PROBLEMS, PROSPECTS AND CHALLENGES OF HEALTHCARE SYSTEM AMONG THE TRIBES OF ASSAM

A PROJECT UNDER THE ASSAM INSTITUTE OF RESEARCH FOR TRIBEALS AND SCHEDULED CASTES, GOVERNMENT OF ASSAM.
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PREFACE

The Assam Institute of Research for Tribals and Scheduled Castes has been working on various aspects of the life of tribes of Assam focusing on their colourful tradition. The tribes of Assam have valuable treasures in their cultural life and their traditional healing system is one notable aspect among these. However, with the passage of time, and unprecedented growth of technology, these practices are gradually on the verge of annihilation. Lack of patronage is another factor, added to this decay. These needs documentation. The present effort is a step towards this by this premiere reputed Institution. We are thankful to Dr. Upala Barua, Associate Professor of Anthropology, Cotton College and Managing Trustee, Navakanta Barua Foundation for coming forward to coordinate the project and submit report accordingly. This report is the result of the survey.

Hope this will serve the purposes as stated above and provide base line information to the future researchers on this matter.

Guwahati

(Dinesh Sarma)

Acknowledgement

It is an acknowledged fact that health is a multidimensional phenomenon. And at the root of all health care systems lie close interconnections between ecology, culture and society. In order to understand the health status of any community this interactions between all these facets could never be ignored. It is true that contemporary health care system have grown out of the observations, experimentation s that were carried out and handed down the generations by numerous anonymous traditional healers, medicine men and the like in traditional societies. This process could be identified and documented through the study of the health care practices of indigenous communities more specifically the tribal communities where science religion and faith are closely intertwined. This has become more relevant today at the age of globalization when the spread of modern medical facilities have grown rapidly. But the question remains has this spread become accessible to all the different segments of the society? If not then what are the major constraints? In a highly complex and diversified country like India, it is not possible to conduct a study using a very broad canvas. Therefore, it was proposed to undertake a study covering the highly diverse tribal communities of Assam entitled

Assam has a sizeable ST population that are spread in diverse socio-cultural and ecological setting. Some of these tribal groups like the Dimasas , Karbi and Hill Lalungs have been living in forests and hills in relative isolation while some others like Boro-Kacharis and the Rabhas have been in touch with the mainstream cultures since long ago. Therefore, the theme of the present study is quite relevant in the present-day world.

The study would not have been possible without the financial grant from Institute of Research for Scheduled Tribes and Scheduled Castes, Government of Assam. We acknowledge our gratitude to its Director, Joint Director and all the office staff for their help and assistance.

The project would not have been completed in time without the constant support of Ms. Rami Baruah, Secretary, NKBF during the tedious stage of data entry and processing.

We offer our sincere thank to all the respondents for their support during fieldwork.

(Dr. Upala Barua)

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CHAPTER – I

INTRODUCTION

1.1: Every society has their traditional system of addressing the health of their members. This system is closely associated with their cultural traits, rules and values tested through ages. Indigenous societies which are predominantly preliterate and were more or less isolated till recent times possess little knowledge about the modern medicines and their health care system functions with limited resources.

1.2: The concept of health and health care:

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1946:1). Undoubtedly it is not a comprehensive definition of health. It has not taken the cultural elements associated with health into consideration. It is because of this WHO was persuaded several times to amend their definition so as to include three other areas namely spirituality, religiousness and personal beliefs to their definition. (WHO: 1988: 6). The concept of health has evolved over time. Prior to the above definition of WHO, Stokes & Shindell defines it as "a state characterized by anatomic, physiologic, and psychological integrity; ability to perform personally valued family, work, and community roles;

ability to deal with physical, biologic, psychological, and social stress.1". In 1984, WHO revised the earlier definition of health and defined it as "the extent to which an individual or group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources, as well as physical capacities 2". Thus, health referred to the ability to maintain homeostasis and recover from insults. Mental, intellectual, emotional, and social health referred to a person's ability to handle stress, to acquire skills, to maintain relationships, all of which form resources for resiliency and independent living.

1.3: Traditional Health practices:

"Tradition" in the anthropological literature often means a time-honored custom; and a "traditional society" usually refers as opposed to modern one (Shanklin, 1981: 71). But concept of Tradition has not confined to this meaning only, rather it has been used as concept that has relation with different sets of phenomena like occupation, culture, knowledge, handicraft, rights, and so on (Dangol, 2010: 4). Tradition has deep rooted importance in human civilization. And this view is supported by Joseph R. Gusfield in his article *Tradition and Modernity: Misplaced Polarities in the Study of Social Change* (1967). According to him "Traditional structure can supply skills, and traditional values can supply sources of legitimating which are capable of being utilized in pursuit of new goals and with new process" (Gusfield, 1967). Traditional knowledge is defined as knowledge of local people about the everyday life, (Agrawal,

1995). It includes the cultural traditions, values, beliefs, and worldviews of local peoples as distinguished from Western scientific knowledge. Such local knowledge is the product of indigenous peoples' direct experience of the workings of nature and its relationship with the social world. It is also a holistic and inclusive form of knowledge, (Agrawal, 1995). That is why Arne Kalland has described indigenous knowledge as knowledge which is in harmony with nature, (Kalland, 2000). Tradition knowledge has importance in modern society as it facilitates development processes in cost-effective and sustainable ways. Traditional knowledge is the kind of knowledge which has been used since time immemorial and has made peoples' lives easier in many important respects. The indigenous community in which I completed my research continues to depend on their indigenous knowledge, and I will explore both the positive and negative aspects of their utilization of this traditional knowledge.

Traditional health systems in indigenous communities are complex and quite structured in their content and internal logic. They are characterized by a combination of practices and knowledge about the human body, and coexistence with other human beings, with nature and with spiritual beings. Practices are in most cases intermingle with religion and magic. In fact, some of the worshiping which are also regarded as components of their traditional cultural practices done directly to get remedy from some diseases. In any society, the response to health and illness is shaped by cultural traits, values and rules that are learnt through participation in that society. (MC Garth et.al, 2001: 1). The role of herbalism or herbal medicine is yet another aspect of infusing traditional

knowledge to medicine or healthcare. Many societies in the world use herbs to treat sickness or the use of herbs for their therapeutic and medicinal values. According to Bratman (1997) herbal medicine falls within the group termed —unproven healing practices. It includes Naturopathy, Chiropractic, Traditional Chinese medicine, Unani, Ayurveda, Meditation, Yoga, Biofeedback, Hypnosis, Homeopathy and Acupuncture (Bratman, 1997).

Historically, many herbs have been used to provide human remedies for diseases that confront men and women. Although Western medical practices seem to have questioned or even denied the efficacy of many traditional herbal remedies, traditional plants undoubtedly continue to play a key role in the well-being of indigenous communities. It is estimated that one quarter of all medical prescriptions are based on plant derivatives or plant-derived synthetic derivatives and approximately 80 percent of the world's population (primarily those in developing countries) continue to rely on medicines derived from herbs (WHO, 2002). Thus, despite the dramatic advances of conventional medicine, it is clear that herbal medicine continues to possess a high level of significance in many social settings.

Health care involves not only the medical care but also pro preventive care too. It covers health care providers of both public and private sector. Experts are of opinion that an ideal health care system must contain four criteria namely, 1) the system should have_universal accessibility and that too at an adequate level and without excessive

burden. 2) Second financial cost burden for accessing the care should be fairly distributed and engagement in constant research for improvement of the system to a more just system. 3) provision for training for attaining competence empathy and accountability, thriving to achieve quality care ad cost effective use of the results of relevant research. Fourth special attention to the vulnerable groups such a children, women, disabled and the aged. Let us now examine the health care system in India.

1.4: Healthcare System in India

As health is in the List III i.e. Concurrent list of the Constitution of India, health sector in India is the responsibility of the state, local and also the central government. But in terms of service delivery, it is more concerned with state. The centre is responsible for health services in union territories without legislature and is also responsible for developing and monitoring national standards and regulations, linking states with funding agencies and sponsoring numerous schemes for implementation by the states. Both the centre and the state have a joint responsibility for programmes listed under the concurrent list.

India's healthcare system is characterised by multiple systems of medicine, mixed ownership patterns and different kinds of delivery structures. Public sector ownership is divided between Central & State governments, municipals and Panchayats (local governments). The facilities include teaching hospitals, secondary level hospitals, first-level referral hospitals (community health centres/rural hospitals), dispensaries; primary health centres, sub-centres, and health posts. Also included are

public facilities for selected occupational groups like organised work force (Employees State Insurance Scheme), defence, government employees (Central Government Health Scheme – CGHS), railways, post and telegraph and mines among others.

The healthcare infrastructure in India includes levels that include primary, secondary or tertiary healthcare providers. The providers of healthcare at these different levels include both public and private actors, but there is an increasing dependence on private providers. The primary level includes village teams comprising ASHA workers, Sub-centres (SCs) and Primary Health Centres (PHCs). The Community Health Centres (CHCs) and Sub-district Hospitals make up the secondary level, and the District Hospitals and Medical Colleges are at the tertiary level.

1.5: National Rural Health Mission (NRHM)

National Rural Health Mission was launched on 12th April, 2005 with an objective to provide effective health care to the rural population, the disadvantaged groups including women and children by i) improving access, ii) enabling community ownership, iii) strengthening public health systems for efficient service delivery, iV) Enhancing equity and accountability v) Promoting decentralization

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1.5.1: Expected Outcomes: 2005 – 2012

- Universal Health care, well functioning health care delivery system.
- IMR to be reduced to 30/1000 live births by 2012
- MMR to be reduced to 100/100,000 live births by 2012
- TFR to be reduced to 2.1 by 2012
- Malaria Mortality Reduction Rate – 60% upto 2012
- Kala Azar to be eliminated by 2010, Filaria reduced by 80 % by 2010
- Dengue Mortality reduced by 50% by 2012
- RNTCP-2 – maintain 85% cure rate
- Responsive & Functional Health System

Table – 1.1: Status of Health care facilities

Particulars	Required	In position	shortfall
Sub-centre	5841	4604	1237
Primary Health Centre	953	975	*
Community Health Centre	238	109	129
Health worker (Female)/ANM at Sub Centres & PHCs	5579	8723	*
Health Worker (Male) at Sub Centres	4604	2386	2218
Health Assistant (Female)/LHV at PHCs	975	452	523
Health Assistant (Male) at PHCs	975	0	975
Doctor at PHCs	975	1478	*
Obstetricians & Gynecologists at CHCs	109	69	40
Pediatricians at CHCs	109	20	89
Total specialists at CHCs	436	122	314
Radiographers at CHCs	109	65	44
Pharmacist at PHCs & CHCs	1084	1303	*
Laboratory Technicians at PHCs & CHCs	1084	1243	*
Nursing Staff at PHCs & CHCs	1738	2795	*

1.5.2: Innovation in Human Resource Management

In order to promote access to improved healthcare at household level the Accredited Social Health Activist (ASHA) has been introduced. ASHA would act as a bridge between the ANM and the village and be

accountable to the Panchayat. They would facilitate in the implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat.

1.6: National Health Profile 2010-11

The following are the basic data relating to the health sector of India. This gives a vivid picture of the sector.

- The doctor population in India is 1:1,500 when compared to an estimated 1:1,000 in China and 1:350 in the United States (USA). In urban India, the ratio is estimated at around 1:500 while rural India it is at around 1:2,500.

- There are about 9.2 lakh allopathic doctors in India and surprisingly about 7.5 lakh doctors practicing 'alternate' medicine (i.e. AYUSH, comprising of Ayurveda, Yoga, Unani, Siddha and Homeopathy), primarily in the rural sector.
- There are about 500 AYUSH colleges with 30,000 doctors graduating annually.
- There are 355 MCI-recognised (Medical Council of India) medical colleges in India, with a total annual intake of about 40,000 doctors for an MBBS degree. Roughly half the colleges are in the private sector, which has seen a growth of 900% between 1970 and 2004. About 22,000 dentists graduate every year.

- There are also over 2,000 nursing institutes registered with Indian Nursing Council, with over 80,000 nurses graduating every year.
- The Pharmacy Council of India has approved over 600 colleges, with about 36,000 students graduating in pharmacy, every year.
- India has about 12,760 allopathic government hospitals, with a bed capacity of 5.76 lakh (Source - Ministry of Statistics and Programme Implementation, 2010). However, India has less than 1 bed per 1,000 populations compared to a ratio of 3 for China and 3.1 for USA.
- There are 23,887 primary health care centres in India

1.7: Research Problem:

Assam is situated on the northeastern corner of Indian subcontinent. At one point of history, the political boundary of Assam included all the present States of Assam like Nagaland, Manipur Meghalaya, Arunachal Pradesh and Mizoram. These States have been carved out of erstwhile undivided Assam since 1950's. This entire northeastern region is bounded by the mighty Himalayas and its offshoots cover its north, north-eastern and eastern sides. Only a small corridor is left open on its western border.

The state of Assam today is constituted by the two valleys of Brahmaputra and Barak rivers and the hilly region in between.

Scholars have classified the people of Assam into two broad categories- tribal and non-tribal or caste population. The ancestors of

present day non-tribal people migrated to the region mainly from the western direction while the different waves of tribal populations belonging to the Great Mongoloid stock came mainly from eastern sides at different point of history and settled in different areas of the hills and valleys. The tribal populations of the region show basically mongoloid physical features.

