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Health Seeking Behaviour among the Migrant Tribal Workers of Tea Plantation in Assam: Some Observations

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Abstract: In anthropology, emphasis is generally put on the group; and on the study of human beings within the framework of a culture. Every culture has its own notion regarding health and health seeking behaviour; and this is often referred to as *Health Culture*. The health of any community, particularly of a tribal community is a function of the interaction between cultural and biological practices, the genetic attributes and the environmental condition. It has long been recognized that *Health Culture* is a suitable field for ethnographic research in anthropology.

In the paper, an attempt has been made to have an understanding of the *health culture* of the migrant tribal worker in Assam tea plantation with special reference to their *health seeking behavior*. The people generally subscribe to their own understanding of *health*, *disease* and *disease etiology*, as defined by their tradition and culture. With regard to disease etiology, they believe in both supernatural and natural forces. Some diseases are believed to be the outcome of the wrath of supernatural powers; and some are caused by natural factors. Their prolonged contact with the modern medicare system for around sixteen decades does not seem to have the desired impact on their overwhelming subscription to the *traditional sub-culture of medicine*. Despite the availability of modern medicare services at the door step, the people usually give priority to traditional or folk medicine. The inability of folk medicine to cure some ailments sometimes may compel them to avail of the services of the hospital or some other modern health practitioners. Sometimes, however, they continue both the treatments simultaneously. On the whole, till date, the migrant tribal tea workers in Assam are by and large, relatively more tradition-oriented with regard to their health seeking behaviour. Sometimes, however, both the traditional and the modern health care systems have been found to complement each other; and the people use both the systems apparently without any reservation or any feeling of contradiction.

Key Words: Health culture, tribal workers, tea industry, Assam, India.

Introduction

Health and well-being is a matter of concern for all the members of a society. Health is seen as a basic need. It is also seen as one of the major components of human development. Improvement in life expectancy and reduction in infant mortality are viewed as indicators of progress in health (Sharma 2005, 89). The success of the bio-medical model of health lies in the fact that it has been able to control many infectious and life-threatening diseases; and has given rise to a hope that one day there will be a pill for every illness. This is however, a very myopic view that only focuses on disease control and therapeutic aspect of health. Health, as a matter of fact, is much larger a do-

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main that does have wider implications for social, economic and political life of an individual; and indeed cannot be fully understood within the confines of medical model only. It is now widely accepted that health is a social problem; and well-being is still more a complex concept to be managed only by the medical professional (Dalal and Ray 2005, 1).

It is now increasingly being accepted that health is not the exclusive domain of medical sciences only. It needs a co-ordination with the social scientists to deal effectively with both prevention and cure of diseases. Health cannot be given to the people, nor can it be brought or sold as a commodity. It invariably calls for people's active participation.

What do we exactly mean by *Health*? Do we have any *universal standard/s of health*? What is *Health behaviour*? The widely quoted *WHO* definition of health goes as, 'A state of complete physical, mental and social well-being; and not merely the absence of disease and infirmity' (cited in Kar and Dutta 2002, 88-95). This holistic view of health has been an essential component of much of the traditional practices such as *Ayurveda* for centuries, *Homoeopathy*, *Unani* as well as the Greek precursor of *Western medicine*. Health is not only the result of interaction between an individual's hereditary contribution with his or her natural and cultural environment, but it is also largely determined by the biological and cultural adaptation and evolution of the society and the population. Health and diseases are measures of the effectiveness with which a human group has adapted to the environment (Laiban 1973).

Health and Disease, as a matter of fact, are very often considered to be the polar concepts (Mahapatra, 1986). It however, becomes apparent that while disease is considered to be a diagnosed and defined concept of a particular type of illness or infirmity of body, health is a holistic concept. Thus, Basu (1990) rightly maintains that there are no universal standards of health and well-being. To substantiate the contention, he observes that while in the arctic cold a globular body-build is ideal, in the hot and humid equatorial region, a linear build with a greater surface area relative to length, conducive to greater evaporation (perspiration) and heat-loss, is better suited. While a large body size with great muscular power may be ideal in general, in an area with scarce food (energy) resources, a small body size may be better suited and capable of rendering an efficient physical performance. He cites the classical example from human genetics of the heterozygous HbAs individual who, on the one hand, is prone to anaemia, and on the other hand, is relatively resistant to the malarial attacks. Similarly, there are evidences that an increased severity of protein energy malnutrition reduces the incidence of malarial parasitaemia in children (Masawe 1974; Murray 1978 a,b; Nurse 1979). Thus, the standards of health and well-being vary with the environment, which varies substantially among populations, or even their sub-groups.

