with the exception of 4 to 5 gardens besides Danguajhar (Ghosh, 1987 : p 36).

Shri B.C. Ghosh (1970) in an article "The Development of the Tea Industry in the District of Jalpaiguri : 1869-1968" mentioned that in 1877, 1878, 1884 and 1886, 7, 9, 20 and 14 gardens were established in the respective years. Twelve gardens were started in 1897. The last garden to be established in the district was Surendranagar Tea Estate in 1962.

The growth of the tea industry in the Jalpaiguri district presented an interesting feature. Conscious and bold attempts were

made by Indians mainly Bengalees to establish tea gardens in the face of stiff competition from the Europeans.

The first Indian to start a tea estate in the Jalpaiguri district was Munshi Rahim Baksh, a Peshkar (Clerk) of the Deputy Commissioner in 1877 (Ghosh 1987 : p 36; Mukherjee, 1978). Probably taking advantage of his official position he was able to take a settlement of Jaldhaka Grant of 728 acres. In 1878, Kali Mohan Ray and Durgabati Sen got Ataldanga Grant of 310 acres which was passed to Munshi Rahim Baksh. The first Indian Tea Company, the Jalpaiguri Tea Company Ltd. was formed in 1879. A few Bengalee lawyers and Clerks of Jalpaiguri joined hands to form this company. The Company owned a garden named the Mugalkta Tea Garden established in 1879 (Ghosh, 1987 : pp 36-37; Mukherjee, 1978).

Bhagwan Chandra Bose, father of illustrious scientist Sir J.C. Bose who was posted as the Deputy Magistrate in the district took a good deal of initiative in the formation of tea gardens by Indians. Two Indian ladies, Bibi Meherunnessa and Bibi Gulabjan made efforts to start tea cultivation in the year 1882, but their efforts failed and their grant was transferred to J. Anderson. In 1884, C.K. Das and P.K. Das started two gardens, Youngtong Grant and Chalauni Grant. They also failed and their grants were transferred to Europeans. Beharilal Ganguli, Mahim Chandra Ray and Jagat Chandra Ray took a grant of 758 acres but failed to establish a garden. In 1886, Bibi Rahimannessa, wife of Munshi Rahim Baksh started the Mal Nudy Tea Garden with 329 acres of land. In the

same year one called Benoda Behari Dutta took a grant of 600 acres but failed in his attempt to start a garden and relinquished the grant. Totapara Tea Estate was started in 1892 by the Saha family of Amla Sadarpur (Nadia district). Munshi Rahim Baksh spurned by his earlier success started Rahimabad Tea Garden in 1896. Ambari Tea Estate was established in 1908 by the Sahas of Nadia district. In the year 1909, a Bengalee started the Turturi Tea Estate in the Alipurduar area (Ghosh, 1987 : p 37).

It is therefore satisfactory to note that in the early stage of the development of the tea gardens in the district the Indians did not lag behind. In fact, the enterprise of the Bengalees was responsible for the development of the tea industry in the region. The present picture however, is different. Most of the ownership of tea gardens have slipped out of the hands of the Bengalees.

Alike the case of Darjeeling district, here too there is lack of unanimity as to the exact number of tea gardens in the district. According to the Tea Board's Tea Directory, at present there are 150 tea gardens. The All India Tea Directory puts the figure at 155 tea gardens (Government of India, 1961). The number is much more according to the figures available with the Revenue Department of the Government of West Bengal. The figures recorded in 1975 shows the number of gardens to be 187. For reasons stated earlier it is safe to accept the figures of the Revenue Department.

It has been said earlier, at the beginning while dealing with West Bengal, that besides the districts of Darjeeling and Jalpaiguri, Cooch Behar and West Dinajpur districts have one garden each. The total number of tea gardens in West Bengal at present is 336 with three plantations namely Sayadabad, Matidhar and Sahabad having fell into West Bengal after the reorganization of States in 1956. These plantations were earlier in Bihar State (Ghosh, 1987 : p 40).

In Tripura tea cultivation was introduced by Maharaja Birendra Kishore in 1916 on the basis of recommendation made by a young scientist Dr. A.C. Bhattacharya. The process initiated by Maharaja Birendra Kishore was furthered by Maharaja Bir Bikram (Ganchoudhuri, 1990 : p 340; Ganguli, 1984 : p 5). To encourage tea plantations 'Tashkhichi Taluk' system was introduced. Under this system, the rights on the estates were permanent, but the rates of land revenue payable on such land holdings were enhancable at the rate of 12.5 per cent at the end of every 20 years. Tea plantation in Tripura was started when the tea industry in India was passing through a period of recession which subsided by 1922. In the year 1931 there were 50 gardens (Ganguli, 1984 : p 6). At present the number of gardens are approximately 54 (Ghosh, 1987 : p 3). Unlike Assam, Darjeeling and Jalpaiguri, tea plantations in Tripura were all started by Indian entrepreneurs.

Background of the Labour force

Tea is the product of the cumulative toil of labourers. Labour in the tea industry of North East India has a vital and significant role in the development and progress of the industry.

Assam was the first area in India to come under tea. Here tea manufacture was started in the early 19th century. The treaty of Yandaboo in 1826 resulted in the annexation of Brahmaputra Valley to the British empire. In 1833 Jenkins planned to settle British farmers in the waste lands of Assam and he thought of cultivation of cash crops like, indigo, sugarcane etc. (Guha, 1977 : p 12). But soon experiments to grow tea on a commercial scale began and tea was first produced in Assam in 1837 (Mazumdar, 1984 : p 1)³. From the beginning of the industry in Assam dearth of labour was being felt. In the beginning large numbers of Chinese were imported for cultivation and growing tea. But their performance proved dismal. Attempts then were made to recruit labour from within Assam but it did not succeed. This was because firstly, there were few landless and secondly, the process of alienation of the tribals was absent in North-East India. The indigenous population of the North-East were traditionally agriculturalist and had enough land to live upon. They were not willing to get employed as wage labourers. The shortage of labour was compounded by the Civil War (1770-1791), Burmese invasion

3. Ganguli, J.B., 1990, writes "in 1840, the first tea company namely the Assam Company started production of tea on a commercial basis in Assam".

(1819-1824) and epidemic (1833-1854). The sole source of local labour was the Kacharis of Darrang district and a small proportion of people of the adjacent areas. But this fulfilled only marginal necessity. Two major steps were taken by the British Government to compel the local population to take up tea garden work; first, slavery was abolished and second, heavy taxation was introduced on subsistence farming of the local peasants (Guha, 1977 : p 12). But these methods proved unsuccessful. Moreover, the government in various ways tried to lure the local peasants which too failed. In 1859 the number of local labourers was 10,000, although the labour recruitment was about 16,000 to 20,000 hands. In 1901, out of 307,000 labourers of the plantations in Kamrup and Darrang districts of Assam, only 20,000 were reported to be local peasants, of which 14,000 belonged to the Boro-Kachari tribal group (Bhadra, 1984 : p 8). The failure of the attempts to recruit local labour made the plantation authorities think of recruiting labour from outside the State. Therefore, in 1853 recruitment of indentured labour from outside got under way. The immigrant labourers were mostly tribals hailing from the provinces of Bihar, Bengal, Uttar Pradesh, Madras and even Bombay. Amalendu Guha (1981 : p 80) noted that the proportion of immigrant labour coming from Chota Nagpur was 44.7 per cent in 1884-85. This proportion increased to 50 per cent in 1889. In the same year 25 per cent workers came from Bengal and from Assam itself 5 per cent. The districts of Ranchi, Hazaribagh, Santhal Parganas, Dumka and Gaya of Bihar; Mayurbhanj, Ganjam, Sambalpur, Chaibasa and Puri

of Orissa; Raipur, Rampurhat and Jabalpur of Madhya Pradesh were the main suppliers of labourers. They belonged to the tribal communities of Santhal, Munda, Oraon, Khasi, Gond, Kisan and Nagesia (Roy Burman, 1968). The Chota Nagpur region of Bihar provided the fertile ground for recruiting tea garden labourers. It was the homeland of the Munda and Oraon tribes. These tribes suffered badly in terms of alienation from their land. With the firm establishment of law and order in the country and as roads and communications were opened up, non-tribal peasants, traders and money lenders from Hazaribagh, Gaya and Manbhum regions started penetrating into tribal areas.

The fundamental factor which contributed to the the extreme miseries of the tribal **pepple** was the replacement of collective ownership of land by private ownership use for profit. This was facilitated by the land tenure system introduced by the British. The Mundas earlier practised the 'Khuntkatti' system of land tenure. Under this system though the land belonged to the lineage others could till the land with the permission of the owner (Bose, 1980 : p 41). The traders, money-lenders and farmers taking advantage of this got the permission from the tribals to till their lands and during the time of Land Settlement Operation on the district of Chota Nagpur got such land registered as private, personal property. It was a case amounting to robbery. To quote Bose (1980 : p 41), "It was thus a case amounting to robbery when land which belonged to the lineages, or even the village commune,

thus passed out of the hand of the tribal folk, for their laws and customs were not known to the Government".

In the pre-British period, the Hindu rajas of this area were paid dues by the tribals in kind or services. With the establishment of British rule, the raja had to pay their dues in cash which they got from the tribals. The latter not being familiar with the system and due to their ignorance and simplicity were always at the losing end. They were duped by the money lenders. The combined effect of alienation from land, increasing demand for payment of taxes and the exploitation of the helpless tribals by the money lenders proved ruinous. Similar, transformation took place in other areas.

It may thus be safely concluded that the British policy was responsible for the plight of the tribals. Whether it was an intentional aberration or not is a pertinent question. However, the whole process cannot be dismissed as to be just an unfortunate coincidence. It can be viewed as a deliberate attempt or move by the British to meet the shortage of labourers for plantations, within and outside India, mining and other labour intensive works. Biplab Dasgupta (1984: pp 133-138) has made an analysis of this phenomenon in detail in the context of Bengal. He has identified six factors those accounted for the increased demand for labour in the second half of the nineteenth century. They are, development of tea plantations and raising of commercial

crops, growth of mining activities, growing process of urbanization and industrialization, expansion of road and rail building activities and rail construction and the demand for labour outside India on rubber, tea and sugar plantations in different parts of the British empire. Keeping in view the high demand for labour it would not be conjectural to say that the British framed the policy to meet the labour demand. Bose(1980 : p 43) also subscribed to the view. He suspected that the Government deliberately followed a policy of encouraging the process of alienation of tribals from lands in order to ensure availability of labourers for plantations. To quote "British firms had discovered that the foothills of Himalayas were excellent for the cultivation of tea. Similarly, there were hilly areas in the southern Peninsula where coffee could be grown. But all this needed a large labour force. The increasing population of tribal folk which suffered from the shortage of land offered a tempting field for recruitment. British companies established depots for the recruitment of indentured labour. These were in Bihar, Orissa and Madhya Pradesh where a large number of Santhal, Oraon, Munda and Kharia labourers were drafted for service in the tea plantations of Assam and North Bengal".

Labour shortage in agriculture plantations, mines etc., was largely met by recruiting the so called "semi-Hinduised aborigines". The Santhals and other tribal groups provided the missing element as they were more vulnerable to pressure and inducement and least tied to particular plots of land. Circumstances

forced other tribal groups also out of their own territories reducing them to the status of wage labourers (Dasgupta, 1984 : P A137). Between 1891-1901 from Santhal Parganas alone ten per cent of the population out-migrated towards eastern areas, including tea plantations of Assam and Jalpaiguri (Dasgupta, 1984: p. A.138).

Before the large scale migration from Bangladesh during the middle of the nineteenth century to the middle of the twentieth century the main immigrants to Assam were the tea plantation labourers. The number of labourers from 1872-1880 was 226,321. In 1872 they were 40,000 (Guha, 1968 : pp 210-212). A rough estimate by Phukan indicates that there were about 30 lakhs of people belonging to the entire immigrant tea labour class in 1971 (Saikia and Phukan, 1979 : p 6). Between May 1st, 1963 and May 1st, 1866 about 84,915 labourers were imported into Assam tea gardens (Papers Regarding Tea Industry). The number of immigrants into Assam Valley from 1874 to 1900 was 729,000 and presumably between 1871 and 1900 not less than 750,000 (Report of the Assam Labour Enquiry Committee, 1906 : p 83). The permanent labour force employed in the year 1951 was over 5 lakhs. In 1961 the number declined to 4.5 lakhs. It further declined to 4.4 lakhs in 1975 and 4.3 lakhs in 1976 (Nag 1990 : p 55).

The decrease in the number of permanent labourers during the decade 1960-70 was of the order 53,000. The subsequent decade 1970-80 experienced a further decrease of 21,000 workers. All these happened inspite of an agreement between the Management and

Labour for increase of permanent employment by providing additional employment to the tune of 15,000 persons by March 31, 1972. The bi-partite agreement was signed on January 1, 1969 by the representatives of the I.T.A., the A.T.P.A. and the Bharatiya Cha Parishad on behalf of the employers and by the leaders of four INTUC affiliated trade unions of tea workers and tea employees of the Brahmaputra Valley and the Barak Valley districts (Nag, 1990 : pp 55-56).

According to the Assam Census Report, a total number of 1,216,661 persons were born outside Assam but enumerated in the Province. The great majority of these were either on tea estates or had been on tea estates and now settled in bastis. Of the above mentioned number of persons 535,565 were born in Bihar and Orissa, 77,082 in the Central Provinces and Berar, 14,311 in the Feudatory States of Central Provinces, 76,982 in the United Provinces, 54,327 in Madras and 17,602 in the Central India Agency (Tea District Labour Association, 1924).

Initially the recruitment of labour was done through "Arkattis" or professional recruiters (Bhadra, 1984 : p 9; Nag, 1990 : p 50). The government passed the "Transport of Native Labourers Act 1853" for recruiting labourers from outside Assam and consequently the "Arkatti" system was introduced (Bhadra, 1984 : p 9). A class of recruitment contractors flourished who operated through the "arkattis". The abuses and exploitation of

the "arkattis" still remain fresh in the memories of the tea garden communities through the varied folk songs and folklores. In 1870 the Act was amended and the "Sardari"⁴ system of recruitment was brought into effect. However, the earlier system of recruitment through "arkattis" did not stop. Both the systems existed side by side till 1915 when under the Assam Labour and Immigration Act of 1915 recruitment through "arkattis" was made unlawful (Bhadra, 1984 : p 9). In 1917 the Tea District Labour Supply Association was formed to control and coordinate recruitment under "Sardari" system (Bhadra, 1984 : p 9).

"The Hand book of Castes and Tribes employed on Tea Estates in North East India" was in all praise for the "Sardari" system. To quote, "For some years past, the "Sirdari" has been a model for other industries which have been compelled to seek labour in distant fields also it is significant to note, that not only is "sirdari" labour more likely to settle down and become absorbed in the permanent labour force but is less susceptible to outside influences of a disturbing nature" (Tea District Labour Association, 1924 : pp 3-4).

The Sirdars were themselves labourers on an estate, consigned to the districts from which they were originally imported, with

4. In Tea District Labour Association (1924) "Sardari" is mentioned as "Sirdari".

the object of persuading their relatives and former co-villagers to accompany them to Assam. The "Sirdars" were held responsible often physically for misrepresentation as to the conditions under which labour has to work.

Bengal Duars, formerly a part of Bhutan was annexed to the British Bengal in 1864. The first tea grant was issued in 1864, since then the story of Duars tea plantation began. Bengal Duars appeared on the tea map of India rather late.

The growth of plantations in the Duars brought a sea change in the economy of the area. The natural economy of the area was transformed into a monetised economy. But the most significant was the demographic change.

In the Census of 1961, 1,359,292 persons were counted in the district of Jalpaiguri. Ten years back the district had a population of 916,747. Therefore, during the ten years the population of the district has increased by 442,545 i.e., 48.27% (Government of India, 1961).

The first attempt to enumerate the people was made in 1858-59, at the time of the Revenue Survey of Rangpur. A rough Census was held then and it was found that the population of the permanently settled parts of the district was 1,89,067 (Government of India, 1961).

At the close of the Bhutan War, a survey of Western Duars was made in 1865-67. The survey officers returned the population at 49,620. A special Census conducted in 1870 showed the figure of population as 100,111 (Government of India, 1961).

It is evident that migration of people from the neighbouring districts to the waste lands of the Western Duars began as soon as the British rule ensured safety. Subsequent Censuses showed remarkable increases. In 1871-72 the population was 327,985 (Government of India, 1961).

The growth of the population of Jalpaiguri district was very much linked to its increasing prosperity due to the growth of tea. In fact the whole history of the growth of population in the Duars was the history of immigration to various tea estates located in the tract. The census of 1961, puts the figure of the people born outside the district at 4,54,177 (Government of India, 1961).

The 1981 Census puts the population figure at 42,214,871 as against 1,750,159 in 1971 i.e., an increase of 26.55% (Government of India, 1981).

As have been stated earlier the tribal society in Bihar was in a state of turmoil in the nineteenth century for various reasons (discussed in the context of Assam). The establishment of tea industry opened up an avenue for employment of the tribals.

Immigration to Jalpaiguri district increased by leaps and bounds in the period 1891 to 1941. The number of immigrants as per the 1901 Census was 188,223 as compared to 143,922 in 1891 (Government of India, 1901). The migration statements showed that 80,436 immigrants were from Ranchi and 10,562 from Santhal Parganas. According to the Census of 1921 the number of persons born in Ranchi but enumerated in the district of Jalpaiguri in 1911 was no less than 126,214 (Thompson, 1923). According to the Census of 1971, the percentage of scheduled tribes to the total population of the district was 24.49 (Government of India, 1971). The number of scheduled tribes engaged in livestock, forestry, fishing, hunting, plantations, orchards and allied activities according to the Census of 1971, was 95,414 (See table I). Bihar's contribution according to the same census was 20,350. The district according to the Census of 1981 had a scheduled tribe population of 491,791 of which 252,842 are males and 238,949 are females. 242,072 persons of the population lived in the Jalpaiguri sub-division. The scheduled tribes inhabiting the 12 towns of the district comprised 1.78% of the population (Government of India, 1981).

TABLE - I

SCHEDULED TRIBES ENGAGED IN LIVESTOCK, FORESTRY,
FISHING, HUNTING, PLANTATIONS, ORCHARDS AND ALLIED
ACTIVITIES

TRIBES	MALE	FEMALE	TOTAL
1. Asur	-	-	-
2. Bhumij	253	481	734
3. Chakma	28	-	28
4. Chero	-	-	-
5. Chik Baraik	182	139	321
6. Garo	61	31	92
7. Gond	-	-	-
8. Kisan	26	59	85
9. Kora	539	472	1,011
10. Kharia	1,986	1,106	3,092
11. Lohra or Lohara	-	-	-
12. Mahali	3,243	2,077	5,320
13. Malpaharia	1,440	862	2,302
14. Mech	734	720	1,454
15. Munda	9,127	6,331	15,458
16. Magh	12	-	12
17. Nagesia	187	199	386
18. Oraon	21,402	17,247	38,649
19. Santhal	7,999	5,688	13,687
20. Lepcha	400	372	772
21. Unclassified	7,203	4,808	12,011
Total	54,822	40,592	95,414

The East India Company acquired the nucleus of the Darjeeling district from the Raja of Sikkim in 1835. At that time it was almost entirely under forest and practically uninhabited. This hill tract of 135 square miles had a population of 100 (Dash 1947 : p 49). The Company decided to raise it as a hill resort. The decision encouraged migration from neighbouring areas. The original inhabitants, probably the Lepchas were out numbered. By the year 1850, Dr. Campbell, the first Superintendent, reported that the number of inhabitants had risen to 10,000 (Dash, 1947 : p 49). A rough Census taken in 1869 stated the total number of inhabitants to be over 22,000.

When Terai was added to the Darjeeling district it was not clear of what was then the population of the area, but it may be assumed that it was considerable from the fact that in 1874, it was reported that at the time of annexation there were 544 jotes (revenue area).

In the first regular census of the district, taken in 1872, the population figure reports was 94,712 (Dash, 1947 : p 49; O'Malley 1907 : p 35). The same census showed the population of Terai to be 47,985. The Censuses of 1881, 1891, 1901, 1911, 1921, 1931 and 1941 put the population figure of the district at 1,55,179, 2,23,134, 2,49,117, 2,65,550, 2,82,748, 3,19,635 and 3,76,369 respectively (Dash, 1947 : p 49). But, the District Census Hand book 1971, put the population figures of 1901, 1911, 1921, 1931

and 1941 at 265,780, 279,899, 294,237, 332,061 and 390,899 respectively. The rapid increase in 1881 has been attributed in part to the incompleteness and inaccuracy of the first census. The main causes have been the development of tea industry and the influx of settlers to cultivate the waste lands. After 1891 there had been a check in the population growth due to the fact that after 1891 upto 1921 the tea industry was in a period of recession. Since 1931 the growth of population increased. Then it was 332,061 i.e., a decadal variation of +37,824. In 1941, 1951, 1961 and 1971, the population was 390,899, 459,617, 624,640 and 781,777 respectively (Government of India, 1971). According to the 1981 Census the population of the district was 1,024,269 of which 542,567 were males and 481,702 were females (Government of India, 1981).

Scheduled tribes constituted a considerable proportion of the population of the district. In 1971 the total tribal population of the district was 108,586, of which 56,047 were males and 52,539 were females (Government of India, 1971). Ten years back 96,444 persons were found to be belonging to scheduled tribe category (Government of India, 1961). The Census of 1981 recorded 151,073 persons as to belong to scheduled tribe category thus recording an increase of 42,488 persons over that of 1971. The following table presents the scheduled tribe population of the district according to 1971 Census.

TABLE - 2

SCHEDULED TRIBE POPULATION OF DARJEELING
DISTRICT ACCORDING TO 1971 CENSUS

TRIBE	TOTAL POPULATION
1. Bhutia including Sherpa, Toto, Dukpa, Kagatary, Tibetan and Yolmo	30,442
2. Chakma	59
3. Chik Baraik	1,544
4. Garo	203
5. Hajang	46
6. Kisan	713
7. Lepcha	13,536
8. Lodha, Kheria or Kharia	1,744
9. Magh	41
10. Mahali	647
11. Malpaharia	2,443
12. Mech	253
13. Munda	6,844
14. Nagesia	855
15. Oraon	26,682
16. Senthali	10,335
17. Unclassified	12,149
Total	108,586

Preponderance of scheduled tribe population is observed in the Siliguri Sub-Division. According to the 1961 Census 58.59% of the total tribal population of the district was found in the Sub-Division. The 1971 Census showed the figure of scheduled tribes inhabiting the Siliguri Sub-Division at 59,931 with Naxalbari, Phansidewa and Kharibari accounting for 13,286, 21,228 and 13,579 persons respectively (Government of India, 1971). The next decade experienced an increase of 30,557 persons bringing the total figure to 90,488 (Government of India, 1981). In the same year, the Naxalbari and Phansidewa blocks experienced increase of 8,340 and 17,359 persons respectively, but the Kharibari block experienced decrease of 1,701 persons. The Naxalbari and Phansidewa blocks as per 1981 Census had scheduled tribe population of 21,626 and 38,587 persons respectively while the Kharibari block had 11,878 persons (Government of India, 1981).

The Oraons were the maximum in number among the scheduled tribes in the district. This tribe immigrated to the district from the Chota Nagpur Plateau. They were recruited primarily to clear out land for cultivation of tea. In 1961 they accounted for 33.18% of the total scheduled tribes of the district in the rural areas. In the year 1872 the district had a Oraon population of 1,648. The number increased to 4,632 in 1891, 8,042 in 1901, 7,543 in 1911, 10,952 in 1921, 12,412 in 1931 and 12,433 in 1941. The figure of 1941 did not include Oraon Christian who were 2,000

in number (Dash, 1947 : p 69). In 1971 they were 26,682 in number (Government of India, 1971).

The Mundas accounted for 9.95% of the total tribal rural population of the district in 1961. They came to the district from Chota Nagpur. They too were recruited for opening outland for tea cultivation. In 1891 their population was 255. The number increased to 3,980 in 1901, 3,365 in 1911 and 5,332 in 1921. After 1921 there had been a decrease in the number in 1931 the number was 5,062 and in 1941 it was 4,993. The 1971 Census put the Munda population of the district at 6,844 (Government of India, 1971).

The Santhals who were immigrants from Santhal Parganas accounted for 8.55% of the districts's scheduled tribe population. This tribe was recruited in Terai mainly for the purpose of cleaning jungles and bringing waste lands under cultivation of tea. In 1891 there were 999 persons of the tribe. The number increased to 3,537 in 1911 and 4,771 in 1931, but came down to 4,045 in 1941 (Dash, 1947 : p 68). The 1971 Census puts the figure at 10,335 (Government of India, 1971). Most of the Santhals of the Siliguri Sub-Division resided in villages only about 1,000 lived in tea gardens (Dash, 1947 : p 69).

Alike Assam labour shortage was felt even in the district of Darjeeling with the expansion of tea industry. In the Darjeeling

hill the shortage was met by large scale migrants from Nepal, but in Terai the need for labour was met by tribal immigrants from Bihar, Madhya Pradesh and Orissa. Tribals like the Oraon, Munda and the Santhals were the main migrants. Recruitments were made through "Sardars" discussed earlier.

CHAPTER III

THE TEA PLANTATIONS THEIR HEALTH UNITS AND POPULATION

It has been mentioned earlier, that three tea plantations, two with better facilities of health and one with minimum facilities of health, have been taken for this study. Also has been mentioned that the tea plantations are inhabited by many tribal communities those are migrants from Bihar, Madhya Pradesh and Orissa. In this chapter it is proposed to present a physical description of the tea plantations under study and their health units and an analysis of their demographic profile.

The Tea Plantations with Better Facilities of Health

The Hansqua Tea Garden: This plantation is located at a distance of nineteen kilometres from the township of Siliguri and six kilometres from the semi-urban settlement of Bagdogra. It has the National Highway 31 passing through it. This plantation is one of the 'A' category plantations in Terai. Communication with the township is not that satisfactory. The only mode of transport available are buses, those run on infrequent schedules. For inter-State transport by train or bus one is required to travel twenty four and nineteen kilometres respectively. Air services are available at a distance of six kilometres.

The National Highway 31 has divided the plantation into two sectors, the northern and the southern sector. The plantation is surrounded by the Taipoo tea estate in the north-east, Gangaram tea estate in the north-west, Monee (a division of Gangaram tea estate) in the south-east, Bhojnarayan tea estate in the south and Gayaganga tea estate in the south-west.

The northern sector of the plantation has two residential lines for the workers, the Bandijot and the Bandijot Ruia, while the southern sector has one residential line, the Factory line. The factory, the manager's bungalow, the staff quarters, the health unit and the canteen are located in the southern sector.

The houses in the Bandijot and the Bandijot Ruia lines are both of Pakka and Kachcha types with the former numerically dominant. The Factory line on the other hand has houses only of Pakka type.

The sources of drinking water are not the same in the two sectors and the labour lines therein. While in the northern sector wells of pakka and kachcha¹ types are the sources of drinking water, in the southern sector, taps are the sources of drinking water. Wells are also existent but they are used as sources of

1. The 'Kachcha' wells are dug by individual labour households for the use of the family.

water for other works like washing. Sanitation facilities are non-existent.

Educational facilities upto the University level are available to the residents of the plantation at varying distances. School education and intermediate education facilities are available nearby the plantation. There is a school and junior college run by missionaries besides the plantation run primary school and a government aided school. For undergraduate and post graduate studies one is required to travel nineteen and nine kilometres respectively.

As regards alternative sources of modern medical facilities besides the plantation run health unit, a missionary run health unit is two kilometres away. Government run medical units are not in the proximity. A small hospital is at a distance of six kilometres and a big hospital, the North Bengal Medical College and Hospitals that draws patient from entire North Bengal is thirteen kilometres away. Private practitioners are available at a distance of six kilometres.

The health unit of the plantation caters to the needs of the plantation population with limitations. The unit has inpatient facilities, with six beds, run by a resident doctor assisted by a Compounder, a staff nurse, a dresser and a mid-wife. Minor

surgical cases are taken up at the health unit. Major cases are referred to the North Bengal Medical College and Hospital.

The Taipoo Tea Estate : Located at a distance of eighteen kilometres away from the township of Siliguri and five kilometres from the semi-urban centre of Bagdogra this plantation too is one of the 'A' category plantations in the region. Communication with the township is not satisfactory and alike Hansqua the only mode of transport available are buses which are infrequent. Inter-State transport by train and bus is available for the population of the plantation at distances of twenty three and eighteen kilometres. Air transport facility is available at a distance of five kilometres.

The National Highway 31 passes by the front of the plantation. A partly metallic road connects the office, the factory, the health unit, the staff quarters and the labour lines with the National Highway 31. This road, which meanders through the plantation divides the plantation into two parts, the eastern and western sectors. All the labour lines, the factory, the office, the manager's bungalow and the health unit are in the western sector. The staff quarters are in the eastern sector but in proximity to the office, factory and health unit.

The plantation is surrounded on the south and south-west by Hansqua tea garden and the National Highway 31, on the east by

a part of Monee tea estate (a division of Gangaram tea estate), on the north by Kiran Chandra tea estate and on the north-east by Gangaram tea estate.

The three residential lines of the plantations, Høtkola, Kothiline and Kotajhar have houses both of pakka and 'kachcha' types. The 'pakka' houses have brick walls and tin or asbestos roofs. The sources of drinking water in the labour lines are wells of pakka and kachcha types. While the former types are dug by the management, the latter types are dug by individual families for their own use. Sanitation facilities like drainage and latrines are almost absent. There are no drains. What exist as drains are shallow trenches. Latrines are existent only in Kothiline numbering only four but they are not in usable condition.

Educational facilities upto the Higher Secondary level are available in the proximity. There is a primary school in the plantation, another primary school is there beyond the National Highway 31, besides the Hansqua plantation. The high school and junior college run by missionaries besides the Hansqua tea plantation is three kilometres away from the plantation. Residents of the plantation are required to travel eighteen and eight kilometres for undergraduate and post-graduate studies respectively.