The total population of Assam in 2001 Census has been 26,655,528. Out of these, 3,308,570 persons are Scheduled Tribes (STs), constituting 12.4 per cent of the total population of the state. The state has registered 15.1 per cent decadal growth of ST population in 1991-2001. There are total twenty three (23) notified STs in the state. Of these, no population of Pawi has been returned in 2001 Census. Pawi is a small community of Mizoram. In the following table the break-up of the ST population of Assam is shown:

Table 1.2 : Population of Major Scheduled Tribes of Assam: 2001 Census

1 .All Scheduled Tribes	3,308,570	100%
2 Boro	1,352,771	40.9
3 Miri	587,310	17.8
4 Mikir	353,513	10.7
5 Rabha	277,517	8.4
6 Kachari	235,881	7.1
7 Lalung	170,622	5.2
8 Dimasa	110,976	3.4
9 Deori	41,161	1.2

It may be observed that among STs, Bodos constitute almost half of the total ST population of the state (40.9 per cent). Miri (17.8 per cent), Mikir (10.7 per cent), Rabha (8.4 per cent), Kachari (i.e. Sonowal

Kachari) (7.1 per cent), and Lalung (5.2 per cent) are the other major STs each having 5 per cent or above of total STs.

The tribes of Assam have been divided into two broad groups on the basis of their habitat. Those tribes living in the plains of Brahmaputra and Barak rivers are referred to as Plains Tribes while those living primarily on the hills of Karbi Anglong and North Cachar are termed as Hill Tribes. Brahmaputra valley is the home of several tribal and non-tribal communities having their distinctive culture and language.

Non-tribal people speak such languages as Assamese, Bengali and Nepali of the great Indo-European Linguistic family while the languages of the different tribal communities belong to Tibeto-Burman linguistic group. Of the major linguistic groups, the Bodo group of language is spread across the entire Brahmaputra valley from its eastern to western corners. In fact, communities belonging to the Bodo group of languages are found in all the districts of Assam. There is no district in Assam where Bodo speaking tribes are not found. All these tribal communities have been accorded Scheduled Tribe status.

The following tribes are Bodo speaking communities :

1. Boro or Boro-Kachari of Kamrup, Nalbari, BTAD, Darang districts o Assam
2. Mech of Goalpara distric
3. Rabhas of Goalpara, Kamrup and Nalbari district
4. Tiwas or Lalungs of Marigaon, Nagaon and Karbi Anglong
5. Sonowal Kacharis of Lakhimpur, Dibrugarh and Tinsukia
6. Chutias of Lakhimpur, Dibrugarh and Tinsukia

7. Deoris of Sivsagar and Jorhat .
8. Dimasa Kacharis of Dima Hasao District.

On the other hand linguistically, the Mishings or the Miri of Dhemaji, North Lakhimpur, Sonitpur, Tinsukia, Dibrugarh, Sibsagar, Jorhat and Golaghat districts of Assam belongs to the Sino-Tibetan group while the Karbis of Karbi Anglong Hills District speaks a dialect akin to the Kuki-Chin group of languages. .

Some common features of the scheduled tribe communities of Assam:

- The tribal people of Assam are basically agrarian, still using traditional means to irrigate their land. Their main agricultural product are the 'Ahu' and the 'Sali' crops. With the changing times, many tribal people have switched over to business and other non-agricultural modes of livelihood. Rice, beer, pork, fowl, duck and dry fish are the favorite food items of the tribal people apart from various vegetables like bamboo shoots, creepers, tuber roots, etc.

The basic occupation of the tribes of Assam is cultivation of the land. Fishing and hunting were traditionally practiced by the tribal people of Assam, wherever possible. Hunting is losing ground due to the modern concerns with the environment. Community fishing is still practiced and is a occasions of great social merriment. The Hill Tribes like the Karbis , Dimasa and other tribes like Kuki, Naga traditionally practiced Jhum cultivation.

The traditional material culture of these ST communities of Assam, like all other tribal communities of the region, is shaped by the ecology.

Bamboo is the major building material from building houses to carrying baskets and winnowing fan. Most of the hill tribes build platform houses on bamboo platforms using the lower section as pigsty. This practice helps them to solve their problem of scavenging but on the other hand creates serious health hazard. Another problem created by their tradition of constructing platform houses on or near river banks.

Over the centuries, all these tribes were habituated in maintaining a distance from the main stream and live in villages in close proximity of forests. Naturally, these tribal communities of Assam have their own folk medicine system. Tribal health and medical practices have evolved as blends between religious beliefs and practices on the one hand and knowledge about the healing power of different biotic and a-biotic elements found in their habitat. But now, most of the biodiversity associated with the tribes have either disappeared or are on the verge of extinction. At the same time, these tribal communities are no longer living in isolated marginal environments without any contact with the spread of modern heath and medical facilities like Primary Health Centre and hospitals. Therefore, there is an urgent need to study the how the tribal populations have been coping with their problems of health and illness at the present time.

Keeping the above in view, it was decided to conduct a study entitled **"Problems, Prospects and challenges of Healthcare System among the Tribes of Assam".**

1.8: OBJECTIVES OF THE STUDY:

The major objectives of the study are :

1. To find out the present health care systems of the Scheduled Tribe (ST) communities of Assam.
2. To identify the socio-economic factors that contribute to the poor health condition of the ST communities.
3. To find out the use of traditional and modern medical system for treatment of common diseases among them.
4. To find out the problems, constraints and challenges in administering health programme and health care system of the tribes.
5. To examine the role/ views of government official (doctor, ICDS etc) in promoting the health care and improve health status of the tribal people."

1.9: Review of Literature

The main objective of the study is to assess the status of traditional health care practices of the tribes of the State. Therefore, books on topics such as: health care in indigenous societies , utilization of public health care Services by tribal people, availability of health care delivery system, superstition and belief of tribal people related to health which were available and were of contextual relevance have been reviewed in this section.

Indera P et al (1988) in their essay "Anthropological Strategies of Tribal Health" concludes that today it is increasingly realized that health

is not only a bio-medical problem but one which is influenced by social, cultural, psychological, economic and political factors of the people concerned and, therefore, the inter- action of the health behaviour of the people with the behaviour of health workers, in addition to more conventional medical factors, work to determine the progress of disease and its ultimate solution. Most causes of illness and total being are not genetic in origin but environmental and these are controllable by human society. Improvement has lead to longer life expectancies and a better quality of life even in human adaptation to natural environments in the absence of modern health delivery services..It can be said that health behaviour research is based upon a bio-psycho-social model of health and is concerned with the origins and causes of human behaviour in relation to social, economic and cultural change Anthropologist by nature of their discipline and training are the obvious persons to carry this kind of research.

Rama Baru (1999) in her "'the Structure and Utilisation of Health Services'. An Inter State Analysis made an attempt to analyse the health scenario using the data made available by 42nd rounds of NSSO (1989) . her study reveals that in economically backward states like Bihar, Orissa and Uttar Pradesh, there has been very little growth of hospitals in rural areas. In few states like Kerala, Maharashtra, Gujarat and Andhra Pradesh there is a higher proportion of institutions and beds in the private sector. Based on the NSSO data she concludes that majority of nongovernment institutions are located in urban areas. She also concludes that it is the relatively more developed states that have a higher concentration of

private and voluntary services. But in majority of the states including the backward states, public sector continues to be the major provider of services especially in the inpatient care.

Krishnan (1999) in his essay **Access to Health and the Burden of Treatment: An international Comparison** analyzes the NSSO data with reference to access to health and burden of treatment in terms of the years 1986 and 1992. His findings show that, at the all India level, 60 per cent of the inpatients get treated at government health care institutions. The proportion is similar in both rural and urban sectors. Broadly speaking about 80 per cent or more of inpatients receive treatment from public health care system in the less developed states while the corresponding proportion is 40 per cent.

*Sonia Marrone (2007)*in *her long essay* "Understanding barriers to health care : a review of disparities in health care services among Indigenous populations, attempted to examine the current status of health care access and utilization among Indigenous people in the North America, Australia and New Zealand. Her studies found that health care access and utilization rates were significantly lower among Indigenous populations. Factors such as rural location, communication and Socio-economic status were found to be barriers to health care services that disproportionately affected Indigenous communities compared with the general population.

Chandra (2002) in his book **Trade in health services** examines the ways in which health services can be traded under the conditions laid down in General Agreement on Trade in Services. He found that health services trade has brought mixed benefits and that there is a clear role for policy measures to mitigate the adverse consequences and facilitate the gains. He indicated some provable policy measures and priority areas for action.

World Health Organization (2009) in its study on increasing access to health workers in remote and rural health areas found that there is inequitable distribution of physicians. They found positive correlation between the movements of health workers in general, such as turnover rates, absenteeism, unemployment or dual employment and factors influencing the choices and decisions of health workers to practice in remote and rural areas and the categories of interventions that could respond to those factors. The deepest concerns of health workers when it comes to practicing in remote and rural areas are those related to the socio-economic environment, such as working and living conditions, access to education for children, availability of employment for spouses, insecurity, and work overload.

Lewando Hundt et al (2012) in their essay "The provision of accessible, acceptable health care in rural remote areas and the right to health: Bedouin in the North East region of Jordan" , found that health care inaccessibility is mainly due to distance while acceptability involves three main factors such as lack of local and female staff, lack of cultural competencies and poor communication. They also found that provision of

accessible acceptable health care in rural areas poses a challenge to health care providers and these providers of health care have a developing partnership that could potentially address the challenge of provision to this rural area.

Ray S.K. et al (2011) found that most of the patients in their study did not avail any health care services when they fall sick especially in the tribal district. Main factors behind this are mentioned as great distance, poor knowledge about the availability of the services and non-availability of the medicine in addition to the cost of treatment and transport. The reveals that government health facilities were utilized to the extent of 38% followed by unqualified Practitioners and Private Practitioners. Referral was done mostly by self or by close relatives / families. Also attention is required with respect to the cleanliness of the premises, safe drinking water, face-lift of PHCs and SCs, clean toilet with privacy.

Buddhadev Chaudhury (1986), has examined traditional tribal medicines and treatment in India in the context of globalization process; because of important implications of traditional knowledge and wisdom in this context, he fears that over the year's traditional knowledge and skills have been neglected and a prejudice has been engineered and encouraged by powerful national and multinational. He puts forth a six fold strategy to meet this challenge so that good health may be delivered to the tribals, being fully conscious of the limitations of traditional knowledge and wisdom in this regard.

In their study on Indigenous Health Care Practices among Rajbanshi of Dakshin Dinajpur, West Bengal Kyundu et al (2012) found that majority of the indigenous Rajbongshi people are dependent on their traditional health practices mainly because of lack of proper medical facilties. They have commented that though the impact of modern medicinal facilities on the indigenous health measures of the Rajbanshi is noticeably striking, the Rajbanshi are still found to be dependent on the surrounding biotic resources due to availability of herbal medicines.

"Tribal health and Medicines" edited by Kalla et al (2004) is a publication of 30 essays divided into five Parts. The book contains several valuable essays. Part III deals with social and cultural aspects of tribal health. This part contains nine essays dealing with prevalence of belief in supernatural powers in various tribal societies such as tribes of Uttaranchal, Nagaland, Manipur, Gujarat, Himachal Pradesh Arunachal Pradesh etc. A.K Sinha and B.G Banerjee's essay "Tribal Witchcraft and personalistic Disease Theory: concepts and issues" deals with theoretical aspects of witch craft, sorcery and magic. In this context, they have elaborately reviewed various literatures concerning these subjects.

Duggal R.(1994)in his study on the utilization of health care in India, found that the rural primary health centers are woefully underutilized because they fail to provide the rural people with the desired amount of attention and medication and because they have inconvenient locations and long waiting times. Public hospitals provide

60% of all hospitalizations, while the private sector provides 75% of all routine care. The private sector is composed of an equal number of qualified doctors and unqualified practitioners, with a greater ratio of unqualified to qualified existing in less developed states. In rural areas, qualified doctors are clustered in areas where government services are available. With a population barely able to meet its nutritional needs, India needs universalization of health care provision to assure equity in health care access and availability instead of a large number of doctors who are profiting from the sicknesses of the poor.

1.10: Methodology

The main target of this study was to trace out the nature and extent of the traditional health care system of the tribes of Assam. For this purpose six prominent tribal communities of the State were selected – they are, Bodos (40.9 per cent). Mishing (17.8 per cent), Karbi (10.7 per cent), Dimasa (3.4%), Rabha (8.4 per cent) and Lalung (5.2 per cent). These six tribal groups represent more than 86 per cent of the total tribal population of the State. They are mainly rural based populace where existences of Government health care facilities are limited.

After selection of the tribal groups for this study, their main habitations were identified. These areas were not difficult to identify as sufficient secondary data are available. In each district, the land records officials have sufficient information about the residents within the areas (lots) they cover. Their information base along with information from

the Land Records were utilized to identify the locations of the tribal groups.

1.10.1: Preliminary survey:

The initial visit to the areas was marked by collection of primary census information along with testing of questionnaires concerning the village profile, the village headman and the traditional healers. Depending on the preliminary survey results, the survey villages were finally identified.

1.10.2: Data Collection:

Several methods of data collection were employed. Three sets of open ended questionnaires cum schedule were used for collecting data. The questionnaires covered various aspects of traditional health care practices and the extent of their uses in the present day. Initially data from cross section of the population of each village were collected. This set of respondents were then bifurcated based on their response to the question –"Did you fall ill during the last two years?" Those who were not ill – not even once during the last two years prior to the time of data collection were identified as Sample –I and those who suffered from any illness at least once during two previous years were identified as the Sample –II. Separate sets of questionnaires were used to collect data from these two sets of sample.

Interview, observation and guide-cum-schedule method was used to collect information from traditional healers. It was a difficult task while dealing with the village doctors and medicine men as in many cases they

hesitate to disclose facts. Observation method was used whenever there were chances to observe any performances/ rites.

Almost all the PHCs and CHCs of the locality or the adjacent to the localities under survey were visited and doctors were interviewed and data collected through questionnaires. Same set of questionnaire was used for collecting data from private practitioners – both allopathic, homeopathic and ayurvedic medicines.

Survey was conducted during July - November/ 2013. Interpreters were used whenever the participants spoke in their local dialects .