In anthropology, an emphasis is placed on the group, and on the study of human beings within the framework of a culture. Culture may be defined as a set of beliefs and behaviour shared by the group of people with a way of perceiving the world at large; and the ways of coming to terms with the problems, they face. These also include attitudes about the body and the ways in which a person should be treated when ill. Every culture, irrespective of its simplicity and/or complexity has its own notion regarding health and health-seeking beheviour; and this is often referred to as *health culture*. It is an integral component of the overall culture of the community. The health of any community, particularly of a tribal community is a function of the interaction between cultural and biological practices, the genetic attributes and the environmental conditions. The widely varying health practices, use of indigenous herbal drugs, taboos and superstitions are also responsible for determining the health behavior and health status of the various tribal groups.

Since antiquity, human beings had some rudimentary systems of medicine to ameliorate physical sufferings and diseases in order to lead a socio-economically productive life. This instinct has led them to seek constant relief from pain and disease. Over the ages, their experiences have led to empirical techniques and methods of healing, which in due course of time crystallized in to dis-

tinct system of medical practices. The early therapeutic agents were mainly derived from their immediate environment; and consisted of plants, animals and other naturally occurring substances, often assisted by a touch of magic or mysticism. What began as the art of healing, gradually became a science, and over the years different systems of medicine established themselves in various regions and depending upon their eco-system and cultural framework (Kar 1993, 158).

Thus, *Health Culture* is a suitable field for ethnographic research in anthropology, as has long been recognized (e.g. Rivers 1942; Aiyappan 1936; Evans-Pritchard 1973; Elwin 1943 and Lewis 1958). In recent times, there has been a spurt in ethnomedical studies, particularly among the rural and tribal communities (e.g., Chaudhuri 1986, 1990; Barua 2000; Dutta 2002; Mibang and Chaudhuri 2003; Kalla and Joshi 2004; Dalal and Ray 2005 and Bhat et al 2013).

While dwelling specifically on the tribal population in this regard, it is assumed that their health status is relatively poor. In fact, the tribal society is guided by traditionally laid down customs; and every member of the society is expected to conform to the same. As such, the health scenario of the people is generally very much influenced by their value system, prevalent health practices, their traditional medicare system, taboos and superstitions etc. Illness and the consequent treatment among them is very often not an individual or familial affair, but becomes an affair of the community. As a result, it is generally observed that the common beliefs, customs and practices etc. associated with health and disease are relatively more intimately connected with the diagnosis and treatment of diseases in a tribal community.

Studies on health problems as well as health behavior of the different tribal communities from anthropological point of view therefore, not only contribute to the development of the sub-discipline (i.e. *Medical anthropology*), but also assist the planners and medical practitioners in contemplating appropriate medicare systems that will be acceptable to the target beneficiaries.

While the interest in anthropological studies of public health and medicine in India is comparatively of recent origin, studies on tribal workers of industries, particularly of tea industry in Assam are very minimum. There are only a few exploratory studies (e.g., Kar, 1990; Barua 2000; Dutta 2002) on some selected communities.

The tribal segment of the tea labour population in Assam consists of various ethnic groups, namely e.g.; the Gond, Khond, Munda, Oraon, Santal and the Savara etc. The people with diverse social and cultural background; and traditional patterns of health practices in their natal homes, migrated to the tea plantations alongwith their traditional sub-culture of medicine. The members of this residential labour force who had earlier agricultural background were suddenly brought under the industrial way of life. This is usually expected to be instrumental in effecting an observable impact on the social-cultural life by bringing substantial transformation in their traditional culture traits, particularly at the level of their sub-cultural of medicine.

In this backdrop, in the present discourse, an attempt has been made to have an overall understanding of the *Health culture* of the *tribal workers* of *tea plantation in Assam*, with special reference to their *health seeking behavior*. Primary data, incorporated in the paper were generated from a few tea plantations in Upper Assam during 2010-2011.

Migration and Antecedents

In the early 19th century, during the formative days of Assam plantation, the labour scarcity was a constant hindrance to its expansion. In the initial stage, however, the local people like the Apatani, Kachari, Kuki, Matak, Naga and the Singpho could be employed with the active assistance of the chiefs of the respective tribes (c.f. Gait 1926; Roy Burman 1961; Chakravarty 1973; Harlalka 1975; Kar 1981 and Sharma 1987). These arrangements however, did not prove to be very successful and sustainable.