For health facilities other than those available at the health unit, one is required to travel a minimum of six kilometres

where there is the Bagdogra Primary Health Centre and private practitioners. To get treated a big hospital one is required to travel twelve kilometres.

The health unit of the garden has facilities of minor surgery. There are four beds for inpatients. The unit is run by a resident doctor who is assisted by a compounder, a nurse, a dresser and a sweeper.

The Tea Plantation with Minimum Facilities of Health

The Matigara Tea Estate: This tea estate is located at a distance of five kilometres from the township of Siliguri and six kilometres from the Bagdogra semi-urban agglomeration. This plantation is well connected both with the township of Siliguri and the semi-urban settlement of Bagdogra by buses and other modes of transport. Facilities of distant transport are available for the residents of the plantation within a radius of ten kilometres.

The river Balasan divides the plantation into two sectors, the eastern Balasan sector and the western Balasan sector. The former is surrounded by a biscuit factory on the south-east, a plywood factory on the east, which is in turn surrounded by small hamlets, the Matigara Bazar, the Matigara railway station and the Matigara settlement on the north, the Balasan river on the west and small hamlets on the north. The western Balasan

sector is surrounded by the National Highway 31 on the north beyond which there is a Missionary school and some settlements which have developed in connection with business and academic related activities, the Sibmandir Bazar and adjoining settlements on the west, the Border Security Force Cantonment, the Kadamtala settlement and the North Bengal Medical College and Hospital (3 kms south) on the south, the Balasan river on the east and the Jesu Ashram (a home for destitutes) run by the Missionaries of Charity on the east.

The plantation has eight residential lines for labourers, five in the eastern Balasan sector and three in the Western Balasan sector. The four residential lines in the eastern sector are the Station line, the Factory line, the Tina line, the Bara line and the Pakka line. The residential lines in the Western sector are line number 9, 10 and 11. The factory, the staff quarters, the office, the health unit and the manager's Bungalow are all located in the eastern Balasan sector.

Houses in the residential lines of the plantation are either of Kachcha, pakka or tina types. Houses in the line Nos 9, 10 and 11 are predominantly of pakka type. The Factory line, the Station line and Bara line have all kachcha houses. The pakka line, as the name suggests, has houses of pakka type and the Tina line has houses made of tin on all sides.

The sources of drinking water in all the labour lines are pakka and kachcha wells. While the pakka wells have been dug by the plantation authority, the kachcha wells have been dug by individual families for their own use. The wells are also sources of water for other purposes like washing of clothes, and utensils and bathing.

Sanitation facilities are at a low level. There are no common toilets and bathrooms. Drainage facilities are practically absent. What exist as drains are shallow trenches.

Facilities of school and higher education are available and accessible to the population easily. A primary school and high school, both of which are government aided are within one kilometre for the people of the western sector. For the population residing in the western sector these schools are three to four kilometres away. A missionary run high school is within one kilometre for the population of the western sector and four kilometres for the population of the eastern sector. Facilities of undergraduate and post-graduate education are comparatively distant. While undergraduate education facilities are available at distances of ten and thirteen kilometres for the residents of the eastern and western sectors respectively, post-graduate education facilities available at distances of two and five kilometres for the residents of western and eastern sectors respectively.

Alternative sources of modern medical treatment are available to the residents of the plantation within a radius of five kilometres. A government run Subsidiary Health Centre is at the entrance of the plantations' eastern sector. For the residents of the western sector the Health Centre falls at a distance of three kilometres. Besides the Subsidiary Health Centre, a big hospital the North Bengal Medical College and Hospital is at a distance of two and a half kilometres for the residents of western sector and a little more than four kilometres for the residents of the eastern sector. Private medical practitioners are available in the adjoining settlements for the residents of both the sectors.

The Health Unit of the plantation caters to only marginal needs of the population. It occasionally organizes immunization camps with the help of the Subsidiary Health Unit.

Demographic Profile of the Plantations

In the preceding chapter it has been stated that the tea plantations are inhabited by various tribal and non-tribal communities, all possessing different cultural backgrounds. This section is a presentation of the demographic details of the population of the three plantations.

Family and Population

Household Censuses carried out in the plantation reveal that there are 276 families in the Hansqua, 102 in the Taipoo and 147 in the Matigara plantations. The Oraons dominate the Hansqua plantation with 169 families while the Parjas and Ghasis dominate the Taipoo and Matigara plantations with 39 and 30 families respectively.

Analysis of the types of families reveals dominance of elementary type² of family in all the plantations. While in the plantation of Hansqua there are 207 elementary families, in the plantations of Taipoo and Matigara there are 76 and 109 elementary families respectively i.e., in the plantations of Hansqua, Taipoo and Matigara elementary families form 75 percent, 74.5 percent and 73.82 percent of the total number of families respectively.

The other type of families found in the plantations are the incomplete elementary type of family³ and the joint type of family⁴.

-
2. According to Murdock, an elementary family is "a household composed of parents, children plus one or more persons not belonging to the particular family".
 3. An incomplete elementary family may consist of (a) husband and wife, (b) widower father and unmarried children, (c) widow mother and unmarried children, (d) unmarried brother and sister, (e) an unmarried, widowed or divorced man, (f) an unmarried widowed or divorced woman and (g) a divorced woman or man with children.
 4. A joint family consists of two or more elementary families.

Household Censuses also reveal the total labour population of the plantations. The population of Hansqua tea plantation has been found to be 1,488, of which 1,295 persons i.e., 87.02 percent of the population are tribals. The labour population of Taipoo plantation is 511 persons, of which 369 persons i.e., 72.2 percent are tribals. The Matigara plantation has a labour population of 680 persons, tribals form 51.02 per cent of the population with 415 persons⁵.

Tables 1(A), I(B) and I(C) show the ethnic background of the population, number of male and female members of reach community and the family types under each community in the plantations of Hansqua, Taipoo and Matigara respectively.

5. Risley (1969 : p 134), has considered the Lohars as a blacksmith caste. Amal Kumar Das (1966 : p. 73) has classified Lohars as scheduled castes in West Bengal. In Tea District Labour Association's book "Hand book of Castes and Tribes" (1924 : p. 326) the Lohars have been considered as scheduled castes. Hence, the Lohars have been considered as a caste group in this study. Similarly the Ghasis have also been considered a caste group following Tea District Labour Association's book Hand book of Castes and Tribes (1924 : p. 297) and Amal Kumar Das (1966 : p. 35). In both of these books the Ghasis have been considered a Dravidian fishing and cultivating caste.

TABLE I (A)
ETHNIC AND FAMILY BACKGROUND OF THE POPULATION OF
HANSQUA PLANTATION

COMMUNITY	NO. OF FAMILIES	MALES	FEMALES	ELEMENTARY FAMILIES	INCOMPLETE ELEMENTARY FAMILIES	JOINT FAMILIES	TOTAL & PERCENTAGE POPULATION
1. ORAON	169	464	460	129	23	17	924 (62.10%)
2. BARAIK	45	120	108	32	10	3	228 (15.32%)
3. NEPALI	21	73	65	16	1	4	138 (9.27%)
4. SANTHAL	10	20	22	5	4	1	42 (2.82%)
5. MUNDA	7	19	21	5	1	1	40 (2.70%)
6. MAHALI	4	15	10	3	1	-	25 (1.68%)
7. LOHAR	4	12	8	3	1	-	20 (1.34%)
8. NAGESIA	4	13	5	4	-	-	18 (1.20%)
9. BIHARI	4	10	8	4	-	-	18 (1.20%)
10. MUSLIM	4	8	9	3	1	-	17 (1.14%)
11. MALPAHARIA	3	4	8	2	1	-	12 (0.80%)
12. KHARIA	1	2	4	1	-	-	6 (0.40%)
Total	276	760	728	207	43	26	1488
		(51.07%)	(48.92%)	(75%)	(15.57%)	(9.42%)	(100%)

TABLE I (B)
ETHNIC AND FAMILY BACKGROUND OF THE POPULATION OF
TAIPOO PLANTATION

COMMUNITY	NUMBER OF FAMILIES	MALES	FEMALES	ELEMENTARY FAMILIES	INCOMPLETE ELEMENTARY FAMILIES	JOINT FAMILIES	TOTAL POPULATION & PERCENTAGE
1. PARJA	39	95	94	29	6	4	189 (37%)
2. ORAON	20	56	52	13	4	3	108 (21.13%)
3. LOHAR	19	43	38	17	2	-	81 (15.85%)
4. BIHARI	7	24	20	6	-	1	44 (8.61%)
5. NAGESIA	7	17	20	6	1	-	37 (7.24%)
6. NEPALI	3	10	7	1	1	1	17 (3.32%)
7. BARAIK	3	7	5	2	1	-	12 (2.34%)
8. MALPAHARIA	2	7	3	1	1	-	10 (1.96%)
9. RAJGOND	1	4	3	-	1	-	7 (1.37%)
10. RAUTIA	1	3	3	1	-	-	6 (1.17%)
TOTAL	102	266 (52.05%)	245 (47.94%)	76 (74.5%)	17 (16.66%)	9 (8.82%)	511 (100%)

TABLE I (C)
ETHNIC AND FAMILY BACKGROUND OF THE POPULATION
OF MATIGARA PLANTATION

COMMUNITY	NO. OF FAMILIES	MALES	FEMALES	ELEMENTARY FAMILIES	INCOMPLETE ELEMENTARY FAMILIES	JOINT FAMILIES	TOTAL POPULATION AND PERCENTAGE
1. GHASI	30	67	68	23	5	2	135 (19.85%)
2. MUNDA	29	63	63	23	4	2	126 (18.62%)
3. MAHALI	20	53	45	16	2	2	98 (14.41%)
4. ORAON	16	43	31	12	3	1	74 (10.9%)
5. LOHAR	18	38	35	13	5	-	73 (10.73%)
6. BHOKTA	9	28	26	4	3	2	54 (8%)
7. NEPALI	6	16	18	5	-	1	34 (5%)
8. BIHARI	3	9	14	1	-	2	23 (3.38%)
9. KHARIA	4	9	8	3	1	-	17 (2.5%)
10. TURI	3	5	7	2	1	-	12 (1.76%)
11. KISAN	2	6	5	2	-	-	11 (1.61%)
12. MALPAHARIA	3	3	7	2	1	-	10 (1.47%)
13. ROHIDAS	2	3	4	2	-	-	7 (1.02%)
14. BHUINHAR	1	2	2	1	-	-	4 (0.58%)
15. BIRIJIA	1	1	1	-	1	-	2 (0.29%)
TOTAL	147	346 (50.9%)	334 (49.11%)	109 (74.14%)	26 (17.7%)	12 (8.16%)	680 (100%)

From Table I(A) it is revealed that there are 276 families in the plantation with a population of 1488. Out of the 276 families 207 i.e. 75 percent are of elementary type, 43 i.e. 15.57 percent are of incomplete elementary type and 26 i.e. 9.42 percent are of joint type. The total population of 1,488 consists of the 760 males and 728 females accounting for 51.7 percent and 48.92 percent respectively. The Oraons head the table with a population of 924 persons i.e., 62.10 percent, comprising of 464 males and 460 females. The population is distributed among 169 families of which 129 are of elementary type, 23 are of incomplete elementary type and 17 are of joint type. The Baraiks come next with a population of 228, i.e. 15.32 percent, of which 120 are males and 108 are females. The population is distributed in 45 families, 32 of which are of elementary type, 10 of incomplete elementary type and 3 of joint type. The Nepalis, who come next have a population of 138 persons i.e. 9.27 percent comprising of 73 males and 65 females. The population is distributed among 21 families of which 16 are of elementary type, 1 of incomplete elementary type and 4 are of joint type. The Santals follow the Nepalis with a population of 42 persons i.e. 2.82 percent. There are 20 male members and 22 female members of the tribe. The population is distributed among 10 families of which, 5 are of elementary type, 4 are of incomplete elementary type and 1 is of joint type. The Mundas who come next, have 40 members i.e. 2.68 percent, of whom 19 are males and 21 are females. The population is distributed among 7 families 5 of which are of elementary type and 1 each of incomplete elementary and

joint type. The Mahalis follow the Mundas with 25 members i.e. 1.68 percent of whom 15 are males and 10 are females. There are 4 families of the tribe of which 3 are of elementary type and 1 is of incomplete elementary type. The Lohars have 20 members forming 1.34 per cent. Their population consists of 12 males and 8 females who are distributed among 4 families 3 of which are of elementary type and 1 is of incomplete elementary type. The Nagesias follow the Lohars with a population of 18 souls i.e. 1.20 percent. There are 13 males and 5 female members of the tribe who are distributed in 4 families all of elementary type. The Bihari castes too have a population of 18 persons accounting for 1.20 percent. There are 10 male and 8 female members of the community distributed among 4 families, all of elementary type. The Muslims numbering 17, account for 1.14 percent. They have 8 male and 9 female members. There are 4 families of the community 3 of which are of elementary type and 1 is of incomplete elementary type. The Malpaharias have a population of 12 persons, 4 males and 8 females and account for 0.80 percent. There are three families of the tribe of which 2 are of elementary type and 1 is of joint type. The Kharias come at the bottom of the table with 6 members of which 2 are males and 4 are females. The tribe has only one family which is of elementary type.

Table I(B), which pertains to Taipoo tea plantation reveals the total labour population of the plantation as 511 persons comprising of 266 males accounting for 52.05 percent and 245 females accounting for 47.94 percent. The total number of families

in the plantation are 102 of which 74.5 percent i.e. 76 are of elementary type, 16.66 percent i.e. 17 are of incomplete elementary type and 8.82 percent i.e. 9 are of joint type. The Prajas have the highest population of 189 persons accounting for 37 percent of the plantation's labour population. The tribe has 95 male members and 94 female members. There are 39 families of the tribe of which 29 are of elementary type, 6 are of incomplete elementary type and 4 are of joint type. The Oraons come next with 108 members constituting 21.13 percent of the total population. There are 56 male and 52 female members of the tribe distributed among 13 elementary type, 4 incomplete elementary type and 3 joint type families. The Lohars follow the Oraons with 81 members and account for 15.85 percent of the population. There are 43 male and 38 female members of the tribe who are distributed among 19 families 17 of which are of elementary type and 2 are of incomplete elementary type. The Bihari castes come next with a population of 44 persons i.e. 8.61 percent of whom 24 are males and 20 are females. They are distributed among 7 families 6 of which are of elementary type and 1 is of joint type. The Nagesias account for 7.24 percent of the population with 37 members. There are 17 male and 20 female members of the tribe distributed in 7 families of which 6 are of elementary type and 1 is of incomplete elementary type. The Nepalis, who account for 3.32% have 17 members of which 10 are males and 7 are females. They are distributed among 3 families 1 each of elementary, incomplete elementary and joint type. The Baraiks follow the Nepalis with 12 members accounting for 2.34 percent of the plantation's labour population. The tribe

has 7 male and 5 female members distributed among 3 families, 2 of elementary type and 1 of incomplete elementary type. Next in order are the Malpaharias with 10 members, 7 males and 3 females accounting for 1.96 percent of the plantation's labour population. The population is distributed among 2 families 1 each of elementary and incomplete elementary type. The Raj Gonds account for 1.37 percent of the population with 7 members, 4 males and 3 females. There is 1 family of the tribe which of incomplete elementary type. The Rautias have the least number of members of 6 accounting for 1.17 percent of the plantation's labour population. There is 1 family of the tribe and it is of elementary type.

Table I(C) reveals that the population of Matigara tea plantation is 680 comprising of 346 males and 334 females accounting for 50.9 percent and 49.11 per cent respectively. There are a total of 147 families of which 109 i.e. 74.14 percent are of elementary type, 26 i.e. 17.7 percent are of incomplete elementary type and 12 i.e. 8.16 percent are of joint type. The Ghasis are the most numerous with 135 persons accounting for 19.85 percent. Their population consists of 67 males and 68 females distributed among 30 families of which 23 are of elementary type, 5 are of incomplete elementary type and 2 are of joint type. Next to Ghasis are the Mundas with 126 persons i.e. 18.52 percent. There are 63 males and an equal number of females of the tribe distributed among 29 families of which 23 are of elementary type, 4 are of

incomplete elementary type and 2 are of joint type. The Mahalis who constitute 14.41 percent of the labour population of the plantation with 98 persons, come next. There are 53 male and 45 female members of the tribe distributed among 20 families of which 16 are of elementary type, 12 are of incomplete elementary type and 2 are of joint type. The Oraons have a population of 74 persons of which 43 are males and 31 are females. They constitute 10.9 percent of the plantation's labour population. There are 16 families of the tribe of which 12 are of elementary type, 3 are of incomplete elementary type and 1 is of joint type. The Oraons are followed by the Lohars with a population of 73 persons of which 38 are males and 35 are females. They account for 10.73 per cent of the population. There are 18 families of the community of which 14 are of elementary type and 5 are of incomplete elementary type. The Bhoktas, who come next have a population of 54 accounting for 8 percent of the population. There are 28 male and 26 female members of the tribe who are distributed among 4 elementary, 3 incomplete elementary and 2 joint type families. The Nepalis have a population of 34 accounting for 5 percent of the labour population of the plantation. There are 16 male and 18 female members of the community who are distributed among 6 families of which 5 are of elementary type and 1 is of joint type. The Bihari castes come next with a population of 23 forming 3.38 percent of the labour population. There are 9 male and 14 female members of the caste community distributed among 3 families of which 1 is of elementary type and 2 are of joint type. The Kharias number at 17 with 9 males and 8 females accounting for 2.5 percent.

They have 4 families of which 3 are of elementary type and 1 is of incomplete elementary type. The Turis number at 12 accounting for 1.76 percent. They have 5 male and 7 female members who are distributed among 3 families, 2 of elementary type and 1 of incomplete elementary type. The Kisans, who come next, have 6 male and 5 female members accounting for 1.61 percent of the total labour population. They are distributed among 2 families both of elementary type. The Malpaharias have a population of 10 members 3 males and 7 females and account for 1.47 percent. There are 3 families of the tribe of which 2 are of elementary type and 1 is of incomplete elementary type. The Rohidas community has 7 members accounting for 1.02 percent. There are 3 male and 4 female members of the tribe distributed among 2 families both of elementary type. The Bhuinhars number at 4 with 2 male and an equal number of female members. They account for 0.58 percent of the total labour population and they belong to 1 elementary type of family. The Birijias have the least number of 2 persons, 1 male and 1 female and account for 0.29 percent of the total labour population. They all belong to 1 incomplete elementary family.

TABLE II

DISTRIBUTION OF MEMBERS IN EACH TYPE OF FAMILY IN THE THREE PLANTATIONS

TEA PLANTATIONS	ELEMENTARY FAMILY			INCOMPLETE ELEMENTARY FAMILY			JOINT FAMILY		
	0-5	6-11	12-17	0-5	6-11	12-17	0-5	6-11	12-17
HANSQUA	112	95	-	42	1	-	1	25	-
TAIPOO	51	25	-	17	-	-	-	9	-
MATIGARA	80	29	-	26	-	-	11	1	-
TOTAL AND PERCENTAGE	243 (62%)	149 (38%)	-	85 (98.8%)	1 (1.2%)	-	12 (25.53%)	35 (74.47%)	-

Table II presented above shows the distribution of members in each type of family in the three plantations. From the table it is revealed, taking the plantations together, that among the elementary type of families 243, i.e. 61.9 percent have members from 0 to 5, 149 i.e. 38 percent have members ranging from 6 to 11 and there is no family having 12 to 17 members. As regards the incomplete elementary type of families, there are 85, i.e. 98.8 percent with 0 to 5 members and 1 i.e. 1.2 per cent with 6 to 11 members. There is no family with 12 to 17 members. Among the joint families, 12 i.e. 25.53 percent have 0 to 5 members, 35 i.e. 74.47 percent have members ranging from 6 to 11 and there is no family with 12 to 17 members.

Plantationwise analysis shows that in Hansqua tea plantation there are among the elementary type of families 112 with 0 to 5 members, 95 with 6 to 11 members and there is no family with 12 to 17 members. Out of the 43 incomplete elementary type of families, 42 have 0 to 5 members, 1 has 6 to 11 members and there is no family with 12 to 17 members. Among the 26 joint type of families in the plantation, 1 has 0 to 5 members, 25 has 6 to 11 members and there is no family with 12 to 17 members. In the Taipoo tea plantation among the 76 elementary type of families there are 51 with 0 to 5 members and 25 with 6 to 11 members. The 17 incomplete elementary type families all have 0 to 5 members. Among the joint type of families in the plantation, 9 have 6 to 11 members. There is no joint family either with 0 to

5 or with 12 to 17 members. In the Matigara plantation 80 and 29 elementary type of families have 0 to 5 and 6 to 11 members respectively. There is no family with 12 to 17 members. Among the incomplete elementary type of families, 26 have 0 to 5 members. There is no family with either 6 to 11 or 12 to 17 members. Among the joint type of families, there are 11 with 0 to 5 members and 1 with 6 to 11 members. There is no family with 12 to 17 members.

Literacy and Occupation

The level of literacy of a community determines, to a large extent, its health culture. Choice of medical systems, hygiene and food habits are some of the aspects directly affected by literacy level. Madan (1981 : p.119), says that preference for effectiveness of a system of medicine as a principal criterion for choice is found to increase with the increase in levels of educational qualification. Reddy (1984 : p. 54) has pointed out that literacy of women is positively related with the favourable attitude towards family planning.

Alike literacy, occupation too is associated with diseases. The nature of occupation determines the type of diseases a person may be afflicted with. Very often economic factors are cultural reasons for ill health. Certain methods of earning have been found to result in tuberculosis in U.S.A. Alwyn (1986: p. 143) has observed that managerial and professional occupation classes

have a high incidence of coronary artery diseases. He further observes that the physically more active occupations are associated with lower mortality rates from the disease. Susser and Watson (1971 : p.) pointed out that physical exercise is linked with blood cholesterol levels which has direct impact on coronary diseases. The authors also made a point similar to that made by Alwyn. They stated that the prevalence of coronary heart disease varies with occupations demanding different degrees of activities. Moreover, persons working with pesticides are prone to breathing problems and skin diseases. Agricultural occupations make one prone to worm infections. Tables III(A), III(B) and III(C) show the literacy level and occupation in the three tea plantations. For calculating literacy persons of the age of 6 and above years have been considered and for calculating occupation persons of the age of 16 and above have been considered. Further, occupation has been classified into two broad categories primary⁶ and secondary⁷.

6. By primary occupation is meant occupations related to tea production.

7. By secondary occupation is meant occupations not related to tea production.

TABLE III(A)
LITERACY AND OCCUPATION OF THE PEOPLE OF HANSQUA PLANTATION

COMMUNITY	LITERARY*		OCCUPATION**	
	LITERATE	ILLITERATE	PRIMARY	SECONDARY
1. ORAON	223 (28.08%)***	571	373 (70.5%)***	4 (0.75%)
2. BARAIK	57 (28.78%)	141	89 (71.77%)	1 (0.80%)
3. NEPALI	38 (30.15%)	88	53 (65.4%)	2 (2.46%)
4. SANTHAL	11 (27.5%)	29	22 (75.86%)	1 (3.44%)
5. MUNDA	10 (31.25%)	22	14 (70%)	1 (5%)
6. MAHALI	6 (26.08%)	17	9 (64.28%)	-
7. LOHAR	8 (42.10%)	11	9 (81.8%)	-
8. NAGESIA	2 (15.38%)	11	8 (80%)	-
9. BIHARI	4 (26.66%)	11	4 (40%)	-
10. MUSLIM	3 (18.75%)	13	6 (46.15%)	-
11. MALPAHARIA	0 (0.00%)	11	7 (77.77%)	-
12. KHARIA	5 (100%)	-	2 (33.33%)	-
TOTAL	367 (28.40%)	925 (71.6%)	596 (66.5%)	9 (1.05%)

TABLE III (B)
LITERACY AND OCCUPATION OF THE PEOPLE OF TAIPOO PLANTATION

COMMUNITY	LITERACY		OCCUPATION	
	LITERATE	ILLITERATE	PRIMARY	SECONDARY
1. PARJA	29 (23.57%)	123	88 (70.4%)	-
2. ORAON	22 (22%)	78	36 (54.5%)	2 (3.03%)
3. LOHAR	8 (13.11%)	53	34 (82.9%)	-
4. BIHARI	6 (21.42%)	22	13 (68.4%)	1 (5.2%)
5. NAGESIA	10 (31.25%)	22	15 (75%)	-
6. NEPALI	8 (57.14%)	6	7 (63.6%)	-
7. BARAIK	1 (11.11%)	8	5 (83.3%)	-
8. MALPAHARIA	2 (25%)	6	5 (83.3%)	-
9. RAJGOND	5 (100%)	-	5 (100%)	-
10. RAUTIA	1 (20%)	4	2 (50%)	-
TOTAL	92 (22.2%)	322 (77.8%)	210 (69.3%)	3 (0.99%)

TABLE III (C)
LITERACY AND OCCUPATION OF THE PEOPLE OF MATIGARA PLANTATION

COMMUNITY	LITERACY*		OCCUPATION**	
	LITERATE	ILLITERATE	PRIMARY	SECONDARY
1. GHASI	4 (4.16%)* **	92	67 (88.15%)* **	-
2. MUNDA	5 (4.71%)	101	63 (87.5%)	-
3. MAHALI	6 (7.69%)	72	42 (93.33%)	-
4. ORAON	6 (9.52%)	57	37 (92.5%)	1 (2.5%)
5. LOCHAR	-(0.00%)	55	32 (74.4%)	1 (2.32%)
6. BHOKTA	1 (2.17%)	45	21 (80.76%)	-
7. NEPALI	9 (33.33%)	18	8 (50%)	1 (6.25%)
8. BIHARI	9 (50%)	9	4 (36.36%)	1 (9.09%)
9. KHARIA	-(0.00%)	13	10 (100%)	-
10. TURI	-(0.00%)	10	6 (66.66%)	-
11. KISAN	1 (11.11%)	8	5 (100%)	-
12. MALPAHARIA	1 (10%)	9	5 (83.3%)	-
13. ROHIDAS	-(0.00%)	6	3 (100%)	-
14. BHUINHAR	-(0.00%)	2	2 (100%)	-
15. BIRIJIA	-(0.00%)	2	1 (50%)	-
TOTAL	42 (8.41%)	499 (91.59%)	306 (84.06%)	4 (1.09%)

* For calculating literacy persons of the age of 6 years and above have been considered

** In calculating occupation persons of the age of 16 years and above have been considered.

*** Figures in brackets are percentages of the population of that tribe or caste group of the age of 6 or more years.

**** Percentage of the total population of the tribe or caste group of the age of 16 and above years.

From table III(A) it is revealed that the total number of literates in Hansqua tea plantation is 367 i.e. 28.40 percent. The number of persons in primary occupations is 596 i.e. 66.5 percent and secondary occupation involves 9 persons i.e. 1.05 percent of the population of the age of 16 and above years.

The Oraons have 223 persons as literate i.e. 28.08 percent and 373 persons in primary occupation. In secondary occupation there are 4 Oraons i.e. 0.75 percent. Among the Baraiks 28.78 percent, accounting for 57 persons are literate. The tribe has 89 persons i.e. 71.77 percent in primary occupations and 1 person i.e. 0.80 percent in secondary occupations. The Nepalis have 38 persons, accounting for 30.18 percent as literates. In the primary occupations there are 53 persons i.e. 65.4 percent and in the secondary occupations there are 2 persons forming 2.46 percent. Among the Santals 11 persons i.e. 27.5 percent are literates. There are 22 members of the tribe, i.e. 75.86 percent in primary occupations and 1 member, i.e. 3.44 percent in secondary occupations. The Mundas have 10 persons, i.e. 31.25 percent as literates. There are 14 members of the tribe, accounting for 70 percent in primary occupations and 1 member i.e. 5 percent in secondary occupations. The rate of literacy among the Mahalis is 26.08 percent i.e. 6 of them are literate. The tribe has 9 of its members, i.e. 64.28 percent in primary occupations and none in secondary occupations. Among the Lohars, 8 persons accounting for 42.10 percent are literate and 9 persons accounting

for 81.8 percent are in primary occupations. There is none in secondary occupation. The Nagesias have a literacy rate of 15.38 percent with 2 persons as literate. There are 8 persons of the tribe i.e., 80 percent in primary occupations and none in secondary occupations. The Bihari castes have a literacy rate of 26.66 percent, i.e., 4 of them are literate. There are 4 of them, i.e., 40 percent in primary occupations and none in secondary occupations. Among the Muslims, there are 3 persons as literate accounting for 18.75 percent. There are 6 members of the community in primary occupations, i.e., 46.15 percent and none in secondary occupations. The Malpaharias have no literates among them. There are 7 of them in primary occupations accounting for 77.77 percent and none in secondary occupations. Among the Kharias the rate of literacy is 100 percent. There are 2 members of the tribe in primary occupations forming 33.33 percent and none in secondary occupations.

Table III(B), which pertains to Taipoo tea plantation reveals that the rate of literacy in the plantation is 22.2 percent which means only 92 persons are literate. As regards occupation, the table shows that 210 persons accounting for 69.3 percent and 3 persons i.e. 0.99 percent are in primary and secondary occupations respectively.