1.10.3: SCOPE OF THE STUDY:

As stated above the study covered only the prominent tribes of Assam. They are Karbi, Dimasa. Boro-Kachari, Rabha Mishing and Tiwa. All these tribes have their own method of dealing with the diseases and ailments. The traditional method is based on the concept of both preventive and curative measures. Preventives exercises are mainly community based and are performed annually or periodically,while curatives are individual or family oriented. In both the cases sacrifices of animal and birds are common. There are fixed rules regarding the numbers and species of birds and animals to be sacrificed. This varies according to the demands of the supernatural powers and spirits. The spirits which cause diseases are considered malevolent and they are always to be kept satisfied.

On the basic structure of their belief system lie a set of supernatural powers who are benevolent followed by some malevolent spirits. Every village has their own traditional healers who are believed to be the medium through which the spirits speaks. Under him/her, there are spiritual assistants who in various ritual performances. The healers acquire his knowledge through generations and experience. There are no written documents ;the knowledge passes on verbally as oral tradition. Folk tales, songs, spells and dances are the major repertoire of these rich oral traditions.

Table-1.3: Samples for Study

Tribe	District	Nos of villages covered	Nos of cross section of population covered (Sample-I)	Nos of Persons covered who suffered from illness/ sickness /ailments during the last two years at least once(None belong to Col-4) (Sample-II)	Nos of traditional Healers covered (None belong to Col-4) (Sample-III)	Nos of MBBS + AYUS doctors covered (None belong to Col-4) (Sample-IV)	Total
1	2	3	4	5	6	7	8
Karbi	Karbi Anglong	4	72 (15.48)	68 (16.62)	11 (25.00)	7 (19.44)	158
Dimasa	Dima Hasao	4	84 (18.06)	77 (18.83)	3 (06.82)	2 (05.56)	166
Rabha	Kamrup & Goalpara	4	62 (13.33)	54 (13.20)	6 (13.64)	7 (19.44)	129
Bodo	Kamrup & Bongaigaon	6	82 (17.64)	79 (19.32)	8 (18.18)	11 (30.55)	180
Mishing	Dhemaji	5	87 (18.71)	71 (17.36)	9 (20.45)	6 (16.67)	173
Tiwa	Morigaon	4	78 (16.78)	60 (14.67)	7 (15.91)	3 (08.33)	148
	Total	**27**	**465 (100.00)**	**409 (100.00)**	**44 (100.00)**	**36 (100.00)**	**954**

Note: Figures within the parentheses indicates percentages to the column total.

Table 1.3 shows the sizes of the four samples taken for this study. Sample-I is the largest sample consisting of members from cross section of the population of the villages. They are the persons who did not fall ill even for even once during the last two years. Sample-II consists of the persons who fell ill at least once during the two years prior to data collection. Sample III is the sample of traditional healers while Sample IV is the sample of doctors who are working either as government of private service providers following either of the allopathic system or Homeopathic or Ayurvedic systems.

1.11: Design of the Report:

The report is designed in a traditional manner. The first chapter as usual is devoted to introduction of the research, its conceptual framework, research methodology and review of existing literature. The second Chapter contains a brief account of the tribes taken up for the study. The third Chapter deals with detail the basic objective of the research i.e. the health care system of the tribes. The fourth Chapter deals with the Socio-economic background of the Sample-I and Sample II and their impact on the health condition of the tribes. Fifth Chapter is devoted to the findings of the survey. While Sixth Chapter deals with the challenges of the health care in tribal areas, government intervention and the role of Doctors, followed by Summary and Conclusion.

CHAPTER – II

TRIBES OF ASSAM: AN ACCOUNT

2.1: Numerous indigenous tribal communities having distinctive customs and tradition are residing in Assam at present. They have strength of around 12% of the total population of Assam. All these tribal communities belong basically to Mongoloid stock. However, not all these tribes are the targets of this study. In Chapter One we have identified six tribes viz, Boro-Kachari, Dimasa, Karbi, Mishing, Rabha and Tiwa who are taken up for detailed study here. Before going to the detailed discussion about their traditional health care practices, a brief account about their origin, society and life style are presented in this chapter.

2.2: The Karbis

The Karbis speak a language akin to Kuki-Chin group belonging to the great Tibeto-Burman linguistic family. The original home of the various people speaking Tibeto-Burman languages was in western China near the Yangtse-Kiang and the Hwang-ho rivers and from these places they went down the courses of the Brahmaputra, the Chindwin and the Irrawaddy and entered into India and Burma. At present the Karbis are distributed in a wider geographical area but their main concentration is found in the Karbi Anglong District. From the pattern of distribution or

habitation, the Karbi are divided into three groups, viz, (i) Chinthong, (ii) Ranghang , and (iii) Amri. Sometimes a fourth group Dumroli is also added.

The Karbis are an agricultural people. Jhum is the mainstay of not only their economy but also of their socio-cultural life. Those living in the valleys and foothills have adopted plough cultivation.

The Karbis have five exogamous clans and each clan is divided into several sub-clans.. In the cremation ground too, separate areas are demarcated for each clan. The 'Ingti' is a priestly clan and has since ancient times occupied higher prestige in the society. Although monogamy is the general practice among the Karbis, polygamy is not prohibited. Widow remarriage is permitted and the younger brother of the deceased may be allowed to marry the widow. Cross-cousin marriage is their ideal. The consent of the girl is essential in marriage of the Karbi society. Marriages are contracted through selection, negotiation or elopement. There is no bride price in Karbi society. The Karbi society is a patriarchal one and the father is the head of the family. Mother's brother has an important role in the life of an individual in Karbi society. Cross cousin marriage of MBD type is the preferred one. Each Karbi village has a village council called *Me* that decides all matters related to their community life.

The traditional religion of the Karbis is animistic. Their pantheon is full of benevolent and malevolent deities, gods and goddesses. While their supreme God is Barithe or Arnam Kathe; Hemphu is propitiated in all their day to day lives. Every life-cycle ritual is incomplete without making

sacrifices to the Holy Trinity –Hemphu, Mukrang (Hemphu's brother) and Rasinja(Hemphu's sister). Their faith in reincarnation and transmigration of soul is deep rooted. Pigs, fowls, goats and eggs are offered to the deities accordingly. Traditionally prepared rice beer is essential in all rituals and festivities.

The death ritual of the Karbis is a distinctive one. 'Chomangkan' is the main death ritual that is observed by the family at any time according to the economic condition of the family. Large quantities of rice beer, pigs, fowls and rice beer are necessary for this ceremony.

Dance and music play an important role in the life of the Karbi Society. Various dances are performed by the youth during the performances of '*Chomangkan*', the death ceremony and other socio-religious rituals and festivals like '*Hacha Kekan'* and Ankimi kitcho.

'*Rongker*' and the '*Hacha Kekan'* are their two main festivals related to their agricultural cycle. The former is celebrated before the Jhum cultivation starts just prior to the planting of rice while the latter is a harvesting festival. The 'Great Rongker' is celebrated after an interval of five years. In all the *Rongker* festivals, only the males are allowed to participate. Public feasting and elaborate dances are organized to mark Hachakekan festival.

2.3: The Dimasas:

The Dimasas or the Dimasa Kacharis, one of the offshoots of the great Bodo race, are the major tribe inhabiting the hilly Dima Hasao District of Assam. They are also found in the present Nagaon, Karbi Anglong, Sonitpur, Hailakandi and Cachar districts of Assam and the neighbouring States of Nagaland and Meghalaya. According to 2001 census, the total Dimasa population of Assam was 1, 10,976 which is about 3.4% of the total ST population of the state.

They are the inhabitants of the region since very early times. The Dimasa Kacharis who live in the plains of the Barak Valley are known as the Barmans. The Dimasas had their kingdom in this region for a long time and their history is of considerable glory. At different periods of history they established their capital at Dimapur, Maibong and Khaspur, respectively.

Dimasas generally like to build their houses on hill slopes beside a river or stream. Average Dimasa villages are small with thirty to fifty households. Big villages comprising of more than a hundred households are quite rare . The houses are built in two facing rows with a timber superstructure, mud-plastered bamboo walls, and thatched roof are called Noh-Dima. The Dimasa mainly cultivate paddy, maize, sesame, cotton and others in their jhum fields. Pineapples, oranges, cotton and mustards are also grown to a limited extent.

Dimasa Kacharis have both male clan and female clans simultaneously. There are forty male clans which are called Sengphong, while the female clans known as Zulu or Zaluk, are forty two in number. In this system, the sons belong to their father's male clan, the daughter on the other hand belong to their mother's female clan. All these clans are exogamous. No one can select their spouse from their father's or mother's clan. In spite of the existence of parallel descent i.e, Sengphong and Zulu, the Dimasa society is basically patrilocal and patriarchal in nature. The Dimasas are monogamous and they like to live in nuclear families. The father is the head of the families. . Only unmarried sons or daughters can live with the parents. After marriage the sons have to live separately in nuclear families. The Dimasas are the only tribe of the region that has double unilineal and parallel descent of this type.

Among the festivals of the Dimasa, *Bishu* is the most joyous and important community festival. The festival is usually celebrated in the month of January, when all sort or works of the jhum are completed. Thus the Bishu is an occasion for relaxation from hard toils.

The Dimasas believe in the existence of a supreme being called *Madai* who controls several other lesser *Madais* including family deities and evil spirits. Dimasa religion is territorially organized in a system called *Daikho* system. Each *Daikho* or a territorial religious group has a presiding deity with a definite territorial jurisdiction and a distinct group of followers known as Khel. The '*Pathri*', a kind of fortune teller, has a special place in Dimasa society.

The traditional economy of the Dimasas revolved around Jhum cultivation. Before sowing of seeds, every Dimasa Kachari family worships its ancestral deity for its general welfare. This annual ritual is known as *Madai Khelimba*. Another ritual called Misengba is performed for the welfare of the entire community.

They cremate their dead. The dead body is washed and dressed in new clothes; the corpse is placed inside the house on a mat. A fowl is sacrificed and kept at the foot of the deceased with the belief that it might show the deceased the right path to heaven. The dead body is cremated by the side of a river or stream.

Hangsao or association of unmarried boys and girls of the village is organized annually for the purpose of working together in cultivation. The members of the Hangsao help each other by working together in their respective Jhum fields by rotation all throughout the year.

2.4: The Boro-Kacharis

The Boro Kachari (popularly referred to as Bodos) are one of the significant tribal community that inhabit the valleys of the mighty Brahmaputra and its tributaries. Boro-Kachari villages are situated in the plains areas of Assam, and hence they are categorized into what is known as the 'Plains tribe'. Numerically, they are the largest scheduled tribe living in the plains of Assam.

As mentioned earlier, the language of the Boro-Kacharis (known as Bodo) belongs to the Tibeto-Burmese linguistic family. The Assamese and Roman scripts were used in the past. Recently, they have adopted the Devanagari script.

Of the 18 ethnic sub-groups within the Kachari group mentioned by Endle in 1911, the Bodo-Kacharis appears to be the largest in numerical strength. These related subgroups of the Boro-Kacharis include Mech (in Nepal, Bengal), Sonowal Kachari and Thengal Kachari of Eastern or Upper Assam, Boro-Kachari in western Assam ; Dimasa-Kachari or Dimasa in Dima Haso Hill District and Barman in the Southern Cachar in the Barak valley. Over the decades, all these communities including the sanskritised Sarania Kacharis have formed separate ethnic identities.

In Assam, the main concentration of the Boro- Kacharis is found in the recently formed BTAD area carving out of former Kamrup, Nalbari, Barpeta, Darrang, and Kokrajhar Districts.

The Boro Kachari society is patrilineal. Their family structure is basically patriarchal, with the father as the head of the family. The family property is usually inherited through the male line. They follow patrilocal mode of residence. Monogamy is the norm. In Endley's description it was revealed that each Boro -Kachari household was surrounded by a ditch and a fence made of reeds or bamboo. Inside the courtyard, one invariably finds a *sizu* (Euphorbia splendens) symbolizing their central deity Bathow. (Endley: 1911 :11-12). Thus their traditional religious beliefs and practices are known as Bathowism. Other deities include Mainao, Agrug, Kholia

ali bura among others. Traditional animistic theme may be observed in their religious rituals and ceremonies. Their pantheon includes benevolent and malevolent deities which control the life of the mortals.

A clean surface near home or courtyard is considered as an ideal place for worship. Usually, a pair of goi (areca nut) and and 'pathwi' (betel leaf) are used as offering. On some occasions , worship offering could include rice, milk and sugar. For the Kherai Puja, the most important festival of the Boro-Kacharis, the altar is made in the rice field. Other important Boro-Kachari festivals include *Bwisagu* and *Domashi.*

In *Kherai puja,* an annual religious community worship, *Bathow, Mainao* and a host of other deities are worshipped on an elaborate scale. The ceremony is marked by dance recitals and singing of ballads accompanied by traditional musical instruments. In *Kherai puja,* a *Deodhai* or *doudini* (oracle or mediumistic person), makes contact with some divine spirit which temporarily displaces the personality of the priest or medium. The spirit then speaks through him/her. This divinatory practice is so integrated into their socio-religious life that it has become an art form. *Kherai puja* is also an occasion for paying homage to their patrilineal ancestors.

The traditional animistic beliefs and practices of the Boro Kacharis came to be discontinued by a section of the Boro-Kachari people when they were initiated into the Brahma dharma by Guru Kalicharan Brahma during early 20th Century who himself became a member of Brahmo Samaj in Kolkata around the year 1906. This section, known as Brahma

follows the Vedic rites in all their socio-religious occasions. The centre of this movement was in and around Kokrajhar area. At present, spread of Christianity has resulted in changes in their traditional belief and practices to a considerable extent.

2.5: The Tiwas

The Tiwa or the Lalungs are an important tribe living in Assam. Formerly they were referred to as Lalungs both in common parlance as well as in medieval Ahom chronicles and colonial literature. Even in the Constitution of India they are mentioned as Lalungs, but they like to call themselves as Tiwas. They are recognized as a Scheduled Tribe within the State of Assam by the Constitution of India.