In course of time, the number of tea plantations were steadily increasing, thereby demanding for a larger number of labourers. But the need could not be fulfilled from the local labourers as they had gradually been showing reluctance to work in tea plantation. Besides the self-sufficient nature of their economy, some scholars (e.g. Griffiths 1967; Kar 1981; Phukan 1984 and Dev 1990) have maintained that the Assam tribes / peasants considered it derogatory in social estimation to work for wages under an outsider. Further, North-east India did not experience the existence of a landless class of people; and thereby a separate labour class did not emerge in this part of the country. In addition, the British planters might also have been reluctant to employ the willing local people, as the uprooted ones were obviously far more easy to control and exploit. Under the circumstances, the planters started procuring labour from other provinces of India. The labourers were recruited from various cultural, linguistic and ethnic heritages, mainly from Andhra Pradesh, Bengal, Bihar, Chattisgarh, Jharkhand, Madhya Pradesh, Odisha (hitherto Orissa) and Tamil Nadu. Desperate poverty and land alienation on the countryside, and the false promises of 'less work and high wages' probably made available this huge supply of labour group. A good number of these migrant labourerssufferreed from maladjustment, some of them died and others went back home after the expiry of the contractual period. A major section of the recruits, however, survived that stage and had gradually made permanent settlement in the new habitat, in a new economy; and far remote from their original home. There are more than 100 tribe and caste groups that compose the tea labour population in Assam (c.f. Crawford 1924; Kar 2014). In terms of their quality of life and cultural ethos, these hetergenous migrant groups, over the centuries, in their natal setting could preserve a distinct pattern. Most of the tribes stand out in sharp contrast to the castes and general village conditions of the country. Again, there are also significant differences among the tribes themselves.

The tea industry, however, exerted some unique influences on the life of the people. They were exposed to a different but common type of economy, administration, housing and ecology. As observed by a number of scholars (e.g., Bhuyan 1960; Barua 1963; Gohain 1974; Ghatowar 1975; Kar 1975; Kurmi 1977; Kar and Barua 1979; Phukan 1984; Karmakar 1985 and Das 1988), for the purpose of the present discussion, the people have been considered as members of a single community (*Tea labour*), subscribing, by and large, to a common social-cultural life, notwithstanding the fact that there are some observable differences at the micro-level.

Morbidity Scenario

Tribal concepts of health, disease, treatment and of life and death are as varied as their cultures. Accordingly, they are guided by traditionally laid down customs and norms. The fate of the individual and the community, by and large depends on their relationship with the unseen forces. If men offend them, the mystical powers punish the offenders with sickness, death or other natural calamities (Gupta 1986). Culture generally shapes the concepts of health as well as the responses to illness. The people under discussion consider health and disease as polar concepts. A disease / ailment is locally termed as *bemar*; and the afflicted person is called a *bemari*. It is interesting to note that when a person, though not having any specific disease, is unable to carryout one's day-to-day activities is referred to as a *bemari* by the fellow members. With regard to disease causation, the people believe that both the supernatural and the natural causes play their roles; and the curative measure depends on the believed disease etiology. Apparently, the people seem to possess good health. Most of the adult members work in the tea bed and agricultural field throughout the day without any physical constraint. The womenfolk, in addition, engage themselves in the domestic chores quite efficiently. But, however, the fact remains that a good number of the people very frequently suffer from a variety of ailments with varied rates of infliction. Some of the diseases are fatal and some are endemic in nature. By taking recourse to *Free listing* technique, a reasonably

detailed list could be prepared with regard to the *bemars* that afflict the people. The data reveal that there are at least *forty nine diseases* that one or other of them suffer from, at some point of time. The list of the different *bemars* has been presented in Table No. 1

Table No. 1: List of Prevalent Diseases / Ailments among the Tribal Tea Workers in Assam