The community-wise analysis shows that among the Parjas 29 persons i.e. 23.57 percent are literate and 88 persons i.e. 70.4 percent are in primary occupations. There is none in secondary

occupations. The literacy rate among the Oraons is 22 percent with 22 literate persons. There are 36 and 2 persons in the tribe accounting for 54.5 percent and 3.03 percent respectively in primary and secondary occupations. Among the Lohars the rate of literacy is 13.11 percent with 8 persons as literate. There are 34 members of the tribe i.e. 82.9 percent in primary occupations and none in secondary occupations. The Bihari castes have 6 persons among them as literate accounting for a literacy rate of 21.42 percent. There are 13 persons, i.e. 68.4 percent in primary occupations and 1 person, i.e. 5.2 percent in secondary occupations. Among the Nagesias the literacy rate is 31.25 percent, i.e., 10 persons are literate. In primary occupations there are 15 persons, i.e. 75 percent and there is none in secondary occupations. The rate of literacy among the Nepalis is 57.14 percent, i.e. 8 persons are literate. There are 7 persons of the community in primary occupations, i.e. 63.6 percent and none in secondary occupations. The Baraiks have a literacy rate of 11.11 percent with 1 person as literate. There are 5 members of the tribe, i.e. 83.3 percent in primary occupations and none in secondary occupations. Among the Malpaharias there is a literacy rate of 25 percent with 2 persons as literate. There are 5 members of the tribe, i.e. 83.3 percent in primary occupations and none in secondary occupations. The RajGonds have a literacy rate of 100 percent and an equal percentage of persons in primary occupations. There is no one in secondary occupations. The Rautias have only 1 person as literate making the literacy rate of 20 percent.

In the primary occupations there are 2 members of the tribe accounting for 50 percent. There is no one in secondary occupation.

Table III (C) which relates to the Matigara tea plantation reveals that in the plantation the rate of literacy is 8.41 percent, i.e. only 42 persons are literate. There are 306 persons in primary occupations and 4 in secondary occupations accounting for 84.06 percent and 1.09 percent respectively.

Among the Ghasis the rate of literacy is 4.16 percent with only 4 persons as literate. The tribe has 67 persons in primary occupations accounting for 88.15 percent. There is none in secondary occupations. The Mundas have a literacy rate of 4.71 percent with 5 persons as literate. There are 63 persons of the tribe in primary occupations accounting for 87.5 percent and none in secondary occupations. Among the Mahalis there are 6 persons who are literate accounting for a literacy rate of 7.69 percent. There are 42 persons of the tribe in primary occupations accounting for 93.33 percent and none in secondary occupations. The Oraons account for a literacy rate of 9.52 percent with 6 persons as literate. There are 37 persons of the tribe in primary occupations and 1 in secondary occupations accounting for 92.5 percent and 2.5 percent respectively. The Lohars have no literates among them. There are 32 members of the caste, accounting for 74.4 percent in primary occupations and 1 member accounting for 2.32 percent in

secondary occupations. Among the Bhoktas the rate of literacy is 2.17 percent with only 1 person as literate. There are 21 members of the tribe in primary occupations, accounting for 80.76 percent and none in secondary occupations. The Nepalis have a literacy rate of 33.33 percent, i.e. 9 persons are literate. There are 8 members of the community accounting for 50 percent in primary occupations and 1 member accounting for 6.25 percent in secondary occupations. Among the Biharis, the rate of literacy is 50 percent with 9 persons as literate. There are 4 members of the community, accounting for 36.36 percent in primary occupations and 1 member accounting for 9.09 percent in secondary occupations. The Kharias and Turis have no literates among them. The two tribes have 10 and 6 members accounting for 100 percent and 66.66 percent respectively in primary occupations. The Kisans have a literacy rate of 11.11 percent with 1 person as literate. There are 5 members of the tribe, accounting for 100 percent in primary occupations and none in secondary occupations. Among the Malpaharias the rate of literacy is 10 percent with 1 person as literate. The tribe has 5 persons accounting for 83.3 percent in primary occupations but none in secondary occupations. The Rohidases, Bhuinhars and Birijias have no literates among them. The tribes have 3 members, i.e. 100 percent, 2 members, i.e. 100 percent and 1 member, i.e. 50 percent respectively in primary occupations and none in secondary occupation.

Migration

Migration has great significance in health behaviour. Migration from one cultural environment to another brings in changes in behavioural patterns of a community. The changes are usually adaptive. Alongside the changes, one shall also find continuity. Changes take place in various aspects of culture of which health is a part. A migrant may encounter different medical systems and has to change his behavioural patterns depending on the need. There is a process of acculturation. Anita Nudelman (1990 : pp 88-101) shows the changes those have occurred among the Ethiopian Jews in Israel. The degree of changes those occur depend on time and there the period of migration is of paramount importance. Tables IV(A), IV(B) and IV(C) show the migration of workers in the three plantations. The tables present a community-wise analysis showing inter-plantation, intra-state, inter-state, and inter-country migrants and their period of migration.

From table IV(A), which relates to Hansqua plantation it is revealed that the total number of migrants are 316 of whom 102 i.e. 32.2 percent are inter-plantation migrants, 19 i.e. 6.01 percent are intra-State migrants, 169 i.e. 53.4 percent are inter-State migrants and 26 i.e. 8.2 percent are inter-country migrants. Out of the migrants 124, i.e. 39.2 percent have migrated 0 to 15 years back, 104 i.e. 32.9 percent have migrated 16 to 31 years back and 88 i.e. 27.8 percent have migrated 32 or more years back.

TABLE IV (A)

TABLE SHOWING MIGRANTS IN EACH COMMUNITY IN HANSQUA AND PERIOD OF MIGRATION

COMMUNITY	BORN IN THE PLANTATION	INTER PLANTATION MIGRANTS	INTRA STATE MIGRANTS	INTER STATE MIGRANTS	INTER COUNTRY MIGRANTS	PERIOD OF MIGRATION		
						0-15	16-31	32 or more
1. ORAON	747	62 (35.02%)	7 (3.95%)	108 (61%)	-	69 (39%)	55 (31.07%)	53 (30%)
2. BARAIK	182	19 (41.3%)	-	27 (58.7%)	-	17 (37%)	13 (28.2%)	16 (34.8%)
3. NEPALI	108	5 (16.6%)	-	-	25 (83.3%)	5 (16.6%)	17 (56.6%)	8 (26.6%)
4. SANTHAL	29	6 (46.1%)	-	6 (46.1%)	1 (7.7%)	6 (46.6%)	5 (38.5%)	2 (15.4%)
5. MUNDA	32	4 (50%)	-	4 (50%)	-	3 (37.5%)	2 (25%)	3 (37.5%)
6. MAHALI	19	2 (33.3%)	-	4 (66.7%)	-	1 (16.6%)	4 (66.6%)	1 (16.6%)
7. LOHAR	15	3 (60%)	-	2 (40%)	-	3 (60%)	1 (20%)	1 (20%)

Contd..

TABLE (A) (Contd..)

8. Nagesia	14	-	-	4 (100%)	-	-	2 (50%)	2 (50%)
9. BIHARI	8	-	-	10 (100%)	-	10 (100%)	-	-
10. MUSLIM	5	-	12 (100%)	-	-	9 (75%)	3 (25%)	-
11. MALPAHARIA	9	1 (33.3%)	-	2 (66.6%)	-	1 (33.3%)	1 (33.3%)	1 (33.3%)
12. KHARIA	4	-	-	2 (100%)	-	-	1 (50%)	1 (50%)
TOTAL	1172	102 (32.2%)	19 (6.01%)	189 (53.4%)	26 (8.2%)	124 (39.2%)	104 (32.9%)	88 (27.8%)

TABLE IV(B)

TABLE SHOWING MIGRANTS OF EACH COMMUNITY IN TAIPOO
PLANTATION AND PERIOD OF MIGRATION

COMMUNITY	BORN IN THE PLAN- TATION	INTER PLANTATION MIGRANTS	INTRA STATE MIGRANTS	INTER STATE MIGRANTS	INTER COUNTRY MIGRANTS	PERIOD OF MIGRATION		
						0-15	16-31	32 or more
1. PARJA	162	9 (33.3%)	-	18 (66.6%)	-	6 (22.22%)	5 (18.5%)	16 (59.2%)
2. ORAON	91	5 (29.4%)	-	12 (70.6%)	-	3 (17.6%)	3 (17.6%)	11 (64.7%)
3. LOHAR	67	11 (78.57%)	-	3 (21.42%)	-	9 (64.3%)	3 (21.42%)	2 (14.3%)
4. BIHARI	33	-	-	11 (100%)	-	4 (36.4%)	2 (18.2%)	5 (45.45%)
5. NAGESIA	27	7 (70%)	-	3 (30%)	-	8 (80%)	1 (10%)	1 (10%)
6. NEPALI	16	-	-	-	1 (100%)	-	1 (100%)	-
7. BARAIK	11	-	-	1 (100%)	-	-	-	1 (100%)
8. MALPAHARIA	9	1 (100%)	-	-	-	1 (100%)	-	-
9. RAJGOND	6	-	-	1 (100%)	-	-	-	1 (100%)
10. RAUTIA	4	-	-	2 (100%)	-	-	-	2 (100%)
TOTAL & PERCENTAGE	426	33 (38.8%)	-	51 (60%)	1 (1.17%)	31 (36.5%)	15 (17.64%)	39 (46%)

TABLE IV (C)

TABLE SHOWING MIGRANTS OF EACH COMMUNITY IN MATIGARA
PLANTATION AND PERIOD OF MIGRATION

COMMUNITY	BORN IN THE PLAN- TATION	INTER PLANTATION MIGRANTS	INTRATE STATE MIGRANTS	INTER STATE MIGRANTS	INTER COUNTRY MIGRANTS	PERIOD OF MIGRATION		
						0-15	16-31	32 or more
1. GHASI	133	-	-	2 (100%)	-	-	-	2 (100%)
2. MUNDA	119	5 (71.4%)	-	2 (28.6%)	-	5 (71.4%)	2 (28.6%)	-
3. MAHALI	95	2 (66.6%)	1 (33.3%)	-	-	3 (3.06%)	-	-
4. ORAON	61	3 (23.07%)	3 (23.07%)	-	7 (54%)	7 (54%)	5 (38.4%)	1 (7.7%)
5. LOHAR	63	7 (70%)	2 (20%)	1 (10%)	-	7 (70%)	2 (20%)	1 (10%)
6. BHOKTA	48	4 (66.6%)	-	2 (33.3%)	-	3 (50%)	1 (16.6%)	2 (33.3%)
7. NEPALI	25	1 (11.1%)	3 (33.3%)	-	5 (55.5%)	3 (33.3%)	4 (44.4%)	2 (22.2%)
8. BIHARI	8	-	-	15 (100%)	-	6 (40%)	9 (60%)	-
9. KHARIA	15	2 (100%)	-	-	-	2 (100%)	-	-

Contd..

TABLE IV (C) (Contd..)

10. TURI	9	-	1 (33.3%)	2 (66.6%)	-	1 (33.3%)	2 (66.6%)	-
11. KISAN	11	-	-	-	-	-	-	-
12. MALPAHARIA	10	-	-	-	-	-	-	-
13. ROHIDAS	7	-	-	-	-	-	-	-
14. BHUINHAR	4	-	-	-	-	-	-	-
15. BIRIJIA	2	-	-	-	-	-	-	-
<hr/>								
TOTAL	610	24 (34.3%)	10 (14.3%)	24 (34.3%)	12 (17.1%)	37 (58.8%)	25 (35.7%)	8 (11.4%)
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Among the Oraons, out of the total population of 924, 177 persons, i.e. 19.15 percent are migrants. Out of the migrants 62 i.e. 35.02 percent are inter-plantation migrants, i.e. 3.95 percent are intra-State migrants and 108 i.e. 61 percent are inter-State migrants. There is no inter-country migrant. As regards the period of migration, 69 i.e. 39 per cent migrated 0 to 15 years back, 55 i.e. 31.07 percent have migrated 16 to 31 years back and 53 i.e. 30 percent have migrated 32 or more years back. The Baraiks have 182 members who are born in the plantation. The number of migrants of the tribe is 46 i.e. 20.17 percent. Among the migrants, 19 i.e. 41.3 percent are inter-plantation migrants and 27, i.e. 58.7 percent are inter-State migrants. There are no intra-State or inter-country migrants. Moreover, 17 of the migrants, accounting for 37 per cent migrated 0 to 15 years back, 13 i.e. 28.2 percent migrated 16 to 31 years back and 16 i.e. 34.8 percent migrated 32 or more years back. Out of 138 NEPALIS, 30 persons constituting 21.7 percent are migrants and out of the migrants 5 persons i.e. 16.6 percent are inter-plantation migrants and 25 persons, i.e. 83.3 percent are inter-country migrants. There are no intra-State or inter-State migrants. As regards the period of migration, 5 migrants constituting 16.6 percent migrated 0 to 15 years back, 17 migrants, i.e. 56.6 per cent migrated 16 to 31 years back and 8 migrants i.e. 26.6 per cent migrated 32 or more years back. Among the 42 Santhals inhabiting the plantation, 13 persons, i.e. 31 percent are migrants of whom inter-plantation and inter-State migrants constitute 46.1 percent each, i.e. in each of the two categories there are 6

persons. Inter-country migrants constitute 7.7 percent with 1 person. Out of the migrants 6 persons forming 46.6 percent migrated 0 to 15 years back, 5 persons forming 38.5 percent migrated 16 to 31 years back and 2 persons forming 15.4 percent migrated 32 or more years back. Among the 40 Mundas in the plantation 8 persons, i.e. 20 percent are migrants of whom 50 percent i.e. 4 are inter-plantation migrants and an equal number are inter-State migrants. Of these migrants 3 persons i.e. 37.5 percent migrated 0-15 years back, 2 persons i.e. 25 percent migrated 16 to 31 years back and another 3 persons, i.e. 37.5 percent migrated 32 or more years back. Out of the 25 Mahalis inhabiting the plantation 6 i.e. 24 percent are migrants of whom 2 i.e. 33.3 per cent are inter-plantation migrants and 4 i.e. 66.7 percent are inter-State migrants. Further, out of the migrants, 1 person, i.e. 16.6 percent migrated 0 to 15 years back, 4 persons i.e. 66.6 percent migrated 16 to 31 years back and another 1 person i.e. 16.6 percent migrated 32 or more years back. Among the Lohars 25 percent, i.e. 5 persons are migrants. Out of the migrants 3 persons i.e. 60 percent are inter-plantation migrants and 2 persons, i.e. 40 percent are inter-State migrants. Of these migrants 3, i.e. 60 percent migrated 0 to 15 years back, 1, i.e. 20 percent migrated 16 to 31 years back and another 1 i.e. 20 percent migrated 32 or more years back. The Nagesias have 4 migrants out of their population of 18 i.e. migrants account for 22.2 percent of the population. All the migrants are inter-State migrants. Out of these migrants, 2 persons each accounting for 50 percent each migrated 16 to 31 and 32 or more years back.

There are 10 migrants among the 18 Biharis accounting for 55.5 percent. All the 10 migrants are inter-State migrants who migrated 0 to 15 years back. Among the Muslims there are 12 migrants who account for 70.5 percent of the population. All the migrants are inter-State migrants of whom 9 i.e. 75 percent migrated 0 to 15 years back and 3 i.e. 25 per cent migrated 16 to 31 years back. Out of the 12 Malpaharias there are 3 migrants accounting for 25 percent. Out of the migrants 1 person i.e. 33.3 percent in inter-plantation migrant and 2 persons i.e. 66.6 percent are inter-State migrants. As regards their period of migration 1 each accounting for 33.3 percent migrated 0 to 15, 16 to 31 and 32 or more years back. Among the Kharias there are 2 migrants accounting for 33.3 percent and all the migrants are inter-State migrants with 1 each migrated 16 to 31 and 32 or more years back.

Table IV(B), that relates to Taipoo plantation reveals that the total number of migrants are 85 constituting 16.6 percent of the plantation's population. Out of the migrants 33 persons, i.e. 38.8 percent are inter-plantation migrants, 51 persons, i.e. 60 percent are inter-State migrants and 1 person, i.e. 1.17 percent is a inter-country migrant. It is further revealed that 36.5 percent of the migrants i.e. 31 persons migrated 0 to 15 years back, 17.64 percent, i.e. 15 persons migrated 16 to 31 years back and 46 percent ~~migrants~~ i.e. 39 persons migrated 32 or more years back.

The Parjas have 14.2 percent of their population, i.e. 27 persons as migrants. Out of the migrants 9 persons, i.e. 33.3 percent are inter-plantation migrants and 18 persons i.e. 66.6 percent inter-State migrants of whom 6 i.e. 22.2 percent migrated 0 to 15 years back, 5 i.e. 18.5 percent 16 to 31 years back and 16 i.e. 59.2 percent migrated 32 or more years back. Among the Oraons, 17 persons i.e. 15.7 percent are migrants of whom 5 persons, i.e. 29.4 percent are inter-plantation migrants and 12 persons i.e. 70.6 percent are inter-State migrants. Further, of the migrants 17.6 percent, i.e. 3 persons migrated 0 to 15 years back an equal number have migrated 16 to 31 years back and 11 persons, i.e. 64.7 percent have migrated 32 or more years back. The Lohars have a migrant population of 14 persons accounting for 17.3 percent. Out of these 14 migrants, 11 persons, i.e. 78.57 percent are inter-plantation migrants and 3 persons, i.e. 21.42 percent are inter-State migrants of whom 9 i.e. 64.3 percent migrated 0 to 15 years back, 3 i.e. 21.42 percent migrated 16 to 31 years back and 2 i.e. 14.3 percent migrated 32 or more years back. Out of the 44 Bihari castes there are 11 migrants accounting for 25 percent. All the migrants are inter-State migrants of whom 4 i.e. 36.4 percent migrated 0 to 15 years back, 2 i.e. 18.2 percent migrated 16 to 31 years back and 5, i.e. 45.40 percent migrated 32 or more years back. The Nagesias have 10 of their members as migrants accounting for 27.02 percent. Out of them 7 i.e. 70 percent are inter-plantation migrants and 3 i.e. 30 percent are inter-state migrants. While 8 of them, i.e. 80 percent migrated

0 to 15 years back, 1 person each, i.e. 10 percent migrated 16 to 31 and 32 or more years back. Among the 17 Nepalis in the plantation there is only 1 migrant accounting for 5.9 percent of the population. The migrant is an inter-country migrant who migrated 16 to 31 years back. The Baraiks too have 1 migrant member accounting for 8.3 percent. The migrant is an inter-state migrant who migrated 32 or more years back. The number of migrants among the Malpaharias is only 1 accounting for 10 percent. The migrant is an inter-plantation migrant who migrated 0 to 15 years back. Among the 7 RajGonds the number of migrants is 1 who account for 14.3 percent. The only migrant is an inter-State migrant who migrated 32 or more years back. Migrants account for 33.3 percent of the Rautia population, i.e. there are 2 migrants among the population of 6 persons. Both the migrants are inter-State migrants who migrated 32 or more years back.

Table IV(C) which pertains to Matigara plantation shows that the number of migrants are 70 accounting for 10.29 percent of the plantation's population. Out of the migrants, 24 i.e. 34.3 percent are inter-plantation migrants, 10 i.e. 14.3 percent are intra-State migrants, another 24 i.e. 34.3 percent are inter-State migrants and 12 i.e. 17.1 percent are inter-country migrants. As regards the period of migration, the table reveals that 37 migrants i.e. 52.9 percent migrated 0 to 15 years back, 25 i.e. 35.7 percent migrated 16 to 31 years back and 8 i.e. 11.4 percent migrated 32 or more years back.

The community-wise analysis shows that among the Ghasis there are only 2 migrants who account for 1.5 percent of the population. Both the migrants are inter-State migrants who migrated 3 or more years back. The Mundas have a migrant population of 7 persons and account for 5.5 percent of the population. Out of them 5, i.e. 71.4 percent are inter-plantation migrants and 2 i.e. 28.6 percent are inter-State migrants. While 5 i.e. 71.4 percent of them migrated 0 to 15 years back, 2 i.e. 28.6 percent migrated 16 to 31 years back. Among the Mahalis, there are 3 migrants who account for 3.06 percent of the tribe's population. Out of the migrants 2 i.e. 66.7 percent are inter-plantation migrants and 1 i.e. 33.3 are intra-State migrants. All the 3 migrants migrated 0 to 15 years back. Among the Oraons migrants form 17.5 percent of the population with 13 persons as migrants. Out of them 3 persons i.e. 23.07 percent each are inter-plantation and intra-State migrants and 7 persons i.e. 54 percent are inter-country migrants. While 7 of them i.e. 54 percent migrated 0 to 15 years back, 5 i.e. 38.4 percent and 1 i.e. 7.7 percent migrated 16 to 31 and 32 or more years back. The Lohars have 10 migrants among them who form 13.7 percent of the population. While 7 of them i.e. 70 percent are inter-plantation migrants 2 and 1 i.e. 20 and 10 percent respectively are intra-State and inter-State migrants respectively. As regards the period of migration 7, 2

and 1 persons forming 70, 20 and 10 percent respectively migrated 0 to 15, 16 to 31 and 32 or more years back. The Bhoktas have 6 of their members as migrants forming 11.11 percent. Of the migrants 4 i.e. 66.6 percent are inter-plantation migrants and 2 i.e. 33.3 percent are inter-state migrants. While 3 i.e. 50 percent migrated 0 to 15 years back, 1 i.e. 16.6 percent and 2 i.e. 33.3 percent migrated 16 to 31 and 32 or more years back. Among the Nepalis there are 9 migrants constituting 26.5 percent of the population. Out of them 1 person, i.e. 11.1 percent is inter-plantation migrant, 3 persons i.e. 33.3 percent intra-State migrant and 5 persons, i.e. 55.5 percent are inter-country migrants. Of these migrants 3 i.e. 33.3 percent migrated 0 to 15 years back, 4 i.e. 44.4 percent migrated 16 to 31 years back and 2 i.e. 22.2 migrated 32 or more years back. The Bihari caste community has a migrant population of 15 persons, i.e. 65.2 percent all of whom are inter-State migrants. While 6 of them i.e. 40 percent migrated 0 to 15 years back, 9 of them i.e. 60 percent migrated 16 to 31 years back. The Kharias have a migrant population of 2 persons, i.e. 11.8 percent all of whom are inter-plantation migrants who migrated 0 to 15 years back. The Turis have 3 persons as migrants accounting for 25 percent. Of them 1 i.e. 33.3 percent and 2 i.e. 66.6 percent are intra-State and inter-State migrants respectively. While 1 i.e. 33.3 percent migrated 0 to 15 years back, 2 i.e. 66.6 percent migrated 16 to 31 years back. The Kisans, Malpaharias, Rohidasas, Bhuinhars and Birijias have no migrants in their population of 11, 10, 7, 4 and 2 respectively.

Income

The income of a household too has a great influence on health behaviour. The choice of a medical system depends, to a large extent, on the income of a household. Madan (1981 : p. 119) has observed that as the monthly income of household increases, the tendency to choose a medical system on the ground of effectiveness of treatment also seems to increase. He (1981 : p. 120) has further observed, that the combination of systems of medicine in a society, where there is coexistence of several systems of medicine, is influenced by the level of income of a household. Therefore, an analysis of the income of families in the three plantations becomes important. Tables V(A), V(B) and V(C) shows the ranges of per day income and the number of families in each range in the three plantations.

Table V(A), which pertains to Hansqua plantation shows that in total 195 families accounting for 70.65 percent have a daily income ranging from rupees 10 to 30, 75 families i.e. 27.17 percent have a daily income of rupees 31 to 51 and 6 families i.e. 2.17 percent have a daily income ranging from rupees 52 to 72. There is no family with a daily income of rupee 73 or more. The community-wise analysis shows that among the Oraons 120 families, i.e. 71 percent have a daily income of rupees 10 to 30, 45 families, i.e. 26.62 percent have a daily income of rupees 31 to 51 and 4 families have a daily income of rupees 52 to 72. There is no family with a daily income of rupees 73 and above. The Baraiks have 34 of

TABLE V(A)

TABLE SHOWING RANGES OF PER DAY INCOME AND THE
NUMBER OF FAMILIES IN EACH RANGE IN HANSQUA PLANTATION

COMMUNITY	RANGE OF INCOME (IN RUPEES)			
	10-30	31-51	52-72	73 and above
1. ORAON	120 (71%)	45 (26.62%)	4 (2.36%)	-
2. BARAIK	34 (75.55%)	11 (24.44%)	-	-
3. NEPALI	10 (47.6%)	9 (42.85%)	2 (9.52%)	-
4. SANTHAL	6 (60%)	4 (40%)	-	-
5. MUNDA	6 (85.7%)	1 (14.3%)	-	-
6. MAHALI	2 (50%)	2 (50%)	-	-
7. LOHAR	2 (50%)	2 (50%)	-	-
8. NAGESIA	4 (100%)	-	-	-
9. BIHARI	4 (100%)	-	-	-
10. MUSLIM	4 (100%)	-	-	-
11. MALPAHARIA	2 (66.7%)	1 (33.3%)	-	-
12. KHARIA	1 (100%)	-	-	-
TOTAL & PERCENTAGE	195 (70.65%)	75 (27.17%)	6 (2.17%)	-

TABLE V (B)

TABLE SHOWING RANGES OF PER DAY INCOME AND NUMBER OF FAMILIES IN EACH RANGE IN TAIPOO PLANTATION

COMMUNITY	RANGE OF INCOME (IN RUPEES)			
	10-30	31-51	52-72	73 and above
1. PARJA	28 (71.8%)	10 (25.64%)	1 (2.56%)	-
2. ORAON	17 (85%)	2 (10%)	-	1 (5%)
3. LOHAR	17 (89.47%)	2 (10.52%)	-	-
4. BIHARI	6 (85.71%)	1 (14.28%)	-	-
5. NAGESIA	5 (71.42%)	2 (28.57%)	-	-
6. NEPALI	-	3 (100%)	-	-
7. BARAIK	3 (100%)	-	-	-
8. MALPAHARIA	1 (50%)	1 (50%)	-	-
9. RAJGOND	-	-	1 (100%)	-
10. RAUTIA	1 (100%)	-	-	-
TOTAL & PERCENTAGE	78 (76.5%)	21 (20.6%)	2 (1.96%)	1 (0.98%)

TABLE V (C)

TABLE SHOWING RANGES OF PER DAY INCOME AND NUMBER OF FAMILIES IN EACH RANGE IN MATIGARA PLANTATION

COMMUNITY	RANGE OF INCOME (IN RUPEES)			
	10-30	31-51	52-72	73 and above
1. GHASI	24 (80%)	6 (20%)	-	-
2. MUNDA	21 (72.4%)	8 (27.6%)	-	-
3. MAHALI	16 (80%)	4 (20%)	-	-
4. ORAON	12 (75%)	4 (25%)	-	-
5. LOHAR	17 (94.4%)	-	1 (5.6%)	-
6. BHOKTA	5 (55.6%)	4 (44.4%)	-	-
7. NEPALI	3 (50%)	2 (33.3%)	1 (16.7%)	-
8. BIHARI	3 (100%)	-	-	-
9. KHARIA	3 (75%)	1 (25%)	-	-
10. TURI	3 (100%)	-	-	-
11. KISAN	1 (50%)	1 (50%)	-	-
12. MALPAHARIA	3 (100%)	-	-	-
13. ROHIDAS	2 (100%)	-	-	-
14. BHUINHAR	1 (100%)	-	-	-
15. BIRIJIA	1 (100%)	-	-	-
TOTAL & PERCENTAGE	115 (78.2%)	30 (20.4%)	2 (10.3%)	-

their families, i.e. 75.55 percent with a daily earning of rupees 10 to 30 and 11 families i.e. 24.44 percent with a daily earning of rupees 31 to 51. There is no family with a daily income of either 52 to 72 or 73 and above. Out of the 21 Nepali families, 10 i.e. 47.6 percent have a daily income of rupees 10 to 30, 9 i.e. 42.85 percent have a daily income of rupees 31 to 51 and 2 i.e. 9.52 percent have a daily income of rupees 52 to 72. There is no family with a daily income of rupees 73 and above. Among the 10 Santhal families, 6 i.e. 60 percent have a daily income of rupees 10 to 30 and 4 i.e. 40 percent have a daily income of rupees 31 to 51. There is no family with a daily income of rupees 52 to 72 and 73 and above. Of the 7 Munda families, 6 i.e. 85.7 percent have a daily income of rupees 10 to 30 and 1 i.e. 14.3 percent has a daily income of ^{rupees} 31 to 51. There is no family either with a daily income of rupees 52 to 72 or 73 and above. Among the 4 Mahali families 2 i.e. 50 percent have a daily income of rupees 10 to 30 and an equal number have a daily income of rupees 31 to 51. There is no family with a daily income of rupees 52 to 72 and 73 and above. The Lohars too, out of their 4 families have 2 i.e. 50 percent with a daily income of rupees 10 to 30 and an equal number with a daily income of rupees 31 to 51. There is no family with a daily income of rupees 52 to 72 and 73 and above. The Nagesias have four families all of which have a daily income of rupees 10 to 30. The same is the case with the Bihari caste community and Muslims. The Malpaharias have 2 of their families, i.e. 66.7 percent with a

daily income of rupees 10 to 30 and 1 family i.e. 1.33 percent with a daily income of rupees 31 to 51. There is no family either with a daily income of rupees 52 to 72 or 73 and above. The only Kharia family has a daily income of rupees 10 to 30.

Table V(B), that relates to Taipoo plantation shows that in total 78 families, i.e. 76.5 percent have a daily income of rupees 10 to 30, 21 families i.e. 20.6 percent have a daily income of rupees 31 to 51, 2 families i.e. 1.96 percent have a daily income of rupees 52 to 72 and 1 family i.e. 0.98 percent has a daily income of rupees 73 and above.