There are two regional groups of the Tiwas or Lalungs each exhibiting distinctive socio- cultural features. A section of them lives in the westernmost areas of Karbi Anglong district (Assam) as well as in the Northeastern corner of Ri-Bhoi district (Meghalaya). They are referred to as Hill Lalungs. Like most other tribes of Assam, they speak a Tibeto-Burman language of the Bodo-Garo group.

The Hill Lalungs (they are generally not referred to as Hill Tiwas) are mainly shifting cultivators as they live in the hilly region of Karbi Anglong and Meghalaya. Their houses are made on bamboo and wooden platforms. The Tiwas or the Lalungs living on the Plains construct houses on plinths and are wet paddy cultivators.

The Hill Lalung society is composed of a number of exogamous descent groups or clans which they referred to as *khul*. These *khuls* are grouped into asome cluslers called *maharsa.* In each cluster, one clan is regarded as the principal clan,but all clans have equal status and position. Some of the clans of the Hill Lalungs are *Masluaiwali, malangwali, sagrawali, agarwali, lumphuiwali, pumawali, amsiwali kholarwali madarwali tilarwali jarphongwal* and others. In Lalung language, *wali* means a female . Therefore the suffix wali denotes that the clans are matrilineal so far as descent is concerned. Thus all the children belongs to the *wali* of their mother. They do not marry persons belonging to both the father's and mother's clan. Thus they do not prefer any form of cousin marriages as among such neighbouring tribal communities like the Karbis and the Garos. Marriages are also prohibited within the clans belonging to the same cluster.

Landed property is inherited matrlineally. They select one of their daughters as the inheritress. The son in law of the daughter comes to live with the family of his wife as resident son in law or *gobhia* while their sons go to another household as *gobhia.* According to their rules of inheritance, the daughter inherits the mother's property. However in recent times there is a changing trend in this respect. The boys after their marriage maintain their relationship with their natal group. They have some special role in the matters of management and decision making regarding inheritance, property, marriage etc.

The village council among the Hill Lalungs is constituted by village headman and other adult male elders. Women are not allowed to participate in the proceedings of the council. Generally cases of offences like theft, violation of rules, breaking of taboos are dealt in the village council. Women are also not allowed to visit some important places. For example, women are barred from visiting Samadi- the youth dormitory of the Lalung. They do not allow women to visit the site of some important rituals like the Jongkhong festival.

The Plains Lalung or Tiwa society on the other hand is quite different. Their clans called kuls or *wali* traces descent patrilineally. Daughters do not *Pala konwar* inherit ancestral property as they do among the hill Lalungs. Residence after marriage is patrilocal although practice of keeping a resident son in law is also quite frequent. This practice of *gobhia rakha,* is generally practiced by parents having only one daughter and no son .

The religion of the Lalung tribe is animistic. While the Hill Lalungs believe that is the supreme God, the Lalungs living in the plains consider Lord *Mahadeo* as their central High god. The religion of the Lalungs living in the plains show considerable influence of neighbouring Hindu caste populations compared to that of the hill Lalungs. However, both the sections believe in the existence of benevolent and malevolent deities who control the lives of human beings.

In the plains, important places of worship are *barghar*, *thaan ghar* and *namghar*. Each extended family or *Khuta* has a *Barghar* which serves as

the place of worship for the deity as well as for ancestors. *Namghar*, the hall for community prayers , is also the place of holding community meetings.

Tiwa villages in the plains have local places of worship of different called *thaans*. These are established for a particular village or a group of villages. *Thaans* play important role in case of treatment of diseases. Public worships are conducted by religious specialist called *deori* . Influences of Vaishnavism sect of Hinduism are also found among the Tiwas living in Nagaon, Morigaon and Kamrup Districts

Important festivals of the Tiwas are *Bihu* or B*ishu,wansuwa and barat.* Barat Utsav is the community festival of the Tiwas which is observed in the month of 'Puh' (December- January.) *Sagra Misawa'* is a spring festival that full of music and dance. It is a popular bachelor's festival that begins with the worship of '*Langkhun'* and '*Mahadeva*' with sacrifices of goats, fowl, and other birds. Jon beel Mela is a famous fair hold annually in Morigaon District.

2.6: The Mishings

The Mishing or Misíng formerly known as Miri, are an ethnic group belonging to the Tani group of communities. They inhabit the districts of Dhemaji, North Lakhimpur, Sonitpur, Tinsukia, Dibrugarh, Sibsagar, Jorhat and Golaghat Districts of the Assam . There is a sizeable Mishing population in Arunachal Pradesh. Numerically, they are the second largest

scheduled tribes in Assam. As they were formerly known as Miris, the Constitution of India still retains the word Miri.

The Tani group of communities include such tribes like Adi, ApaTani , Nyishi, Padam,Minyong in Arunachal Pradesh . This group also shows some similarities with the Tibetan culture. According to available knowledge of history and folklores the Mishings were a branch of the Adis or Minyongs who migrated to Assam from their hilly abode. Somewhere around the 13th century, they started migrating towards the plains of Assam, most probably in search of fertile land. Thus they had to adapt to a new ecological setting in course of time.

In their new settings, the Mishings preferred to live near the banks of Brahmaputra and its tributaries. They continued to construct their houses on bamboo platforms as they did on the hills. In this way they could avoid the effects of annual flood that come regularly, to some extent.

Here, they came into contact with other communities living in plains of Assam which further enriched their cultural heritage. Many Mishing people were influenced by the doctrine of Neo-Vaisnanvism spread by Srimanta Sankardeva in Assam in during the 16^{th} century.

The yearly floods ensured that majority of Mishings lived a life of abject poverty and misery. Agriculture being their main occupation, floods affect them in more ways than one. Moreover, due to their affinity towards living close to river banks brings about Malaria and other water-borne

diseases. But 94% of them still continue to live along the banks of Brahmaputra and its tributaries, unfazed by the disasters striking them.

According to Census of India 2001, the population of Mishing in Assam is counted to 5,87,310; of which 2,99,790 male and 2,87,520 female.

Literacy rates of Mishing tribe are quite high. It is more than 78% among males and 59% among women averaging to be 68.8% which is higher than that of Assam as well as India.

Mishings are a patrilineal society. It is organized into two broad divisions Da Gam and Barogam . Scholars are not unanimous on the origin of this division, but there are some variation with regard to their dialect, social practices and customs. Gam in Mishing refers to chief. Each /Both Da Gam and Barogam are further divided into a number of clans. Some of the clans within the Dag am are: *Chayang,Pamegam,Bori, Moying, Taye, Murung< Pangging, Yein, Panchang, Noroh, Koman, Pogag, Saro,Padun, Ayan,Paow,Darik, Nagate, Regon, Bosing . The clans of the Barogam include Doley, Patir, Basar, Kardong, Kuli(Kouli)Pait, Pegu, Kutum, misong etc.*

They follow clan exogamy strictly. No marriage can take place within the clan. Their kinship system includes both descriptive and classificatory terms. Descriptive terms are those which are meant for a single specific relative while a classificatory term may be used to denote two or more different relatives.

Mishings generally live in large extended families in long platform houses made of bamboo and thatch. It is patriarchal and patrilocal.

Mishings are animist by nature. Traditionally their religion revolved around worship of the Sun (Donyi) and Moon (Polo) like all other Tani tribes. Mishings believe that humans are surrounded by innumerable spirits called u*ei* of various kinds who control their lives from birth to death. Some of the different *ueis* are

1. *Urom uei* are the ancestral spirits;
2. *Dabur ueis* are responsible for causing flood or other natural calamities and diseases
3. *Taleng uei* control thunder, lightening, storm and draught etc.
4. *Gumin uei* is a benevolent spirit of a family akin to ancestral spirits.

Mibu or the religious specialist can appease theses *uei* through offerings of pigs, fowls and rice beer. In Mishing society, the *Mibu* are the true medicine men per excellence. They are believed to have supernatural power of finding out causes of illness and offer remedial measures through rituals and offerings.

At present, the Mishing religion is a blend between traditional animism and Bhakatia cult of the Assamese Vaisnavism. The followers of *bhakatia* cult owe allegiance to the Vaisnava monastery called *satra.* They donot play active role in animistic rituals like *dabur uei.*

Recently, a revitalstic religious movement called *Donyi Polo Yelam,* literally meaning *Donyi Polo* religion has been gaining popularity. Many Mishings have been embracing Donyi *Polo Yelam.* . But at present, most Mishings follow Hinduism along with their age old religious rituals, and there are a few Christians who follow the Catholic or Baptist faith. Conversion to Islam is rarely observed.

2.7: The Rabhas:

Rabhas are widely scattered but mostly concentrated in the districts of Goalpara, Kamrup, and Darrang. Rabha settlements are also found in Meghalaya, Bangladesh, Nepal, Bhutan, West Bengal and Manipur. Ethnically, they are more close to the Garos rather than to any other tribe of Bodo group.(Das 1960). The Rabha tribe consists of several endogamous sections like Pati Rabha, Maitori Rabha, Rangdani Rabha, Hana Rabha, Totola Rabha, Modahi Rabha, Dahuri Rabha, , Bitlia Rabha. It is believed that these groups were created on the basis of their division of labour in carrying out religious rituals and other activities. Of these Rabha sub-tribes, the Pati Rabhas who had been in constant touch with other neighbouring Hindu peasants, have abandoned their traditional customs and have embraced popular Hindu faith. At present, only the Rongdanis have been able to retain their old Rabha dialect. Others have lost their mother tongue so they now speak a local dialect of the Assamese known as Rabhamese.

Rabha villages consists of one or two compact blocks each comprising 40 to 100 households. The residential arrangement of a typical Rabha

household include four separate houses –one outer house for the adult family members, one guest house, one main house and a cooking shed. Apart from these, there are separate sheds for cattle and granary. These are arranged on the four sides around a common courtyard. However, there are variations among the different Rabha sub tribes in this respect. But the raw materials for construction of houses are same: bamboo, wood and thatch. They construct their house on plinth and not on platforms.

Rabha society is governed according to their customary law which they call *pandulipis.* These *pandulipis* were framed by "the consensus of the village people on the basis of customs, usages, traditions and religious beliefs covering such subjects like judicial power of the society, mode of inheritance, succession to office of socio-religious nature, type of marriage and principle of marital relationship and degree of prohibition, the roles of *khoum* and *baray,* the liability for atonement on committing mischief and unnatural offences and the procedures governing these atonements, birth and death rites etc. In other words, the Pandulipis have sought to synthesize the diversities of customary practices prevalent in different localities although region wise they may differ in contents and application as they are not co-ordinated homogeneous sets of law. (Bordoloi et al :124)

The Rabha society today is patrilocal and patriarchal. However, there is reason to believe that the Rabhas were once a matriarchal tribe (ibid: 125). The Rabhas reckon descent from the mother - the children belong to the Barai or clan of their mother. But, their principles of inheritance and succession are patrilineal. Only the sons and not daughters inherit the

father's property. The property is equally shared amongst the sons. Daughters may inherit the father's property only if the father makes arrangements before his death daughters. Succession to hereditary posts is also patrilineal. Their marriage is also patri-virilocal i.e. after marriage the newly married couple live with the ancestral home of the husband's father. The authority is vested on the male.

The traditional religion of the Rabhas is full of animistic beliefs and practices. Different sub-tribes perform different rituals and festivals according to their own ritual calendar. Thus a regional variation may be observed in this respect. *Baikho or khoksi* puja was celebrated annually by the Rongdani and the Maitori Rabhas to appease the Goddess of wealth Baikho in the months of April-May. This festival has now lost its former splendor and gaiety. It is observed that, *Baikho* puja is substituted by *hasangpuja* organized at specific localities called *hachang*.

Pati Rabhas also propitiate *Baikho* along with their principal deity *Langadeu* during the Langa puja. Some Rabha people also observe the 'Kechaikhaiti' Puja along with the *'Langa' Puja or 'Dinga' Puja*. During the *Dinga Puja* all the materials used in the puja are placed on a dinga or boat made out of bamboo trunks. The *dinga* is then carried to the river bank and the rituals are performed, and finally the boat is immerged on the river. *'Marei'* puja, is another popular worship, is performed by the *'Deodhani'* a shamanistic dance and ritual. *'Hana Ghora'* is a festival of merriment, dedicated to a god of fortune. They believe that ill health, misfortune, diseases are caused by 'evil spirits' and perform special pujas to appease

the demons. Many Rabhas, at present, have embraced Hinduism or Christianity.

No Rabha can marry within his/her own clan or Barai which is traced matrilineally. Levirate is allowed, cross cousin marriages of both MBD and FSD are practiced. But parallel cousin marriages are prohibited.

There is no specific rule for disposal of the dead. It may be buried or cremated according to the circumstances of death. After the cremation is over, the participants take a ceremonial bath to purify themselves. After that a ritual is observed at the home of the deceased. The last rites are performed seven days after the death. The sons and daughters do not consume milk for a full year if the mother has died and give up the banana in case of the father's death

CHAPTER- III

HEALTH CARE SYSTEM OF THE TRIBES OF ASSAM

3.1: One of the basic objectives of this study is to find out present health care system of the tribes of Assam. Initially the study began with the hypothesis that all the tribes have their own age old traditional healing system and they follow this system. The findings of the study however do not conform to this hypothesis.

The basic characteristics of the indigenous health care practices are that:-

- It is closely associated with their magico-religious practices of the community.
- Two prominent functionaries of a village are usually involved in the system – they are the religious head of the village and the village medicine man.
- Some practices are preventive while some others are curative.
- Some diseases which may take epidemic form are fought communitywise.
- Medicines are mainly collected from nature locally and the offerings are distributed as *Prasad* of the *puja* performed.
- The system of medicine is not in competition with any other system.
- The traditional health care system is based on experiences and is a trial and error exercise in most cases.

For example, they believe that there are supernatural factors, more so than biological factors, which contribute to sickness. Consequently, they

seek treatment from priests who they believe can communicate with higher beings. Women from these groups often refuse anesthesia when giving birth.

