CHAPTER – V

GENERAL OBSERVATION AND CONCLUSION

All communities have their own concept of health, as part of their culture. Health, one of the most common themes is variable from culture to culture, one society to another. But study of health is considered in each context to be absence of disease or the state of positive well being whether physical, psychological or both. It involves not only study of definitions and theories of disease but also that of all those cultural and social conditions and elements which contribute to the person's concept of health and his or her development and relationship to the world and to others. This has to be attended by every person and has to be considered as social goal.

Every culture, irrespective of its simplicity and complexity has its own beliefs and practices concerning disease and evolves its own system of medicine in order to treat disease in its own way. Every known human society has developed a pharmacopoeia and a therapy be it magico-religious, secular, empirical or scientific according to western system. The presence of professional healers and the practice of medicine have been cultivated as part of health care system also in India for several centuries before. There have also been instances of definite system of medicine based on nature on the earliest Indian Literature. The traditional professional healers have been reported since the time of Rig Veda. This system has survived after centuries neglect. In this global era this system has emerged as an alternative to the modern medicine. A substantial number of rural as well as tribal people still depend on this alternative system of medicine as this system is intermingled with their culture.

India is the seventh largest country of the world. 70% of Indian lives in villages. Inhabiting mainly in rural India, the tribal folk forms about 8.08 % of the total population. About 67.5 million people have been enumerated in the country as being member of indigenous population. The independence of India from British dominance however has been a turning point in India's destiny and consequently of its huge tribal inhabitants. The tribal, for the first time became a political entity and incorporated as section of society needing special attention in matters concerning education, employment and health condition. The planned development made special provision for the tribal regions and this was closely monitored through the constitutional bodies. Although, after fifty years of independence still majority of them goes hungry nights, lack access to even the basic necessity like safe drinking water, sanitation and live in a state of object poverty. In the developing countries like India, the threats to health security are usually greater for the poorest people in the rural areas and particularly among the tribal.

It is stated that the present study is made to explain the concept of health, disease, medical system, medical belief, related religious practices, diagnostic process and treatment among the Totos of Totopara, Alipurduar Sub Division, District- Jalpaiguri, West Bengal, India. Village Totopara was selected because Totopara was the only residence of the primitive tribe Toto population. With their own unique cultural identity the only primitive tribe of North Bengal Toto population only resided in that particular village partially secluded from the main stream population. But the region was tribal dominated area and number of tribes resided in the surrounding location. The village was also surrounded by dense forest which was helpful for ethno- medical enquiry. As the present study deals with the health behavior, disease pattern, treatment process i.e. health condition among the Totos, so objectives were made considering the facts of different situation. Depending on facts and considering the situation data were collected. Data were collected about types of disease, healing techniques preferred, traditional medicines among the said tribe along with the magico-religious as well as ethno-medical healing processes. Role and activities of traditional healers were evaluated. Individual as well as community level health related cultural and religious practices were also evaluated in detail. Study was also made to know the role of modern Medical Institutions in their life. Particularly the infrastructure and facilities which were extended to the studied tribe were evaluated in detail from the ground level medical institution Sub-Centre, Primary Health Centre (PHC) to Madarihat Block Primary Health Centre (BPHC) and State General Hospital at Birpara. The role, activities and acceptance of the modern medical practitioners were also evaluated. One of the objectives of the present study was to know the implementation and extend of success of different Government initiated preventive and promotive health care services (such as Integrated Child Development Service). Special emphasis was also given to the health hygiene concept and child health condition of the population. Attention was given on drinking water, sanitation and also family planning concept among the studied tribe.

It has already been stated that there were six village sectors where the studied population resided. Considering the scope and objective of the proposed study all the six village sectors were selected and all households were also covered. For pursuing specific objectives the village sectors were categorized. Categorization was made on the basis of certain criteria viz. distance from the local Primary Health Centre and market place. Literacy rate and economic condition were considered criteria while categorization was made.

Category-1:- Located farthest from the said market place and from the only modern medical institution (Totopara PHC). So, limited health facilities were available in close proximity. Very ill equipped communication was noticed to the local PHC or any other place. The absence of quack was also additional parameter. Three village sectors were chosen under this category viz. Dhumci gaon, Mitran gaon and Puja gaon.