Sl. No.	Name of the Disease / Ailment	Local Name
1	Abdomen Pain	*Pet dorod*
2	Allergy	*Pitanga*
3	Anaemia	*Khoonkomi*
4	Appendicitis	*
5	Arthritis / Rheumatism	*Bat bemar*
6	Backache	*Pit dorod*
7	Body pain	*Gotordorod*
8	Boil	*Phoka / BishPhoora*
9	Bronchial Asthma	*Damaphila*
10	Bronchitis	*Chanchi*
11	Cancer	*
12	Cardio-respiratory failure	*
13	Cerebral stroke	*Behoosh*
14	Cerebro-vascular Haemorrhage	*
15	Chest pain	*Chatidorod*
16	Cirrhosis of liver	*
17	Cough and cold	*Khoki*
18	Diabetes	*
19	Diarrhoea	*Dainik*
20	Dysentery	*Jhora*
21	Eczema	*Khujli*
22	Epilepsy	*Mirgi*
23	Fever	*Bukhar*
24	Gastritis	*Pet dorod*
25	General Weakness	*Komjuri*
26	Giddiness	*Mathadorod*
27	Headache	*Mathachakkar*
28	Hepatitis	*
29	Hypertension	*
30	Influenza / Viral infection	*SardiBukhar*
31	Injury	*Chutloga*
32	Jaundice	*Halodipesab*
33	Malnutrition	*
34	Measles	*Mata / Mai bemar*

35	Melina	*
36	Meningitis	*
37	Neckache	*Ghardorod*
38	Night Blindness / Eye Disease	*Chook bemar*
39	Paralysis	*
40	Pneumonia	*
41	Postnatal Anaemia	*Chutki*
42	Pyorrhea	*Kesumuriya*
43	Scabies	*Ghao*
44	Tonsilities	*Ghesadorod*
45	Tuberculosis	*Khun khaki*
46	Ulcer	*
47	Urinary problem	*Dhatu / Gormi*
48	Vomiting	*Ulti*
49	Worm	*Pelu*

* Not available

It will be seen from the *table (no. 1)* that they use generic terms for a variety of diseases that are sometimes distinguished from one another by adding some prefixes. Thus, e.g., *bukhar*refers to fever of all kinds, but influenza o viral fever is termed as *sardi-bukhar*. Similarly, *Dorod*refers to pain in general. But, if it is *Chatidorod*, it indicates some problem with the heart or the lungs, Whereas *Ghesadorod*refers to the problem of Tonsilitis

It will also be seen from the *table (no. 1)* that the people do not have any local terms for a good number of diseases. Thus, for example, *cancer, hepatitis, liver cirrhosis, ulcer* and a *few other diseases* do not have any specific local terms. Some of the elderly respondents from the micro-field believe that those diseases for which local terms are not available might have appeared in the community after their coming in contact with the *Urban/Industrial* culture. But, however, the traditional medicine man can make a diagnosis of any ailment on the basis of the manifested symptoms; and also sometimes through divination. On the basis of the diagnosis as well as disease etiology, he generally administers a treatment. In other words, the people have the option of availing of both the traditional as well as the modern medicare system for most of the diseases they confront with. With regard to the prevalence of diseases without having any equivalent local terms, it may relevantly be noted that this is not unique with the tribal workers in tea plantation only. Thus, e.g., while discussing he health scenario of the Nocte tribe of Arunachal Pradesh (North-east India), I have elsewhere (Kar 1993a,40-52) observed that the diseases like *cancer*, *diabetes*, *hyper* and *hypotension*, *polio*, *tetanus* and *Veneral diseases* etc., were not familiar among them and also in many other groups in the area; and they did not have any local terms for those diseases. Somilarly, Barua (1984), while generating data on health status from three Mishmi (Kaman) villages in Lohit district of Arunachal Pradesh, was told in the field that in the remote past, they did not suffer from any disease except certain seasonal ones like *cough, cold and fever* etc. But with the advent of modernisation and increased contact with the technologically advanced people, they had been suffering from various ailments.

In order to have a quantitative perspective of the morbidity history, secondary data from the hospital records have been collected for a period of one year (2010).The data, generated from the plantation hospital have been presented in *Table No. 2*. A cursory glance of the *table (no. 2)* makes it apparent that during the period under consideration, the people have suffered from more

than 30 different types of diseases. The total number of reported ailment episodes during the period stand at 4474. The *table (no. 2)* further reveals that the incidence rates of different diseases in the population show a wide variation that ranges from around 18 per cent to 0.50 per cent. The frequently confronted disease among the people include *fever, scabies, cough and cold, dysentery, night blindness, rheumatism, ulcer, pneumonia, general weakness, urinary problem, tuberculosis, malaria and jaundice* etc. It may relevantly be noted here that the disease episodes listed in the table provide only an illustrative picture. A good number of patients, suffering from a variety of diseases, in fact, do not report to the hospital for treatment.