The community-wise picture reveals that among the Parjas, out of their 39 families, 28 i.e. 71.8 percent have a daily income of rupees 10 to 30, 10 i.e. 25.64 percent have a daily income of rupees 31 to 51 and 1 i.e. 2.56 percent has a daily income of rupees 52 to 72. There is no family with a daily income of rupees 73 and above. The Oraons have 17 of their families, i.e. 85 percent with a daily income of rupees 10 to 30, 2 families, 10 percent with a daily income of rupees 31 to 51 and 1 family i.e. 5 percent with a daily income of rupees 73 and above. Among the 19 Lohar families, 17 i.e. 89.47 percent have a daily income of rupees 10 to 30 and 2 i.e. 10.52 percent have a daily income of rupees 31 to 51. There is no family with a income of rupees 52 to 72 and 73 and above. Out of the 7 Bihari families, 6 i.e. 85.71 percent have a daily income of rupees 10

to 30 and 1 i.e. 14.28 percent has a daily income of rupees 31 to 51. There is no family with daily income of rupees 52 to 72 and rupees 73 and above. The Nagesias have 5 of their families, i.e. 71.42 percent with a daily income of rupees 10 to 30 and 2 of their families, i.e. 28.57 percent with a daily income of rupees 31 to 51. There is no family with daily income of rupees 52 to 72 and 73 and above. The three Nepali families all have a daily income of rupees 31 to 51 and the three Baraik families all have daily income of rupees 10 to 30. Among the 2 Malpaharia families 1 each, i.e. 50 percent have daily incomes of rupees 10 to 30 and rupees 31 to 52. The only RajGond family has a daily income of rupees 52 to 72 and the only Rautia family has a daily income of rupees 10 to 30.

From Table V(C), which pertains to Matigara plantation, it is revealed that 115 families, i.e. 78.2 percent have a daily income of rupees 10 to 30, 30 families i.e. 20.4 percent have a daily income of rupees 31 to 51, 2 families i.e. 1.3 percent have a daily income of rupees 52 to 72 and there is no family with a daily income of rupees 73 and above.

Among the Ghasis 24 families, i.e. 80 percent have a daily income of rupees 10 to 30 and 6 families i.e. 20 percent have a daily income of 31 to 51. There is no family with a daily income of 52 to 72 and 73 and above. Out of the 29 Munda families, 21 i.e. 72.4 percent have a daily income of rupees 10 to 30 and

8 i.e. 27.6 percent have a daily income of rupees 31 to 51. There is no family with a daily income of rupees 52 to 72 and 73 and above. Among the Mahalis, 16 families i.e. 80 percent have a daily income of rupees 10 to 30 and 4 families, i.e. 20 percent have a daily income of rupees 31 to 51. There is no family with a daily income of rupees 52 to 72 and 73 or more. Out of the 16 Oraon families 12 i.e. 75 percent have a daily income of rupees 10 to 30 and 4 families, i.e. 25 percent have a daily income of rupees 31 to 51. There is no family with a daily income of rupees 52 to 72 and 73 and above. Among the ~~Lehars~~ 18 Lehar families, 17 i.e. 94.4 percent have a daily income of rupees 10 to 30 and 1 has a daily income of rupees 52 to 72. There is no family with a daily income of rupees 31 to 51 and 73 and above. Among the Bhoktas, 5 families, i.e. 55.6 percent have a daily income of rupees 10 to 30 and 4 families, i.e. 44.4 percent have a daily income of rupees 31 to 51. There is no family with a daily income of rupees 52 to 72 or 73 and above. Out of the 6 Nepali families, 3 i.e. 50 percent have a daily income of rupees 10 to 30, 2 families i.e. 33.3 percent have a daily income of rupees 31 to 51 and 1 family i.e. 16.7 percent has a daily income of rupees 52 to 72. There is no family with a daily income of rupees 73 and above. Among the Biharis all the 3 families have a daily income of rupees 10 to 30. Out of the 4 Kharia families, 3 i.e. 75 percent have a daily income of rupees 10 to 30 and 1 i.e. 25 percent has a daily income of rupees 31 to 51. There is no family with a daily income of

rupees 52 to 72 and 73 and above. Among the Turis all the 3 families have a daily income of rupees 10 to 30. Among the Kisans 1 family each i.e. 50 percent have a daily income of rupees 10 to 30 and 31 to 51. There is no family either with a daily income of rupees 52 to 72 or 73 and above. The Malpaharias, Rohidasas, Bhuinhars and Birijias have all their families of 3, 2, 1 and 1 respectively with a daily income of rupees 10 to 30.

The average ^{income} per day per family in the three plantations of Hansqua, Taipoo and Matigara have been found to be rupees 26.80, rupees 24.70 and rupees 24.80 respectively. As the average per day income has been found to be so low it seems that it will be detrimental factor in the adoption of modern health practices.

CHAPTER IV

TRADITIONAL CULTURE OF THE TRIBAL WORKERS

Earlier it has been mentioned that the tribals inhabiting the tea plantations have different cultural backgrounds and different cultural practices. Also has been mentioned that the migration of the workers to tea plantations, which presents a new environment to them is likely to bring in changes in their culture patterns. Therefore, it will not be irrelevant to present a brief ethnographic note on the different tribes under study as, a view of the traditional culture will help in assessing the changes those have occurred in the traditional culture patterns. The cultural backgrounds of the tribes which have been discussed in what follows, are mainly based on the secondary sources depicting their traditional customs, beliefs and practices. This will reflect to a certain extent some of their beliefs, practices and concepts related to health and diseases.

The Mundas

The Mundas are Dravidians but linguistically they are classified as belonging to the Kolarian group. They inhabit the Chotanagpur division. In the Census of 1901, the total number of Mundas in India, excluding the Christian converts was found to be 466,668. According to Dalton (1973; p 164), they came to ChotaNagpur (earlier called Jharkhand) from Pipra and Paligarh, names found in Santhal traditions. When they first came to

Chota Nagpur they had no Raja. There were congeries of small confederate states. Each village had its chief also called a Munda. As a village often consisted of one family, the inhabitants were all of Munda dignity, hence it became the name of the whole tribe (Dalton, 1973: p. 165). Roy (1970: p. 207) believes that the name Munda have been given to this people by their Hindu neighbours. The Mundas call themselves 'Haro-ko' (men) and their race the 'Horo' (man). The original name of the tribe in their own language is unknown but the Mundaris of ChotaNagpur Plateau call themselves Konk Pat Munda, probably Konk or Konk Pat had been their national denomination. The Mundas are divided into number of exogamous groups called Kilis. All the members of the same Kili are descendants from one common ancestor. Though exogamous as regards the Kilis, the Mundas are endogamous so far as other tribes are concerned. It is only with the Bhumijes of Pargana Patkum which adjoins the Tamar Pargana of the Ranchi District that the Mundas of Tamar side still intermarry (Roy 1970 : p228).

The religion of the Mundas possess a Shamanistic rather than a Fetish character. They do not make images of gods, nor do they worship symbols, but they believe that though invisible to mortal eyes, the gods may when propitiated by sacrifice take up their abode in places specially dedicated to them for a time (Dalton, 1973 : pp. 185-186).

At the head of Munda religion stands Sing Bonga whose blessings are invoked before every important religious ceremony (Dalton, 1973 : pp 185-186; Roy 1970 : p 266). Ote-Boram¹ or Sing Bonga is believed to have created everything including the earth. Ote-Boram and Sing-Bonga are believed to be self created, they made the earth with rocks and water, clothed it with grass and trees and then created animals, at first those that man domesticates and later wild beasts. When all was prepared for the abode of man, a man and a girl was created (Dalton, 1973 : p 185). The man and the girl is believed to have originated from the egg laid by a swan (Roy, 1970 : p 328).

Sing Bonga, the creator and preserver is adored as the sun. Prayers and sacrifices are made to him as a beneficent deity who has no pleasure in destruction of any of the creatures.

The worship of sun as the supreme deity is the foundation of the Munda religion and also of the Oraons who address him as Dharmi. He is not regarded as the author of sickness or calamity, but may be invoked to avert it. Appeal is made to him when sacrifices to minor deities prove unproductive (Dalton, 1973 : p 186).

There are other deities who are considered subordinate to Sing Bonga. The second class of gods are the presiding deities of

1. Ote-Boram is but another name for Sing Bonga.

the village, called Hatu-Bongako (village gods) such as the Desauli Bonga, the Jaher Buri and the 'Chandi Bonga'. These gods help in agricultural operations, hunting excursions and guide in every concern of life and order every human event. They are worshipped by the 'Pahn' or village priest at stated times in the sacred groves of each village. The third class of gods are the gods of the household, the Ora-Bongako. These gods are the spirits of the deceased ancestors of each family. The Hatu-Bongako and the Ora-Bongako are the manating Bongas, who require to be worshipped. Besides the manating bongas there are the banita-bongas who are not gods but malevolent entities. They require propitiation done by ghost finders — Najos, Matis and Deonars. There is among the Mundas certain elemental spirits or Nature gods who stand midway between the beneficiary deities and the malevolent deities and are powerful for good and evil alike. Usually, these gods are believed to do good to humanity but when offended bring in wrath and have to be propitiated by a Najo or Deonara and sometimes by a Pahn. Buru Bonga, Ikir Bonga and Nage Era are such deities (Roy, 1970 : pp. 267-268). Buru Bonga also known as Maran Buru is the mountain god. The highest or most remarkable hill or rock in the neighbourhood is the shrine of the deity or spirit. Buru Bonga is regarded as the head of the heavenly water department. Recognizing the need for rain for irrigation special attention is paid to Buru Bonga². In most places buffaloes are sacrificed

2. Referred as Buru Bonga by Dalton (1973: p187).

every third year and fowls and goats every year in honour of the deity. There is no visible object of worship (Dalton, 1973: pp. 187-188). Ikir Bonga³ is believed to preside over the tanks, wells and anybody of stagnant water (Dalton, 1973 : p188). There is again a class of beneficent deities whose duty is to protect. An example is Achrael Bonga who presides over the interests of married women (Roy 1970: p 268).

All these deities and spirits are considered subordinate to "Sing Bonga". Though they possess supernatural powers there are cases beyond their authority, and when they are invoked in such cases it is their duty to intercede with Sing Bonga.

Alike all tribal communities the Mundas too cherish superstitions and beliefs. All disease in men or animals is attributed to one of two causes, the wrath of some evil spirit who has to be appeased or to the spell of some witch or sorcerer (Dalton, 1973 : p199). Generally Nasan Bongas and some other evil spirits are believed to cause diseases. Diseases of the skin, particularly leprosy which is of three kinds namely Berel sud, Ror sud, and pundi sud are believed to be caused by the Nage Era. Madness is believed to be caused by ones own bhut (ayega bonga). Cholera and diorreah are caused by Rog Bonga or Deb imai. The origin of certain diseases are however traced to physical causes. Thus epilepsy (Hanab-gonoi) is said to be caused by two

3. Dalton (1973 : p188) refers Ikir Bonga as Ekir Bonga.

insects fighting in the brain. Headache (Bo-hasu) is attributed to a poison from liver or rather bile ascending the head (Roy, 1970 pp.278-279).

The Mundas are essentially agriculturalists and they use a large variety of agricultural implements. A Munda usually manages his own carpentry. Cotton is grown by the Mundas in their own field and the women folk spin the cotton.

The staple food of the Mundas is boiled rice. For a side dish, the more well to do uses boiled pulse or dal. Except on special occasions, the poorer Mundas have only some boiled green herb or sag. The daily meals of the Munda are three in number, the morning meal, the noon meal and the evening meal. Except among the Mundas of the Panch Parganas and the only respectable portion of the Mundas of other parts of the district, beef, pork and buffalo meat as food is not disfavoured. The Hinduised Munda however abstains from most meats.

The favourite drink of the Mundas is rice beer or ili brewed at home. The drink is made by boiled rice which is fermented and mixed with certain kind of vegetable roots. This liquor is stored in earthen jars and becomes ready for use in about five days. Now-a-days however the Mundas frequent the distilled liquor shops. Smoking of tobacco is not generally undertaken by the Mundas except in the eastern parts of the district where powdered tobacco rolled up in sal leaves in the form of cigattes

is smoked. The use of betel and betel nut is unknown.

The Mundas have many festivals. The first or principal of them is Magh Parab or Desauli Bonga. This festival is held in the month of Magh or January. The spirits of the deceased ancestors — the household gods of the Mundas are the main objects of worship in this festival. The festival opens with a sacrifice to Desauli of three fowls, a cock and two hens, one of which must be black and offered with some flowers of Palas tree, bread made from rice flour and sesamuna seed (Dalton, 1973 :p196).

Next in order is the Sarhul festival. This festival is called Bah Bonga by the HOs. The festival takes place during the month of March-April (Chait). During this period the Sal trees are in full bloom. The boys and girls collect basket full of flowers, make garlands of them weave them in their hair and decorate their houses with them. Sal flowers are gathered and taken to the sacred grove and placed at the foot of the Jaher Sarna tree. The Pahy worships all the gods of the Munda pantheon in general and Chandi Bonga in particular (Roy, 1970 : p272). Each household makes a offering of Sal flowers and a cock.

The third festival is the Damurai held in May. Roy (1970: p272) mentions this festival as the Hon-Ba-Parob. The festival is held at the time of the sowing of the first rice crop. There is no public worship. The head of each family worships the household gods — the spirits of the deceased ancestors — as well as other deities (Roy 1970 : p272).

Hero Bonga is the next festival held in June. The Mundaris call it Harihar. Desauli and Jahir Burhi are propitiated. Every householder plants a branch of Bhelwa tree in his field and contribute to the general offering. In Singbhum district a goat is offered (Dalton, 1973 : p198).

Batauli⁴, also known as Radleta is held in the month of June (Asarh), just before the transplanting of paddy seedling commences in every village. The festival is essentially a sacrificial feast. Fowls are sacrificed at the Jaher Sarna of the village by the Pahn with offerings of rice beer, leaves of marua tree, gandharisag and fowls. All the bongas or deities are worshipped (Roy, 1970 : p273). Dalton (1973: p 198) adds that after some mysterious rites each cultivator strips off the wings of the sacrificial fowl and inserted in the cliff of the bamboo and struck up in the rice field and dung heap. It is believed that if this rite is omitted then rice will not mature.

The Karam festival, celebrated in the month of Bhado (August-September) is celebrated in certain Munda families. The head of the family, celebrating the festival brings two branches of the Karam tree and plants them side by side in the courtyard of his house. Milk, ghee (clarified butter) and bread made of rice flour is offered to the gods. Next day in the morning, Karam

4. In Dalton (1970: p198) 'Batauli' is mentioned as Bah-Towli Bonga. Also is mentioned that the festival is held in the month of July.

branches are carried by young men and thrown into a tank or stream (Roy, 1970 : p 273).

Kolom Sing Bonga⁵ is celebrated in the month of November (Aghran) and is also known as 'Karihan Puja'. The festival takes place after the transplanted paddy has been harvested. Paddy is not threshed before this festival. The bongas are worshipped with sacrifices of fowls supplied by the villagers and with offerings of rice beer (Roy, 1970 : p274).

Jom Nawa⁶ celebrated during Ashwin or Bhado (September) is not a religious festival nor is it observed by the Mundas in general. It is said to be an adoption of Hindu custom (Roy, 1970 : p274). The first fruits of the harvest is offered to Sing Bonga. Till the offering is complete no one shall eat the new rice (Dalton, 1873 : p198). Some villagers sacrifice a fowl each.

The Pha-Gu festival corresponds to the Holi festival of the Hindus. The festival is celebrated in March-April (Falgun) on the day of full moon. The Pahan or the village priest propitiates all the deities or bongas presiding over the woods, the hills, the streams, the fields and groves (Roy, 1970 : p271).

5. Referred to as 'Kalam Bonga' by Dalton (1973: p198).

6. Referred to as 'Jum-nama by Dalton (1973: p 198).

The Oraons

The Oraons form a community of settled agriculturalists who are presently distributed over a large tract of eastern India. They are a Dravidian speaking tribe found massed in the northern and western parts of ChotaNagpur proper and eastern parts of Sirguja and Jaspur and scattered in Singbhum, Gangpur, Bonai and Hazaribagh all in ChotaNagpur Province. The tribe is also found in Sambalpur of Central Provinces. The tribe is the best known Dravidian tribe on the tea gardens.

The tribe is believed to have migrated from the western coast of India. While some of the Oraon elders point to Gujrat as the starting point others point to Konkan (Dalton, 1973 : p245). The Oraons were for many generations settled in the Rothas and adjoining hills and in the Patna district from where they say, they were driven out by the Mohamedans. They claim to have been in ChotaNagpur before the birth of Phani Mukta Rai the first Nagbhangsi Raja.

When driven from Rothas, they divided into two parties, one under the chief went towards the north to the Ganges and eventually occupied Rajmahal hills, the other, under the younger brother of the chief went south east. They later on left Rajmahal hills and proceeded up the Sone river to Palamau and pursuing their course eastward found themselves on the highlands of ChotaNagpur.

The constitution of a Oraon village is the same as that of the Munda. In each, the hereditary 'Munda', or headman and the hereditary pahn or the priest have their lands on privileged terms as the descendants of the founders of the village.

The Pahn of the village is also in charge of the land dedicated to the service of the village gods. The priestly office always does not go from father to son. The post is filled by divination. The 'Munda' or 'Mahato' is the functionary to whom the proprietor of the village looks for its secular administration.

The Oraons have a curious system of dormitories for boys and girls. The system is now said to be dying out. The dormitory is called Dhunkuria (Dalton, 1973 : p247).

The Oraons are divided into tribes and are exogamous like the Mundas. The tribes are totemistic bearing usually the name of an animal or plant (Dalton, 1973 : p254). The names of the tribes are Tirki, Ekhar, Kirpotas, Laknar, Kujrar, Gedhjar, Kokhar, Minjar, Kerketar and Barar (Dalton, 1973 : p254).

Marriages among the Oraons follow the rule of exogamy. One cannot marry within ones own sept. Marriage of children is not favoured by the Oraons. Marriages are arranged by the parents but, if the boy and girl has preferences they are recognised. Bride price is prevalent. The bride groom with a large party of friends proceeds to the bride's house, the males go armed with warlike

weapons at their approach to the bride's place they are met with the bride's friends similarly armed, a mimic fight ensues which ultimately assumes the form of a dance. The bride and the bride groom also join the dance riding on the hips of one of their friends (Dalton 1973 : p252).

A bower is constructed in the front of the bride's father's residence where the bride and the bride groom is carried by women and made to stand on the curry stone, under which is placed a sheaf of corn resting on a plough yoke. Here the mystery of the Sindurdan is performed. The process is screened from view. Just after the Sindurdan is over the vessels full of water which are placed on the bower are capsized and the bride and the bride groom receive a drenching after which they have a change of clothes. They do not come out for sometime and when they emerge they are saluted as husband and wife (Dalton, 1973 : pp252-253).

There are no prescribed wedding garments. The bride is attired in ordinary habiliments. However, the bridegroom is more dressed than he is usually. There is no special season or months for marriages. But, hot and dry months are generally selected as there is not much work on land then (Dalton, 1973 : p253).

Polygamy and widow remarriage is permitted. Though Polygamy is not objected, men usually content themselves with one wife. Divorce may be obtained with the consent of both the parties.

The Oraons are predominantly agriculturalists. Occupations such as hunting, fishing, cattle rearing and crafts are subsidiary. They are found to work as labourers in construction works, tea gardens, mines and factories in neighbouring States (Bhowmick, 1971 : p148).

Dalton (1973 : p 256) says, that the Oraon religion is of a composite order. They, after coming in contact with the Mundas have either shed many of their original customs or have blended them. But they have no doubt retained some customs. The present Oraon religion has been described by Roy (1985 : p1) as a system of animism or rather spiritism set on a background of a still more primitive vague animatism. Bhowmick (1971 : p116), views it as a form of animism which is closely allied to that practised by the Dravidian tribes.

The Oraon recognised a Supreme Deity called Dharmesh, symbolized by the Sun. He is considered the creator of the Universe (Dalton, 1973 : p 256; Roy 1985 : pp 1, 15,19). Dharmesh is also referred to as Biri-Belas or the Sun-Lord (Roy, 1985 : p 19). There is no sacred grove or other seat specially assigned to Dharmesh nor is there any special season for worshipping Him. But the Oraons offers the sacrifice of a white cock at every important feast. Before every sacrificial feast too, the Oraon offers a libation of a few drops of water in the name of Dharmesh. In extreme distress when other deities or spirits fail, the Oraons offers prayers and sacrifices to Him as a last resource. The other

gods and spirits are under the control of the Dharmesh (Roy, 1985: p22). Just as the sun sees all that is going on in the earth and in the heavens, Dharmesh is also believed to see everything that man and the spirit does and what they think. He is regarded anterior to all, the Author and Preserver, Controller and Punisher of men, gods and spirits and all that exist in the visible and invisible Universe. The only ceremony in which the Dharmesh is invoked alone is the Danda Katta (tooth breaking) or Bhelwaphari (Bhelwa-twig splitting). Dharmesh is placed in a class apart. Alike are placed the spirit of the dead ancestors known as Pachbalar (Roy, 1985 :p26). The Oraon belief of the ancestor spirit seems to be the natural outcome of their belief in human soul. The soul, it is believed to leave the body temporarily daily during sleep and occasionally in sickness, trances and similar conditions. To Oraons dreams are realities. The supreme God or Dharmesh is believed to protect a wandering soul of a sick person. Ancestor-Spirits are also believed to guard a wandering soul. When an Oraon shows no sign of improvement from illness, the relatives call upon their ancestor-spirits (Roy 1985: pp 27-29).

The soul of a deceased is believed to enter the community of ancestor-spirits on the annual Koha Benja (great marriage) or Harbora (bone throwing) day when bones of all of a clan who have died in the course of one year are ceremonially drowned or deposited in the clan ossuary or Kundi (Roy, 1985 : p 29).

Offerings are made invocation is done to the ancestor-spirits at every feast and on every suitable occasion though there is an annual ceremony Harbora (All Souls' Feast) wherein offerings or sacrifices are made solely to the ancestor spirits (Roy 1985 : p 32). In the case of serious illness in the family, a vow is sometimes taken, to offer a grey fowl to the ancestor spirits. Ancestor-Spirits are classified into beneficent and maleficent. The beneficent ancestor-spirits are those who are died a natural death and maleficent spirits consists of those who have met with unnatural death (Roy 1985 : p38). The ancestor-spirits are believed to reside under the earth near their Clan-Pulkhi at the Kundi where their last remains, their bones are deposited.

There are the tutelary deities and spirits to whom periodical sacrifices are offered by the Oraon village-priest or Pahn on behalf of the village community. Some of these are regarded as Deotas or Gods and the others as Bhuts or Ghosts. To the former belong Pat or Pat Raja, Chala Pachcho or Sarua Burhia and Devi Mai and to the latter belong Darha and Desauli. In some villages Duarua or Duarsini and Mahadania are propitiated besides the Darha and Desauli. There are also certain minor spirits such as Bansakti, Garhadhora-Chatursiman and Tusabhura.

Chala Pachcho or the Old Lady of the grove ranks as the chief of the village deities and spirits. She is the most popular of the Oraon deities and receives sacrifices with most elaborate

ritual at the annual spring festival Sahrul held in her honour. Every Oraon village has a grove of Sal trees known as Chala or Sarna sacred to this deity. Chala Pachcho is said to be visible at times in the shape of an old woman with matted locks of white hair (Roy 1985 : pp 42-44).

Pat or Pat Raja is the master of all the village bhuts or spirits whom it controls and keeps under check. It thus protects the village from sickness and other misfortunes. Duaria or Duarsini is said to be the attendant spirit of Pat Raja. Pat is said to ride a Pony and patrol the village at times of epidemic. At one time Pat was regarded the foremost of all deities but now Pat has fallen in the background (Roy 1985 : pp45-46).

Darha is the most dreaded of the village spirits. This spirit acts as the guard of the village and protects the village from intrusion of other spirits. It has its seat on a plot of upland known as Darha-tonka or Darha-tanur situated near or on the boundary of every village. The land is left fallow. In some areas Darha is said to have another spirit named Deswali for its wife and a separate grove is allotted. But mostly Darha-Deswali is regarded the same spirit. In the Oraon villages of Palamau district Darha is considered to have a female companion by the name of Cherni (Roy 1985 : pp47-48).

Darha is ordinarily considered a beneficent spirit but in the case of a breach in his propitiation he brings in calamity on

on men and cattle. At stated intervals (varying from village to village) from three to twelve years) a buffalo has to be sacrificed in honour of the spirit. In the intervening years sheep or goat besides fowls are offered (Roy 1985 : p48; Dalton 1973: p258).

In some areas a spirit called Mahadania is considered to be more terrible than Darha. It is also called Daha-Pachcho. It is a male spirit. To Mahadania human sacrifice use to be offered which is to a great extent abandoned. However, in distant remote areas human sacrifice is still believed to be practised. Once in every nine or ten or twelve years, the spirit has to be propitiated with a big sacrifice. The spirit, if not properly propitiated at the appointed time, is believed to bring about most terrible epidemics and death to villagers (Roy 1985 : pp 50-51).

The Devi Mai or Mother-Goddess is borrowed from the Hindu neighbours. Near the entrance to Oraon villages there is a Devi-asthan or Devi-manda or alter for this deity usually by the side of a palas tree. The symbols those represent Devi Mai are three, five or seven lumps of earth in the form of small cones representing the breasts of the goddess (Roy 1985 : pp 52-53).

Besides these general spirits there are certain special spirits who may be offered with periodical sacrifices by the villagers, e.g., in village Bandi a sheep or buffalo is sacrificed alternately once in twelve years to a spirit known as Chappar Burhia (Roy, 1985 : p 55).

There are believed to be minor deities who reside in woods, rivers and streams and in the nooks and corners of the villages and are collectively called Garha-dhorha-chatur-siman or Banshakti. These deities are invoked on the occasions of periodical sacrifice.

Chandi, a female deity is believed to bring success in hunting and war. This is the deity par-excellence of bachelor young Oraons. In an Oraon village there may be more than one seat for this deity. Married persons are not allowed to offer sacrifices to this deity. The great annual sacrifice to her is celebrated on the full moon-day. It is believed that Chandi appears in various terrible shapes such as those of tiger, snake and elephant and if one gets frightened he is sure to be punished with an attack of fever (Roy 1985 : pp 60-64).

Acharel and her companion Joda are special spirits of women. Once in a generation, each Oraon family must celebrate the puja of Acharel for the well being of the female children married as well as unmarried young or old. Periodical as well as special sacrifices are offered to her. Joda the female companion of Acharel to receive sacrifices for the welfare of the nieces, daughters and sisters of the head of a family. While Acharel is propitiated with sacrifice of goat-kid Joda is offered sacrifice of a female sheep (Roy 1985 : pp 65-68).

Clan spirits or Khunt-Bhuts, spirits of the original families of a village are propitiated by the descendants called Bhuinhars. The Bhuinhars are divided into Khunts entrusted with the propitiation of their respective Khunt-Bhuts. Ordinarily, some land belonging to the Khunt is fixed as the seat of the Khunt-Bhut and at that place, at stated intervals, sacrifices are made the failing of which brings sickness or other calamity on the members of the Khunt or their cattle and on the villagers generally. The sacrifices are made ordinarily by a member of a Khunt but now a days the village Pahan is invited to officiate (Roy, 1985 : pp 68-72).

Household spirits such as Baranda Pachcho, Chigri Nad and Goesali Nad are propitiated with sacrifices made to them by each non-Bhuinhar or separated family in each generation. Baranda Pachcho or Lady Baruda is believed to be the guardian spirit of each separate household (Roy 1985 : p 72).

The Oraons also believe in some supernatural powers which are more or less impersonal. To this category may be included certain totem symbols, the village flags and certain other village emblems, certain musical instruments and weapons, some particular tree or grove and tank or a well. In some of these the existence of spirit is recognized and in others an immanent power or mysterious energy is believed to be there.

There is also a class of mischivious spirits who do not require any propitiation but have to be scared away by exorcists. These spirits are spirits of persons dying unnatural deaths, certain water spirits and stray disease spirits (Roy 1985 : p,96).

There are certain forces of evil known as najar gujar, bhaibhak, and Chhut, evil eye, evil mouth and evil touch recognized by the Oraons and appropriate measures are taken. Misfortunes to himself or his family or cattle are attributed to the evil eye or the evil word of some malicious witch or sorcerer which either acts directly or has the effect of arousing some spirit (Roy 1985 : pp.102-104).

Besides propitiation of gods and spirits of various degrees of power the Oraons also observe special rites and ceremonies to ensure safety at the turning points of an individual life. Thus there observances connected to birth, puberty, marriage and death.

The festivals of the Oraons are the same as the Mundas. The festivals are observed to ensure the safety and prosperity of the village community. The festivals are connected with their economic pursuits, mainly food-gathering, hunting, cattle tending and agriculture.

Two festivals, the Phagu and the Khaddi or Sharul are connected with food gathering.

The Phagu festival celebrated in the month of Phagun (February-March) is really the festival of the Hindus adopted by the Oraons in mutilated form, because it stands in similarity with their own Khaddi or Sarhul festival. The month of 'Phagun' not only marks the end of the Dying Year but also the birth of a New Year. It is only after the Spring-hunt and the Phagu that the Oraons may gather Mohua flowers for use as food. The Phagu now-a-days is more associated with hunting among the Oraons. It is preceded and followed by a hunting festival called Phagu Sendra (Roy 1985: pp.192-193).

Khaddi or Sahrul is observed in the month of Chait (March-April) i.e. spring. Some observances of the Oraons during this festival differs from those of the Mundas. The Oraons believe this to be the season of the marriage of Dharti the earth and the celebration cannot be had without the blossoming of Sal flowers (Dalton 1973 : p.261). The ceremony takes place at the sacred grove or Sarna, in which the Sal flowers form the essential element. Untill this festival is held no Oraon is supposed to consume or use the new fruits, flowers or edible leaves of the season (Roy 1985 : p.194).

On a day fixed after consultation the Pahan accompanied by the villager go to the sacred grove and sacrifice five fowls after selecting according to colours for each deity (Dalton 1973 : p261; Roy 1985 : p208). The fowls are later cooked with rice and offered to the persons present. The people then return to the village laden

with sal flowers. The next day the Pahan with some males pays a visit to each house of the village with an open basket of 'Sal' flowers as he approaches each house the women folk washes his feet. There is a common feasting and beer drinking.