Category-2:- Those were nearest to the modern medical institution and market place. Communication was good in comparison to the category-1 village sectors. Three village sectors were chosen under this category viz. Mondal gaon, Panchayat gaon and Subba gaon.

The only modern health institution Primary Health Centre (PHC) was situated in Panchayat gaon. Main market place was located just at the junction of Mondal gaon and Subba gaon. The house of only quack of Totopara village was situated in the Panchayat gaon village sector. Libraries, Bank and Post Office were situated in Panchayat gaon.

In general it could be said that the studied tribe distributed in all the six village sectors had supernatural belief. It was also found that the belief was particularly prevalent in connection to health (both in case of individual well being as well as community well being) disease and disease related symptoms and misfortunes. Differences were although found in terms of level of observances of different norms and regulations. Differences in belief pattern and in understanding about the role of supernatural agencies behind the causation of misfortune were also observed. Belief upon the supernatural forces was very prominent among the villagers of category-1 village sectors, especially among the villagers of Dhumci gaon. The belief was less prominent among the villagers of category-2 village sectors, especially in the village sector Mandal gaon. Point to be noted that literacy rate was higher in category-2 village sectors in comparison to the category-1 village sectors. Further those village sectors were well communicated with Health Centre and market place where interaction with the outside people was possible. So, it is seen that education, modern medical system and communication are important factors for stimulating people to less belief in supernatural power.

Differences were noticed between the villagers of category-1 and category-2 village sectors regarding the level of participation in community level worship. In community level festivals

like *Ongchu, Mayu* and *Sordey,* participation of category-1 village sectors was much more prominent which intern indicated more dependence on the supernatural power among the people of category-1 village sector. Eventually, that dependence sometimes molded their psychology regarding choosing option of treatment procedure. It was also observed that the young generation of category-2 village sectors did not prefer active participation in religious festivals. One point should be mentioned here that supreme deity *Senja,* worshipped for the well-being of the community is compulsorily propitiated in the festival of *Ongchu* and *Mayu.* So in the context of worship of the prime deity a small difference was found between category-1 and category-2 village sectors which often diversely reflected in their health behavior.

All the villages had some belief upon ghost and soul in relation to attack of specific disease and disease related misfortunes. In majority of the cases, there was no specific demarcating character between ghost and soul. According to the villagers, character of soul or ghost is always malevolent in nature and always causes harm to the people. This concept was equally supported by both category-1 and category-2 village sectors. One point should be added here that villagers from category-2 village sectors reported that ghost could be seen in category-1 village sectors as forest was situated in close proximity. Surprisingly, the fact was supported by the villagers of category-1 village sectors. So, the presence of the concept of ghost or soul was recorded, although it was less prominent in category-2 village sectors, particularly among the villagers of Mondal gaon and Panchayat gaon. Higher percentage of literate people seems to be the main influensive factor to overcome from such belief.

But in case of health related family level worship and clan level worship a clear demarcation was also observed between category-1 and category-2 village sector. Family level worships were performed regularly with all the required ingredients in number of Toto families in category-2 village sectors (viz. Mondal gaon and Panchayat gaon). But the same family level worships were not regularly observed among the villagers of category-1 village sectors although they wished to perform all those rituals. Economic solvency may be the only probable cause behind this phenomenon.

The issue of village level participation was reported for observing taboos and worshipping deities in relation to health, disease, treatment and over all well-being at community level disease causation. For example, community level participation was observed at the time of

worship of supreme deity *Senja* although the extent of participation varies sector to sector as well as family to family. So the taboo and restrictions connected with *Senja* were more or less followed by the community members irrespective of sectors. But, in case of disease causation at individual level, disease related taboos and restrictions were mainly confined within the family members only. Village level participation was not reported for observing taboo and worshipping deities (related with particular disease) at individual disease causation. Many of the villagers, particularly from the category-2 village sectors realized that disease and health was the individual personal affair and should be handled at personal level. Nothing could be achieved through community participation. Sometimes the young generation did not prefer the family level participation also and the disease related taboo and restriction was followed by the affected individual only. Overall village level participation was reported to decrease among the studied tribe particularly in the context of health and disease causation. Changes in the concept of health, disease and treatment may be reshaped their health behavior.