Table No. 2 Distribution of the Diseases Ailments in the studied population (2010)

Sl.No.	*Name of the Disease/Ailment*	*No. of episodes (%)*
1	Fever	820 (18.33)
2	Gastritis	500 (11.18)
3	Anaemia	350 (07.82)
4	Scabies	313 (06.10)
5	Cough and cold	310(06.93)
6	Dysentery	296 (06.62)
7	Diarrhoea	267 (05.97)
8	Injury	228 (05.10)
9	Night blindness	187 (04.18)
10	Rheumatism	139 (03.11)
11	Ulcer	133 (02.97)
12	Pneumonia	92 (02.06)
13	General weakness	87 (01.94)
14.	Urinary problem	71 (01.59)
15	Tuberculosis	67 (01.50)
16	Bronchitis	46 (01.03)
17	Malaria	44 (0.98)
18	Jaundice	44 (0.98)
19	Hypertension	42 (0.94)
20	Influenza	41 (0.92)
21	Measles	36 (0.80)
22	Indigestion	36 (0.80)
23	Bronchial Asthma	34 (0.76)
24	Eczema	30 (0.67)
25	Tonsilitis	30 (0.67)
26	Chest pain	28 (0.63)
27	Vomiting	26 (0.58)
28	Headache	25 (0.55)
29	Giddiness	23 (0.51)
30	Allergy	22 (0.49)
31	Others (Miscellaneous)	107 (2.39)
	Grand Total	4474 (100.00)

Many morbidity episodes thus go unrecorded. As a specific instance, we may mention, e.g., of the recorded *pneumonia* episodes. It is 2.06 per cent which seem to be a reasonably low figure. In reality, this disease has been found to be relatively more frequent among the people. This is mostly caused by their exposure to severe cold. They do not possess sufficient warm clothes to wear; and most of them sleep on the damp floor on hessian clothes. Blanket is also a very rare item for covering the body. In some cases, for this prolonged exposure to cold; and also non-acceptance of any medical care, the disease takes a fatal turn, especially in case of children and elderly persons.

Incidentally, the different diseases apparently show an observable correlation with specific age and sex groups. Thus, e.g., infancy (0-4 years) and childhood (4 -8 years) seem to be characterised by the incidence of relatively limited number of disease The most frequently incident diseases in these stages of life include *pneumonia, diarrhoea, cold, cough and fever, worm, skin diseases* and *injuries* of various types. *Pneumonia, diarrhoea and nutritional deficiency* cause majority of the morbidity episodes with regard to the infants. This happens partly because of their tradition, e.g., the mother of a new born baby is required to sleep on the floor and wash her clothes by herself during the confinement period, and mainly because of their ignorance.

From the generated data, it seems the adults are more prone to all types of diseases in varying degrees. One of the possible explanations for this observation lies in the fact that during adulthood, the people exert sufficient toil in the tea beds as well as in their agricultural field. But most of them do not take food with requisite nutrient contents. Thus, undernutrition, coupled with their overall unhygienic living condition, poor sanitation and addiction to alcohol may make them more prone to various diseases which they cannot fight successfully because of a relatively poor defence system as well as for not taking medical services on time. It may however, be noted here that skin disease and dysentery seem to cut across the age and sex parameters.

With regard to the morbidity scenario among the womenfolk, to start with, it must be noted that in addition to the productive engagement in the plantation activities on a par with the men folk, they are to carry out the reproductive as well as home making duties. In the process, they remain too much pre-occupied to find out sufficient time to take care of themselves, even in the form of having the required relaxation and recreation.This continuous excessive strain, coupled with an imbalanced and under-nutritious / mal-nutritious food habit; and some other associated factors may probably have contributed towards the frequent incidence of a number of diseases among them.

Very often they get afflicted with *anaemia* and *gynaecologialdisorders.* Pre and postnatal anaemia are quite frequent among the pregnant women and the mothers of the newly born babies. This may be considered as one of the major health problems affecting majority of women of child bearing age, contributing substantially to maternal morbidity. Very often this happens to be responsible for low birth weight; and sometimes for still birth too. On the basis of two different micro-studies, I have, elsewhere (Kar 1990) observed that *stillbirth* rate among the tea laborers in Assam ranges between 56.14 and 111.11; and the *infant mortality* rate between 60.66 and 123.07.