Almost all the tribes have their reigning deities, demons and spirits for various types of diseases or ailments. When these spirits or deities get angry with any person they inflict punishment by way of giving the ailment. The village religious head is the appropriate authority to say which spirit has become displeased and what to do to gain confidence of his or her. The whole system rests on their belief system. The belief system of the Karbis is inclined towards divination[1] and thus in times of illness they first move to religious head who decides what to do next. While the belief systems of the Dimasas and Tiwas are inclined towards *Kabiraj* of *Baidya* and as such they to the village medicine man first.

In case of any treatment of diseases all tribes have a system of Magico-religious practices. They provide solutions depending on their vast experiences. When religious solutions don't work it is almost certain that the patient will not survive. However there are other indigenous options which are opted till the final hours.

Normally, the vocation of a traditional healer runs within tribal families and is practiced for the benefit of the community. Traditional

[1] A diviner is a religious specialist whose major function is to discover the will and intentions of the supernatural or to ask for divine judgment. Diagnosis of illness if carried out within a religious framework, usually takes the form of divinations, for the priest tries to find out what has angered the supernatural powers or which particular evil spirit entered the body of the sufferer. Diviners are sometimes divided into diagnostician and curers. The interpretation of the divers is not based on individual religious expression but upon the tradition s of his profession. These traditions in turn, reflect the system of belief and values within the culture. (Malefijt 1968 Religion and Culture: 240-241)

healers inherit their spiritual gifts and skills from either or both their paternal or maternal ancestral lineages. To maintain good relationship with these ancestral spirits, the traditional healers periodically make sacrifices and offerings to those spirits. Generally, traditional healers come in four different types: the diviner, whose duty it is to make a diagnosis; the herbalist, who prescribes and treats ailments; the traditional midwife; and the exorcist, who plays a large part in freeing people from troublesome and evil spirits. Traditional healers have knowledge of herbs, roots, and even fruits that can prevent, protect, or cure diseases and pain. When people visit the traditional healers, the first requirement for healing is to have confidence in the healer. Those seeking help should believe in the traditional healer's supernatural powers, the healer's ability to deal with the unseen mysterious forces, and the healer's ability to convey messages from the spiritual worlds

The role of *Baidya* or *kabiraj* indispensible in this count. They have exceptional knowledge of herbs and their effectiveness on human body. These are based on experiences and passed on to the next generations. These are not documented and therefore there are always chances that these will lost someday.

In many societies there are distinctions between natural and supernatural causes of illness. People usually attempt to know the causes from the religious healers but do not deal with it if it is not confirmed that cause is supernatural. In that case, he refers the case to local medicine man (Taylor, 1951: 111). But in case of the Assamese tribal societies, this distinction is rarely made. The whole tribal society is tied to the same rope

of religious supremacy in this area. In the succeeding paragraphs we will discuss the prevailing health care practices in the targeted tribal societies.

3.2: Karbi Traditional Health Care System.

The traditional Karbi religion can be considered as animism. Like most of the hill tribes, traditionally the Karbis have no idols, temples or shrines. They believe in the immortality of the soul, life hereafter and reincarnation. "*Arnam Sansar Recho*" or God Almighty is considered to be the creator of this universe. Among the innumerable deities, some are considered to be benevolent and some malevolent. Each disease is associated with a presiding deity. The household god is called "*Peng*", they offer a white male goat to him. They also worship *Hemphu* and *Mukrang*, the two benevolent household gods. "*Rek Anglong*" and "*Anglongpi*" are the spirits of the land and hills. Besides these, they also have several lesser gods and deities and they worship them in different ways at different times and at different places. For the appeasement of the deities, the Karbis observe many religious rituals throughout the year where the sacrifice of pigs and fowls and use of rice-beer are indispensible. They also believe in witchcraft and black magic.

Traditional medicine is still prevalent among the Karbis as means of primary health care although there are many government hospitals and other private clinics available . The practice involves numerous magico – religious performances and administration of plant and animal or this products .The treatment for illness is called "seh-kelang " which involves "kapherem" or curing an ailment by incassting holy verses related to

concerned deity to cure certain ailments like dog bite *(methan kekor)* stomach pain (*pok keso,pok chokor*), etc. When in case of dog bite , the priest uses mustard oil in a small amount and pours it on his hand and spit on it , then by enchanting holy verses he would apply it on the mound . In case of stomach pain, the priest uses turmeric root to cure the pain.

He holds the turmeric and chant holy verses for some time, later the patient is asked to eat the turmeric.

Apart from " *kapherem* " there are other ways to treat an ailment such as " *kachihi*" or local therapy by applying the medicine on the mound which may or may not involve *kapherem* . Ailments like eye sore (mek keso) and snake bite (*phurui karchu*) is an example of such case . When an individual suffers from eye sore the priest uses lukewarm mater and breast milk .He mixes the two and apple the mixture to the patient's eyes. In case of snake bit e a certain type of hub is used, which is made in paste and apply it on the bite mound. The medicine man pastes the medicine on the wound and wraps the mound with a cloth.

Another way to treat an ailment is "*kecho* " (oral therapy) which involves treatment of traditional medicine orally . Ailment like tooth ache *(eso engki keho* and jaundice . In case of toothache a bitter brinjal is roasted and which the brinjal is still hot the patient is asked to put the brinjal in his /her mouth for some time . Then when the brinjal is taken out the worms from the tooth falls which can be seen with naked eye. When an individual is suffering from jaundice, the medicine man uses the root of a certain plant

which he grinds and later mixes the powder with mater and makes the patient drink it.

For some ailments "*she karkli* " or the ritual involving in blood-sacrifice is performed for recovery of the patient .In *sch-karkli*" a priest after sacrificing the foul or animal reads the intestines and liver of the sacrificed animal, the sacrificed animals maybe fouls , goats or pigs which is according to what type of ritual is being performed . This practice of divination was carried out from the times of the ancestors of the Karbis . Besides reading the intestines and livers, the direction of the head and image of the fouls being sacrificed is also examined to predict the effectiveness of the ritual.

An ailment called '*Nihu kachiri'* is a socially defined conditions where as individual bites his/her nails, ,loses appetite with no physical evidence of illness and urinating in bed even when grown up (*nihu-maternal uncle ; kachiri-longing)* or the curse of maternal uncle with the help of "*kurusar*" or priest is sought to determine the cause of such unusual conditions . As customary practice, the *nihu* or maternal uncle of the patient is approached and he is hanoured with specially prepared rice –beer. The maternal uncle then prepares '*andum*' or rice balls (six in case of a boy and five in case of a girl) and along with six or five prices of "*menthe*" (dried fish which is salted) offers to the patient if the patient takes the ritual gifts , it is considered as a positive sign that he/she will return to normal state of health . The "*nihu kachingtung* " is an integral part of traditional religion of the karbis and the practice is still vibrant in the society irrespective of economic status.

Patient suffering from throat problem , goiter or leprosy is restricted from eating scaled fishes as such fishes are said to make the condition worse patients suffering from tuberculosis are restricted to eat any kind of fish .

3.2.1: Sangtar kelang

When an individual suddenly fall very sick and the parents of the individual don't know the reason behind the sickness, they go to the "*Kurusar*" priest of the village taking one bottle of rice-beer along with them. They first of all offer the priest with the rice-beer that they brought with them and tell him their problem. The priest after hearing them out, takes a winnowing fan and a whole piece of ginger to see as to what is the reason for the individual's illness. He placed the winnow on the floor and also "Sakhi". 'Sakhi' is a metal ring like object the size of a small bangle; it is believed to be the messenger to the gods. Then with the help of a knife cuts the ginger into two. He then lightly throw the two pieces of ginger to the winnow, if the ginger pieces face upward or downward it is considered as a bad sign and therefore does the same thing for the next time as well, this routine can be done only three times. If one of the ginger piece face upward and one downward it is considered as good. While all this is going on the priest also chants along with his work. At the end of the ritual he takes the Sakhi on his hand and hits it with the knife 3 times, to sign the gods that works are done. It is only after this ritual that the reason for the individual's illness is known by the Priest and he later reveals to the parents. If the individual is suffering from simple fever he tells them to

observe '*Vur matha*' for the sick individual. If it is more than that he would tell them according to what he saw from his divination.

3.2.2: Vur matha:

There are six types of *Vur matha*, they are-

1) *Hemphu a-vur*
2) *Mukrang a-vur* (for 1 person)
3) *Sing-Kong a-vur*
4) *Ram-Lakhan a-vur*
5) *Arnam pharo a-vur* (100 gods)
6) *Kro-kre a-vur kethom*

In each of these rituals only 1 red cock is required. This is the ritual observed for an individual or for the family as a whole for good health, wealth and other good things. First of all a '*Duwan*' (mound of mud) is made outside the house just like the other rituals, the only thing added is the sweet basal or Tulsi dipped into a jar of water. First of all the priest takes the cock and starts to chant at the front door of the house with the jar of water at his side. While chanting he signs the man near him to sprinkle the water with the sweet basal to the person whom the ritual is kept for. This ritual can be observed even if the recipient is not present, in such case the individual's belongings, be it clothes, books or any other things that the individual keeps with him or herself. This sprinkling of water is done for three times, then the priest takes the cock and the water jar with him to the 'Duwan'. There he starts to chant some more and while chanting he pulls some of the cock's feather and place them on the '*Duwan*'. Other things apart from the jar of water is needed near the '*Duwan*', like, '*An-bo*' a

small amount of boiled rice in banana or plantin leaf, '*Beng*' a dryfish, '*Hijung*' or 'Dhuna' and fire. Then he sacrifices the fowl and sprinkles the blood of on the 'Duwan', then he throws the fowl on the ground the priest continues to chant. When the sacrificed fowl dies, the position of its head and wings is being studied. After this he studies the lever and intestines of the fowl as well and accordingly he reveals the result whether it is good or bad. After studying the lever and intestine the lever is then roasted and along with the 'Beng', 'An-bo' the roasted lever is given to the recipient to eat.

3.2.3: Karjong Kekur:

This is another ritual observed when an individual is seriously ill. The individual may not be sick but his behaviour may change comparing the other days, like, over aggressiveness or mumbling things that other people could not understand and other odd behaviours. Family members may think that the gods are not happy with the person or has done something wrong that may have made the gods angry it may not only be because of the wrong doing of the individual but may also be because of his family members. The family members call the priest and observe this ritual. The ritual is same as '*Vur Matha*' with '*Duwan*' at the outside of the house and all other things like red cock, 'An-bo', 'Beng', 'Hijung', fire as used in 'Vur Matha'. Poverty and limited access to modern medicine are the main factors for the people's dependence on tradition medicine, particularly in rural areas . In Hamren town , though it is a small town there are numbers of Karbi villages in and around the town . But there are no proper medical facilities or schemes for common rural people for

regular health checkup. Even if there are Government hospitals, rural people are unable to utilize due to lack of awareness . Therefore it was observed during the study , that when the village people receives free medicine or check –up on regular basis, for single checkup they are to pay Rs 50-100 to the doctors as fees and they are also pay for the medicines separately .Therefore they are at a dilemma whether to follow traditional healing techniques or to go for allopathy. Today both the systems have become expensive: for traditional therapy money is needed for holding rituals and sacrifices and modern medicine is also not free.

At the same time, traditional medical practices of the tribal communities are facing problem due to the ambivalent or negative attitude of the youth toward traditional medicine as being unscientific and superstitious. Acculturation, conversion to Christianity and spread of modern education are the main causes of decline of such practices in Karbi society.

3.3: Dimasa Traditional Health Care System

Dimasas believe that illness disease death occurs due to bad eye of evil spirit. They believe that spirits of ghosts, witchcraft (*Madai*) live in the tree *Lila*, *Hamlai* wood apple, *shamuli*, *khandar* and Banyan tree, (*Frang Fang*). They never cut these trees or even never go under these tree oftentimes or at dawn. *Naiju, Phorongma*, noon *Sainjer, Sainjorba Lamaine.*

To satisfy these supernatural spirits they perform pray before these trees as a god and also perform worship. To satisfy these supernatural

powers they sacrifice various kinds of animals like fowl, pigeon, goat, pig and others

Table 3.1 List of Deities, related disease and animals required for sacrifice

Sl No	Name of the presiding Spirit/ Damon/ deity	Related disease	Animals sacrificed or items offered the Puja
1	Fartha Puja	Bad dreams	Fowl-1, Rice beer (Joo)
2	Dinarani or dina-rani Puja	Fever & headache	Pig-1
3	Daini Puja	Severe Fever Stomach pain and blood pressure	Pig-1, hen-1, duck-1
4	Ramdi Daini Puja	Fever Stomach pain and weakness	Goat-1, cock-2-3, and eggs.
5	Thaiba puja	Fever headache and blood vomiting	Fowl-2
6	Shain Mungrung	Fainting and fever	Fowl-1, pig-1. Curry of banana tree and wine.
7	Haramdi gabra	Dysentery, fever and headache	Pig-1, fowl-5 egg of hen 5 laopani-ju.
8	Hakline or Hagrani	Senseless off and on	Hen-2, duck-1
9	Faimangma Thaimangfa	Fever accompanied by vomiting	Goat-1 , hen-5
10	Dakinsa	Problem of eyes/ conjunctivitis	Hen-15-16, egg-5, duck-1
11	Khanda	Fever and fainting of Children	Hen-3, goat-1
12	Jhampara	Headache and stomach troble in children	Fowl-1, pigeon-2, chilly, ginger
13	Sanai-daxa	Unsuccessful in attempts	Pegion-2, fowl-1
14	Baraigabang	Disease of ear mainly hearing problem	Hen-1, pegion-2
15	Kharangpang (A community Puja)	Occurrence of natural calamities, breaking of diseases like small pox , cholera in the villlage	Hen-1, cock-1 curry of banana tree and lowpani- Ju
16	Bairagi puja (A Community Puja)	-do-	Fowl-1, goat-1, pigeon-2, flower of three kinds,

Farha Puja

Farha is considered as one of the important worship by the Dimasa. When people have bad dreams at night to get rid of the horrific experience of those bad dreams and to prevent the occurrence of the dream in reality this puja is performed. This is a household puja and is performed by the village priest.

