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 (1967) 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 Health[1] 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

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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 drmatically 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:p.35) 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 inappropiate 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 Valunjkar 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 epedemiology 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 paraphernallia 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 'vaids' and 'hakims' claimed superior status to indigenous practitioners by virtue of their aquaintance 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 diseases 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 instrusion, 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: p.30) 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.

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 Dinajpur[2], with Darjeeling having 147, Jalpaiguri having 187 and Cooch Behar and West Dinajpur having one each tea plantation.

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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

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 facilated 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 culture[3] of the

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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 tradition 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 preculiar 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 acceptnace 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 epedemic 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.