One of the probable reasons for this state of affairs may be sought in the fact that during pregnancy a woman generally does not have any special diet, necessary for both the mother and the foetus. Besides, though the plantation hospitals have the provision of supplying iron and vitamin tablets to the pregnant women free of cost, the people, by and large, do not seem to be in the habit of availing of the benefit. Even after the manifestation of some symptoms of anaemia, they prefer *folk-medicine* to the modern one. Generally, the people go to the hospitals only at the last stage of an ailment. In this context, it may be noted that with regard to the child-birth too, most of families prefer *home delivery.* In the plantation hospitals, there are facilities for the safe and secured delivery, but most of the people prefer to have it at home with the assistance of an untrained, but ex-

perienced *dai* (mid-wife), usually hailing from among the tea labour community itself. Their reluctance to the hospitals for child-birth seems to be mainly because of conservatism and shyness rather than for any objective reason. As a result, in many cases, there develop complicacies *Home delivery*, at times, leads not only to *infant mortality* but also to *maternal death*.

Living Condition vis-à-vis Morbidity

Besides insufficient management of the health care services and the people's traditional beliefs and practices, it seems, a good number of other possible human factors too contribute towards the observed morbidity scenario among the people under investigation. Incidence of quite a good number of diseases can probably be explained in terms of environmental sanitation, food habits and the overall life style of the people.

The environmental sanitation in a tea labour settlement is by and large very poor. The *Plantation Labour Act (P.L.A.)*, 1951, along with Plantation *Labour Rules*, 1956, has defined many conditions of labour employment in clear terms. Various social security benefits for them have been provided in the Act (cf.Barua, 2000). However, in reality, most of the provisions, especially those with regard to health, hygiene and sanitation (and also education) have not been found to be implemented properly in most of the plantations. Thus, for example, under clause eight of the P.L.A., in every plantation, effective arrangements shall be made by the employer to provide and maintain a sufficient supply of wholesome drinking water for all the workers at convenient places in the plantation. According to the *Clause 9(1),* a sufficient number of latrines and urinals of prescribed types shall be provided separately for males and females in every plantation so situated as to be convenient and accessible to the workers employed therein.

The standard of these facilities has been found to be quite good in some plantations. But in other ones, the facilities are far from being satisfactory Provision of drinking water, community bathrooms and drainage system is inadequate in many plantations. Besides the numerical insufficiency in many cases, the tube wells have not been provided with any pucca platforms and drainage outlets from their basements. Absence of proper drainage arrangement sometimes converts manylabaour settlements into pigsties with the accumulation of filth and muck that provide a breeding ground for various organic disease agents.As a consequence, the people are afflicted with a number of diseases. The situation worsens during the rainy season.

According to *cause 58* of the P.L.A. at least eight per cent of the labour quarters should be made *pucca* annually. But, a huge number of *kaccha* quarters with thatched roof in a very dilapidated condition are seen in many plantations. Because of water logging in many labour settlements during monsoon, these quarters become very damp; and the inmates suffer from a number of ailments. Family latrines are also absent in most of the cases and the members respond to the nature's call in tea bushes, bamboo grooves or in some other convenient outdoor spots.

A probing observation ofthe household and housing pattern make it apparent that the overall living condition of the people is responsible for good numberof diseases. As a matter of fact, *gross lack of personal cleanliness, sanitation, potable water, minimum light and ventilation in the house* are responsible for the incidence of a number of diseases. Thus, there seems to be positive association between diseases like tuberculosis and conjunctivitis and lack of light and ventilation in the house; infantile diarrhoea and impurity of water and lack of cleanliness; skin disease and lack of personal cleanliness; and poor sanitary habits and occurrence of warm infestations. Poor lighting during night hours, absence of suitable exit arrangement of smoke, i.e., too much of smoke in crowded and ill-ventilated houses may be a cause (in addition to Vitamin A deficiency) for the high incidence of eye troubles (*night-blindness*). Non-availability of fresh air during night may be a contributing factor towards respiratory troubles.