On the day of puja, people wear clean or new clothes. There is no bar for anyone to attend the puja_. Rice powder, banana leaf, one fowl and rice beer (Ju/joo) are the essential ingredient of this puja. The fowl is offered (sacrificed) in the name of the presiding deity along with the other items. Once the puja is over the remaining items are distributed as *Prasad* to all attending the Puja.

Daini-rani Puja:

Dainirani or *dinarani* puja is performed sometimes in groups or sometimes individually. When This puja is performed when someone is suffering from high fever accompanied by headache This puja has some restriction for women who are not allowed to attend the puja neither they are to take the Prasad of the Puja.

The Puja is usually performed on a river bank at the dusk *(Sainjoroba Lamaine)* . Usually the head of the household or the group of household perform this puja. Priest is not essential. On the day of puja- the performer after bathing get purified and then wear new clothes and a ring. Those involved gather along the river bank. A pig is scarified with chanting of mantras. The meat of the pig is then distributed among the members.

Daini (Sagaigi) Puja

In Daini Puja *dainiees* are propitiated. They are considered as malevolent spirits and because of their dreadful activities people suffer from various types of fevers, stomach pain and high blood pressure. To get rid of these, people perform *daini puja.* This puja is performed in the similar manner as that of the *Dainarni Puja.* However, this puja is costlier because apart from a pig, two other essential puja items are two fowls, and one duck. All these animals are sacrificed and then the meat is distributed among the persons. In this puja however only old persons are allowed to attend.

For fever and stomach pain, another puja is also performed namely *Ramdidani puja.* When a person suffers from fever or from stomach pain or from both, he or his family members visit to the village priest for diagnosis and identification of the spirit who causes the illness. If the spirit is identified as *Ramdidani* then this puja is performed. This is a household puja and can be performed without a priest. This puja is performed only on Saturday and at dusk. On the day of puja the person who is to perform the puja bathed and wear clean clothes and get ready for sacrifices. The sacrificial items are one goat, two or three cock and four eggs. After puja, these items are taken as Prasad.

Thaiba Puja:

Like the above two spirits, *Thaiba* is also the causes fever and headache of a person. It is believed that *Thaiba* may also cause the patient o to vomit blood. When identified by the priest that Thaiba's evil

eye is on the patient, a puja is performed. In the puja two fowls are sacrificed.

Shaine Mungrang

Shaine Mungrang is a kind of spirit who believed to inflict punishment on its victim by way of high fever. Due to the high fever the patient sometimes faints. To propitiate the spirit puja is organized. Performance is same as the *Ramdidani* puja. However the items here require only one pig, two fouls, well cooked curry of plantain leaves, and Joo.

Haramdi gabra

Another spirit believed to cause fever, dysentery, headache etc is the Haramdi gabra. When the priest identifies the presiding spirit, it is for the family to perform a puja to appease the spirit. This puja is elaborate and performed by the village priest. After chanting of mantras the priest sacrifices one pig, five fowls, five eggs curry made of banana and also offer rice.

Haklini or *Hagrani*

Haklini puja is performed seeking cure of mainly dysentery or diarrhea; but Haklini is also believed to be the cause of fever accompanied by senselessness and stomach trouble. Puja is performed under a Hamlai tree where two cocks and one hen is sacrificed.

Fatimangma Thaimangfa

New born children are believed to be the target of this spirit. It causes the new born child to suffer from fever and vomiting. The spirit is believed to live in *Hemlai* tree. Thus to appease the spirit, the nearby Hemlai tree is chosen and its base is cleaned. At night the elders of the family gathers around the tree and the puja is performed. A got and five fowls are to be sacrificed to appease the spirit.

***Dakinsa*:**

Dakinsa is also described as red eyed monster. People gets panicked when Dakinsa attackes. It is believed that his favourite living place is the Jhum fields. When people get fractured bones of hand or foot it is believed to be the works of Dakinsa. Dimasas believe that bones fractured by *Daksina* never got joined again. The spirit is worshiped to with varieties of items such as seven nos of banana leaves, 15-16 numbers of hens, 6 pigeons, one duck, and rice powder (hon) and rice beer. Dakinsa puja is usually performed either on Saturday or Sunday. But that has become a convention only. There is not fixed date for holding this puja. Everybody can attend this puja and have the *Prasad.*

Khanda

The attack of khanda is manifested in the form of loss of sense and followed by fever. It usually attacks children. As soon as the attack is identified, the father of the child would go to the nearby Banyan tree,

(*Frang Fang*) and offer betel nut and betel leaf with wine on a banana leaf. Then addressing the spirit he promises to perform a puja. If the child gets cured, the puja is arranged.

This puja is performed by the Ojha of the village with two of his assistants. The priest gets new clothes to wear with a cap on his head. Then with chanting of Mantras he makes the following offerings- fowl =3, one goat, rice power on banana leaf. After the puja the family members take the *Prasad.*

Jhampara

Like *Khanda, Jhampara* is also another spirit that mainly causes the children to suffer from fever, headache. The priest identifies which among the presiding spirit is the cause of fever and then advices the parents to arrange for puja. This puja is performed in a unique location- i.e on a crossroad. The puja is performed by the village priest and for appeasement of the spirit, one pair of pigeon, one fowl and spices like chilly, ginger are offered.

Sani dãxa

An unsuccessful man is said to have fallen under the grip of the evil power of Sani. To appease the sprit, the priest advises the victim to arrange for puja to get rid of his Sani Dãxa. The puja is performed by the village priest. It is only the victim who attends the puja. A pair of pigeon, and a hen is scarified during the puja.

Baraigabang

Problem of hearing or any water related accidents are believed to be the action of the *Baraigabang.* This spirit is believed to live near a water body. When such problem or accidents occur, the priest is consulted and under the advice of the village priest puja for *Baraigabang* is arranged. For hearing problem puja may be performed near any water body but when it is water related accidents the puja is perfumed in on the spot where the accident occurred. For sacrifice one hen and a pair of pigeon is required in the puja.

Karangphong

Karamphong is a community spirit. It is believed that its evil power is capable to destroy a village. It can cause various diseases in the village like small pox, cholera, fever etc. It may also cause destruction by natural calamities like, flood drought, etc. It is because of this, that the villagers try to satisfy the spirit. Elaborate arrangement is made for this puja. The date of the puja is fixed after a discussion with the village headman and prominent villagers and the priest. Usually a Thursday or a Saturday is fixed. On the day of discussion it is also decided the rate and type of contribution to be given by each households for the puja. This puja is held once in a year and a central place of the village is chosen for the puja.

On the day of puja as usual the priest and his two assistants wear new clothes and amid chanting of mantras sacrifices one hen, one cock, curry of banana tree and Joo. People gathering around the puja place take

the Prasad. People outside the village and women are not allowed in the puja.

Process of curing some ailments and diseases

Ailment: 1 – *Bema waibaha pherenyaba* (for spider –bite)

Process :- Immediately , the spider is searched and caught . Then enchantments of words are done by the traditional healer which rubbing on the bitten area, with his hands .The enchantment is done for fine or seven times. Then the spider, if found , is killed , smashed with a stone and the whole thing is smeared on the bitten area . If it is not found, it is left as it is , after enchantment .

Ailment : 2 – Tsi mathasyaba (to stop bleeding in case of any injury)

Process :- Banana leaf is taken which is torn almost wholly seven times and it is brushed onto the injured area while uttering the enchantments, for fine to seven times sometimes banana leaf is not used , only hands are used .

Ailment : 3 – Muthaiha buphin habshngbaha (for eye infection)

Process :- Banana leaves may or may not be taken, to rub on the eyes softly while uttering the enchantments sometime only hands are used .

Ailment : 4 - Gerebaha pherenyaba (for joint pain or body sprain)

Process :- First mustard oil is smeared on the hands thoroughly , then the hands are hung near the fire to heat up the oil , and then uttering the enchantment , the hands are smeared and rubbed on the area of body pain sometimes , banana leaves are used , instead of plain hands .

Ailment: 5 – Na bushu skaibaha pherenyaba (for the cure of fish bone stuck inside the throat)

Process: - Take a glass of water and flap your hands oner it while uttering the enchantments for 5 -7 times mictimissed with the ailment, and a drop of the same water is smeared on his/her navel. Then the glass is kept upside down.

Ailment: 6 – *Bohosaba:* Stomach pain:

Process: Guava' s bud (sucram), Pineapple's bud (laiamuri), stem of Maisandhai and Gangrook (like ginger) all these items are crushed and mixed with water and (suckled by)/ wraped in a clean cloth. This medicine is used thrice in a day after meal. Patint is allowed to eat soft rice with dal without chilly.

Disease: Bhuhorhouba or khamri jaba: Blood dysentery

Process : 1. Bonaphi, 2.Muli, 3. Nim, 4. Argam Yhatti, 5. Roktapoma's bud are the basic ingradients for preparing medicine. First a paste is prepared out of the three items namely. Bonaphi, 2.Muli, and leaf of Nim along with a crab (kakra) which then is mixed with water. The potion is now ready to be taken by the patient as medicine. The doze is three time a day for adults and once a day for children. When the dysentery is not severe the patient may chew Roktopoma's bud as medicine. Chilly, egg, meat, etc are prohibited during the time of treatment and soft food only is allowed at that time.

Disease:: (<u>Lamti jaba</u>) Small Pox

Process: 1. Morgaon- leaves of Neem and 2. Leaves of Laboir are the basic ingredients of small pox medicine.leaves of neem are boiled in water and then mixture is cooled. This mixture is taken three to four times daily. Leaves of Laboir are however used for bathing so as to keep the body cool.

In every ailment , after the 5-7 times uttering of enchantments respecting to each ailment ,there is one common enchantment of words , allied " shot" in Vernacular (Dimasa) language, which is uttered only once . This "shot" means the following:

Words by god are not a joke
But to be taken seriously
Until we have the earth
Until we see the sky
Until the mortar and pest do not crush the roots
Until the stone floats on water
Until the rice beer container sinks
Until the crow turns white
Until the crane turns black
The nature is a witness
The ailment has to be cured
Words by god are not a joke.

Table : 3.2 List of medicinal plants used for curing major ailments by the Dimasa tribe

Plant name	Family	Assamese/Dimasa	Parts used	Diseases	Method of preparation
Acacia farnesiana (L)willd	mimosaceae	Bokul	Bark	Jaundice	1cup of bark boiled water is given orally in empty stomach
Allium sativum L	Liliaceae	Shyamfhrangufu	Bulb	High blood pressure	Bulb is edible to normalise blood pressure
Andrographis paniculata (Burm.f) wall.ex Nees	Acanthaceae	Chirata	Leaf	High blood pressure	1cup boiled water of leaf is given to drink in high blood pressure
Annona squamasoa L	annonaccae	Ata	Bark	Diabetes	Bark decoction is given orally once a day in empty stomach
Averrhoea carambolo L	averrhoaceae	Kamranga	Fruit	Jaundice	Fruit is prescribed in jaundice
Baccourea romiflora Lour	eophorbiaceae	Khusmai	Fruit	Jaundice	Young fruit is prescribed to eat in jaundice
Cajanus cajan (L)huth	papillionoceae	Orol	Leal	jaundice	1/2cup of leaf juice is given orally in the morning in empty stomach
Catharanthus roseus (L) G.don	Apocynaceae	Khimdari	Leaf	Diabetes	Leaf juice is given orally in the morning in empty stomach in diabetes
Chrysopogon aciculatus (Retz) Trin	Poaceae	Simtai	Root	Haematuria	Root infusion is given orally
Citrus ourantifalia swing	rutaceae	Thaisamiai	Fruit	High blood pressure	Fruit juice is applied on the skull
Clerodendr	Verbenaceae	Misimao	Tender	High blood	Boiled leaf is given

am glandulosum				pressure	orally
Clitorea ternatea L	Papilionaceae	Apprajita	Leaf	High blood pressure	Leaf juice is applied in the skull in high blood pressure
Cuscuta reflexa roxb	Cuscutaceae	Swarnalota	Whole plant	Jaundice	Boiled water of the plant is given orally in jaundice
Entada pursaetha DCvar sinohimalensis gierson & litsaea sp	Mimosaceae	Sutai	Innerport-ion of seed bark	Skin cancer	Paste of both the plant parts is applied externally in skin cancer
Ficus hispida vahi geodorum densifloru m rhaphidophora glauca stephania japonica	Moraceac orchidaceae aracene menispermace	Khandaojala laidisa methapla uthar	Bark tuber leaf tuber	Carbuncles	Pasts of the mixture of all these part is applied externally
Ficus religiosa L anisameles sp	Moraceae lamiaceae	Profand	Root leaf root	Jaundice	Mixture of some quantity of both the plant parts given orally
Houttuynia cordata thumb	Sauraraceae	Mosokmao	Leaf	Heart problem	Chatni of leave is edible in heart problem
Hyptis suaveolens (L) poil	Lamiaceae	Tukhma	Seed	Urinary track infection	Seed is soaked overnight in water and next morning water is given to drink
Lagenaria siceraraia (Molina) standley	cucurbitaceae	Melau	Fruit ,stem	Heart problem ,weakness preventive of stroke	a. Fruit juice with little amount of salt is edible in heart problem ,weakness and as preventive of stroke

Michelia champaca L	Magnoliaceae	Champa	Seeds	Jaundice	2tbl spn full of seed powder dissolved in a cup of cold water & is taken orally in empty stomach
Droxylum indicum (L)vent	bignoniaceae	Khalong	Bark	jaundice	2cup of bark decoction is given orally in empty stomach for few days
Richordiac scabra L	Rubiaceae	Khangkhraireg u	Shoot	Urinary track infection	Shoot past is applied externally on the lower abdomen to get relief from abdomen pain urine infection
Saraca asoca (Roxb) de willed	caesalpinioceae	Ashok	Tender leaves	Jaundice	Tender leave juice is given orally in empty stomach
Sesamum orientale L	pedaliaceae	Shibling	Seed	High blood pressure	Oil is used to apply in the skull in high blood pressure
Solanum viarum Dunal	salanacece	Khimkatai	Fruit	Heart problem	Raw or boiled fruit is edible in heart problem
Sysygium cumini (L)skeel	myrtaceae	Jambu	Seed , bark	Diabetes	Seed powder with water is given orally in diabetes bark boiled water is also given to drink in diabetes
Termiinalia arjuna (roxb) weight &arn	Combretaceae	Arjun	Bark	Heart problem	Bark infusion is given orally in empty stomach in heart problem
Tinspora cordifolia	menispermacea e	Dasthulu	Short	Gasstice & diabetes	Pieces of short soaked overnight in a glass of water & in the next morning water is given to drink in empty

					stomach in jaundice & diabetes
Welia chinensis (osb) merr	Asteraceae	Vringaraj	Leaf	High blood pressure	Leaf juice is apply in the skull in high blood pressure

Source: Medicinal Plants Used in Major Diseases by Dimasa Tribe of Barak Valley[2]

3.4: Boro Kachari Traditional Health Care system

Boro-Kacharis have their own traditional healers almost in every village who use various methods and techniques such as divination, cleansing rituals, protective amulets, and herbs to cure and heal. They expertise in identifying the cause of a disease. If they identify that the sickness is supernaturally caused, then the healer uses rituals apart from herbal medicines. They believe in various spirits, demons and deities who are responsible for various sufferings of people.