Very crucial role and activities of traditional healers were noticed and reported in various circumstances. In case of category-1 village sectors (no modern health facility in close proximity), people were much dependent upon them as the healers were living in those village sectors. So, people could access them whenever they needed their assistance. There was a difference found between men and women folk. Women were much much fond of traditional healing process (table 3.6). Distance of Primary Health Centre could be the probable cause of their reluctance towards modern medical technique. People from category-2 village sectors were found comparatively less interested regarding choosing traditional treatment in comparison to the category-1 village sectors. One point should be mentioned here that while choosing the treatment procedure, the type of disease or disease related misfortunes were evaluated separately by the patient himself (personalistic belief system) or the family members. For example, quantitative data showed that patient suffering from jaundice always preferred traditional medicine, not the modern one. On the other hand, in case of malaria and high fever they preferred to consult modern medical practitioners in Totopara Primary Health Centre. This phenomenon was observed among all the studied villagers irrespective of sectors. Psychological assurance and faith could be the prime cause of choosing traditional treatment. On the other hand, fast relief from fever seems to be the cause of choosing modern treatment in case of Malaria (table 4.3.1-4.3.6).

As observed reluctance towards health related magico religious practices had arose among the studied tribe particularly in Mondal gaon and Panchayat gaon. As reported by the villagers, death of number of traditional medical practitioners could be the probable cause. The descendants of the traditional healers were not so much interested to acquire or to learn the process of traditional treatment because they did not have much faith on traditional healing process. They also opined that, only through magico-religious practices recovery from diseases like malaria, tuberculosis were possible. One point should be mentioned here that, traditional healing practices had never been primary occupational pursuit among the Totos. All the traditional healers took traditional healing practices as secondary occupation or sometimes they exercised it as a welfare task. So, in one hand if decreasing faith towards traditional medicine was considered one cause, lack of monetary gain or business profit should be the another probable cause behind that reluctance. Faith on herbal medical practice was another striking feature among the studied population. This phenomenon was seen among the villagers of all the six sectors although faith on magico-religious practitioners (without the applications of herbs) was decreasing among the people. Particularly the younger generation argued clearly that disease or misfortunes could not be ward off only through magico-religious practices. As reported, the long term treatment of traditional healer was no more accepted among the community people. They wanted quick relief. Instances were reported, to achieve quick recovery sometimes they took overdose of the prescribed medicine. Villagers reported that serious patient could not be tackled by the traditional healers (particularly in case of high fever, loose motion). According to the villagers of all the six sectors, if cause of disease was considered supernatural, then they preferred to avail the traditional way of treatment, considering the availability and efficiency of the healers. Regarding the belief pattern, differences were much more prominent between the present generations and previous generation rather that sectors.

So, variations in the educational attainment particularly among the present generation could be the responsible factor for changing conception among the studied tribe. Tendency of less dependence towards traditional treatment arose due to non availability and less efficiency of the traditional healers. Less tolerance and demand of quick recovery of the patients were another two responsible factors which often reshaped their traditional concept of achieving well-being.

Restriction to forest accession and monocultural forestry were another two important causes for not getting proper treatment through the traditional healing procedure. As part of commercial aforestation betel nut, ginger cultivation took place at Totopara at a large scale. Sal, Segun, Gamari etc were newly introduced as part of forest policy which often replaced the previous forest ecology. As a result, important as well as essential medicinal plant species were gradually disappearing from the surrounding forests. Deforestation was another important factor. Due to monocultural forestry, deforestation and commercial aforestation various medicinal plants were unavailable to the traditional healers which intern adversely affected the whole traditional treatment system of the Toto society.

The belief in the interference of supernatural agency in the context of health was still found among the studied tribe. The idea that different deities and spirits were connected with various disease and disease related misfortunes was very much found among the elderly folk of the population. The above facts gave a valuable support that role of traditional healer was important in Toto society particularly among the elderly folk of the studied tribe. Same cultural value of healers and patients actually portrayed a positive picture.