Absence of any drainage system, as noted earlier, helps the germs of different bacterial diseases, e.g., *diarrhoea*, *dysentery*, *typhoid* and *paratyphoid fever* to multiply. Flies, which also breed in the accumulated sullage water, may carry different viruses from sewage to food during the monsoon, and this may be aggravated by the habit of defecation in the open. Improper disposal of night soil and human excreta may be responsible for (a) direct infection in man, (b) the contamination of soil, and (c) the possibility of disease transference to man through the agency of insects or animals. The habit of defecating in the open is an important factor, responsible for *hookworm infestation*. The eggs of the hookworms pass out with faeces and are deposited on the soil. These may be scattered to nearby soil by rain and wind. In suitable environment, these eggs may develop into larvae. These larvae usually find their way back into the human body through the skin of the barefoot. The retention of wet soil or mud between the toes greatly favours the larvae's entry into the human body.

It has been stated earlier that the incidence of anaemia is quite high among the people. Hookworm infestation alongwith repeated pregnancy also results in anaemia. This may be a reason why anaemia is more frequent among women of reproductive age. Among the menfolk, one of the other contributing factors may be their regular habit of drinking alcohol. Gastritis generally follows the regular drinking of liquor which in turn prevents iron absorption that ultimately leads to anaemia. All these however, relate to the observed deficiencies and flaws in the preventive and promotive strategies with regard to the people's morbidity scenario.

With regard to the curative aspects, it may once again be highlighted that the medicare service facilities and the management of the same are not satisfactory in many cases; and in many other instances, the traditional beliefs and practices of the people deter them from timely acceptance of the available health care services.

Morbidity vis-à-vis Medicare Services

The people do have their own concepts of various ailments; and preventive and curative measures. Besides the *natural* causes, they generally believe in a number of conditions resulting into affliction of various diseases. These are as follows:

(i) Wrath of ancestral spirits for showing negligence / disrespect to them.
(ii) Interference of some super-natural agency. If any deity is dissatisfied for any act of omission / commission of a person, he / she or any member of his / her family may be inflicted with diseases by way of punishment.
(iii) Aggressive intention of *jati* (community) mates or neighbours with magical potentiality to cause harm out of envy.
(iv) Projection of morbid objects or substances.
(v) The action of sorcerer on some part of the body or some objects, once associated with the body of a person. This concept of diseases is based on the belief in *supernaturalism and sorcery* as an expression of *contagious magic.*
(vi) Spirit intrusion and
(vii) Individual act of breach of taboo etc.

The traditional curative measures are highly valued by the people. These include; (i) *magical extraction* and counter-magical endeavours, (ii) *sacrifices*, *offerings* and *prayers to the deity* and (iii) *administration of medicinal herb.* As a general rule, in the event of any ailment in a family, at first the *ojha* (traditional medicine man) is approached for diagnosis as well as for the necessary follow-up measures. The *Ojha* through divination or by some other means, diagnoses the disease and accordingly advises about the treatment. Depending on the nature of the disease as well as the diagnosed disease etiology the treatment may be pursued through magico-religious performances,

herbal medicine or sometimes the patient may even be advised to take recourse to modern curative measures.

The people believe in a number of spirits and duties, many of whom are malevolent in nature. Whenever a person offends or dishonours any of them, even if it has been done inadvertently, the respective deity is believed to be annoyed; and as such punishes the offender by inflicting some ailment. Sometimes, even the village level deity, who is otherwise supposed to be benevolent in nature, is believed to be indirectly responsible for some endemic diseases like *fever*, *gastritis* and *tuberculosis* etc. The village deity (*Gram Devta*) generally protects the dwellers of the settlement unit (*line*) from the influences of evil forces; and thereby protects them from being affected by various ailments. The village deity is therefore, worshipped at regular intervals at the community level. It is believed that the exercise in the form of propitiation; and sacrifice of birds and animals etc., keeps the *Gram Devta* in good humour. The ritual is locally known as *Gram Puja*, *Mai Puja* or *Sarna Puja*. Similarly, the people believe that the overall welfare of a household depends on the pleasure of the souls of the inmates, forefathers (*Mata-Pita*); and it is obligatory on the part of a family to keep them pleased to protect the inmates from various ailments. For the purpose, they organize a family level ritual at regular interval. This is locally known as *Mata Pitar Puja*. Likewise, *Thakurani Ma* (the spirit, believed to be responsible for epidemic diseases like small pox and cholera etc.) is propitiated in *Mongal Puja*; and *Kali* (the deity, connected with the family welfare) gets a share of any sacrifice made in a family ritual and soon and so forth. They believe that the propitiation of the different deities, spirits and family ancestors saves the families and the entire community from odds and hazards. For all the diseases, believed to be caused by the supernatural and magical forces (e.g, *Jaundice*, *measles*, *eczema* and *Pox* etc.) they consult the diviner for necessary curative measures. The diviner, through divination, advises as to the required propitiation, sacrifices and/or the counter-magic to be organized for the purpose. For some disease (e.g. *eczema* and *sores* etc.) herbal and natural curative measures are also prescribed.