In Boro-Kachari belief system, all forms of the supernatural forces like ghosts, evil spirits, banshee and all other gods and goddesses who are the controller of diseases and ailments, live in damp nooks and corners in back yards, in rivers, streams and natural ponds, or in big bushy trees. These are invisible to human eyes. But they have been entitled to receive offerings and worship from human beings by God-the Creator. So these ghosts and spirits try to create sickness among men to receive offerings and sacrifices.

When a person is sick, first the actual ailment or disease and the deity controlling that particular ailment are to be determined along with the

[2] *Madhumita Naui=, B.K. Dutta & & P. K. Hajra'* Assam University Journal of Science & Technology: Biological and Environmental Sciences Vo!. 7 Number I 2011

means to appease the deities concerned. In Boro-kachari religion this is done through divination which they refer to as "*thikana sowa*" which literally means "to spot the address" . There are different forms of divination found among them like divination by paddy grains, water, oil and through cowri shells.

After ascertaining the cause and the presiding deity of the ailment, the next step is to worship and make required sacrifices and offerings .However; it is observed that they generally perform such a ritual only when they get well. But during illness the family make a promise to the concerned deity that they would hold the requisite Puja and make appropriate offerings when the sick person recover/ recuperates.

Boro-Kacharis believe that during illness the family may make a promise that it will held the required worship and make offerings and sacrifices when the illness is cured. This is done through a small ritual by the medicine man or the Kabiraj which is known as *topola bondha* or to "tie a bundle". For this purpose, a handful of aroi rice and an old copper coin or one rupee coin is offered in the name of the deity concerned and a small bundle is tied with a tulsi stem. Sometimes an egg of a fowl or duck may also be included in the bundle according to the findings of divination.

All these communications with the supernatural world is done by the Kabiraj –the medicine man. The medicine men are considered as the mediator between the gods and the human beings. If the families of the ailing person do not keep their promise of offerings or sacrifice, the gods

and spirits held the medicine man as responsible, because all the communication was conducted through him. They believe that in such a situation the Gods do not believe in that particular medicine man in future. That is why, no Kabiraj likes to come to treat in a family who have the record of not performing the " promised pujas" after recovery in the past. Thus there is an informal and subtle pressure of social sanction for not ignoring the promises made to the supernatural forces.

The core of Boro-Kachari religious beliefs centers round their Divine Parents *Mahadev* (the primordial Father) and *Ai Kamakhya* (the Primordial Mother) . According to them, the Mother nurtures and the Father controls all living things – animals and plants- on Earth. An army of minor Gods and minor deities try to extract sacrifices and worship from human beings by creating and spreading sickness in society.

They also believe that plants and animals having medicinal properties used for treatment of diseases and ailments are ultimately created and controlled by the medicinal purposes are the Divine Parents. Therefore, their use of herbal medicines is often preceded by worship s and offering s to these deities. The medicine works only if the concerned deity could be satisfied.

3.4.1: *Kubir Devata:*

For the Boro-Kacharis, *Kubir* is one of the most malevolent deities who may attack a person for no reason at all. There are different types of *Kubir Devata*. When a person suddenly feels severe unbearable piercing

pain in the chest and abdomen, Boro-Kacharis consider it to be the evil action of the *Kubir* .

The ritual for propitiating *Kubir Devata* : The patient is asked to offer one betel nut and one betel leaf on a banana leaf facing towards the North in case of males . The females have to sit facing south with an offering of two pairs of betel nut and leaf on a banana leaf. The Kabiraj or the medicineman sits at the back of the patient with a red chicken in hand and

The literal meaning of a sample spell is given below:

"*O Jal Kubir(Kubir* of the Waters) *Kola Kubir*(dark Kubir), *Nal Kubir* (Kubir of the Reeds). *Boga Kubir*(The Fair Kubir), If your children have been trampled and have suffered you should console them . We have offered you betel nut and leaf; we will offer worship when the ailing person gets well." The ailing person moves round the area three times taking the chicken in hand which is then released. The family then keeps and takes care of the chicken in order to sacrifice later i.e. on recovery. Only then the medicine man starts his actual treatment.

They have to perform worship again when the ailing person gets well. They select a place quite away from the family of the ailing person which is not frequented by children or adults. The placed is

First cleaned and two pairs of betel nut and leaves are placed on a banana leaf. A lamp is also lit. The meaning of the spell uttered by the medicine man.

"O Fathers! Oh Jal Kubir, Kola Kubir, Nal Kubir, etc. on that day you had let so and so person (Name of the sufferer) suffer so much. You were told that if you cure him/her you will be offered worship. That worship is offered today. O Gods. We offer our salute!"

After this the *kabiraj* sacrifice the red chicken and the blood is offered to the Gods. They should cook the sacrificed bird and finish it off at the field itself. They are not allowed to bring it home.

After completion of the ritual, just before reaching home, the *Kabiraj* sets fire to a bunch of straw moves in a circular motion and then throws these backwards.

Kubirs are very powerful. One cannot expect to get well by medicines alone without worshipping *Kubirs.* Several types of Kubirs *are* there in Boro-Kachari popular belief. However red *kubir* and fair or white *kubir* are very commonly referred to. Of these, the red kubir is more influential than the white *kubir*. If red *kubir* attacts then no one can get well without offering *Puja* . The white *kubir* is not very complicated. In case it is determined that the illness is due to white *kubir,* the patient can get well if he/she lay down in bed and sleep for a while holding an egg on his/her belly.

3.4.2: *Khethra or Khetor:*

Sometimes illness or some misfortune may be attributed to possession by *Khethra* due mainly to the evil gaze of some malevolent deities. In such cases, they believe that the attached person will have psychiatric disturbances followed by severe anaemia and other related weaknesses. Expectant mothers or small babies are generally possessed by

Khethra. Different types of *Khethra* are there according to borokachari. All these different Khethra are to be propitiated according to the findings of divination. Some Khethras attact small children (*Daba Matri*) while there are other *khethras* like *moudam bugar nai*(puffy body), *Doi Khethra*(Water *Khethras*) upayosi *Khethra*(areal *Khethra)*

In the village when a person fell ill the village doctor or the diviner is contacted at once. It is then the turn of the diviner to find out the particular spirit responsible for the disease and give directions about the rituals to be performed as remedial measure. Each such ritual has fixed rules regarding the type and number of animals to be sacrificed to appease the presiding deity. Among the animals, pigs (*Oma*) and fowls (*dhao*) are indispensable items of sacrifice while among the offerings rice beer (*Joo*) occupies the prominent position. .

Among the Household gods of Boro-Kacharis the most powerful is the *Bathou*, who is believed to be the guardian of the families. *Bathou* protects them from all sorts of disasters, including health. In their Bodo language , *Bathou* means five deep philosophy i.e the father or creator of the earth, water, light or sun, air and sky. He is believed to be expressing himself through air, water, light, earth and sky[3]. He is eternal omnipresent. *Kherai* is the central festival of Bodos. In a *Kherai, Bwrai Bathou* is the

[3] Ms. Anjalee Hazowary * Dr. Mangal Singh Hazowary: Kherai Festival: A Traditional Religious Festival of Bodos
(A Descriptive Study of the Traditional Religious Festivals of the Bodos). International Indexed & Referred Research Journal, September- 2012, ISSN 0974-2832, RNI- RAJBIL 2009/ 29954; Vol. IV * ISSUE- 44

centre of worship. He is worshiped in most festive manner with significant dances and prayer songs.

Cholera is a known fever among them in the rural areas. Sometimes it also takes epidemic form. They propitiate the supernatural spirit – the presiding spirit of Cholera in a performance called the *Morong* Puja. To appease the spirit they sacrifice a he goat, pigs, fowl and betel nut.

They rely on their indigenous medicinal herbs with which they diagnose and treat all kinds of disease. The common diseases are *Lumjanoi* (fever), *Gugla* (Boil), *Gujunai* (cough), *Khinaijadu* (dysentery) , *Hatai Sanaidu* (tooth ache), *Hateng Sanai* (joint pain), *Sinciri Sanai*(waist pain) , *Udwio Sanai* (gastric pain), *Debaleng* (asthmatic trouble), *kalai impu Jadu* (dead nail) *kharo sanai* (head cahe). For treatment sometimes they use amulets and religious spell also.

3.4.3: Treatment of a few diseases: Cough:

Treatment: Basil leaves (*Dhulunysi Bhongbang*), pepper (Gul morich) and ginger (*haijing*) are the basic ingredients of preparing a mixture for the cure of cough. These items are mixed together and grinded properly in a pounder made of stone. Juice is then pressed out from the paste by applying a little pressure. This concentrated juice is given to the patient usually three times a day.

Bleeding and wound (*Hakhai hadu*)

Treatment: The milky juice of black arum plant is a commonly known medicine for stopping external bleeding . Juice of s mild grass commonly known as Dubari grass is used to check bleeding from external injury. Juices of dubari mixed with the juices of ginger are also used as antiseptic. Other two flowering plants used for this purpose is the *Gendhai* and *Malati.*

Disease: Dysentery, Diarrhea: (*Khisongnai*):

Treatment Ingredients: - Bark and leaves of neem, veto tita, *Ronga bahaka's* bark (Justicia adhatoda) and leaves of kamals (lotus). These items of washed properly and then mixed in specified proportion. Then these are grinded and made a paste. Juice from this paste is then collected and boiled in a clean container. This is the potion. It is cooled first and then given to the patient to drink t least twice a day. Another alternative medicine in this case is the use of mango bark which is grinded properly and then mixed with lime water to make the medicine.

Disease: Indigestion or gas formation (*Baiyu Mantra*) :

Treatment: The milky juice of Mukunda plant, leaves of Nagdeo plant, naturally grown ginger from forest, . All these things are mixed properly and then grinded and squeezed to collect juices. This juice is then given to the patien as medicine.

Disease : Constipation (*Khinaigora Jadu*):

Treatment: Milky juice of (Xiju) Hiju plant and an egg of chiken are boiled and these preparation is then mixed together in specified proportion. This potion is then made three parts. One part is taken early in the morning before taking any food, one at noon time and the remainingone at night.

Disease: Blood Dysentery : (*Thui Buijol- Khinal Jadu*) :

Treatment: Green banana (*Kachkol*) is either in boiled or in raw form is considered as the best medicine. It may be taken with rice.

Disease: Tooth ache: (*Hatai Sanaidu*):

Treatment: A piece of '*Basanta Loya*' is soaked in salty water for some time. Gradually the water absorbs the elements from the plant. This is then used for gargling by the patient. Apart from this the bud of the pipli plant (pepermia reflexa) is also considered having good medicinal value for tooth ache. This bud paste is used to brushing the teeth for getting relief from tooth ache.

Disease: Chest pain (*Bikha Sonai*) and Joint pain: (*Hateng sonai)*

Treatment: The leaves of Bihuli, rhizome and kerosene oil are mixed together and an ointment is prepared. The *Kabiraj* or *Baidya* then gives

massage on the chest or the joints of the patient where pain occurs with this solution.

Disease: Gout:

Treatment: Mustard oil and Garlic are the main ingredients. Garlic is peeled and grinded. Then it is mixed with mustard oil thoroughly and an ointment like solution is made. This ointment is then massaged on the affected portion. The affected person while under treatment should not take lemon or any sour food or cold water.

Disease: Headache (*Khoro Sonai*) :

Treatment: Leaves of Brahmi is first collected and cleaned and then grinded and squeezed to collect the juice. This juice is taken one or two time depending on severity of the headache.

Disease: Hyper Tension: (*Khoro Gininhai*):

Treatment: Leaves of Mukunda and nagdeo, Jungali ada. The milky juice of Mukunda leaves , leaves of Nagdeo plant and naturally grown ginger are mixed properly and then grinded and squeezed to collect juices. This juice is then given to the patien as medicine. Some portion of the collected three items are kept seperately and later put in an amulet. The patient is to wear this amulet in his neck in such way that the amu;let remains attached to the chest.

Disease: Snake bite: (*Jibo-Soudong*)

Treatment: An un-ripened papaya (*Modfol*). The papaya is first cut into pieces which are then placed on the area bitten by the serpent one after another. The belief is that the pieces of papaya will turn black signifying that these have absorbed the poison of the bite and gradually this blackish colour will fade out and the original colour will remain signifying that the whole poison has been drawn from the body.