Since independence, Government of India has been planning various centrally sponsored programmes for the overall development of the tribal population. Main responsibility of infrastructures and manpower lays on State Government which is supplemented by Central Government and external agencies (like World Bank, UNICEF, WHO etc). The primary responsibility for providing drinking water and sanitation facilities in the country rests with the State Government and more specifically the local bodies in both rural and urban areas. The central allocates funds. Regarding the family welfare and disease control program, India became the first country to formulate a National Family Planning Programme in 1952. The focus of Indian Health Services right from the early 1950s has been health care for women and children also. Successive five years plans have been providing the policy frame work and funding for the planned development of nationwide health care infrastructure and manpower. For example, centrally funded Integrated Child Development Scheme provides food supplement to the mother and child.

At the time of independence, healthcare services were hospital based and curative, but unfortunately urban. However, efforts were made to improve coverage and extend the integrated maternal and child health care services to rural areas as part of block development

programme. In 1960s safe effective vaccines for the prevention of 6 childhood disease became available. During 1970s initiatives were made to improve the health and nutritional status of women and children. The massive dose Vitamin A programme, National Anemia Prophylaxis programme, food supplement to the pregnant and lactating women and pre-school children through ICDS were major initiatives. The major thrust during the 1980s was to operationalize the WHO's Alma Ata declaration of health for all by 2000 AD by establishing a network of centers in urban and rural areas to provide essential primary health care. To meet the need Government made effort to build up primary, secondary and tertiary care institutions and link them through appropriate referral system. The national health policy gave high priority to provide health services to those residing in the tribal, hilly, backward areas as well as to detect and treat endemic disease affecting the tribal population.

The studied tribe came under the umbrella of modern health care system after the establishment of Totopara Primary Health Centre. Various Government initiatives came into reach of the studied people after 1993. In the present study it was noticed, at primary level all the village sectors were covered by the sub-centers. As it was mentioned in the previous section of study, there were only one sub-centre in the studied village and it was attached with Totopara Primary Health Centre. Villagers from category-1 village sectors (distant from Primary Health Sector and market place) had to face difficulties to access the sub-centre due to long distance and adverse road condition along with natural barriers such as rivulets. They had to face much more difficulties particularly in rainy days. Despite the said constrains villagers went to the sub-centre for various immunization purpose. Accession of sub-centre was quite easy for the people of category-2 village sectors. Sub-centre was situated itself on Panchayat gaon and close vicinity to Mondal gaon and Subba gaon.

In the context of PHC, the villagers from all the six studied village sectors were reported to avail it as per requirement, because that was the only modern medical institution of the village. As stated the communication between the category-1 village sector and PHC was not good enough and also difficult in rainy days. The villagers from category-1 village had to travel 2-5 Kms to reach PHC. This could be one of the probable cause that women folk from category-1 village sectors preferred to avail the traditional healing system in comparison to the women folk of category-2 village sectors (table 3.6). But the institution was easily accessible to the villagers of category-2 village sectors, as it was situated in close vicinity. The reverse scenario was observed among the population of category-2 village sectors.

Regarding the male-female differentiation, female population in comparison to male, much preferred the modern institution of the village. According to them as the PHC was situated as close vicinity, they could easily access the institition any recess time at anyday even after completion of regular household activities.

Villagers availing the treatment of PHC were more or less satisfied by the treatment and existing infrastructure. Doctor, nurse and health staff tried to extend maximum service with their limited infrastructure. After the establishment of PHC, in a general sense it could be said that for any type of ailment, the studied population prefers the only PHC of the village. This fact can be supported by quantitative finding also (table 3.6). But critical patients were referred to Madarihat BPHC or Birpara State General Hospital depending on the condition of the patient. But the natural barriers such as river and rivulets caused obstruction in the referral service system, particularly in monsoon. Ambulance facility was available and serious patients could be transferred to Birpara State General Hospital. But it was difficult particularly in rainy season. Villagers had to face lots of difficulties for shifting the patients. Almost 24 hours emergency service was provided by the PHC as reported by the villagers. Steady supply of medicines was also reported except few.