The Oraons have three festivals connected with hunting, Phagu-Senda, Bisu-Sikar and Jeth-Sikar. Phagu Senda is undertaken every year in the month of Phagun or March, Bisu-Sikar in the month of Baisakh or April-May and Jeth-Sikar in the month of June. The Danda Katta ceremony to ward off the evil eye and the evil mouth and sacrifices to Chandi the presiding spirit of hunting are the religious and magico-religious rites connected with these hunts (Roy 1985 : pp.227-228). Phagu Senda or the Spring-hunt terminates with the Phagu festival. Bisu-Sikar or the Summer hunt is celebrated just before the time of sowing of paddy seeds is believed to be connected with the growth of paddy. For two months after Jeth-Sikar or Rainy Season hunt, an Oraon should abstain from killing any animals. A breach of this taboo is likely to affect the growth of paddy crops.

Each hunting festival is followed by Jatras of dancing festival. The Jatras are not merely festivals of rejoicing but are of magical importance to the tribe for they are believed to have influence on the economic prospects of the tribe. The Jatras also carry a social significance.

The only festival connected with cattle is the Sohorai . This festival is adopted from the Hindus, to be specific, from the cattle tending Ahirs (Roy 1985 : p.231).

The main agricultural festivals celebrated by the Oraons are Hariari celebrated during June-July (Asarh), Kadlota celebrated in the month of August (Bhado), Khara Puja celebrated in October-November (Kartik or Aghan), the Karam and the Jitia festivals which respectively precede and follow the Kadlota. Hariari is celebrated after paddy and cotton seeds are sown in all the fields of the village. Unless Hariari is celebrated no one in the village may transplant his fields. Though Hariari is a public celebration still individual Oraons also make private Hariari puja by offering sacrifices of fowls in their houses to their ancestor spirits and Khunt spirits before they begin to transfer paddy seedlings to their fields. On a day appointed after consultation amongst the Panch or village elders the gairahi or public Hariari is held. Fowls are sacrificed as are sometimes goats and sheeps. Each sacrificial animal is identified to a particular spirit (Roy 1985 : pp.235-237).

Kadlota or Kadleta is celebrated when rice grains have formed in the rice plants. Apprehensions of danger to the crops not only from mischievous birds and beasts but also from evil eye; envious tongue of man and evil spirits is the source of this festival. The Kadlota festival is followed by the Danda Katta ceremony. Generally the tenth day of the moon in the month of August is selected for the celebration of Kadlota. Fowls are sacrificed, collected from the houses of some of the villagers and taken to some upland where the festival is held (Roy 1985 : pp.238-239).

The Karam festival according to Mr. Luther is the most important festival of the Oraons (Dalton 1973 : p.259). It has been borrowed from the Hindu or the semi-Hinduised Neighbours. It is in a manner incorporated with the Kadlota festival of which it forms a part (Roy 1973 : p.240). The Karam is essentially a festival of the women and particularly of maidens. Medicine men or witch doctor or spirit doctors conduct their disciples on the day of the Karam festival. According to Dalton (1973: p.259), the festival is celebrated when the time comes for planting rice grown in seed beds. But, according to S.C. Roy (1985 : p 240), it forms a part of Kadlota, but this does not seem to hold good.

The Jitia festival is celebrated twelve days after the Karam festival. This festival too is a borrowing from the Hindus. The festival is not celebrated at a public place but, an individual's house is selected every year where the villagers gather. Ancestor spirits of that individual's family are propitiated with offerings of rice-gruel or pumpkin, Jhingi and Gongre flowers (Roy 1985: PP 247-248).

Kharra Puja or Kharihani is the last agricultural festival of a year. No villager ~~th~~resh his paddy before the village priest has prepared his threshing floor and has performed public Kharra Puja on it. Fowls are sacrificed to the principal deities and spirits. Each villager perform this puja privately in the threshing floor of each Khunt (Roy 1973 : pp.249-250).

The dichotomy of the supernatural world into the Spirit of Good and the forces of evil has led to the origin of two classes of magicians — the White Magicians known as Bhagats or Sokhas and the Black Magicians known as Matis or Deonras. The former class derive their beneficent powers from the God Mahadeo while the latter derive their power from magic spells or mantrams and also seek the help of some evil spirit. Witches or dains and wizards or bisahas are also Black Magicians.

The Bhagats or Sokhas are summoned to divine the cause of some calamity and remove it. The Matis or Deonras are professionally employed not only to divine the causes of similar calamities and to exercise spirits set up by other Matis or by Dains or Bischas but also to cause calamity to a clients enemy (Roy, 1985 : pp.256-251).

The art of each class of magicians has to be learnt through an intensive training imparted by low caste Hindus.

The Gonds or Raj Gonds

The Gonds are perhaps the principal tribe of the Dravidian family and the most important of the non-Aryan tribes. They found in the States of Madhya Pradesh, Orissa, Maharashtra, Andhra Pradesh, Bihar, Mysore, West Bengal and Gujrat, but their highest concentration is in Madhya Pradesh. The origin of the term Gond is uncertain. It is probably the name given by the Hindus and Mohammedans. The members of the tribe call themselves Koi or Koitur (Bhowmick, 1971 : pp.92-100; Tea District Labour Association,

1924 : p.188). The tribe has a language of its own known as Gondi and are found to speak a number of dialects of Dravidian family of language. Some Gonds are found to be expert in speaking the neighbouring languages. According to Dalton, he has not met any Gond in Bengal who has knowledge of Gondi.

Among the Gonds proper there are two aristocratic divisions the Raj Gonds and the Khatolas. The Raj Gonds are a landholding class (Tea District Labour Association, 1924 : p.160). They are supposed to be descendants from families who attained the dignity of chief (Risley, 1891). According to Dalton (1973: p.275), the Hindu subjugators of the Gonds are traditionally styled Rajputs, who formed alliances with the families of the chiefs and hence sprung a superior class of Gonds who assumed the title of Raj Gonds.

The Khatolas are suspected of mixed descent and in some parts they are not married by ordinary Gonds.

The Koya Gonds inhabit Andhra Pradesh. The Gaita and Gattu Gonds are found in the Chanda region. Gond groupings are also found named after the territories they inhabit e.g., the Larhia, who inhabit Chattisgarh, the Mandlaha, who inhabit Mandla and the Lanjiha of Lanji etc.

The Gonds of Bastar have two sub divisions, the Maria Gonds and the Muria Gonds. Muria means a group with permanent settlement. The Marias are wild and are apparently named after 'Mad' as the hilly tract of Bastar is called. Dalton says that the

name Maria is derived from the Gondi term for tree. The Murias live on plains and are more civilized. These two groups are further divided into small exogamous septs. According to Russell (1916), the septs of Maria Gonds are divided into two great classes; there are ninety septs in class 'A' and sixty nine in class 'B'. The Muria Gonds are divided into large exogamous clans named after animals in Hindi.

The Gonds of Chhindwara and other places are divided into moities on the basis of number of gods worshipped. Some worship two, some three, some more than three upto seven. There are restrictions on the inter marriage of different classes. However, there is no individual name for each moeity (Bhowmick, 1971 : p.101; Dalton, 1973: p.280). The name of the gods are different in different places.

The territorial units of the tribe are divided into phratries. Each phratry is exogamous. The Gonds in Chanda have four phratries. The members of a phratry distinguishes themselves from those other phratries by the number of gods they worship.

The patrilineal clan or Kur is another important group of the Gonds. The clans are territorial in nature and each clan has a respective place of origin locally known as bhum. Members of a clan maintain territorial affinity with the bhum. Each clan is exogamous and have a set of clan gods. The clans are also totemistic. Recently there has developed among the Gonds a type of ancestral clan known locally as gotra. This is a borrowing

from the Hindu neighbours (Bhowmick, 1971: p.162).

The exogamy of the Gonds appear to preserve traces of the system found in Australia. Though the Gonds are described as monogamous, polygynous marriages are not unknown. Sorroral polygyny is preferred. Tribal endogamy is highly esteemed though now-a-days marriages with members of other communities are noticed. Junior Levirate is in practice.

Cross cousin marriage of parallel type is not practiced, but mother's brother's daughter and father's sister's daughter types of cross cousin marriages are popular. Adult marriage is a rule, though child marriage is not opposed. Pre-marital affairs are usual. Mates are acquired through negotiations, by purchase, by exchange, by service, by intrusion and by elopement (Bhowmick, 1971 : p.105). In case of negotiated marriages Bethrotals take place about two years before marriage but a divination is employed to ascertain if the proposed union will prove to be a happy one (Dalton, 1973 : p.279).

Marriage customs of the Gonds differ from place to place and from group to group, however, there are certain items common such as perambulation at the sacred pole anointing of a paste of turmeric and oil on the body of bride and bride groom, drinking and dancing and ceremonial feasting (Bhowmick, 1971: p.105). A distinctive feature of Gond marriage is that the ceremony takes place at the bride grooms house (Tea District Labour Association, 1924 : p.161).

Divorce is allowed and sanctioned by the community. Divorce can be obtained on the grounds of adultery, quarrelsomeness, sexual disorders. Childlessness is never considered a cause for divorce (Bhowmick, 1971 : p.106; Tea District Labour Association, 1924: p.162). Divorce is obtained by summoning of village panchayat, reclaiming of bride price and a feast.

Widow and widower remarriage is permitted (Tea District Labour Association, 1924 : p.162; Bhowmick, 1971 : p.106; Risley 1891).

In mind the Gond society does not consist only those who live on the earth. Dead members of a clan also form part of a community. The Gond funeral is in many respects a sequel to the marriage rite. For the Gond who dies unmarried the full rites may not be performed and he remains for ever outside the company of god and the departed clan members. On the other hand even a virgin boy or girl who has undergone wedding rites is eligible for cremation and ritual introduction to the god and the departed clan members (Haimendorf, 1979 : p.363). The funeral rites relate much more to the passage of the spirit from the dwellings of the living to the world beyond.

The Gonds ascribe the inception of life in a human embryo to the entrance of a jiv, a life force sent there by Bhagavan, the supreme god. Death is considered the direct result of the jiv leaving the body and diseases are taken to be devices designed by Bhagawan to facilitate the work of jiv leaving the body (Haimendorf, 1979: pp.363-364).

Elaborate rites and rituals surround a death. Natural or normal death is followed by cremation. Those who die un auspicious death and women who die during pregnancy or child birth are not cremated (Haimendorf, 1979: p.369). Due to economic constraints sometimes persons eligible for cremation are buried with minimum of ceremony (Haimendorf, 1979 : p.369). A child who dies before name giving ceremony is buried (Bhowmick, 1971 : p.106). In the case of normal death the body is laid on the floor of the living room with the head pointing towards the east. In the case of burial the body is buried with head pointed towards the north.

In all funeral rites specific parts are assigned to both agnatic and affinal kinsmen. Certain acts may be performed by the agnates while others are the duty of the affines. However, two persons are chosen as the chief actors. One of them must be the son failing which a close agnatic kinsmen and the other must be a affinal kinsman. Bhowmick (1971 : p.106) mentions of 'sister's son and son in law as the chief actors. Several women also play conspicuous roles. There is no specific mourning period (Haimendorf, 1979 : p.370).

The traditional Gond religion represents a form of animism considerably influenced by doctrines, beliefs and rituals of the Hindus and Muslims. The propitiation of various spirits and deities is still important. Animism is reflected in the cult of objects supposed to be the abode of spirits. Bar Deo and Dulha Deo are characteristic deities. The spirit of the dead are worshipped.

The distinctive feature of Gond religion is the worship of phratry and clan deities described as Persa Pen or Great God. The vital role of the worshipping this deity is furthering the cohesion of the clan (Haimendorf, 1979 : p.428). The Gonds of Chindwara consider Dula Deo and Persa Pen⁴ as one (Dalton, 1973: p.280). Persa Pen has the symbol of a battle axe fastened to a tree.

Besides the Persa Pen cult which forms the mystical tie between the members of a clan, there are village deities which invite no corporate action but the cult of which is the responsibility of the community, limited by the confines of a village. The foremost among the village deities are the Aki Pen, the village mother. Both of them are worshipped whenever the village community as a whole takes up any ritual activity (Haimendorf, 1971 :p.432). There are certain other female deities, all referred to as Auwal. Some of them are associated with specific regions, while some have functional characteristics. Unlike other tribals of middle India the Gonds are not worried about evil spirits. Basic to Gond belief is the idea that none of the invisible things peopling the world is fundamentally evil. It is only when they are angered by offensive action by human being that danger arises. The spirit of the dead is propitiated. There is not periodical worship of the ancestors of a family.

4. Mentioned as Pharsi Pen in Dalton (1973: p.280).

Human sacrifice was practised by the Gonds, but it has been given up. Now-a-days they make up an image of a man with straw and other materials to serve the purpose (Dalton, 1973 : p 281).

Sorcery is believed to be prevalent among the Gonds and is the prerogative of the males. Sorcerers play a vital role in all stages of life.

The main festival of the Gonds is one which resembles the Holi of the Hindus. The Holi of the Gonds though has outward featural resemblance with the Holi of the Hindus is of different significance. It is a solemn affirmation of the unity of the village community. The festival also signifies the beginning of the new agricultural year which starts with the full moon of Durai.

The full moon of Chait passes inconspicuously but the following new moon, the beginning of Bhave is the occasion of a feast celebrated by the entire community. Chenchi Bhimana and Irku Pen or Persa Bhimana receive worship. Fowls and goats are sacrificed. The night is believed to be the wedding of Chenchi Bhimana. The rites have two parts, the first fruits offering of Chironji and the Pantomime of sowing, harvesting of crops and the performance of sympathetic magic par-excellence. All the phases of the agricultural year are enacted.

Bhave is the month of feasts and celebrations. The great feasts in honour of the clan deities are preceded by the more or

less elaborate rites for such deities as Jangu Bai, Boani, Bhimana and Rajul Pen. The worship of such a deity is the responsibility of individual families.

At the new moon of Bur Bhaye, the month of the breaking of monsoon, is the season of the beginning of the ploughing and sowing and culminates with ripening of the first crops. The Gonds see the need for creating an atmosphere of harmony. On a day the boys of the village collect golden Cassia and scatter in at all shrines and sacred stones. They also strew the thresholds of every house with the flowers.

Akari rites corresponds to June-July, the first month belonging to the rainy season. Two important rites are performed on consecutive days. The object of the rites is securing divine protection for cattle and herdsmen on their wandering in the forest. For the first of these rites men assemble at the village border and on the path leading from the village a fowl is sacrificed to Datur Auwal praying for protection of cattle. The second rite known as Akari rite helps to secure in a magical way the safe return of the animals. This is held in honour of Polam Rajul, a god holding sway over villages and forests. Sacrifices of chicken and goats are made. A separate offering is made to Gauri Pen who protects the cattle from tigers.

Pola rite is observed in July-August. The herd boys go from house to house and beg millet flour and dal. Taking provisions with them they drive cattle to a stone sacred to Chopen Pen, the god of salt lick. The cattle are gathered near the stone and

offerings are made to Chopen. The same day in the evening when all the cattles have returned to their cattle sheds are rite in honour of Dodi Marki the mother of cow sheds is performed. Days before Pola, offerings are made to Siwa Marki the goddess of village boundary. A fowl and a sheep is sacrificed. On the full moon day of Pola the Gonds in conformity to the practice of Hindus perform Nagalpanch rites to propitiate the cobras. In some places Hanuman and Shiva are worshipped.

In the month of August-September when the rain crops begin to ripen the ritual first eating of the crops is performed before any of them may be eaten. Even the vegetables of the kitchen garden should not be touched until the ritual first eating is done. The Nowon rite is therefore performed. The rite consists of the offering of the first Sama ears and early vegetables and subsequent ceremonial eating of the new crop. All the village deities are propitiated on this occasion.

On the dark moon night between Akurpok and Diwali, the month corresponding to September-October is held, the rite 'Petre Amas' for the honour of the departed. This rite is observed only by the members of the Raja families. Twelve married couples eat at the dead of the night a sacramental meal, and it is believed that the spirits of the departed attend the ceremony and share the meal. The rite is a minor one and domestic is character. New rice is offered to Aki Pen and Auwal.

Formerly, the Gonds had to depend on food gathering. But now-a-days the life of the individual Gond and indeed the life of the whole community is sustained by agriculture and the whole nature of the Gond culture can be understood against the background of agricultural activities (Haimendorf, 1979 : p394). Though majority of the Gonds follow agriculture as their primary occupation many have been found to be engaged as field labourers, wood cutters, milkmen, herdsman, artisans and other activities. Many work as boatman, carpenter and many are in white collar jobs.

The Gonds domesticate animals like cow, bullock, buffalo, pig, goat, sheep, dog, fowl and pigeon. Buffalo, goat and cow are domesticated for milk. Bullock and buffalo are used for plough harnessing. Pig is domesticated for meat and fowl for egg and flesh (Bhowmick, 1971 : p. 96).

The Gonds usually have a uniform food habit. They take three meals a day. Their staple food is gruel of millet and rice boiled in water. Another common dish is the broth of millet. Rice is held as a special dish and usually prepared for feasts. Vegetables such as pumpkin, cucumber, leaves of gram, yams, mangoes, tamarind and others are consumed. Moreover, different roots, tubers, mushrooms are consumed. They are not particular about choice of meat of animals but, pig, fowl, deer, rabbits, pigeon, white dove, snake are preferred.

The Baraiks

According to Risley (1891), the Baraiks are sub-castes of the Pans of Chota Nagpur. The Pans of Manbhum are said to call themselves Baraiks. In Ranchi they are found under the name of Chik or Chik-Baraik.

The tribe has numerous totems including the tiger, buffalo, monkey, tortoise, cobra, owl, king crow etc. The totem follows the male line of descent and a man may not marry a woman who has the same totem as himself.

Marriage among the Baraiks is usually adult. A bride price of Rs. 2 in cash, a mound and a half of husked rice, a goat and two saris is paid. 'Sinduran' and tying together of the hands of the bride and the bridegroom and considered to be the essential parts of the marriage ceremony.

The religion of the Baraiks is a sort of bastard Hinduism, varying with the locality in which they happen to be settled. Traces of primitive animism are found beneath the thin covering of Hinduism. Bar Pahar is worshipped in the month of Phalgun (February-March) with the sacrifice of a he-goat.

The Baraiks do not have any particular festival. They observe every festival according to their convenience.

The Baraiks are traditionally weavers and basket makers. Their traditional occupation is slowly being replaced by agriculture and other occupations.

Beef and Pork are relished by the members of the tribe. They also drink heavily.

The Kharias

The Kharias are a Dravidian cultivating tribe of Chota Nagpur and classed on linguistic grounds as Kolarian. One of their traditions suggest that they succeeded the Oraons as settlers in the country between Rothas and Patna. Another tradition suggests that they came from Moharbhaj (Risley, 1891)⁵. From Moharbhaj they made their way up the valley of the Koel river to the south western corner of Lohardaga district where they are now concentrated.

The Kharias of Lohardaga are divided into four sub-tribes — Dil-Kharia, Dud-Kharia, Erenga-Kharia and Munda-Kharia. The Dud-Kharia affect a leaning towards Hinduism and do not eat beef. The Munda-Kharia are supposed to be the offspring of an intrigue with a Munda woman. Hypergamous relations subsist between the two tribes. Kharia women are at times taken as wives by the Mundas.

5. Dalton (1973: p. 159) mentions that there is also a tradition which says that they had come from the south and ascended the valley of the Koel river till they found themselves in the present location.

Exogamy is practised and a man may not marry a woman of his own sept. The Kharias are said to have a certain degree of laxity in terms of consanguineous marriages. Girls are married after puberty and pre-marital sexual intercourse is tacitly recognised. Lately, some rich Kharias have taken upto infant marriages following Hindu fashion (Risley, 1891).

Marriages are fixed by the parents and bride price ranging from one to ten heads of cattle must be paid before the day can be fixed. The day of marriage must be in January-February (Risley, 1891).

The primitive idea of marriage with the Kharias was a dance and a feast. The Kharias have no word for marriage in their own language. They have borrowed the term bibah from the Hindu neighbours along with certain ceremonies (Dalton, 1973 : p. 160). The day before the marriage the bride's party escorts her to the bridegroom's house and stay at a place prepared for them. Both the parties are provided with a earthen jar of water wreathed by ears of rice and crowned with a lamp. The day is spent with dances and songs. Early next day the bride and bridegroom are anointed with oil and taken to bathe. After this the bride and the bridegroom stand facing each other on the yoke of a plough placed on five bundles of straw spread on the ground and the bridegroom smears vermillion on the brides forehead (Risley, 1891; Dalton, 1973 : p. 160). After the rituals the party sit down under a tree to feast. While the feast is on the bride is

required to wash a cloth before the company. This signifies that the bride is prepared to do all sorts of work in the family.

Widow remarriage is permitted and divorce is allowed on the ground of adultery. A divorced woman can marry again.

The religion of the Kharias may be defined as a mixture of animism and nature worship, in which animism predominates. As the nominal head of their system we find Bar-Pahar, to whom buffaloes, rams and cocks are offered at uncertain intervals. He seems to be a deity who brings neither good nor evil to mankind and is not in-charge of any special department (Risley, 1891). There are, then, working deities such as Dorho-Dubo who delights in muddy places and takes care of the darhis or spring of water. Pigs, goats and red fowls are offered to him. Nasan Dubo is the god of destruction who scatters death and disease and must be propitiated with sacrifices of five chickens. Giring Dubo is the sun⁶. Every family must offer five sacrifices to this divinity. The first of fowls, the second of pig, the third of a white goat, the fourth of a ram and the fifth of a buffalo. In praying to Bero or Giring Dubo the Kharias refer to him as Parameshwar. The moon is worshipped as Jyolo Dubo. A black cock is offered to this god. Pat Dubo is a god who loves rocky places

6. Dalton (1973 : p. 159) mentions that the Kharias worship the sun under the name Bero.

and is propitiated by offering of grey goat or reddish brown fowls. Donga Darha and Mahadan are hill gods propitiated with offering of a white goat and rams respectively. Gumi is the god who lives in the sacred grove a cow is offered to him. Agin Darha is the protector of the rice crop and is offered a white goat. Kara Sarna is believed to be responsible for cattle disease and a buffalo is sacrificed at the outbreak of a disease (Risley, 1891).

The religious festivals of the Kharias are identical with the Mundas. They have adopted from the Hindus the custom of the boring of the ears of the children and the occasion when the hair is for the first time tied up.

The Kharias do not employ Brahmans for religious and ceremonial purposes. They have their own priest called Kalo whose office is usually hereditary. They also take the help of the village Pahan who is usually a Munda or a Oraon.

Corpses of married persons are cremated while those of unmarried are buried. The ashes and bones of the dead who has been cremated are put into an earthen vessel and thrown into a river and tank (Risley, 1891; Dalton, 1973 : p. 160).

The settled Kharias are cultivators and in the south west of Lohardaga many of them claim to be bhuinhars. In other parts

they are tenants at will and farm labourers. The wild Kharias of Manbhum and Gangpur practise Jhum method of cultivation. The Dud-Kharias abstain from beef and eat Kachchim. The other Kharias eat monkeys and various types of other animals.

The Parjas

The Parjas are believed to be the offshoot of the Gonds. They reside principally in the Zamindari of Jeypore in the Madras Presidency and in the Central Provinces. There is a certain degree of confusion as to the name of this tribe but it appears that it is derived from the Sanskrit word Praja meaning a subject (Tea District Labour Association, 1924 : p. 166).

The tribe appears to have resided originally in the Madras Presidency and migrated from there to the Central Provinces. According to one of their traditions, the Parjas were the original Gond inhabitants of the country and were supplanted by a later immigration of the same tribe who reduced them to subjection and became Raj Gonds.

The tribe has exogamous totemistic septs, as bagh, a tiger, Kachim, a tortoise, bokda, a goat, netam, a dog, etc. Killing of the animal after which the sept is named is prohibited.

The tribe has many endogamous sub-divisions such as, Barang Jodia, Pengu Proja, Khondi, Parengi Parja, Bonda or Bunda, Tagara Parja and Dur Parja.

Marriage is prohibited between members of the same sept. As however the number of sept is small, the rule is not adhered to now and members of the same sept is allowed to marry so long as they do not belong to the same village. The proposal of marriage is made by the boy's father, who first offers a cup of liquor to the girl's father in the bazar and explained his wishes. If the girl's father disapproves of the match he returns an equal quantity of liquor to the boy's father. The girl is usually consulted but little heed is payed to her wishes. In the event of a girl becoming pregnant before marriage, the man is required to take her giving the presents customary in the case of a marriage. The man may if he wishes subsequently marry some other woman but the girl may not marry again.

Marriages take place at the boy's house and it is a peculiar custom that a bride going to the bridegrooms house to be married is accompanied only by her female relations.

In the Barang Jhodia, Phengu and Khond divisions, it is customary for a man to marry his parental aunt's daughter. Dormitory for boys and girls is in force amongst the Parjas.

Widows are permitted to remarry and a widow is forced to marry her deceased husband's younger brother if he has one. A divorced woman may marry again and she has the same rights as

a widow for remarriage.

The Parjas worship the same class of divinities of the hills and forests as are usually revered by the primitive tribes. They also worship Dhanteswari, the tutelary goddess of Bastar. Most villages have a man possessed by the deity and his advice is sought in religious matters. Nedha Ghuntia is another important person who fixes days for weddings, construction of houses and commencement of sowing.

The principal festival of the Parjas are the Hareli, or the feast of the new vegetation in July, Nawa Khani, or feast of the new rice crop in August or September and the Am-Nawakhani or new Mango crop in April or May.

The dead are buried. The corpse being laid in the ground with the head to the east and the feet to the west. Rice gruel, water and a tooth stick are placed on the grave for sometime during the nights after death. The period of mourning varies from three to nine days.

The tribe are cultivators and grow rice and other crops. Many of them are village headman and the term Dhurwa is more practically applied. Fowls, pigs, large lizards, field rats, bisons and buffaloes are eaten by the tribe. Some of them eat beef while others abstain from it.

The Malpaharias

The Malpaharias are found in the Ramgarh hills of Birbhum district and at the foothills of the Raj Mahal hills. They appear to be almost unconnected with the RajMahal hillmen. According to Mr. Ball, the Malpaharias show certain similarities with the Kharias and Paharias of Manbhum but their language does not lead to infer ~~and~~ such close affinity (Dalton, 1973 : p. 274). The Malpaharias are a non-Aryan tribe and are supposed to be a Hinduised section of the Males or Sauria Paharias, but they deny having any relationship with the Males.

The tribe has two sub-tribes Malpaharia proper and the Kumar or Komar Bhag. The latter is more Hinduised (Tea District Labour Association, 1924 : p. 148; Risley, 1891). Each sub-tribe is further sub-divided into exogamous septs such as Ahriti, Dehriti, Girhi, Manjhi, Patra, Pujhor and Sikdar. The septs are totemistic in character (Risley, 1891).

Prohibitions in marriage arising out of totemism is practise. Also is practised prohibitions of the ordinary Hindu type.

Marriage among the tribe is either infant or adult with the former being considered more respectable. Girls are rarely married before the age of ten or eleven (Tea District Labour Association, 1924 : p. 149; Risley, 1891). Pre-marital sexual

intercourse is tacitly recognised. It is understood that if an unmarried girl becomes pregnant her lover will come forward and marry her. A professional match maker, Sithu, is usually employed by the bridegroom's party to find suitable bride. After the selection the bridegroom's people make a formal inspection and bride price is paid. Sinduran forms the binding part of the actual ceremony (Tea District Labour Association, 1924 : p. 149; Risley 1891).

Polygamy is practised at least in theory. A man may marry two sisters, but should follow the order of age. Widows are allowed to remarry. It is expected that she will marry her late husband's younger brother if there is one, but if she wishes she may not (Risley, 1891).

The tribe worships the earth and the sun. At the head of their religion stands the sun to whom obeisance is made morning and evening and in whose honour goats are sacrificed. Dhati Mai (mother earth) is also worshipped (Tea District Labour Association, 1924 : p. 149). They have one great festival in a year in the month of January or Magh, corresponding with the great harvest joy of the Hos and Mundas. It is called Bhuindeb, which is evidently Hindi meaning earth god (Dalton, 1973: p.274). Singbahani who rules over tigers, snakes, scorpions and similar noxious beasts is also held in honour (Tea District Labour Association, 1924 : p. 149). The Hindu goddesses Kali and Lakshmi are also worshipped. Ancestor worship is also prevalent and every

village has a tutelary deity.

The dead are usually cremated. A piece of bone is preserved to be thrown into a running stream or deep tank.

Hunting, food gathering and jhum cultivation is said to be the livelihood of the tribe and large proportion of the tribe adhere to these modes. But, there is a gradual shift towards settled cultivation.

The tribe has no tradition worth mentioning except that their first parents were born of a cow.

The Santals

The Santals have of late been the most honoured of the aboriginal races of Bengal. They are found at intervals, sometimes in considerable masses but more generally much scattered, in a strip of Bengal, extending for about 350 miles from the Ganges to the Baitarini, bisected by the meridian of Bhagalpur or 87° east longitude and comprising of the districts of Bhagalpur, the Santal Parganas, Birbhum, Bankura, Hazaribagh, Manbhum, Medinipur, Singbhum, Mayurbhanj and Balasore. The Santal Parganas contain the most number of members of the tribe and is considered the nucleus of the tribe (Dalton, 1973 : p. 207).

The tribe is of Dravidian origin classed on linguistic grounds as Kolarian. The tribe is believed to have immigrated from the northern parts of India but their own traditions hardly supports this. The Santhal settlements that skirt the Rajmahal hills are readily traced back to more southern districts.

According to Santhal tradition the origin of the tribe is traced to a wild goose (Hasdak) which laid two eggs out of which one male and female Pilchu Haram and Pilchu Burhi were produced. The two are the parents of the tribe (Risley, 1891). The eggs were laid at Ahri Pipri. From Ahiri Pipri the progenitors of the tribe migrated to Hara Duttie where they multiplied in number and were called 'Kharwars'. From Hara Duttie they moved to Khariagarh and Hurredgurhi and eventually settled in Chai Champa in Hazaribagh district where they lived for several generations. From Chai Champa the tribe was forced by the Birhors to migrate. The tribe moved to Chotanagpur, from there to Jaldah, Patkum and then to Saont. They stayed at Saont for a considerable period of time. It was at their stay at Saont that they took up the name of Santal. The stay at Saont was short lived and the tribe was forced to leave the place and they moved to Sikhar (Dalton, 1973 : pp 209-210).