With regard to women's reproductive exercise vis-à-vis medicare services it may be noted that though pregnancy is considered to be a natural phenomenon, the people do believe that a woman conceives only by the blessings of God.

They do not seem to consider it necessary to have regular medical check-up and administer medicine during pregnancy. Only a very few educated and the baptised families go for the same in plantation hospitals. As noted earlier, the delivery generally takes place in the respective homes, being attended by women only. No male member including the husband is allowed to be present in the delivery spot. The expectant mother is helped in the delivery by the old and experienced women of the plantation usually the relatives (e.g., mother-in-law or the likes) and/or the neighbours. The members of the medical staff, as a convention, never attend a patient in the labour quarters. Data generated in this regard reveal that not more than around ten per cent of the deliveries take place in the hospital. In a different study, in this context, I have observed that in many groups, the traditional belief is that the placenta is to be disposed of by some specific kin member within the household compound. So, hospitalization of a parturient mother, in many cases is the last resort (Kar 2000, 198). While dwelling some more on the issue of morbidity vis-à-vis medicare services among the people, it may be noted that sometimes (e.g., in disease like *cough and cold*, *fever* and *dysentery* etc.) modern medical attention is sought immediately; and is followed by traditional treatment; and the two go side by side. Sometimes again, they attend hospital only to avail of the medical leave, sanctioned with full wages, as per the existing provision of the P.L.A 1951. The nature and intensity of the people's faith and dependence on the traditional medicine man can be gauzed from the following illustrative episode that was recorded in the field while generating data, incorporated in the discourse.

The nine-month old girl of a Munda family was taken to the plantation hospital, apparently in a critical condition. The patient in fact died on the way to hospital. So, the attending physician informed the guardians accordingly; and asked them to do the needful. But, they did not believe it. They took the child back home and consulted a traditional medicine man. He examined the patient by taking recourse to his own modus operandi and declared that the patient had been still alive. The parents took the girl again back to the hospital only to listen to the fact that she had actually been dead. There was a commotion in the hospital premises; and it continued for quite sometime. The management had to call the traditional medicine man in the hospital; and the people got pacified only when he confirmed the declaration of the physician.

With regard to their overall approach towards the curative measures, in fine, it may be emphasized that the people, by and large, do not find any contradiction in changing from one system to the other or sometimes continuing both the systems simultaneously.

Concluding Observations

The foregoing discussion makes it apparent that both the elements of culture in the form of health habits as well as the inadequate provision of requisite health care services provided by the management, do make a significant contribution towards the observed morbidity scenario among the tea labourers in Assam.

Thus, it seems the problem of health welfare and an overall development of the community needs, a two-way approach for finding a probable solution. Alongside the provision for the proper medical and sanitation facilities, the people need to be carefully motivated and educated, on the one hand, for undoing some of their unhealthy habits (e.g. addiction to alcohol and outdoor defecation practice; and on the other hand, for availing of the available modern health facilities in appropriate time and in true spirit.

The following tentative strategies may be contemplated for the purpose:

(i) Efforts be made for proper sanitation, personal hygiene, safe drinking water and dispelling misbeliefs, taboos and magico-religious practices etc.

(ii) Health services in the form of health education be given more emphasis by developing effective communication strategies on health education and health care.

(iii) Young boys and girls from the labour community be given training in public health and mid-wifery respectively. They may regularly visit the labour settlements and advise the people on health, sanitation and the necessity of availing of the modern medical attention in time. In the meantime the trained midwives may attend the expectant mothers in the labour settlements in need. This is expected to reduce the stillbirth and infant mortality rate among the people.

(iv) Efforts be made for an effective family welfare programme among the people.

(v) Empirical studies at micro level be organized at regular intervals to evaluate the nutritional status and health of the people.

(vi) In view of the fact that the people have their traditional concept of ailment and health seeking means, efforts be made to have a negotiable synthesis between the two systems in order to avoid confrontation; and enhance medicare system.

(vii) An effective collaboration and co-ordination between the management and the suitable NGOs is expected to be a fruitful exercise in this direction.

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