Villagers of all the studied six sectors were availing the facilities of Madarihat BPHC (upgraded rural hospital) but it was mainly confined within OPD except delivery cases. As reported in the previous chapter the concern BPHC was upgrading to the rural hospital during the field survey, so only one category of patients was admitted and they were the malaria and fever patients. There was no such bed available for admission, so the people were not getting the full facilities. As reported by the BMOH villagers can get all the facilities after completion of the whole process of up gradation including in patient provision. One point should be mentioned that the studied villagers visited Madarihat BPHC mainly for snake bite purpose if medicine was not available in Totopara Primary Health Centre. According to the studied villagers, facilities provided by Madarihat BPHC and Totopara PHC were almost same.

The Birpara State General Hospital was one of the most preferred hospitals among the studied villagers of all the six sectors of Totopara village. The communication and road condition between Birpara and Totopara was so adverse and it was totally cut off during rainy days. It was noticed that they had to spend whole day for OPD treatment only. So, for further

diagnosis they had to stay either in Madarihat or Birpara which was difficult to afford by the poor section of the studied villagers. For that reason, they preferred to take admission in the hospital to carry out the whole process of treatment at a stretch. The study also reported that people from both the poor and rich section of Toto Society accessed State General Hospital. But as reported by the villagers, they were not fully satisfied with the medical aids from the hospital. Purchasing of expensive medicines from the outside shop was found to be one of the important causes. They also complained about the out of order pathological as well as diagnostic instruments. They also had to face difficulties for managing free beds.

A conspicuous psychological and cultural difference was found between the modern medical practitioners and the studied tribe. The modern medical practitioners who came to Totopara PHC belong to different cultural background and hence in various cases they did not able to understand the conception of the studied tribal patient. Not only that, they were always in hurry to change their job place and to get transfer outside Totopara. As an obvious result, they even not egger to know the actual consequence of the diseases and patients perception about that. So, there was always some gap found between the two. It was observed; sometimes patients were not properly guided by those practitioners regarding the causes, precautions of the diseases. Only the course of the medicines was prescribed. Doctor from Totopara PHC did not involve with private practice, although doctors from Birpara State General Hospital were reported to engage with private practice. As the study showed, villagers did not frequently visit private medical practitioners. Only few well-to-do families could afford the expanses of private medical practitioners. According to them, the behavior was noticed to change in case of same person doing his Government duty and private practice. This said persons were reported more conscious and friendly while doing private practice.

The study showed that the concerned tribe was also comfortable to visit the quack than a doctor. As stated in previous chapter there was only one quack in the whole Totopara village. As he was residing in the village since a long period, he was well aware about the perception of the studied community. He was well known about the socio-cultural framework of different strata within the community itself. That knowledge helped him a lot regarding clinical diagnosis and also at the time of prescribing medicines. On the other hand, villagers reported that the quack had more patience to listen the problem in the patient's own way and also gave the prescribed medicines at a minimum cost. Villagers also reported that, they

consulted quack for some specific minor ailment because he was failed to treat the critical patients, and referred to Cooch Behar. According to the people from the six village sectors, remedy from the quack treatment was less than that of the hospital doctor. As the quack was an aged person and he himself maintained his chamber, he was unable to properly maintain the overall hygiene and sterilized environment of his chamber. In spite of various constrains, villagers from all the studied sectors consulted with the quack, for various minor ailments. It was also seen from the present study, there was a difference found between the male and female section of the population. Male folk was found much more dependent on quack in comparison to the female folk. Quantitative data obtained from table 4.1.6 also supported the above said fact.