The internal structure of the tribe is singularly complete and elaborate. There are twelve exogamous septs, Hasdak, Murmu, Kisku, Hembrom, Marundi, Saren, Tudu, Baske, Besra, Pauria,

Chore and Bedia. The first seven are said to be descendants from the seven sons of Pilchu Haran and Pilchu Burhi. The five others were added afterwards. All these septs are patriarchal. Dalton (1973 : p 212) mentions the twelve septs as Saran, Murmu, Marli, Kisku, Besera, Hansda, Tudi, Baski, Hemrow, Karwar and Chorai. The twelfth sept is not named.

Each Santal village has a Jagmanjhi whose duty is to look after the morals of the boys and girls. There is also a Paramanik whose function is to attend the farming arrangements and to apportion of lands. He disallows any monopoly of peculiarly fertile rice lands. All must have the share of good and bad. Each village also has a priest who is called Naia or Nayaka. The offices of the Jagmanjhi and Paramanik are hereditary (Dalton, 1973 : p. 213).

A Santal cannot marry within his sept or sub-septs. He may marry into any other sept including the sept in which his mother belonged. Polygamy is preferred and there are indications of existence of fraternal polyandry. Girls are usually married to men of their choice but only after they have attained adulthood. Widows are allowed to marry again but must marry her deceased husband's younger brother. Divorce is permitted at the wish of either of the parties at the presence of the assembled villagers (Risley, 1891). Six forms of marriages are recognised in Santal society, regular marriage (bapla or kiring

bahu, bride purchase); ghardi jawae; nirbolok; sanga; kiring jawae or husband purchase.

The Santhal religion is animistic. The supreme deity is the sun god or Sing Bonga (Dalton, 1973 : pp 213-214). Every third year and in some families every fourth or fifth year, the head of the family offers a goat to the supreme deity⁷. Sing Bonga is identified with Thakur or Thakur Jiu (Mukherjee, 1962 : p. 273).

There are several village spirits who are worshipped during all public festivals. The chief among these is Marang Buru or Maran Buru. This deity is believed to have the widest possible powers and is associated with good and mischievous godlings. Marang Buru is a malignant and destructive deity. He is propitiated during all Santal festivals with offerings of a white fowl or goat and rice beer (Dalton, 1973 : p. 214; Risley, 1891; Mukherjee, 1962 : p. 275).

There are other village deities like Monrenko Tuauiko, his sisters Gosane Era, Jaher Era and Manjhi Haran⁸. Each of these deities have a Jahirthan or sacred grove allotted to them (Risley, 1891; Mukherjee, 1962 : p. 275). Monrenko is worshipped

7. Mukherjee, C (1962 : p. 274) writes that the tribe worships Sing Bonga every tenth year.

8. Dalton (1973 : p. 214), mentions of a deity named Monika.

for the general welfare of the village and propitiated with a brown hen or a red she-goat. In the eastern part of ChotaNagpur Chando Bonga, the moon god and Bagh Bhut, tiger devil is worshipped (Dalton, 1973 : p. 214).

Apart from village spirits, there are hill spirits who are propitiated to prevent any harm done by such spirits. These super-human agencies are called Pats. The Pats derive their names from the hills they are believed to reside in. The chief hill deity is Behra Pat worshipped for success in hunting, incidental harms in that connection and protection of people while undertaking journey. The deity delights in receiving red fowls and uncastrated he-goats. The other deities of this category are Mangar Pat worshipped for reasons similar to those related to Behra Pat and used to be in the past propitiated with human sacrifices. Budha Pahar is propitiated for successful journeys with fowls and uncastrated goat. Pauri Pat, a female deity is invoked for success in journeys and used to be propitiated with human sacrifices now replaced by fowls and goats. Chandra Pat and Duar Sani Pat are worshipped if there is no rainfall with sweets, bananas, hens and goats (Mukherjee, 1962 : p. 277).

Besides these, there are other Pats such as Dagarsila invoked during warfare with sacrifices of red cock and goat. Sula Pat, worshipped during litigation and epidemics with offerings

of cock and goats. Buru Bonga is believed to be a horrible deity who delights in human blood and Ronkini who also likes human blood (Mukherjee, 1962 : p. 278).

Ancestor worship is prevalent among Santals. In all festivals, public or private Haramko or Burha Burhi (the old man and woman) are offered a cock and hen respectively along with rice beer. During harvest festivals two fowls are sacrificed in their honour. Reverence is paid to the dead relatives. Departed spirits receive supplementary worship after propitiation of Burha and Burhi (Mukherjee, 1962 : pp 280-281).

The Santals believe in a number of mischievous spirits who are said to bring in epidemics to men or cattle such as Kalachandi, a male spirit, Kalamahi Chandi and Nason-Kudra, both female spirits, Acraeli Bonga and Baghut Bonga (tiger spirit).

Apart from the deities and spirits mentioned, the Santals have Orak Bongas (household deities) and Abge Bongas (secret god) presiding over each family. The names of the Bongas are kept secret and told only to the eldest son. Mr. Skrefsurd procured some names of Orak Bongas from Christian Santals. These names are as follows:

Orak Bonga : (1) Baspahar, (2) Deswali, (3) Sas,
(4) Goraya, (5) Sarchawadi and (6) Thuntatusra.

Abge Bonga : (1) Dharamsore, (2) Ketkomkudra,
 (3) Champa-Denagar, (4) Garshinka, (5) Lilachandi, (6) Dhanghara,
 (7) Kudra Chandī, (8) Bahara, (9) Duarseri, (10) Kudraj,
 (11) Gosainera, (12) Achali and (13) Deswali⁹.

Like other tribes the Santals also believe in evil eye. Children are made to wear amulets of parasites on Bhela trees. Ojhas (exorcists) are summoned when the spell sets in.

Witchcraft is quite prevalent in Santal society and the members of the tribe believe that witchcraft is known to many. The Ojha (Witchdoctor) is summoned to identify the witch and neutralise the effects of witchcraft. Besides Ojhas there are Jan Gurus or orthodox witch finders whose help is also taken. Witchcraft is believed to be not in-born but is learnt.

The Santals observe a number of religious and semi-religious festivals. They are found to participate in Hindu festivals also. The first agricultural festival is Erok-Sim celebrated in the month of June (Asar) and is connected with sowing of paddy seeds. Each household subscribes fowls which are sacrificed by the Nayaka or village priest at Jaherthan (Holy grove) in honour of Maran Buru, Jaher Era, Monrenko, Gosane Era

9. Source, Mukherjee, C (1962) "The Santhals", A. Mukherjee and Co. Pvt. Ltd., Calcutta.

and Manjhi Haram. After the sacrifices at Jaherthan, a special dish is cooked with rice and meat. All the Santals dine. But the meat of the fowls offered to Jaher Era and Monrenko can be had by the Nayaka alone. Abge Bongas and Orak Bongas are offered sacrifices of fowls by each householder on the second and third day of the festival. Also are propitiated Moran Buru and the patriarchs of the tribe.

Harihar Simko, celebrated in July is a thanks giving ceremony to the gods as the paddy appears green and there are indications of good crop. Only the village deities are worshipped.

Iri Gundi Nanwani (the Millet Festival) is held in August (Sraavan-Bhadra), is connected with the offering of the first fruits of millet to the tribal gods. The Nayake, after purificatory ablution goes to the field of a raiyat where the crop has ripened and cuts as much as he can of the crop and goes to the Jaherthan where, after cleaning the crop with cow dung offers the corn to all the gods of the Jaherthan. Next he sprinkles milk. On his return to the village from the Jaherthan the priest goes to the house of the headman where he offers corn at the shrine. The festival is called Muchri by the Santhals of Mayurbhanj.

Side by side with the harvest festivals Gamah Purnima is observed on the full moon of Sraavan, August, cows are fed with

salt, mahua flowers and their horns are rubbed with oil after which men and women dance around a Karam tree planted in the akhra. At the conclusion of the dance the branch is immersed in water. Ancestors are also propitiated with rice beer.

Karam Porob is celebrated in September-October (Bhadra-Aswin), no harm is believed to result in the non-performance of the festival. No sacrifices are offered, but a libation of liquor is poured out to the manes of the village priest and Maran Buru. Men and women dance around the branch of Karam tree fixed in the village lane from night till morning and throw the branch in a tank at the conclusion. It should be noted that those who worship Karam Bonga perform this Porob as a must.

Janthar is celebrated in November (Kartik-Agrayan) in honour of the tribal deity Janthar. Villagers subscribe towards a Xog or a ram sacrificed in propitiation of the deity. A special priest Kudam Nayeke makes the sacrifice. A unique feature of the festival is that articles for worship are supplied by the priest himself and only the male members of the tribe are allowed to eat the meat of the animals sacrificed. Janthar is in effect the offering of the first fruits of low land paddy. In Mayurbhanj this festival is known as Maa mane. It is observed for two days, Um-Narka and Sardi. On the second day fowls are sacrificed to Maran Buru, Jaher Era, Monrenko, Maran Manjhi, Hudin Manjhi and the boundary deity.

Shorae or Shorai is the biggest annual festival of the Santals held in the Bengali month of Pous (mid January)¹⁰. This is a common day of thanks to the god as rain, the sun and fair weather have contributed to a bumper crop. The festival starts with an initial purification. On the first day the tribe sing a song on the field with water near about after which they take a meal and assemble at the Jaherthan where they witness a sport. The second day is devoted to preparation of food for the gods. Fowls, goats and pigs are sacrificed. Cows are worshipped on the third day. The same day the women, during the night, dance in lanes of the village. The next day cows are tied to the posts erected the previous night and young men dance around the animals which are decorated. Hunting follows the next day. On a special day called Jale the members of the tribe visit house to house and exchange greetings. The festival ends with Bejha, shooting at a target.

On the last day of Pous (mid January), is observed the festival Mokor, also known as Sankrant puja. Chira (flattened rice) and molasses are offered to the dead ancestors. On the first day, called Banundi people catch fish and crab in the belief that if they can eat them on the day they will be given long lease of life. Tasty cakes of meat, sun dried rice-flour are prepared in all households and the people eat them with

10. Dalton (1973: p. 213) mentions that Shorae or Shorai is held in December.

treacle, til (sesamum) and Chira. Drinks of rice beer is also there.

In the evening archery competition takes place. The festival concludes with great deal of mirth in all houses.

Magh Sim is celebrated in January-February. This signifies the end of Santal year and it has got appropriate ceremonials with the cutting of jungle thatching grass. New contracts and entered into with old contracts terminated.

Towards the latter part of February is celebrated the festival of Baha or Sahrul when the Sal trees blossom. The festival signifies the advent of spring. The festival continues for three days. The first day is the day of purification, the second day involves propitiation of deities. Jaher Era, Monrenko, Gosane Era and Maran Buru with sacrifices of fowls and offerings of Sal and Mahua flowers. The third day is devoted to merry making and feasting.

Jom Sim¹¹ is the festival in which offerings of sheep or goats are made to Sing Bonga. There is no definite time for the festival. This is not a public festival and restricted to particular clan groups.

11. The Marandis of Mayurbhanj observe this festival before the full moon of Falgun (February-March) or Baishak (April-May).

In Mid April is observed the Pata, the Santal version of Hindu Chorok (Hook Swinging festival). The festival is held in honour of Mahadeo.

The Santals are predominantly agriculturalists. They supplement agriculture with hunting which has become more or less occasional now-a-days.

Boiled rice is the staple food of the tribe. As regards the side dishes there is a saying that "the Santals will eat anything that flies except aeroplanes and anything that swims except boats"¹². They eat almost all kinds of available fish and crabs and have a great relish for meat. Flesh of tiger, bear, crow, mice, frog and snake are eaten. Fowl is a luxury and consumed only on special occasions. Worms and insects are also consumed. Various kinds of edible leaves like Purai Arak (*Basella Alba*), Kedok Arak (*Argyreia speciosa*), Matha Arak (*Antidemsa Diadrum*) and Munga Arak (Horse Raddish leaves) are consumed. Besides these various types of flowers like Mahua (*Bassia Latifolia*), Khonda Baha (Pumpkin flower) and Horse Raddish are consumed. Fruits are also eaten.

Now-a-days under Hindu influence some dietary habits have changed.

12. Ref. Man., Sonthalia and the Santhals.

Handia or rice beer forms an compulsory item during festivals, offering to gods and social occasions. A Santhal would prefer death rather than not having Handia (Mukherjee, 1962 : pp 75-76).

The Mahalis

Risley (1892) mentioned that the Mahalis are a Dravidian people of labour class who are palanquin bearers and work in bamboo. He further mentions that the tribe is a branch of the Santals separated comparatively at a recent date. Russel (1916) is was of the opinion that the Santals and the Mundas are no doubt one tribe and the Mahalis are derivatives of both of them. He also holds the opinion that the Mahalis are a forest tribe. Hutton (1946 : p 148) describes the Mahalis as a caste of labourers pasturers and basket makers of Central India having affinities with the Santal, Ho and Munda tribes.

The tribe is found chiefly in ChotaNagpur, Santal Parganas and Orissa (Government of India, 1901). In Bengal they have an uneven distribution. They are mainly found in the districts of Jalpaiguri, West Dinajpur and Burdwan.

The tribe has five sub groups, Bansphor Mahali, Pator Mahali, Tanti Mahali and Mahali Munda (Risley, 1892).

Disease is thought to be a potential danger by the Mahalis. They believe that an individual gets affected by disease if there

is aggressive intention of another vested with magical potentiality to do harm to others out of mutual envy, the individual's susceptibility to disease, wrath of ancestral spirits or deities, projection of morbid objects or substances and action of sorcerers. The concept of evil eye is very much prevalent among the tribe.

The medicine man among the Mahalis is known as gunni or ojha. Diseases caused by malevolence of others or sorcerers are treated by gunnis or ojhas. Diseases caused by some agencies owing to susceptibility to diseases and those which occurs in every day life are treated by quack doctors and herbalists. Diseases caused by wrath of spirits and bongas are cured by propitiation with the help of ojhas.

In the foregoing discussion much has been said about the traditional culture of the tribes taken for the study. But not much has been presented concerning their health practices. However, from the discussion it is clear that supernaturalism pervades all aspects of tribal life. Health forms an integral part of life and therefore it too must be surrounded by supernatural beliefs and remedial measures in accordance.

CHAPTER V

ASPECTS OF HEALTH CULTURE

Socio-cultural factors affecting health can be classified into two categories. Those which directly affect health of an individual and community and those which indirectly work. Hasan (1967), classified customs, beliefs, values, religious taboos and practices as direct factors and problems of health care as indirect factors in health. Rizvi (1986 : pp. 226-227), in his study of the health practices among the Jaunsaris of Uttar Pradesh, categorized the factors affecting health into two. First, those factors responsible for fostering diseases in the people, such as, surrounding and state of cleanliness, hygiene of the people, dietary habits and nutritional status of the people and drinking habits of the people. Second, factors which affect health in an indirect way, such as, health concepts, illness and local medicine systems.

A community's concepts and practices in regard to cleanliness, hygiene and sanitation directly determines the health status of that community. Awareness as regards to hygiene and cleanliness has direct impact on health and diseases. Practices regarding bodily cleanliness are directly responsible for occurrences of certain diseases. Defecating habits, housing, food habits, drinking habits and smoking too directly affect health.

Each community has some traditional customs, beliefs and practices related to these factors or aspects of health culture. The practices of a community in relation to these aspects reflects its health status as also its health modernity.

Rizvi (1986 : pp. 227-235) has observed that lack of clean water supply, inefficient drainage system, absence of awareness as regards to animal borne diseases, unhygienic practices relating to bodily cleanliness, unhygienic housing, improper defecating habits, lack of nutrition, smoking and drinking habits are responsible for many diseases those occur among the Jaunsaris. Kocher and others (1976 : pp. 287-288) have pointed out that defecation habits have a direct relationship with hookworm infection. Choudhury and others (1986 : p. 129) have related malaria to unhygienic conditions of living and stagnant water bodies.

It is commonly believed that the level of hygiene and sanitation among the tribal and rural folk is very low. Dutta Choudhury and Ghosh (1984 : pp. 25-26) in their study of the Idu Mishmi of Arunachal Pradesh observed a very low level of sanitation and hygiene. Smilar observations have been made by Hasan (1979 : pp. 63-94), Rizvi (1986 : pp. 227-230) and Basu (1990 : pp. 22-23). But this belief does not seem to hold good when viewed against the observations made by N.K. Bagchi and

G.C. Ghosh (1987) and Anima Guha (1990 : p. 215). Guha (1990: p. 215) observed that both the populations — the Boro-Kacharis and the Koch-Rajbanshis — she studied lack theoretical knowledge of hygiene but are clean. They take bath once a day, wash hands before eating, wash clothes and use twig of medicinal plants to clean teeth. But their defecation habits and cattle rearing habits are not hygienic.

An important feature of many of the diseases which affect society is the extent to which they lie in personal behaviour. Food habits, occupation and indulgence in cigarette smoking drugs and alcohol intake have for long been known to influence health. Several important diseases may be more or less directly caused by such influences.

Food is the most important of man's needs. It is extremely vital that the food he takes is nutritious and wholesome as this food will deter his health and entire life. Dietary habits to a great extent determines the diseases one may be afflicted with. Eating of pork, for example, is a cause of intestinal worms. Quality of food determines the nutritional level and lack of nutrition exposes an individual to various diseases. Nutritional deficiency causes direct or indirect diseases. Some directly caused diseases are night blindness, angular stomatitis, tooth decay, rickets and anemia and indirectly caused diseases

are diarrhoea, desentery, bodyache and leprosy.

There are numerous beliefs and practices connected with food among the tribals. There are taboos which are negative in character and rites surrounding food production which are positive in character. The most commonest of food taboos are connected with totemism. There are food taboos connected with pregnancy, birth, marriage, death, sickness, hunting, mourning, etc.

Lack of nutrition, unhealthy practices of cooking and consumption of food are said to be common among the tribals. Again their dietary habits differ greatly from those of the non-tribals. These have great impact on health. Singh et al (1987 : p. 3) reported that even after four decades of independence the tribal community, they studied, presents a grim picture of health status. Less than 8 per cent of the children were immunised, two thirds of the children under five were malnourished, 44 per cent have severe malnutrition. A large number chewed tobacco with lime (Khaini). Most of them drank alcohol mainly haria (home brewed rice beer). Daily consumption of egg, meat, fish and milk was less than 1 per cent. Consumption of green vegetables was also less.

With these in mind this chapter is an appraisal of the behaviour of the tribal workers in relation to sanitation, personal hygiene, food habits, drinks and narcotics. Aspects like housing, drainage, sources of drinking water, disposal of

house refuse, defacing habits and domestication of animals have been considered under sanitation and bodily cleanliness, clothing and cleaning of utensils under personal hygiene. Food habits, drinks and narcotics have been dealt with separately. The implications of such aspects have also been dealt with.

Sanitation

Housing

It may be recalled that earlier, in the chapter on "Tea Plantations, Their Health Units and Population", we have made a brief mention of housing in the plantations. There, the types of houses, i.e., the materials by which they are constructed received attention. Here, aspects like ventilation, overcrowdedness of rooms, dampness and cleanliness along with their implications on health have been discussed.

In the tea plantations with better facilities of health the houses are mostly of pucca types with two rooms one of 14/10 ft and the other 10/6 ft, and a verandah. Ventilation in this type of houses is upto the mark with windows, one in each room and ventilators. The houses are mostly overcrowded as one room is used as kitchen leaving the other room for use as living room. The average size of a family is 4 members per family. In some cases workers have been found to construct a kachcha room within the compound to meet the inadequacy of rooms. This room is usually used as kitchen and mostly has no windows which leaves

the room full of smoke while cooking which, in turn, renders a person prone to respiratory ailments. But having an additional room does not put the families in a better position in terms of hygiene. They have been found to maintain a very low level of cleanliness of their houses. But for families who do not have an extra room and use one of the pucca rooms as kitchen proneness to respiratory problems are less but overcrowdedness of rooms and thus sleeping in close proximity increases the possibility of contagious diseases and problems of cleaning the house. The pucca houses are not damp during winter and summer but damp during rainy season which leads to cough and cold problems.

The Kachcha houses are mostly one roomed. An average worker who does not have a pucca house lives with his family in an one roomed kachcha house. The affluent of them have two or more kachcha rooms. But these rooms are ill-ventilated with a small window and door. Those living in a kachcha houses of one room cook as well as live in the same room, rendering the inmates prone to respiratory ailments. Moreover, inadequacy of space leads to family members hudding together and thus, increases chances of contagious diseases. For those who have more than one room, proness to contagious diseases are comparatively less but the problem of ventilation remains and thus remains the chances of being afflicted with respiratory ailments. Moreover, the kachcha houses due to their lack of proper windows are damp and dark and serves a good breeding ground for germs.

In the plantation with minimum facilities of health.

The Matigara plantation, three types of houses are found, pucca, kachcha and tina types. Kachcha houses are numerically dominant. The pucca houses have two rooms of 14/12 ft each, but have been allotted to two families occupying one room each. The rooms are ill-ventilated. The families usually cook and sleep in the same room leaving them prone to respiratory diseases. Some families have erected a kachcha room for use a kitchen which eases the problem of inadequacy of space and proneness to respiratory diseases to some extent. The families who live in one room are required to huddle together even if the family has only four members. Thus they face threat of contagious diseases. Unclean houses also result from overcrowding.

The Tina houses, as the name suggests are made only of tin on all sides. They are not houses in the true sense of the term. What actually exist is an elongated structure of tin divided into small compartments of 12/10 ft in size with one compartment each allotted to one family. The compartments are illventilated, devoid of windows. The families use the compartments both as kitchen and living room leaving them prone to respiratory ailments and contagious diseases. The compartments are damp and dark and serve as breeding place for germs.

The workers seem unaware of the fact that such conditions of living are hazardous to health. None of the workers have mentioned that they need more rooms to safeguard themselves from

diseases. Their need for additional rooms seem to be surrounded by space consideration rather than health consideration. Though most of the respondents agreed that dirt, smoke and filth cause diseases, they showed ignorance in their behaviour patterns related to warding off such hazards.

A factor, which should not be overlooked, is that there is an economic dimension of the thing. The lack of economic soundness among most of the workers forces them to be concerned with fulfilment of basic needs. Cleanliness, inadequacy of rooms, hygiene receives tertiary treatment.

Drainage

The drainage system in the residential areas of the workers in all the plantations is extremely poor. There is no cemented drains. What exist as drains is 1 foot deep open trenches encircling a cluster of houses. These are mostly choked with rubbish and weeds those grow in them. Water does not flow through these drains and gets stagnated which act as breeding place of mosquitoes and germs. Water from wells and houses flow to these drains. Clothes and utensils are washed near the wells as a result of which soap water and organic materials flow into the drains. Families are also found to wash clothes and utensils at a corner of the house compound. Where they have either a flat stone or a cemented slab. This water is led to the main drains by narrow and shallow drains dug by individual households who have the

the main drain nearby. For the households, who have the main drain far away, water from the house is led outside the house compound by a narrow and shallow drain and left to accumulate there. The accumulated water serve as breeding place for mosquitoes, flies and germs.

There is no effort on the part of the workers to maintain a proper drainage system. This suggest a lack of understanding on the part of the workers and the relation of unhygienic practices and disease causation. These conditions are regarded to be in the nature of the things.

Disposal of House Refuse

House refuse is collected in the corner of the house compound to be thrown away later. The refuse is thrown usually into the main drains which results in chocking of the drains. Refuse is also thrown by the residents just outside the house compound. The inhabitants do not take the trouble to throw house refuse outside the residential areas. In some houses there are pits in the corner of the courtyard for house refuse. The families have this for two purposes, to dump household refuse and also to obtain manure from rotting of the refuse. Such pits are usually uncovered. They serve as fertile ground for breeding of mosquitoes, germs and flies and also emmit smell. The fact that such pits and inconsiderate throwing of house refuse

are hazardous to health does not seem to affect them. It does not strike them. When questioned on the issue the answers reflected their indifference. The absence of dumping pits also is a reason for such behaviour.

Domestication of Animals

Each family on the plantations has domesticated animals, either cows, oxen, buffaloes, pigs, goats and fowls or two or more types of species. These animals have some utilitarian aspect or the other. Oxen are used for ploughing. Cows and buffaloes for milk and cow dung, pig for sale and consumption domesticated by the Mundas only, goats for sale, for meat and milk and fowl for egg and meat.

During the day time most of the cattles are out in the field except the fowls who move in and around the house compound. In the evenings all the cattles are brought back to the house. Small animals like fowls and goats are kept on the verandah of the house by most of the families. Cows, buffaloes and oxen are kept under a small shed constructed adjacent to the living rooms for fear of cattle lifting. Pigs are kept loose and allowed to roam about in the courtyard. Some families however, do not have a separate shed for cows and buffaloes. The cows are tied to a pole near the verandah so that during winter and rains the cow can use the verandah as a shed.

The people do not seem to be aware that domestication of animals has a role to play in environmental sanitation and is an important and influential factor affecting health and even if they are aware they do not seem to take the matter seriously.

The presence of animals in close proximity definitely increases chances of infection. Rabies, plague, tetanus, tapeworms and other intestinal parasites are transferred to man from animals.

Habits of Defecation

According to the Plantation Labour Act, 1951, Clause 9(1), there shall be provided separately for males and females in every plantation a sufficient number of latrines and urinals of prescribed types so situated as to be convenient and accessible to the workers in every plantation (Kar, 1990 : p. 34). But unfortunately none of the plantations except Taipoo have such provisions. However, whether the existence of latrines and urinals would have served any purpose is doubtful as workers when asked if they need latrines and urinals answered in the negative. Moreover, the latrines in Taipoo are not used. The reasons cited are feeling of discomfort and problems of maintenance. The workers defecate in fields, bushes and near the rivulets. Those who go to the bushes and fields carry with them a can of water for ablution and those who defecate by the rivulets wash the parts with river water. The pattern of defecating

behaviour is the same in all the plantations.

Defecating in open places renders the workers prone to helminthic infections and diseases, conveyed from diseased persons.

The workers seem not aware of such dangers and even if they are, they are ignorant.

Water

Adequate supply of pure drinking water is essential for the prevention of certain diseases.

In all the plantations except one, the Hansqua plantation, sources of drinking water are pucca wells with parapet, constructed by the plantation managements. In the Hansqua plantation one residential line has water supply through common taps. Wells are existent but are used for drawing water for washing utensils and clothes and bathing. Bathing and washing of clothes are also undertaken near the taps by the families staying in proximity of the taps. Drinking water is drawn exclusively from the taps. This reflects the awareness of the workers as to pure water for drinking. The wells in none of the plantations are covered as a result of which leaves and other materials fall into them contaminating water. Washing of clothes, utensils and bathing near

pucca wells is not hazardous as they have parapets. Cleaning of the wells are undertaken after long intervals whimsically by the workers themselves. The only help, the management provides is in the form of supply of materials. The initiative of the workers come only when the water has become visibly unclean.

Those who draw water from wells do not purify the water before drinking. It is not so that they are unaware of the concept. The fact is that they view it as troublesome. They also do not feel it necessary, though many are aware that impure water causes diseases, as they take it to be natural. However, they are prepared to drink water if supplied pure.

Personal Hygiene

It may be recalled that in the beginning of this chapter it has been mentioned that the level of personal hygiene among the tribal and rural folk is very low. Also have been mentioned that there are reports and studies of hygienic behaviour among such communities.

Bodily Cleanliness

While discussing defecating habits it has been mentioned that people wash the parts of the body with water of rivulets or they carry water in tin cans for the purpose. People also at times, wash their face and mouth with water from rivulets

which leave them prone to water borne diseases. The tin in which water is carried for post-defecation ablution practices is also used to pour water for washing face and mouth which renders them prone to transmitted diseases. Moreover, soap like substance is not used for washing hands after post-defecation ablution. Either mud or nothing is used. The use of soap is usually absent even for washing hands before meals. People use simple water.

For cleaning of teeth, the most popular thing used is Sal twig, twig of Varanda tree and Neem tree. The use of charcoal is also there. In some families, however, use^{of} tooth-paste, tooth-powder and tooth-brush has been found.

Daily taking of bath is not the usual practice among the people specially during winter. However, washing of foot and hands are done daily. Not taking bath daily is justified by the people on the grounds that ~~they~~ do not get time to bathe daily. Bath usually is taken once a week, i.e., on the day of weekly holiday. The use of soap during bath is not a usual practice. Soap is used occasionally or after two or three baths. The people are unaware of the fact that the use of soap is necessary to keep the skin clean to facilitate perspiration.

Shaving and cutting of nails and cleaning them involve no regular intervals. Such acts involve an element of whim. Shaving is usually not done by the people themselves. They take the help

a barber and therefore economic factor creeps in which acts as hindrance in regular shaving. Those who grow beard do not take the trouble to keep it clean. Cutting and cleaning of nails are undertaken only after the nails have grown too big and also when it arises in the whims of the people.

Clothes are not changed frequently nor are ~~they~~ washed at regular intervals. It is only when the clothes become intolerably unclean that they are changed and washed. On an average people have been found to change clothes after six to seven days. Washing of clothes coincides with changing of clothes. The changing and washing of clothes coincide usually with the weekly holiday. The use of washing powder or soap is prevalent. The infrequent changing and washing of clothes has been attributed by the people to inadequacy of number of clothes and lack of time.

Wearing of shoes is not prevalent. Most of the workers stay bare footed. This increases their chances of hookworm infection and diseases of the feet. Shoes are worn occasionally. The necessity of wearing shoes for protection against infections are not known to most of the people.