Regarding the child birth, before the establishment of Totopara PHC, villagers were very much accustomed with homebirth as there was no other alternative. Ill communication and distance between Totopara and nearest medical institution (before the establishment of Totopara PHC) and also the poor economic condition compelled them to depend upon the home birth. According to the villagers, there was a time when almost all the elderly women could perform the task of *dai* (midwife) for the said purpose. During the field study period it was found, the trend of home birth had been changing, specifically after the establishment of Totopara PHC. Villagers from both category-1 and 2 village sectors were found satisfied with the treatment regarding prenatal and post natal care of the mother and were willing to avail the service provided from PHC. Education and large scale campaigning could be the probable cause behind the recent trend. Apart from that 'Janani Suraksha Yojona Scheme' was found to be another important factor which attracted the poor tribal for choosing hospital delivery. Through that scheme a mother could get up to Rs 500/- for the said purpose. As noticed, not only poorer section of population, many well to do families who could afford the private doctor or nursing home they also largely depend on Totopara PHC for the delivery purpose. For cesarean cases, the studied villagers had to go at least Birpara State General Hospital, although communication was no good-particularly in rainy season. Further the Totopara PHC had also ambulance facility for smooth referral procedure.

More or less all the studied people had grown a concept about immunization programmes particularly polio vaccine and pulse polio dose. They had realized the necessity of polio dose. In this context, Primary Health Centre, Sub-Centre and Anganwadi centres played very vital role. The concept had grown because of large scale campaigning. Education and interaction

with outside world could play a vital role. Villagers also reported that they came to know the National Polio dates through various T.V Channels also. It was already stated that category-1 village sectors (distant villagers with no modern medical facilities) had been facing problems regarding the polio dose, as the polio distributing centre (the only sub-centre) was located in category-2 village sector Panchayat gaon. So, the villagers had to travel 2-4km distance to reach the location. To solve the problem Anganwadi centres were engaged as polio distribution camp in various village sectors. Apart from that all the village sectors were covered by the ASHA (Accrediated Social Health Activists) workers for regular polio dose. But the studied tribe showed interest about polio dose and pulse polio programmes and general awareness had risen up to the mark.

Government funded ICDS (Integrated Child Development Service) Scheme was properly executing though Anganwadi centre. Villagers were also getting the facilities provided in ICDS Scheme. As noticed, it was not always upto the mark as recommended by Family Welfare Department. Irregular food supply was also noticed in various cases. As noticed, altogether twelve ICDS centers were working in all the six sectors of the said village. Angandwadi worker and helpers were reported regular in their work schedule. Irregular payment sometimes made them reluctant in their job. It was found that cooked food was the main attraction of the centre. The timing of the centre (8am to 11am) sometimes clashed with the parents work schedule, so they could not accompany their kids; for that reason many small kids did not feel interest to attain the centre. There were various instances that small kids alone came to the ICDS centres. This was particularly true among those whose houses were situated at close proximity to the ICDS centres.

The role and activities of few Anganwadi teacher and worker was not satisfactory as recommended by the Government rule. They did not take regular initiatives to inform the parents and communicated the idea and concepts about the actual role of Anganwadi Centres. This was particularly true for those teachers who came from outside the Totopara. They were found always in hurry to close the centre right at 11:00 am. One striking feature was noticed among the studied population; they compulsorily registered the name of their children and sent their kids to the centre twice or thrice in a week for retaining their name in the centre. They do that compulsorily for getting the certificate which is inevitably needed for taking admission in the primary school. Another point should be mentioned that, sometimes communication gap was noticed between the Non-Toto teachers or helper and the Toto

parents. Apart from that, as the Totopara village was overall Nepali dominated, so the Nepali kids got more attention than that of Toto children. It was also noticed that pregnant mother very frequently visited the ICDS Centre. Less campaigning may be the cause of such kind of reluctance.

Regarding the health hygiene concept, the studied population was found not very much conscious. But there was a difference found between the poorer section and the economically solvent families. It was noticed, those who were living in concrete houses they maintained proper hygiene. But it was lacking among the poor section of population. Unfortunately due to poor economic condition they were not able to purchase many things which were necessary for the said purpose. Due to economic crisis they were unable to construct separate house for keeping domestic animals. This compelled them to share same courtyard and even same house with them. Due to the long practice of cohabitance with the domestic animals, they were habituated to stay together. They do not even feel the urge to construct separate animal houses. As a result, numbers of villagers were found to suffer from various animal borne diseases. Comparing to the main stream population, general health hygiene concept among the studied population did not reach up to the mark and needed much more attention from the Government. Regarding the dust pollution, the people did not know how to fight against the problem. They adjusted with the said problem, but they had a long term demand of concrete road. According to majority of the villagers, permanent metal road could minimize the dust problem.

The studied population was also devoid of getting pure and safe drinking water. Not only the safe drinking water, water scarcity had been the acute problem of Totopara village, and the problem was equally same in all the studied six sectors. Swajal Dhara Scheme under Rajiv Gandhi National Drinking Water Mission could not be possible due to natural constrains. As stated earlier, water of "Tading Khola" from Bhutan was stored in tanks used for drinking water purpose. As noticed it was insufficient as per the requirement of the population. The poor villagers were not able to construct individual tank for personal use only. They usually stored the supplied water once or twice in a day in some big containers and use as per the requirement. The poor section of population personally did not use any purifying agent to purify the water which they store for drinking purpose. This was common in particular for category-1 village sector. But many well to do families in category-2 village sectors,

particularly in Panchayat gaon and Mandal gaon used separate personal purification system. But it was noticed that whole village had been suffering from acute water crisis.

It was noticed that Total Sanitation Programme was not properly implemented in studied village. This was due to poor economic condition and also lack of awareness. The villagers were not well aware about the water borne as well as infectious diseases that can be happened due to improper sanitation. Further, it was also noticed that few villagers had enough awareness but due to bad economic condition many of them were not in position to purchase the required material for sanitation as recommended by the Government. There was a sectarian difference found between category-1 and 2 village sector. In category-2 village sectors altogether 62 numbers of families had scientific latrine. In comparison to that, in category-1 village sectors only 38 numbers of families had scientific sanitation. If lack of awareness was one prime cause of this difference, economy was another important cause. Lack of educational attainment also made some difference in various cases. Apart from that, enough space within the village (particularly in case of category-1 village sector) also made them reluctant to make sanitation and helped them to continue their traditional practice. An intensive and right way of campaigning about the issue was not noticed in all the studied village sectors, particularly among the category-1 village sector.

Concept of family planning is very sensitive and controversial issue among the studied tribal population. As the tribe is categorized as Primitive Tribal Group; so, permanent or surgical ligation is restricted to the said population as per the Government rule. But present study reflected a reverse scenario. Use of contraceptives was very much found among the studied villagers. This was particularly preferred by the young generation. Because contraceptives were easily available and they could get that from local Primary Health Centre at totally free of cost. As result of population control campaigning, people started to avoid using the traditional method. Unavailability of herbal medicines and also the traditional practitioners were also the added criteria in this regard. Study also showed that, hiding their identity many of the studied tribals went for surgical ligation in various places outside Totopara village. This trend was found mainly among the young generation.

Government afford to increase the population size of the concerned tribe is not working because of the above said mal-practice. Poor economic condition is to be the prime cause behind such misdeed. In case of many diseases, it was found that the studied people were

confused about choosing the treatment procedure. They used to go for specific treatment for the particular disease. For example, in case of malaria they preferred modern treatment technique whether in case of jaundice they preferred traditional way of technique. But in case of tuberculosis, people used to go for both traditional and modern way of treatment. This was supported by the quantitative data also (table 4.2.-4.3.6.). So, it was found that the studied tribe had their own perception whether to undergo traditional or modern treatment considering the nature and cause of ailment. In various cases, simultaneously they acquired both traditional and modern method of treatment. But unfortunately did not get expected result, because of less availability and patience in one and not taking the prescribed medicines properly in the other. In this globalized era, they expected quick recovery which was not possible for traditional treatment. Due to various forest laws, restriction was imposed to them for the easy accession of the forest resources essential for traditional treatment. Due to deforestation many important plant species extinct from the village and surrounding forest which adversely affect their indigenous treatment process.

Present study reveals that there was a definite concept about health, disease and treatment among all the studied villagers. It seems to be the admixture of both traditional and modern way of treatment. Interactions with the surrounding environment often reshape their perception towards disease and influence their choice at the time of opting treatment procedure. Even in the same village sector, variations were found considering the education and economy. The study also revealed the present status of existing traditional medical system, availability of modern medical system, impact of modern medical system among the studied tribe. It was also seen that traditional medical system and modern medical system is cohabiting side by side in Toto society.