Food, Intoxication and Narcotics

Food habits, occupation, indulgence in such pleasures as cigarette smoking, drugs or alcohol intake, have for long been known to affect health.

The tribes studied have been found to lack nutrition, specially the children. Nutritional deficiency diseases such as tooth decay, rickets, anemia, diarrhoea, dysentery are rampant. Their lack of nutrition is due to their poor economic conditions, lack of proper idea about nutrition and cleanliness. A factor which is of considerable importance in the low nutrition and consequent low health status of the people is the growing destruction of fauna and flora.

The low level of awareness as regards to cleanliness is reflected in cooking and consumption practices. The items are not properly cleaned, nor are the utensils washed in the desired manner. Moreover, food is consumed even with animals moving around. Utensils are left unguarded which are often licked by dogs, pigs and cats.

The traditional food items of the tribes differ very much from that of ours. The traditional food habits of the Oraons, Mundas, Gonds, Malpaharias, are more or less the same. The Oraons consume flesh very frequently. Small games are considered delicacies. Flesh of bullocks, goats, buffaloes, sheep, tigers, bears, jackals, foxes, snakes, lizards and most birds are consumed. But pork is the most preferred one. The staple food is rice and pulses called Urid and Kalai. The staple food of the Mundas is boiled rice. For side dishes pulses and green vegetables are taken. Fowls and goats are eaten. Beef and pork are not relished though not disfavoured. The staple food of the Malpaharias is boiled rice.

Fish and meat are rare items. Gonds alike their other counterparts have rice and millet as their staple food. Pulses and spices are taken with rice. Vegetables and fruits such as pumpkin, cucumber, leaves of gram, yams, mangoes, tamarind and others are consumed. They take meat of any animal but prefer pig, fowl, deer, crocodile, cat, red ants, rabbits, pigeon, quail and dove. Some scholars believe that the Gonds take beef in secrecy.

Milk is not a taboo for any of the tribes except the Oraons who now a days, it has been reported drink milk.

The rate of intoxication among the tribes is traditionally very high. Home brewed rice beer is very popular. Besides this country liquor, toddy and liquor of Mahua flower is also popular.

As regards narcotics, traditionally the tribes except the Gonds indulge in no narcotics except chewing raw tobacco with lime commonly known as Khaini and smoke tobacco. The Gonds are reported to take hemp drugs, betel leaves and areca nuts.

In light of the above let us now see the change from the traditional patterns in respect to food habits, intoxication and drugs. There is every possibility that due to long time migration and depending on the availability of items there may be a change in the habits.

The respondents have been found to take food thrice a day, morning, noon and evening. The morning meal which is the breakfast, is taken early morning around 6 A.M. consisting of roti (hand made bread) prepared the previous night or boiled rice preserved in water, and tea. The noon meal usually consists of rice and dal (pulses) and occasionally sabji (vegetables) The noon meal is taken between 12.30 P.M. and 1 P.M. The meal in the evening usually consists of rice or roti, dal (pulses), vegetables and occasionally meat or fish. It should be mentioned that meat or fish are at the most taken once a week on the pay day when some people set up make shift shops with vegetables, fish, meat and groceries in the plantation premises. The workers also visit the weekly markets of Bagdogra and Matigara¹. The weekly holiday coincides with the weekly markets for the facility of the workers.

Pork and chicken seem to be the most popular form of meat taken. Mutton is not popular due to its cost. Besides pork and chicken, kachchim (tortoise) is also found to be taken by the people. Beef is not so popular but is not disfavoured. Pegions and dove has also been found to be consumed, but they are not bought from market. The people specially children hunt them.

1. The people of Hansqua and Taipoo visit the weekly market of Bagdogra on Sunday.

The people of Matigara visit the weekly market of Matigara on Tuesday.

Fish of every available kind is consumed. But those which are less expensive is favoured.

All available vegetables are found to be consumed. Some vegetables like sag (leafy vegetables) are grown by the people in their kitchen garden.

The amount of fish, meat and vegetables consumed is not adequate to meet the nutritional need due to economic constraint. Moreover, the people lack concept of nutritive values of food items and balanced diet. Respondants said that they cannot buy good foods in adequate amount due to economic constraint. Buy good food they mean fish and meat.

Milk is not consumed by any of the members of the tribes as a separate item. Whatever amount of milk consumed is consumed mixed with tea. People cannot buy milk due to economic constraint. Those who have cows prefer to sell the milk leaving some amount for tea.

Intoxication is rampant among the people. All the respondents have been found to consume haria (home brewed rice beer). Even children are found to consume it not to speak of the adults of both sexes. Consumption of country liquor is not rampant but not disfavoured. There are some who are regular consumers and

some who consume if they get a chance. Toddy has been found to be consumed by all occasionally. An adult person has been found to consume on an average a litre of haria a day if brewed at his own home and a maximum of half a litre if required to buy. Women who do not work on the gardens prepare haria for sale at the rate of 75 paise per glass. The consumption of haria is more during summer as the people believe it keeps the body cool. Respondants have been found to believe that haria is not harmful. Respondants when asked whether they would give up haria said they will not as, it is harmless and also because it is their traditional drink. As regards the bad effects of alcoholic drinks, people are aware that they cause harm but they are not aware of the form.

Indulgence in narcotics is not alarming among the population. Consumption of hemp drugs is practically absent. The only forms of narcotic prevalent are tobacco and betel-nut. Tobacco is taken in the form of Khaini or in the form of biri smoking. But the most prevalent form is Khaini. Cigarette is smoked by some. Bidi is preferred to cigarette. The preference of Khaini may be due to tradition and also due to economic reasons. Betel-nut is taken by almost all.

It may be thus concluded that beliefs, customs and practices related to sanitation, personal hygiene, food, intoxication and narcotic intake are inextricably linked with health and diseases. They determine to a great extent the health status of a community and thus, they form the bases of health culture.

The level of sanitation and personal hygiene among the workers is very low. But this is not attributable to their lack of awareness and ignorance. There are other factors too. Karve (Report, 1957) observed that when people cannot afford to spend adequately even on food and clothing they do not just bother about environmental sanitation. The author also observed that sanitation is inextricably woven with the economic and social life of the people. In many cases it has been found that the people have the concept of good sanitation but ignore the aspect. This may be due to existence of problems like food, shelter and clothing which are more important. Existence of economic constraints forces people to divert money to fulfilment of basic needs.

The low level of sanitation and hygiene has led to prevalence of diseases like dysentery, diarrhoea, skin diseases and helminthic infection.

The intake of food among the workers has been found to be low in terms of nutritive value, thus causing anemia, weakness, etc.

The high rate of harira intake and intake of Khaini has led to tuberculosis and gastritis.

CHAPTER VI

TRADITIONAL AND MODERN SYSTEMS OF MEDICINE

Earlier in the introductory part it has been stated that there is a common belief that the tribals and other backward communities refuse to part off with their traditional medical beliefs and practices and accept modern health practices. This is reflected in the studies of Mital (1979), Bang (1973), Guha (1986), Joshi (1988) and Gupta (1986) all of which have talked of traditionalism in tribal and folk health culture. But there is on the other hand, studies like those by Marriot (1955), Gould (1965), Hasan (1967), Leslie (1968) and Khare (1981) all of which show acceptance of modern medical practices. O' Lewis (1958) has talked of the co-existence of traditional and modern medical systems side by side and their simultaneous acceptances. This has been viewed by the author as a pragmatic attitude of the people who are prepared to accept anything that may work. The acceptance of modern medicine can be gauged from the fact that Marriot (1955: p. 259) has pointed out that the fascination of the people with certain tools used by men of modern medicine has forced the indigenous medicine men to take up certain methods and tools of modern medicine.

Though studies have shown acceptance of modern medicine, claim can never be made of a total acceptance. It is alleged that there are certain factors like the urge of the tribals and other

backward communities to preserve their traditional culture, the inaccessibility to and availability of modern medical facilities, the structural handicap of the Primary Health Centres in the countrysides, the clash of ideals of traditional and modern medicine, the failure on the part of modern medicine to take into consideration the social milieu and the lack of seriousness on the part of the propagators of modern medicine which are responsible for the failure of modern medicine and the persistence of traditional medicine to a considerable extent.

In the light of the above, in this chapter, it is proposed to deal with the persistence of traditionalism in health culture and the acceptance of modern concepts and practices. This will be dealt from an interactionist perspective. In doing so aspects like concepts of etiology and diseases, choice of medical systems and the reasons effecting the choice, interaction between traditional and modern medical practitioners, child care and family planning have been covered.

Concepts of Etiology and Diseases Among the People.

Beliefs, ideas, values and practices are directly or indirectly related to the phenomenon of health and diseases. The concept of being healthy varies from society to society. In general, those persons are regarded as healthy who can afford to eat strengthening food, have good muscular bodies and can work hard. Also does vary is the concept of illness. What is considered to be

illness in one society may not be viewed the same in another. Illness as such, is taken primarily to mean feeling of unwell. Thus, a number of maladies are not recognized as illnesses. Marked differences are also observed in disease entities recognized from culture to culture. Phenomena considered to be symptoms of diseases by one group may not be done so by others, on the contrary they may be regarded as signs of health. The Thongas of Africa for example, consider intestinal worms as necessary for digestion (Ackerknecht, 1946 : cited in Honigmann, 1973 : p. 1044). The same is true with the Yap islanders. The Mayan islanders of Guatemala consider worm infestation as unpleasant but a fairly normal affair and requires treatment only when the worms emerge through the esophagus and cause vomiting or choking (Adams, 1953 : Cited in Honigmann, 1973 : p. 1044).

The study of the incidence and the prevalence of illness in society belongs within the scope of etiology. Etiology of disease is central to any discussion on the relation between medical phenomena and their cultural environment. In most indigenous medical systems the primary consideration in the diagnosis of disease is its cause (Glick, 1967; Adams, 1953 : Cited in Honigmann, 1973 : p. 1048). Causality in these systems is usually sought in the relationship between the victim of illness and his surroundings and this relationship is culturally interpreted. Traditional etiologies may attribute illness to mechanical and emotional as well as magical and religious causes.

In general magic and religion play important roles in indigenous explanations of the occurrence of disease (Hughes, 1968 : Cited in Honigmann, 1973 : p. 1048). Physical causes too find place in traditional etiologies.

Primitive people attributed disease and sickness to the malign of human, spiritual and supernatural agencies rather than biological agencies. This gradually led to the origin of various gods and goddesses.

Among the tribes of India, the belief in the influence of supernatural agency is particularly strong in case of the main economic pursuits and in the context of health and diseases. Different deities and spirits are believed to be connected with different diseases. Among the Hos there is Dessauli, who protects the villagers from evil spirits. Elwin (1955) noted that in the Saora Pantheon, there are gods and goddesses associated with various diseases. There are gods associated with children's diseases, cough and cold, blindness, madness, disease of pregnant women and animals. Most of the diseases are believed can be cured or warded away by propitiation of the gods and goddesses either directly or through shamans.

Besides gods and goddesses, spirit intrusion, sorcery, evil eye and breach of taboo are also regarded as causes for

diseases. Das (1986 : p. 212) noted that the Parjas of Orissa regard, wrath of gods and goddesses, spirit intrusion, sorcery, evil eye and breach of taboo as the main causes for diseases or afflictions.

The Oraons hold a belief that the sorcerers carry with them a rag bundle containing Nasans (destructive and harmful agencies), which they mix with food with appropriate spells and kill the victims. The Kharias believe in spirit basis of illness and so do the Korwas. They believe that fever in children and women is caused by Churail a female spirit. The belief in evil eye has a strong footing among the Mundas and in the case of prolonged illness in a family the help of a witch finder is sought.

Moreover, natural and physical causes too find place in tribal and folk etiologies. Excessive heat in the body, impure blood, diet and climatic conditions are some natural causes and bodily infirmities are physical causes recognized.

Dr. F.E. Clements (1932 : pp. 185-252) has classified the tribal concepts of diseases into three categories, supernatural, human and natural. Under the first category is included soul loss, spirit intrusion, spirit of sickness and breach of taboo. In the second category is included evil eye, evil touch, evil mouth and sorcery and in the third and last category is included

object intrusion and modern medical theory.

The Santhals according to Bodding (1925), have a theory of disease which has resemblance with modern etiology of disease, i.e., disease caused by bacteria. They believe that disease would be caused by a Tijo which may be large or small. These are located in different parts of the body and enter the body through food, etc. Tijo germs are also believed to be collected by witches to spread diseases. The theory may also be viewed as natural and supernatural and sometimes diffused with human agency.

Modern scientific theory has been able to penetrate the minds of the tribal and rural folk. Attribution of disease to germs have been reported. Brilliant et al (1982 : p. 145) stated that besides the traditional concepts of causation of small pox like spiritual, imbalance of bodily humours and impurity of blood, viral intrusion has found its believers. Karna (1976 : pp. 55- 56) reports that the villagers of Rampatti, in the Madhubani district of Bihar attribute germs besides the supernatural, physical and natural causes for diseases like tuberculosis, malaria and small pox. He adds that the concept of germs have come due to the long experience of the village people with the disease and contact with modern allopathic medicine.

A question that arises in mind is, whether traditional etiologies still enjoy popularity in the face of widespread spatial

diffusion of modern medicine. India adopted a National Health Policy in 1983. The emphasis was on the preventive, promotive and rehabilitative health services. There has been an increase in the budget allocation from rupees 65.2 crores during the first five year plan to rupees 3,393 crores during the seventh five year plan and at the same time increase in the health facilities in terms of personnel, training and hospitals. The number of Primary Health Centres increased from 725 in 1955 to 16,735 in 1988. Hospitals increased from 2717 in 1970 to 8,000 or more in 1988. There has been increase in the number of personnel too (Sundaram and Nundy, 1992 : p. 6).

Keeping these in mind, this section is an analysis of the prevailing concepts of etiology and the diseases those occur among the labourers in the tea plantations under study.

Roy (1991 : pp.371-372) observes that among the Oraons of Birpara tea plantation in the Jalpaiguri district of West Bengal, the concept of illness is what we may term as internal, i.e., those accompanied by pain, fever, vomiting, debility, breathing troubles, bowel problems and so on. External ailments like skin diseases and long standing states of disorder are not included. He further observed that no distinction is made between illness and sickness, but diseases are considered as causes for sicknesses. The latter is recognized in terms of ability to work.

The same is true with the tribal workers of the three tea

plantations. Here too afflictions accompanied by pain, fever, vomiting, bowel problems and debility or the symptoms themselves are taken to be as illnesses. In other words, those afflictions or symptoms causing hindrance to work or forcing people to abstain from work are considered as illnesses. Illness and sickness are not distinguished.

Health to the tribal workers seems to mean nothing but absence of physical infirmities and ability to work. Thus, a person is considered to be healthy only when he has no physical infirmity and can work unhindered.

Many diseases which even in their primary stages should be considered as indicators of ill health are found to be ignored for the simple reason that they do not act as obstacles in their work processes. Thus, helminthic infestations, skin diseases, small sores on the leg or arm are not taken seriously. However, it is only when these diseases cause serious problems leading to obstacles and giving rise to other health hazards that they are treated as sicknesses.

Ill health has been found to be attributed to more than one causes. The various causes attributed may be categorized under five heads, supernatural, human, natural, physical and scientific. Under supernatural causes may be included wrath of gods and goddesses, ghost intrusion, spirit intrusion and breach of taboo.

Sorcery, witchcraft and evil eye may be categorized under human causes, climatic conditions under natural causes and loss of blood, excess heat in the body, impure blood, weakness, wrong food under physical causes and cold, impure water, intake of liquor and mosquito bite under scientific causes. Scientific concepts of disease causation have not infiltrated that much in the society. This appears interesting in the presence of modern medical facilities and the availing of them by the workers.

A disease has been attributed to various causes. Thus fever has been attributed to spirit intrusion, ghost intrusion, evil eye, bad climatic conditions and witchcraft; Typhoid to evil eye; vomiting to evil eye and intake of wrong food; Diarrhoea to excess heat in the body, ghost intrusion, evil eye, witchcraft and intake of bad food; Weakness to loss of blood, sorcery, witchcraft and malnutrition; Chicken pox to spirit intrusion and wrath of god. Dysentery to witchcraft, ghost intrusion and impure water; Asthma to wrath of god and witchcraft; Liver problems to intake of liquor, breach of taboo (sin committed) and witchcraft; Paralysis to wrath of god or goddesses, spirit intrusion, witchcraft and sorcery; Rheumatism to weakness, sorcery, ghost intrusion and witchcraft; Malaria to mosquito bite; Mental imbalance (psychic disorder) to witchcraft, breach of taboo; Measles to spirit intrusion and wrath of goddesses; Chest pain to cold and cough; Tuberculosis to excessive hard work, malnutrition

and sorcery; Leprosy to breach of taboo and supernatural wrath.

The infiltration of modern scientific concepts of disease causation like mosquito bite, cold, impure water and malnutrition must be due to the high incidence of the diseases they have been shown against and the contact with modern medical practices in the connection and the contact with the outside world.

Supernatural causes: It has already been indicated that certain types of illnesses and diseases are attributed to supernatural causes. Diseases with a high intensity or causing a great degree of disability are invariably classified as to be caused supernaturally. Again, a disease, if failed to be cured by modern medicine, earlier diagnosed to be physically or naturally caused is attributed to supernatural agencies. Prolonged sufferings are also attributed to supernatural agencies. However, there are certain diseases like measles, leprosy and pox which are attributed solely to supernatural agencies.

Human agencies as causes: Witchcraft, sorcery and evil eye are believed to be effective in disease causation. A person, usually a female who has supernatural powers to do evil is called a witch. Many diseases are believed to be caused by witchcraft or sorcery, e.g., fever, psychic disorders, rheumatism, paralysis, weakness, asthma, diarrhoea, dysentery, typhoid, vomiting and liver cirrhosis. While for some of these diseases witchcraft and

sorcery alone are held responsible for others they are one of the possible causes.

Natural causes: Climatic conditions are often held responsible for diseases. Fever, cold and cough are regarded as to be caused by humidity, low temperature and heat. Besides these accidents are also recognized as causes.

Physical causes: Physical causes like loss of blood, weakness, impure blood, excessive heat in the body and wrong food are held responsible for many of the diseases those occur. The respondents have been found to regard loss of blood as a factor in weakness and weakness at the same time to rheumatism. Impure blood is held responsible for skin diseases like scabies and sores. Excessive heat in the body has been related to diarrhoea, dysentery and bodyaches. Taking of wrong food are considered to be causes for cholera, diarrhoea, dysentery and vomiting. Excessive hard work has been attributed to chest pain and tuberculosis.

Scientific causes: Scientific causes and their attribution to diseases have, as has been said before, penetrated the society though they enjoy a low profile. Causes like mosquito bite, intake of impure water, malnutrition, cold, liquor intake and blood pressure have found place in the etiology of diseases of the tribal workers. Malaria has been attributed to mosquito bite, intake of

impure water to cholera, diarrhoea and dysentery; excessive liquor consumption has been related to liver problems and cold has been cited as a cause of fever. Except for mosquito bite none of the causes have been accepted as to be the sole reason for the disease they have been associated with. Though mosquito bite has been regarded as a cause, the respondents failed to give an explanation as to how mosquito bite causes the disease. This reveals that the concept of germ has not found place in the minds of the tribal workers. The same is true with impure water consumption and cholera, dysentery and diarrhoea occurrence. The workers believe that it is the dirt in water which is responsible of the disease. In respect to paralysis and blood pressure, the explanation offered is akin to the scientific explanation. The respondents mentioned that increased blood pressure leads to collapse of brain and thus leads to paralysis. It should be mentioned however, that the number of respondents who have cited scientific explanations to diseases are very few in number.

The diseases those occur among the tribal workers are numerous, ranging from fever to chronic amoebiasis and liver cirrhosis. The most prevailing diseases are bacilliary dysentery, diarrhoea, amoebiasis, helminthic infestations, and bronchial asthma. Besides these, skin infections, general weakness and rheumatism are found among considerable numbers of the population. Roy (1991 : p. 373), reported that among the Oraons of Birpara tea plantation, helminthic infestations was at the rate of 99.07

per cent. The prevalence of such diseases has been attributed by the medical staff of the health units of the plantations to the lack of knowledge among the workers, the working conditions, the low level of personal hygiene and sanitation and the ignorance of the workers.

Helminthic infestations do not arouse any serious concern among the workers unless they take an alarming proportion and act as impediments in the work process.

Asthma, dysentery, diarrhoea and rheumatism all of which hinder their work process are treated by the workers with the help of an ojha or modern doctor.

The Choice of Medical Systems

This aspect has been approached from a comparative view point taking into account the two types of plantations. Moreover, case studies of persons who are suffering or have suffered from diseases in the recent past have also been included to enrich the data.

Investigations reveal that in the plantations with better facilities of health, the workers mostly resort to modern medical facilities except for cases wherein they believe involvement of supernatural or human agencies, ascertained with an ojha (traditional medicine man). In such cases the treatment resorted to is

~~is~~ exclusively traditional involving magico-religious rites. Cases like fever accompanied by very high temperature, perspiration and abnormalities in speech and behaviour are undoubtedly branded as to be caused by supernatural or human agencies. Modern medical practitioners are usually not consulted in such cases even if the patient does not show signs of improvement after repeated trials by a traditional medicine man. There is a deep rooted belief in the people that modern medicine is ineffective in cases where supernatural or human agencies are involved. A respondent said that diseases caused by either supernatural wrath, witchcraft or sorcery, can cure only by propitiation of the god or goddess responsible and applying anti-witchcraft or anti-sorcery methods respectively.

Diseases like dysentery, diarrhoea, cholera, amoebiasis, headache, bodyache, malaria, anemia and scabies have been found to be usually treated by the workers with the help of modern medical systems either in the form of treatment at the health unit of the plantations, government aided Primary Health Centres and hospitals or private practitioners. But all these are done after the ojha who is consulted at first ascertains that supernatural or human agencies are not at work. It should not be however thought that traditional medical systems are not considered in treating the diseases mentioned. The consideration is always the last and depends on the factors of accessibility, availability of modern medicine and the effectivity of the same. In other words, when the workers have tried all the available and accessible sources of modern medical

facilities but failed they resort to traditional medicine. Accessibility depends on the distance, nature of transport available, the nature of reception available at the health units and the cost of treatment. Distance has been found to be a great deterrent when the sources of modern medical treatment are far and there is no cheap transport available. The treatment metted out to the people has also been found to be an important factor. However, the most detrimental factor has been found to be the poverty of the workers. All these problems have been reported by the people. A respondent in desperation said "What to do? When we are not cured at our plantation clinic we are left with no option other than going for traditional medical treatment. Hospitals are overcrowded and the procedures are hazardous. We are treated shabily there. Moreover, they are far off and there is no proper transport. Even if we can manage a transport it is expensive and if a patient is admitted daily communicating to attend to the patient is a problem. Again taking leave to attend to the patient is not possible as it will give rise to economic problems. Consulting a private practitioner involves high cost in the forms of consultation fee and high price of medicines". Respondants have been found to withdraw themselves from visiting a modern private practitioner and discontinue treatment due to want of money. The case of Tulsi Parja of Taipoo tea plantation may be cited in this connection. Tulsi Parja's daughter Phulo Parja, aged 18 years has been suffering from a badly infected ankle of the left leg since the past one year or more. The infection is the result of negligence to a minor

injury received while playing with a sickle. For a month the wound remained untreated and as a result puss was formed in the wound. After a month the child complained of pain in the part. She was taken to the plantations health unit from where the case was referred to the North Bengal Medical College and Hospitals. The doctors there performed a surgery and after four days of stay and treatment in there she was discharged. The doctors advised alternate day dressing of the part with antiseptic lotion and prescribed ampicilin capsules to be taken for two weeks. Tulsi bought a week's dose with all the money he borrowed. Later on she could not buy the second weeks dose. The treatment was discontinued. The wound did not heal properly and the infection relapsed and Tulsi was rendered helpless. She was suggested by the well wishers to consult a private practitioner which she could not do due to want of money. As a last resort she tried herbal medication with the help of an ojha which proved a failure. The condition of Phulo is now precarious. She cannot walk due to pain. The wound emitting puss and smell. What any modern doctor would suggest is amputation of the ankle..

The sequence thus found to be usually followed by the people in treating diseases is, first, consult an ojha for ascertainment as to whether supernatural or human agencies at work. Second, if supernatural or human agencies are not at work, visit the plantation health unit. Third, if not cured at the health unit of the

garden visit alternative sources of modern medicine if they are accessible and fourth, if alternative sources are not accessible consult an ojha due to helplessness.

A factor, though not a very influential one in the process of availing of modern medical treatment, has been found to be the fear psychosis among some workers as regards the surgical part of modern medicine. A respondent, named Dumroo Oraon of Taipoo tea plantation discontinued his treatment of gal bladder stone due to fear of surgery and consulted an ojha.

Non-availability of proper medicine at the plantation health units has also been alleged by respondents. This has been cited as a factor which, along with the above discussed factors force the workers to approach an ojha for treatment.

The past experiences of the workers with the two systems of medicine in treating a disease have been found to be instrumental in the choices of medical system in treating the disease. Respondents have said that they adopt modern medical systems in diseases like diarrhoea and dysentery even when they have been attributed to supernatural or human agencies as in the past they or members of their families have been cured. During my field work at Hansqua, I happened to come across a respondent whose son had been afflicted with dysentery. When I met him he was preparing to take his son to the plantation's health unit. Asked as to why he was not consulting

an ojha he replied that in the past he had been cured thrice of the disease by modern medicine and moreover it works quickly. Effecting quick results seem to be a factor as is reflected from the last few words of the respondent.

However, certain diseases like leprosy, mental disorders, paralysis, physical disorders and rheumatism have been found to be treated with usual preference to traditional medical systems. This is due to their strong conviction that these diseases are super-naturally or humanly caused and modern medicine can never be fruitful in these cases. Moreover, the experiences of the patients did not show modern medicine prove useful. However, sporadic cases of modern medical treatment have been found but this is just to give a try to modern medicine after traditional medicine has effected no cure.

Though the workers have been found to have faith in modern medicine and treat diseases attributed to natural, physical and scientific causes with usual preference to the system, there are cases wherein strong faith in traditional systems of medicine and consequently treatment by traditional medicine man first. Salu Parja's wife Fagni Parja, aged 38 years of Taipoo tea plantation had diarrhoea. She waited for two days and consulted an ojha who stays in a village next to the plantation. Abdominal disorder due to intake of wrong food was diagnosed and the treatment was herbal.

She was cured within four days. Fagni did not consult a modern medicine man as she had faith in traditional medicine which is partly due to fear of ojhas.

Another case is that of Jamuna Nag who had menstrual problem. She happened to meet an ojha of the plantation by chance and casually put forward her problem. The ojha offered to treat to which she agreed. But the herbal treatment of the ojha did not succeed and Jamuna had to consult a private practitioner of modern medicine.

The picture in the plantation with minimum facilities of health is more or less the same. The respondents have been found usually to resort to modern medical treatment except for cases wherein supernatural or human agencies are believed to be involved. In such cases traditional medicine men get the first preference and the treatments are magico-religious. The resorting to either traditional or modern medical treatment is preceded by ascertaining the causes of diseases by an ojha. Leprosy, chickenpox, mental and physical abnormalities are believed to be caused by either supernatural wrath or witchcraft and sorcery. Afflictions of other than these, such as bacillary dysentery, diarrhoea, gastro-enteritis, mild fever, anemia, abdominal pains, bodyache and headache are usually treated with the help of modern medicine after being sure that no supernatural or human agencies are involved. A patient suffering from such diseases is first taken to the doctor attached

to the plantation health unit where if not cured the workers try alternative sources of modern medicine like government Primary Health Centres or hospitals or private practitioners if they are accessible and available. It is only in the event of non-accessibility and non-availability of these sources and the failure of treatment at these sources that the people resort to traditional medical treatment.

The workers in the case of a disease not supernaturally or humanly caused first visit their plantation health unit from where, if not cured they go to the Subsidiary Health Centre adjacent to the plantation's eastern sector. They even at times go straight to the Subsidiary Health Centre. The doctors at the Subsidiary Health Centres refer cases those are beyond their limits to cure, to the North Bengal Medical College and Hospital which is a few kilometers away. It has been found that there is a tendency among the workers to avoid the big hospital. The people rather prefer to consult a private practitioner or traditional medicine man. This tendency has often resulted in serious consequences as, consulting a private practitioner is not always possible due to economic constraint and thus ultimately resulting in seeking help from traditional medicine man. The low level of preference given to the big hospital is due to certain apprehensions nursed by the workers, the difficulties faced by the workers there and the shabby treatment they receive there.

As regards afflictions those receive exclusive treatments by the traditional medicine men, it should not be taken for granted that they are not treated with the help of modern medicine. Though the workers believe that modern medicine is not effective in such cases, they consult a modern doctor just to give a try. The case of Birsingh Oraon's son may be cited in this connection. Birsingh Oraon's son Ashok, aged 20 years is a paralytic patient. Birsingh recalled that when his son was 12 years of age he complained of pain and wekaness in his legs. In discussing with his father it struck him that it must either be a case of witchcraft or supernatural wrath. He, after a few days, consulted an ojha who diagnosed witchcraft and appropriate measures followed to neutralize the power of the witch who was detected to live in the neighbouring basti. The ojha after doing the needful suggested to wait and see for two weeks. But even after two weeks no improvement was noticed. The ojha was summoned again who then diagnosed supernatural wrath (the name of the goddess could not be obtained) and propitiatory measures followed. This also did not yield any result and after a month the boy sank. He was unable to walk. But Birsingh was so much convinced to supernatural wrath that he tried with another ojha who after doing propitiation prescribed massage. Even after continuing this treatment for a month there was no improvement. Later, disgusted he took his son to the North Bengal Medical College and Hospital where, the doctors expressed their helplessness.

Another case, that of Telesphor Oraon of Matigara tea plantation will show, that the workers prefer to avoid the big hospitals (in this case it is the North Bengal Medical College and Hospital) and get treated by traditional medicine men. The case will also show that they are prepared to spend money and consult a private practitioner rather than visit a big hospital. Moreover, the case will throw light on the fact that the workers resort to treatments at big hospitals at the last moment. Telesphor Oraon, aged 38 years was suffering from ulcer. He was passing blood in the stool. He at first consulted Chaitu Naik an ojha of the garden. The cause was diagnosed as excessive heat in the body and he prescribed herbs. The treatment did not respond. Telesphor then consulted the doctor of the plantation health unit who referred the case to the Subsidiary Health Centre at Matigara from where the case in turn was referred to the North Bengal Medical College and Hospital on the ground that the case cannot be treated there. Telesphor had in mind the hazards they face at the big hospitals and decided not to go to the North Bengal Medical College and Hospitals. He instead thought of consulting a private practitioner but could not afford due to financial problems and decided against and sought the help of an ojha staying at Chandmani tea plantation. The treatment did give him partial relief but his condition deteriorated after a few days and had to be forcefully shifted to North Bengal Medical College and Hospital by the plantation authorities where he had been for 15 days. He is cured now.

Child Care

Child care assumes great importance as the health of a child is the crux of the community. Social factors of child care relate particularly to the neighbourhood and the family. Methods of child care are indicators of health modernity.

Investigation in the three plantations reveals that there is usual preference to have the delivery of the child at home with the help of a mid-wife. In all the plantations except Hansqua there is no trained midwife and therefore the process of delivery takes place under the care of untrained midwife. In most cases no desired scientific precautions are taken. It has been said by the respondents that the umbilical cord is cut with the help of a knife or the head of an arrow. The instruments are not disinfected or sterilized before use.

The respondents have been found to nurse certain apprehensions in regards to maternity homes or hospitals and they avoid them unless things get complicated at which the midwife suggest shifting to the same.

A new born immediately after birth is cleaned with warm water and the body is smeared with turmeric and mustard oil.

No special care except providing extra amount of rest is taken for a pregnant mother. Though some respondents have pointed out the need for good food besides rest, they do not practise so due to economic constraints. Usually the workers do not feel the need to give good food to a pregnant lady. They are unaware of the fact that health of the mother is vital for a healthy baby. Periodic checking of a mother by a doctor is not taken up by the workers. The people are unaware of the need for doing so.

The common and most prevalent method of post-natal care of a child is to massage a child with warm mustard oil for 20 to 30 days. This is done with the view to make the bones of the child strong. There is lack of awareness among the workers as to the need of keeping a child clean. However, in Hansqua tea estate some families among the Oraon and Munda tribes have been found to give a child daily bath for a month. Moreover, no care is taken to maintain cleanliness of the clothes and vessels in which a child is provided food.

Preventive measures according to modern medical system have been found to have partial acceptance. The number of children vaccinated against diseases is very low in the Matigara plantation, moderate in the Taipoo plantation and quite high in the Hansqua plantation. In the Matigara plantation the rate is very low despite the existence of the government Subsidiary Health Unit adjacent to the eastern Balasan sector of the garden. It is alleged by the

doctor of the Subsidiary Health Unit that the workers are unwilling to accept the vaccination. Very few attend the immunization camps with their children. But, this appears astonishing in view of the fact that the workers bring their children to the Subsidiary Health Unit for treatment of ailments on many occasions.

In the Taipoo plantation, the moderate rate of vaccination of children is the cumulative effect of ignorance, non-serious attitude and non-availability of facilities throughout the year. Workers who are aware of immunization and its importance, alleged that they do not come across such facilities in the plantation or anywhere in the proximity, thus, hampering their children getting immunized.

Traditional preventive measures in the form of amulets and magico-religious rites are taken up by all. These go side by side with modern preventive measures. The traditional preventive measures centre around evil eye, ghost-intrusion and spirit intrusion. There is a belief among the tribal workers that evil eye causes illness among the children. The symptoms of which are vomiting, high fever and diarrhoea.

No special diet or restrictions on diet are found to be maintained for the children after the suckling period, which is found to vary from 1½ years to 2 years. A child is given all solid food consumed by an adult except fish and meat. A child in a family

is given to eat what is given to eat to the other members of a family. The workers are found to be unaware of the restrictions and diet to be maintained for a child. During the suckling period a child is fed exclusively on mother's milk which, if not available is substituted by ~~cow~~ cow's milk. No tinned powder milk is given.

Family Planning

It has been found that the workers have the idea of family planning but not in detail. All the workers in all the three plantations have heard of family planning either from the media or neighbours. Their idea is limited to not having many children and sterilization. Though respondents agreed that having more children poses rearing problems not many of them practice birth control either by traditional or modern methods. This is due to the fact that there is a common belief that preventing birth would antagonize god. A child is taken to be a gift of god.

There are other factors which singularly or together act as barriers to adoption of modern medical practices. Some workers have been found to nurse a fear that sterilization leads to weakness and also death at times. A reason which may be a factor in birth is that for each birth there is a payment of rupees 250 made to each family by the plantation authority towards upbringing of the child.

Sterilization has been found to be the most popular method of birth control. Contraceptives, though the people are aware of them, have not been found to be made use of. An interesting feature found related to adoption of sterilization is that those who have undergone sterilization have done so at an older age and all are women. The motive seems more of economic rather than birth control. After sterilization a compensation of rupees 120 is paid by the government.

Awareness as regards maintaining of adequate annual intervals among conception of babies has been found to be not at a high rate. Very few people know of it. The mean interval of conception is 1 year. Those who are aware are ignorant.

The use of traditional methods of prevention of birth are limited only to illegal conception as the people fear being scandalized. Such methods are adopted secretly. The traditional methods used are herbal prescriptions and abortion done by midwives. The latter is usually avoided and made use of only when the former fails. Visit to hospitals for abortion is avoided as the people fear to be scandalized and also as the people nurse apprehension in that respect. Moreover, accessibility to such facilities is a problem. The case of Jumroo Oraon's daughter, of Atal tea plantation (a neighbouring plantation) may be cited in this connection. Jumroo's daughter who was of the age of 18 had an illegal conception which Jumroo came to know after 2 months.

He secretly called a traditional medicine man from Hatighisa who prescribed herbal medicine. But this yielded no result. The fetus grew. Jumroo after a month took his daughter to an untrained midwife in a neighbouring village secretly and wanted the fetus to be removed. The midwife's efforts proved futile as the fetus had grown fairly big. The process was so crude that it led to profuse bleeding and ultimate death of the girl.

The Traditional and Modern Medical Practitioners

Gandhi (1981 : p. 72) pointed out that instead of dichotomizing the two systems of medicine one should emphasize the interaction between the two which is a common feature of Indian life.

In the different sub-sections those preceeded, I have discussed different facets of interaction between the two. This sub-section is devoted to the analysis of the interaction between traditional and modern systems of medicine through the methods adopted by their practitioners and their attitudes of each towards the other.

Traditional medical systems have been found to incorporate elements of modern medicine. Marriot (1955 : p. 259) observed, that the fascination of the villagers with stethoscope and thermometres have. Similar observation have been made by Gould (1965 : p. 207). Newman, Bhatia, Andrews and Murthy have reported

that the most successful of the indigenous medical practitioners have adopted modern medicine in combination with indigenous medicine.

The diagnostic methods of the traditional medicine men have been found to involve divination, observation, pulse reading, feeling by touch and intuition. Very often, all these methods are used together in diagnosis. Divination, however, is believed to be the most effective and is the most popular.

In the process of divination, the medicine men take a sal leaf and applies on it some sindur (vermillion) and mustard oil and placed it in front of him. Then he calls the gods and goddesses for aid. It is believed, that by doing so, the face of the god or goddess appears on the leaf. The disease also appears on the same leaf. This process also reveals cases of witchcraft and sorcery.

The methods for identification of the direction in which the witch stays is putting some straws in linear fashion and uttering of mantras at which the straws move in the direction of the witches house.

Observation, pulse reading, feeling by touch and intuition are mostly used as methods which aid in diagnosis. But these singularly serve as effective diagnostic tools.

Reading of pulse seems to be an adoption from modern medical treatment but this adoption is not with the motive of popularization. Instead it is just to aid diagnosis. Popularization of the system of medicine does not seem a motivating factor as for none of the medicine men it is a primary occupation.

Traditional medicine men do not view modern medicine with hostility. Instead, they view it as another medical system in its own right. That it is not viewed with hostility is evident from the fact traditional medicine men often offer themselves for modern medical treatments and refer cases for modern medical treatments.

The modern medical practitioners on the other hand though they do not view traditional medical system with hostility are unwilling to brand it as efficacious. When it was pointed out that many of the modern medicines are derived from herbs used in traditional therapy they agreed, but at the same time pointed out that traditional medicine men did not have knowledge of their proper application. The modern medical practitioners have been found to be very severe on the magico-religious practices. Some have viewed it as ploys to kill people. Though, the traditional medical systems have been viewed as inefficacious by the modern doctors they do not object to their existence for two reasons first, as they are not harmful to their profession and second, as they form a part of their tribal custom.

The fact that traditional medical practice is not the primary occupation for none of the traditional medical practitioners may be due to the decline of popularity. The practitioners pointed out that it is not possible to earn livelihood through it. The decline of popularity has been attributed to change of attitude of the people and emergence of modern medicine. A consequence of reduction in popularity and failure to earn livelihood through the practice is that the practitioners do not demand remuneration. However, they do not decline if given in cash or kind.

Case studies of three traditional medicine men one of Hansqua tea plantation, one of Matigara tea plantation and one of Atal tea plantation a neighbouring tea plantation north of Taipoo beyond Kiran Chandra tea plantation may be mentioned in this connection. The case study of the medicine man ^{of Atal} has been taken as the workers of Taipoo has often mentioned of him.

Mangra Oraon of Hansqua tea plantation, aged fifty eight years is working as a traditional medicine man for the past twenty years or more. He learnt the art from one of his friends Bigal Oraon for five years. He started learning it at the age of twenty. Bigal's father was also a traditional medicine man who specialized in magico-religious treatments. Mangra received some training from Bigal's father too. Mangra besides magico-religious treatments also knows herbal treatments which he learnt from Bigal who had learnt it from his grand father. Mangra has no hostile attitude towards modern medicine. He thinks that modern medicine is effective in diseases which are not supernaturally or humanly

caused. It is needed as traditional medicine is not effective always. His faith in modern medicine has developed out of his cure of ulcer five years back besides other small ailments. He does not object to anyone adopting modern medicine at the same time he does not insist on anyone adopting traditional medicine.

Mangra uses mainly divination to diagnose diseases. Observation, pulse reading and intuition are used as aids to diagnosis. However, Mangra at times with the help of observation and experience is able to diagnose diseases. In the process of divination Mangra uses a sal leaf smeared with sindur (vermillion) and mustard oil. He lights some incense sticks also. He places the leaf on the ground in front of him and calls the gods and goddesses for aid. The god or goddess appears on the leaf. Also appears is the disease.

Mangra said he treated as many as two hundred cases but has cured only eighty to ninety of them. He never demands remuneration but does not refuse if anyone offers. According to him he treats more with a welfare motive rather than economic.

Chaitu Naik of Matigara tea plantation, sixty years of age is also a traditional medicine man. Chaitu is practising the art for the past thirty years. He learnt the art from his father. It took him seven years to master the art. Chaitu's methods of treatments are propitiation and herbal. His aids of diagnoses are divination, observation, pulse reading and intuition. He relies

more on divination. The other methods are used to aid the process of diagnosis. However, due to his experience he at times is able to diagnose disease by observing symptoms. The process of divination is the same as have been described earlier.

Chaitu agrees that modern medicine had brought about a decline in the popularity of traditional medicine at the same time he points out that modern medicine is effective in many cases. He further points out that modern medicine has to be there as it works quickly and also because traditional medicine is not always effective. Chaitu himself has on many occasions been treated with success by modern medicine.

For Chaitu working as a traditional medicine man is not his primary occupation. He does it with the motive of social welfare. He admits that by only being a traditional medicine man he will not be able to earn much. He demands no remuneration but does not refuse if given. Remunerations are either in cash or kind.

Taran RajGond aged sixty years of Atal tea plantation is competent in both magico-religious and herbal treatments. He learnt the art from his father. It took him fifteen years to learn the art. He accompanied his father during his visits to patients' places and observe him work. When he attained the age of fifteen he was asked by his father to help him in his work. From the age

of twenty five he started curing patients independently.

Taran uses divination, pulse reading, and observation of symptoms to diagnose diseases, but he relies mostly on divination. The process of divination is the same as showed earlier with the only difference that Taran calls goddess Kali for aid. He said that goddess Kali appears on the leaf and reveals the disease and cause. The other methods are used to facilitate the process of diagnosis. However, at times just by observing symptoms ~~■~~ a disease is diagnosed.

Taran believes that modern medicine has brought down the popularity of traditional medicine but he does not nurse any hostile feeling against modern medicine. He thinks that modern medicine is needed as traditional medicine is not able to cure all diseases. This attitude has developed out of his experience with modern medicine. He has been cured of chronic bronchities six years back.

Taran has cured many patients but cases which proved beyond his capacity were referred for modern medical treatment.

Taran does not demand any remuneration for treating, but does not refuse to take is offered. Traditional medical practice is not his profession he does it just for social welfare.

CHAPTER VII

CONCLUSION

I

There is a commonly held belief that the tribals and the rural folk are averse to new cultural patterns. Health is an integral part of culture. It is often alleged that the tribals and the rural folk ^{refuse} to part off with their traditional health practices and take up modern health practices. There are reports of under utilization of the Primary Health Centres in the countryside and consequent persistence of traditional methods of cure for diseases. The structural facilities of the Primary Health Centres, clash of ideals of traditional and modern medicine, the failure of modern medicine to accommodate with the social milieu, inaccessibility to modern medicine and non-availability of the same, lack of seriousness on the part of practitioners of modern medicine in the countryside and the urge of the people to preserve their traditional culture have been cited as reasons.

While on the one hand, there are studies which have shown traditionalism in health culture among the tribal and rural folk, there ~~is~~ ^{are} on the other, studies which have shown partial acceptance of modern health practices. There are also studies which have shown that the tribals are prepared to accept modern medicine if facilities are provided and they are easily accessible.

With these in mind the study aimed at studying the tribal tea plantation workers in three plantations of the Terai region of West Bengal. Two with better facilities of health and one with minimum facilities of health.

Every society and community has its own culture and the tribals are no exception. Supernaturalism, traditionally, dominates every aspect of tribal life. The tribal tea plantation workers have their origin in Bihar, Madhya Pradesh and Orissa. They migrated during the early stage of the development of tea industry due to alienation from land and consequent poverty. The migration was in bulk and the workers were kept isolated from the outside world. Both these factors were conducive to continuity of traditional practices. Moreover, during the early stage of the development of tea industry, specifically, prior to 1951, it was not compulsory for tea plantations to provide health facilities. This was another factor favourable for continuation of traditional health practices. Besides these factors illiteracy among the workers was also a factor.

The year 1951 saw the formulation of the Plantation Labour Act. It became compulsory for every plantation to maintain a health unit according to standards prescribed by the State Government and also provide for drinking water and sanitation facilities. While most of the plantations fail to maintain such facilities, some plantations maintain better health facilities.

The development of communication and transport has brought the tribal workers in contact with the outside world and provided access to alternative sources of modern medical treatment. Moreover, the governmental effort to disburse medical facilities to rural areas has made modern medical facilities more accessible. These are factors conducive to bringing about changes in the health culture of the population.

With this view in mind, aspects like the prevalent diseases, etiology of diseases, sanitation and personal hygiene, food, intoxication, narcotic intake, choice of medical systems, the factors those effect the choice, family planning practices, mother and child care, and the interaction between traditional and modern medical practitioners have been covered to assess the changes those have taken place. These aspects constitute an important part of culture, i.e., health culture of a population.

It has been stated that only the numerically dominant tribes on the tea plantations have been considered for the study as the results of the numerically insignificant tribes will not be significant. Following this, nine tribes, the Oraons, the Mundas, the Gonds, the Santals, the Mahalis, the Baraiks, the Malpaharias, the Parjas and the Kharias have been considered. It should be mentioned here that all these tribes have their traditional beliefs and practices regarding health and diseases and other aspects of health culture.

II

The analysis of the health culture of the population reveals that, to the people, good health means nothing but absence of physical difficulties to work. It implies that only afflictions those lead to abstinence from work are considered as illnesses and receive treatment. Many diseases those even in their primary stages receive our attention are ignored by the people. Such diseases receive the attention of the people only when they act as serious obstacles. Afflictions accompanied by pain, bowel problems and debility or the symptoms themselves are recognized as illnesses. The people have been found not being able to distinguish between illness and sickness. Diseases are taken as causes for illnesses.

More than one causes have been found to be attributed to ill health. The causes believed by the workers to be responsible for diseases are supernatural agencies like ghost intrusion, spirit intrusion, breach of taboo and wrath of gods and goddesses; human agencies like sorcery, witchcraft and evil eye; natural causes like climatic condition; physical causes like excess heat in the body, loss of blood, impure blood, weakness and wrong food; and scientific causes like mosquito bite and cold. A disease has been found to be attributed to more than one causes. For example, fever has been attributed to spirit intrusion, ghost intrusion, evil eye, bad weather conditions and witchcraft; Diarrhoea to excess heat in the body, ghost intrusion, evil eye, witchcraft and intake of wrong food; weakness to loss of blood, sorcery, witchcraft and

malnutrition; chicken pox to spirit intrusion, and wrath of god/
goddess; dysentery to witchcraft, ghost intrusion and impure water;
Asthma to wrath of god and witchcraft; liver problems to intake
of liquor, breach of taboo and witchcraft; Paralysis to wrath of
god or goddess, spirit intrusion, witchcraft and sorcery;
Rheumatism to weakness, sorcery, ghost intrusion and witchcraft;
Malaria to mosquito bite; Psychic disorder to witchcraft and
breach of taboo; Measles to spirit intrusion and wrath of goddess;
Tuberculosis to excessive hardwork, malnutrition and sorcery, etc.

Infiltration of modern scientific etiological concepts is noticed to a certain extent. The recognition of causes like mosquito bite, cold, malnutrition and impure water are indications of that. This may be due to high incidence of diseases they have been attributed to and contact with modern medical practices in the connection.

The most prevalent diseases found among the population are bacillary dysentery, diarrhoea, amoebiasis, helminthic infestations and general weakness. Besides these, skin infections, bronchial asthma, problems of liver and rheumatism are found among considerable numbers of the population. Diseases of the skin and helminthic infestations are not taken seriously by the workers unless they take alarming proportions and act as impediments in the work process. Bronchial asthma, diarrhoea, dysentery and rheumatism which hinder the work process are treated by the workers with serious consideration.

The choice of systems of medicine for treatments has been found to be very much linked to the cause of diseases which is ascertained by an ojha. The ojha ascertains whether a disease is caused by supernatural or human agencies in the case of which the treatments are exclusively on traditional lines. If found otherwise, the treatment resorted to is usually according to modern systems of medicine. But, it should not be thought that diseases not supernaturally or humanly caused, i.e., diseases which are treated with usual preference to modern medicine, are not treated with the help of traditional medicine. The resorting to traditional systems of medicine in such cases is conditional to the success of modern medicine in curing the disease, the past experience of the workers in the regard, the availability of modern medical facilities, accessibility to the facilities and economic constraints. Diseases believed to be supernaturally or humanly caused are treated usually with the help of traditional medical systems involving magico-religious treatments. This is because there is a deep rooted belief that such diseases are not amenable to modern medical treatment. However, sporadic cases of resorting to modern medical treatments for such diseases are found. This is only after repeated trials by traditional medicine men have failed and the workers wish to give modern medicine a try.

Among the constraints or hindrances in the adoption of modern medical facilities of treatment, economic constraints, problems of accessibility and availability of alternative sources of modern medical treatments are prominent ones. The lack of

adequate income has forced the workers to spend very little for medical purposes. Many refrain themselves from consulting private practitioners even when they are sure of better results. Want of money has also forced many to discontinue treatment. Economic constrain is also a factor when the sources of better modern medical facilities of treatment are at a distance. This proves the point that availability of medical facility is a vital factor in the adoption of modern medical facility. The fact that the workers of Matigara tea plantation frequent the Subsidiary Health Centre in the proximity and the workers of Taipoo and Hansqua due to the absence of such facility resort to traditional methods makes the point more stronger. Besides the above constraints, illtreatments received by the workers at the Government Health Units/Hospitals. The negligent attitude of the medical staff towards the workers is also a factor. The workers, due to this at times choose not to visit the Government Health Units/Hospitals.

These factors are reinforced by lack of knowledge of the people as regards to certain aspects of modern medicine and apprehensions.

The above discussion makes one thing clear, that the tribal workers are not averse to modern medical treatment except for cases wherein supernatural and human causes are involved. It is the constraints which act as barriers.

Family Planning and scientific methods of birth control have gained partial acceptance among the workers. The workers have been found to be more or less aware of family planning but, few practice it. Prevention of birth is considered by the majority, specially women, as a sin. A child is considered a gift of the god. However, a number of persons mostly women have undergone sterilization (ligation in the case of women and vasectomy in the case of men). It has been found that there is a preference for permanent rather than temporary prevention of birth. An interesting feature noticed is that sterilisation has been resorted to by the people at an age varying from 35 to 45 and after having 4 to 5 children. This gives rise to questions as regards to the motive behind sterilisation. It seems that the motive is economic. For each birth a family is given an allowance of rupees 500 and for sterilization a compensatory allowance of rupees 140 is paid. The birth allowance may be an encouraging factor for birth and thus, non-practice of birth control. Other methods of birth control like contraceptives are not popular. Traditional methods of birth control are restricted to cases of illegal conception as they require secrecy.

None of the plantations except for the Matigara plantation, provide for birth control facilities or have such facilities in the proximity. But surprisingly the practice of birth control is low at the plantation. On the other hand the workers of Taipoo and Hansqua have cited availability of such facilities as a factor.

Thus, we find that beliefs, ignorance, economic consideration and lack of facilities are factors in non-adoption of family planning practices to a large extent. The low adoption of birth control practices at Matigara may be due to their traditional beliefs.

The average food consumed in a family is not of high order in terms of nutritive value. Food is consumed thrice a day — morning, noon and evening. Vegetables, fish, meat and milk are not consumed in adequate amount. Rice is the staple food. Meat and fish are ^{taken} occasionally, on the pay day. Very little heed is paid by the people to the nutritive values of food. The workers are handicapped due to lack of awareness and adequate earnings. Milk, though is not a taboo for all is not consumed. The food habits of the workers are largely influenced by their traditional culture. No noticeable changes are noticed in this aspect.

Consumption of harira is very popular. Country liquor is consumed to a certain extent. Harira is consumed by persons of both sexes and persons of all age. Many believe that harira is not harmful to health. Those who believe that it is harmful refuse to give up as it is their traditional drink. The workers are aware that other forms of intoxicants are harmful but not all have detailed knowledge.

Smoking of cigarette or bidi is not popular. But bidi is

preferred to cigarette due to economic reasons. Khaini (tobacco mixed with lime) is the most popular form of narcotics. The popularity of khaini is due to economic reason and also due to tradition.

Child rearing practices show continuity of traditionalism among the workers. Children are in most part reared up in natural conditions. No special care is given to a child except massaging with warm mustard oil for about twenty days from birth. This, the people believe, helps in the formation of strong bones. The scukling period varies from one and a half to two years. No special diet is provided after the scukling period however, certain restrictions are followed. Vaccination of children is low either due to lack of awareness, ignorance and lack of facilities. There is a strong belief in evil eye causing diseases among children and appropriate measures are taken for prevention and cure with the help of ojhas.

As regards to the relation between health of mother and health of child, there has been observed lack of awareness among the people and ignorance. Also has been observed that the economic condition of the workers has a vital role. An expectant mother is not given any special care except abstinence from hard work. The fact that a mother during the period of pregnancy deserves proper nutrition does not receive serious attention not to speak of

vaccination. The lack of seriousness is due to the lack of awareness, economic constraint and ignorance.

Lack of proper knowledge and fear surrounds child birth. The birth of a child usually takes place at home under the care of midwife~~d~~ trained or untrained. Hospitals are avoided unless absolutely necessary. The preference of having a child birth at home is due to psychological reasons.

The interaction between traditional and modern medical practitioners is not of a hostile nature. The traditional medicine men though they allege that modern medicine has brought down the popularity of their system of medicine agrees that modern medicine is effective in certain diseases. This can be gauged from the fact that modern medicine men are at times, themselves patients of modern medical practitioners. Alongside their recognition of modern medicine, the traditional medicine men believe that certain diseases can be cured only with the help of traditional medical treatments. The acknowledgement of the effectivity of modern medicine may be due to their experience with modern medicine. The modern medical practitioners though they view traditional medicine as a hoax do not take a hostile stand against it as it forms a part of tribal culture. A reason for the absence of hostility is that for none of the traditional medicine men it is the primary occupation.

The level of sanitation and personal hygiene has been found to be very low. The workers have very little idea of the intricate relationship between sanitation, personal hygiene and health. Even if they are aware, they are either ignorant or due to constraints fail to pay attention. The drainage systems in the residential areas of the workers is absolutely poor in all the plantations. Water gets accumulated and serve as breeding place for mosquito, germs and flies. The defecating habits of the workers is unhygienic. They defecate in fields. Common latrines and urinals are uncomfortable to them. Housing in the tea plantations is not upto the mark and are hazardous to health. The workers seen unaware of this.

As regards drinking water, the workers are aware of the need for pure water. This is reflected in their drawing drinking water from taps in Hansqua tea garden. Despite such awareness the workers are not serious of keeping the wells clean. This reflects their ignorance. They also do not purify water drawn from wells before drinking as they find it troublesome. Moreover, their concept of purification is nothing but removal of dirt.

As regards personal hygiene, the workers do not take bath daily. The use of soap during bath is minimal. Washing of hands before meals is usual but not with soap. Washing of parts after defecation is done with water from rivulets or by water carried in cans. The use of soap for washing hands after post-defecation ablution is uncommon. The workers usually use mud or simple water.

Clothes are changed once a week and washed. They are washed with cleaning agent, usually soap. Shaving and cutting and cleaning of nails have no specific intervals. Twig of neem tree, sal tree and varanda plant are used for cleaning teeth. However, the use of tooth-paste, tooth-powder and tooth-brush is also found.

III

The comparative analysis of health behaviour of the workers in the two types of plantations reveals that in the plantation with better facilities of treatment the workers utilize the health unit of the plantation to the fullest extent. But in the plantation with minimum facilities of treatment the utilization is minimal. This is because the workers are aware of the infrastructural facilities of the health unit. They instead utilize the Subsidiary Health Unit near the plantation.

The behaviour pattern of the population of the two types of plantations follow the same sequence. In both the types of plantations the workers treat supernaturally or humanly caused diseases preferably with the help of traditional medical systems. Diseases caused otherwise are treated with the help of modern medicine. The ascertaining of the cause of disease is done with the help of an ojha who is consulted at first.

In the plantations with better facilities of health, the workers after ascertaining the cause of the disease resort to treatment accordingly. In the case of a disease not supernaturally

or humanly caused the workers first visit the plantation health unit where if not cured they try alternative sources of modern medicine after they can overcome the hindrances or if hindrances are absent. If they are not cured or they fail to gain access to the facilities they try traditional medicine. It should be mentioned that the workers usually avoid the big hospitals due to certain apprehensions and prejudices. Should also be mentioned, diseases supernaturally and humanly caused receive treatments according to modern medical systems. But this is with the intention of just taking a chance.

The plantation with minimum facilities of health presents a similar picture. The only difference lies in the fact that due to the presence of a Subsidiary Health Unit in the proximity, the workers are in a better position in terms of accessibility to alternative sources of modern medicine.

As regards to the hindrances, whereas the alternative sources of modern medicine are in proximity for the workers in the plantation with minimum facilities of health, they are far away for the workers in the plantations with better facilities of health. The economic constraints and the social constraints are existent and are of the same nature in both the types of plantations.

The behaviour of the workers in terms of sanitation and personal hygiene, food, intoxication, narcotic intake and mother

and child care has been found to be same in both the types of plantations.

Family planning practices depict a difference. Whereas in the plantations with better facilities of treatment the accessibility and availability of birth control measures is to a certain extent responsible for the non-adoption of birth control measures, in the plantation with minimum facilities of health, the existence of the Subsidiary Health Unit with facilities of birth control has not met with much success among the workers. The adoption of birth control measures is strikingly low. This is due to beliefs cherished by the workers.

We have earlier stated that studies have shown that traditionalism persists in the health practices of the tribal and rural folk. We have also stated that scholars have pointed out that availability of modern medicine, accessibility to modern medicine, the facilities provided at the health centres, the clash of ideals of the two systems of medicine and the failure on the part of modern medicine to accommodate with the social milieu as factors responsible for non-acceptance of modern medicine.

The picture we get from the two types of tea plantations is that the workers are not averse to modern medical treatment in most cases. Aversion to modern medical treatment is not a factor in the persistence of traditional medical practices to a certain extent. Availability of proper facilities at the health units of

the plantations and the accessibility to alternative sources of modern medicine and economic constraints have been found to be the main reasons behind the partial persistence of traditionalism. The beliefs of the workers as regards to certain diseases and certain aspects of modern medicine are also found to be responsible though not very much.

The inclination of the workers towards modern medical practices has come about due to their long contact with modern medicine and the demonstrated effectivity of modern medicine. Literacy has been found not to be an influencing factor. The people are more concerned with the positive results of treatment no matter what system it may be. The choice of medical systems is dependent on the effectivity of a system and the above mentioned hindrances.

Therefore, to make modern medicine more acceptable to the workers the need is for improvement of the facilities provided at the health units of the plantations, development of transport to make alternative sources of modern medicine easily accessible, rise in the income level of the workers, implementation of health education programmes and activate workers participation in health.

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