So, in brief it could be said that the concept of health, disease and treatment is changing and losing its traditional way due to impact of modernization. It was specifically true in case of magico-religious practices. On the other hand, wide acceptance of modern medical system among the studied people still needs time. There are some possible recommendations for the well being of the community.

- The best possible way for maintaining any indigenous culture is to preserve and encourage the culture. The indigenous Toto society had their own concept

of health, disease and treatment as part of their indigenous culture which should be protected, preserved and encouraged.

- The studied tribe Toto had a huge knowledge of traditional medicine (both plant and animal originated). This traditional medical knowledge should not only be protected but also should be cultivated.
- Majority of the traditional medicine men of Toto society belong to lower economic group. Help should be extended from the Government in such an extent that they could devote their life only in cultivating traditional knowledge without any interruption. Government should provide separate infrastructure, so that they can manufacture their indigenous medicines.
- In majority of cases, descendants of Toto traditional medicine men did not show any interest to learn or practice the traditional medical knowledge of their ancestor. As a result, after death of traditional healers various indigenous healing techniques disappeared from their culture. Government should take necessary step for documenting the indigenous knowledge of Toto society, so that it could be used for larger society.
- Government should take step to aware this forest dwelling tribe regarding the protection of their own environment. They should be involved directly for the said purpose.
- Regarding the modern medical system, there was only one Sub-centre for serving the whole population of Totopara village (more than 3000 population) which was not sufficient. Number of sub-centre should be increased for providing quality service as well as to cover the whole population. Sub-centre should be more equipped with medicines and instrument. It was observed during the study days that sub-centre was using refrigerator of PHC. There was an urgent need of separate refrigerator for sub-centre. It was also found that there were only three working and timing was from 8.00 a.m. to 1.00 p.m. It was a demand from the studied population that the sub-centre should be open in all working days instead of three days. Timing should also be extended, so that the people can access the institution for longer time.
- Condition of only PHC of Totopara village should be improved. According to the working doctor of Totopara PHC, it should be equipped with more instruments. Gyne ward should be introduced. Operation theatre was an urgent

need especially for the purpose of cesarian delivery. PHC also needed a full time gynecologist. During the study days it was observed number of delivery cases were referred to Birpara State General Hospital only due to lack of OT and specialized gynecologist. Apart from that steady and regular supply of medicines should always be maintained. It was noticed that the Totopara health centre suffered from scarcity of anti-venom. Regular supply of anti-venom in PHC can save life of the poor tribals specifically in rainy season. Another point should be mentioned over here that generator facility should be introduced in Totopara PHC for uninterrupted power supply. Because power cut was a regular and common problem of Totopara village.

- As per the demand of the studied population, Madarihat Block Primary Health Centre (BPHC) upgraded Rural Hospital should be more equipped, through establishing separate departments like ENT, Cardiology, Eye and Orthopedics. Diagnostic tools, X-ray machines should be maintained properly, because numbers of machines were found out of order during the study days. Government aided ambulance facility was not available, but should be introduced urgently for executing proper referral system.
- According to the superintendent, Birpara State General Hospital needed a burn unit & Child health care unit.
- In every institution (from PHC to District hospital) separate section should be introduced for tribal patients (both in Indoor and Outdoor) particularly the tribal dominated area like duars. Timing should be extended. Considering the economic condition of the studied people, the population should get the modern health facilities totally free of cost.
- Awareness campaigning in Totopara village should be more extensive on Government part for enhancing the people's knowledge about safe drinking water, sanitation and immunization.
- Regarding the establishment of Anganwadi centres distance of village sectors and natural barriers should be considered properly. Anganwadi teachers, helpers, local health officers and teachers should play more active role regarding the health education.

- Regarding the execution of treatment doctor, nurse and health workers should be more attentive keeping in mind that the beneficiaries carry a separate socio cultural identity.
- Population control programs should be executed in such a way that the balance could be maintained between the demand of the population and the Government.
- Government should be more careful to initiate any health scheme, keeping in mind the poor economic condition, education attainment, faith and of course distinct ideology.

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