If the outcome of the above exercise is not fruitful, then another alternative is that the bitten area is tied up with a good rope – so as to hinder the blood circulatory activity in the area. The affected area is then cut with a sharp knife and some blood is allowed to get drained. Thereafter a medicinal and magic stone commonly called '*Johor Mohor*' is heated and rubbed against the wounded area. It is believed that '*johor mohor* will absorb remaining poison in the body. On completion of the task the *Ojha* places the *johar mohor* in a utensil filled with cow's milk. The colour of the milk gradually turns blackish or bluish. Thus, it is believed the milk has absorbed all the poison in the stone

Disease: Cat bite:

Treatment: '*Thekhera tenga* (Garcinia laceaefolia). This fruit known for its sourness. It is cut into pieces and dried under the sun. It is then dipped into a glass of water which is gradually disintegrated into water. This glass of water is to be taken by the patient . The process is to be continued for at least three days.

Disease: stinging by Caterpillar:

Treatment: lime in water and alkali: Lime when dissolved in water some part of it is rubbed in the ear. Usually that should relieve the irritation. But it continues, alkaline is put on the affected place.

Disease: Jaundice (*Khop Laga*) or (*gumo beram*) :

Treatment: leaves of *Mezankori* (Litesa citrate), *kordoi, chirota* and akeho. All these leaves are taken in appropriate proportion and then grinded. The mixture is then fried (without turmeric) and then given to the patient.

Disease: Small pox (*Linthai*) :

Treatment: - The treatment begins with purifying water taken in a pot by chanting mantras. Once the water is purified it is sprinkled on the patient chanting a mantra. This is called *panijara.* The neem leaves boiled in water is cooled and and patient is bathed with that water. Neem leaves are also kept under the mattress of the patient.

Disease: Headache during sunrise (suraj Kapila) **and sunset**(Goros Kapila) :

Treatment: leaves of buriwall plant are given to the patient to eat and a small piece of this plant is touched in the forehead of the patient and after chanting mantras this shoot is kept on the roof of the house.

3.5: Tiwa (Lalung) Traditional Health Care System

The Tiwa traditional health care practice is no different from what we have seen in case of the above three tribes. Its main contents rest in on one hand magico-religious performances to appease the supernatural beings followed by use of herbs for medicines. They believe in supernatural spirits who live in the surrounding countryside. When they are dissatisfied they cause diseases to the people. For curing the affected person sacrifices are to be made.

Tiwa religion revolves round its supreme god Mahadeva and his associate deities. Any religious ceremony begins by worshipping Mahadeva.

Disease: Fever:
Treatment: Fever is believed to be the manifestation of anger of *Ai Gosani*. Therefore when a person is caught with fever, first *Ai Gosani* is worshipped chanting mantras, and *Naams* (lyrical praises for various Gods & Sri Krishna). In cases, when fever does not show any sign of receding, a few *bhakats* (persons who engage their life in the services of the God) are treated with meal which is considered as a sacred act. The *Bhakats* also perform *Naam* and finally give blessings to the patient.

Stomach pain –
Treatment: Ingredients:- *Nelikut* and *Chirots tita (swertia Coirata)* . When a person suffers from stomach pain, Nelikut – a wild creeper is collected and grinded properly. Then its juice is extracted and mixed with water and

served to the patient one or two times a day. Similarly, dried *Chirota* is dipped into water for some time and when dissolved in water, it is given to the patient as medicine.

Disease: Loss of appetite:

Treatment: Ingredient: Posotia (*Justicia gendarusa*): The leaves of *Posotia* s collected and dried under the sun. These are usually preserved in the households. Such dried leaves are boiled in water and the cooled. This mixture is then given to the patient early in the morning before taking any food.

Disease: Diarrhea:

Treatment: **Ingredient** -Nayan Flower. The leaves of Nayan plant are grinded and juices extracted from it. This juices then mixed in a half a glass of water and given to the patient. This should be taken twice a day.

Disease: Rabies:

Treatment: Ingredient: White Dhotura (Dotura stramanium), ginger. 5 newly sprouted leaves of white dhotura taken together with a piece ginger are grinded and juices are extracted. Juices then mixed with water and boiled and then cooled down. Half a glass of this mixture is given to the patient.

Disease: Snake bite

Treatment : Darun (Lucar cephalates): leaves of Darun are collected and grinded well. Then its juices are extracted. It is believed that if the affected area is on the right side of the person, then a drop of dorun extract is given on the left eye or vice versa.

Disease: Fracture:
Treatment: Ingredient: Kopou Dhekia (Lygodium Flexuosum) Kopou dhekia a type of creeper. The creeper with leves is collected and grinded and a paste is made. This paste is then spread on the area where the bone is fractured and the covered well. This bandage is kept for 24 hours and then removed. It is believed that if the bandage is kept for mpre than 24 hours, the bone gets extended.

Disease: Skin Disease
Treatment: Ingredient*: khoir* (Acacia catechu): leaves of this tree is directly applied on the skin for skin diseases.

Disease: Eye problem: (wart)
Treatment: leaves of Bogori: 5 leaves of Bogori are collected. With each of the leaves, touches both the eyes one by one. This is supposed to cure the disease.

3.6: Mishing Traditional Health Care System

Indigenous health practices and system of curing illness is still very common among the Mishing tribes. The socio-religious beliefs and practices of the Mishing people plays significant role in ensuring health prosperity and protection to the community. They belief that the spirits of ancestors are to be appeased, otherwise they will bring miseries to the members of a family by way of causing epidemics to humans and animals.

Some of the healing systems are- Jarinaam (Magical types), *Ku:sere teinaam* (liquid made of medicinal herbs for stomach disorder, jaundice),

ta:rehgomnam (broken bone or wound is wrap with traditional prepared medicine),

It is observed that the Mishing men and women are expert in recognizing medicinal herbs for different ailments. They are habituated to go to the diviners for some illness happening in the family. They perform various pujas for well being of the family and community like- (a) *Urom* (Ancestral worship), (b) *Do:bur* (worship to heavenly spirit), (c) *Taleng Uie* (Ethereal deity), (d) *Dangoriang Uie* (Home-Deity), (e) *Aai Uie* , (f) *Pijap Uie*, (g) *Sathjonia*, (h) *No:bhat*, (i) *Kirton puja*, (j) *Po:rag puja*, (k) *Dodgang* (post-death rituals)

There are several types of *'Uies'* like *Dobur Uie, Urom Uie, Taleng Uie, Gumin Uie* etc and each type of 'Uies' is believed to cause particular type of problem. Dobur Uie causes all natural calamities like flood, erosion, drought, death etc. and therefore Dobur Uie is observed for getting rid of all these calamities.

The types of ritual and offering are determined according to the nature of the spirits or 'Uie'. Generally the spirits causing the troubles are diagnosed by the *'Mibu'* (Mising priest).

Disease: Jaundice
Methods of treatment: Testing Process and Actual treatment
Materials/items used – plate + water+ lime+ mustard oil+ mango bark (taken from trunk of the mango tree)
Testing method – a plate of normal water is taken and lime stone is applied in the water. The patient's both the hand is applied with mustard oil

and then the patient's both the hand is given a piece of mango bark to hold firmly inside the palm and is made to immersed inside the lime water.

Result – if the color of the water shows yellowish then the patient is said to be suffering from Jaundice. If the water remains the same or no change then it is said that there is no jaundice in the patient.

Treatment method of Jaundice

Materials/items used –_small varieties of herbs in Mishing it is known as *Aksupakyub* + raw milk + raw haldi (turmeric) + touch me not herbs in Mishing it is known as *yupmiyuptap* + manimuni – two varieties i.e. big and small variety + bon jaluk + laijabori + dorka taker soft end a wild varieties of creeper.

Result – liquid or juice of these medicinal herbs is made to drink with milk to the person suffering from jaundice.

Disease : Sinustic Problems

Materials/items used – *bungkirepuk* + bon sumoni pat (5 or 7 leaves) + jaluk (7, 9 or 11 in numbers) + gur (200 gm.) + water + kettle for boiling.
Preparation process – 1 litre of water is boiled by adding bungkirepuk, bon somoni pat, jaluk and gur. From the one litre liquid 3 puwa is given to evaporate and the remaning 1 puwa is medicine for jaundice.
Process of drinking – 1 glass before breakfast and evening 3 or 4 pm 1 glass.

Disease: Ailment: Bone fracture

Material/items used – teteli pat + kula haldi + a variety of grass in Mishing it is known as kumteng + salt.
Both kula haldi and grass is powdered.
The medicinal herbs like teteli pat, powdered kula haldi and grass is boiled by adding a little bits of salt in it for nearly half an hour. And then it is made to cool up for some time.

Used – the fractured portion is wash with the boiled liquid and the boiled teteli pat, kula haldi, kumteng is wrap or tied in the fractured portion for one or two days.

Fracture
Materials/items used – durun bon+kumteng+ahkaki lota + raw haldi
Results- all these natural herbs are grind together with mustard oil and is applied in the fracture portion for nearly one or two days until the pain get relief.

Broken bone
Makat guti (available in the market) + long + dal + gur mirich + mustard oil + honey + giapol guti (available in the market)
Preparation process: All these herbs and items are grind together and applied in the broken portion of the body.

Headache, leg pain & hip pain
Materials/items used: required amount of Mustard oil is taken and magical deeds are done by the traditional healer. After the magical deeds the oil is the medicine which is applied in the pain part of the body.

Burn case
Material used: K R S Bon juice is applied in the burn portion of the body.

Urine problem
Materials/items used: bon jaluk + K R S Bon + Bark of Soti tree + salt
Preparation process: all these herbs are boiled with water and the liquid portion is used as the medicine.

Pneumonia
Materials/items used: letaiguti + ahlokoni +losun (garlic) + gur mirich
Preparation process: is boiled with water.

Nari gastric

Materials/items used: Hilika guti + Amlakhi guti + Bumurah guti + kula nimok (salt) + hagar pan (available in market) + letai guti.

Preparation process: All these herbs and items are grind and boiled with water. Most of the liquid are made to evaporate and less amount liquid is used as the medicine. The patient suffering from such disease is made to drink morning and evening after meals.

Table : 3.3 List of medicinal plants used by Mishihgs with local name, assamese and English equivalents and their scientific names

Mishing name	Assamese name	English name	Scientific name
1. Alokoni	Bos	Sweet flag	Acorus calamus L.(Acoraceae)
Medicinal use	It cures bronchitis, rheumatic pain, diarrhoea, flatulence, Pneumonia and cough.		
2. Otmul	Satmul	Wild Asparagus	*Asparagus racemosus* Willd (Liliaceae)
Parts used	Tuberous roots, whole plant		
Medicinal use	Root decoction is used as health tonic, it is diuretic, ophthalmic, galactagogue, aphrodisiac and carminative.		
3. Gendelabon	Gendelabon	Goat weed	*Ageratum conyzoides* L. (Asteraceae)
Parts used	The flowers, leaves, roots		
Medicinal use	Infusion of roots is used as appetizer and ophthalmic; leaves are used to stop bleeding		
4. Jati dibang	Jati banh		*Bambusa tulda* Roxb. (Poaceae)
Parts used	Root, stem. leaves		
Medicinal use	The decoction of roots taken internally to promote flow of		

	urine.		
5. Anaras	Matikathal	Pineapple	*Ananas comosus* (L.) Merr. (Bromeliaceae)
Parts used	Tender leaf		
Medicinal use	Leaf base is crushed and the extract is given one time daily for amoebic dysentery and intestinal worms		
6. Beilang	Kathal	Jack fruit	*Artocarpus heterophyllus* Lamk. (Moraceae)
Parts used	Roots, seeds		
Medicinal use	Roots are used for diarrhea		
7. Bonjaluk	Bonjaluk	Diamond flower	*Oldenlandia corymbosa* L. (Rubiaceae)
Parts used	whole plant		
Medicinal use	The plant is diuretic, stomachic, carminative and used as liver tonic. It is also used in jaundice.		
8. Manimuni	Manimuni	Indian Pennywort	*Centella asiatica* (L.) Urban (Apiaceae)
Parts use	Whole plant.		
Medicinal use	The leaves are used in amoebic dysentery or any kind of liver problem.		
9. Tezpat	Tezpat	Indian cassia lignea	*Cinnamomum tamala* Nees & Eberm. (Lauraceae)
Parts used	Leaves.		
Medicinal use	The leaves are useful in gonorrhoea, rheumatism, diarrhea, enlargement of spleen and diabetes.		
10. Pakkom	Nephaphu		*Clerodendrum colebrookianum* Walp. (Verbenaceae)
Parts used	Leaves		
Medicinal use	The leaves are used to kill the intestinal worms. Tender leaves are boiled and the soup is used for reducing blood pressure		
11. Sompa	Outenga	Elephant apple	*Dillenia indica* L. (Dillenniaceae)
Parts used	Sepal of the fruit.		
Medicinal use	Fleshy calyx is used for stomach disorder. The jelly like pulp of the fruit is applied to scalp for curing dandruff and falling hairs.		

12. Tajjig	Jagnya dimaru	Cluster fig	*Ficus racemosa* L. (Moraceae)
Parts used	Leaves, latex		
Medicinal use	The latex is used for piles and diarrhoea; Powdered dry leaves are mixed with honey and given in bilious affections.		
13. Bhedaitita	Bhedaitita		*Gomphostemma parviflora* Wall. (Lamiaceae)
Parts used	Leaves		
Medicinal use	Leaves are used in Malaria		
14. Kase	Ulu kher	Thatch grass	*Imperata cylindrica* (L.) Raeusch. (Poaceae)
Parts used	Leaf and root		
Medicinal use	Root is used for wounds and piles. It is anthelmintic. Decoction of root is taken in diarrhea and dysentery		
15. Bhumi champa	Bhumi champa	Indian crocus	*Kaempferia rotunda* L. (Zingiberaceae)
Parts used	Tubers		
Medicinal use	The tubers are used for wounds, ulcers, tumours, swellings and gastroenteritis.		
16. Ising Okang	Kapau dhekia	Climbing bird's nest fern	*Microsorum punctatum* (L.) Copel (Polypodiaceae)
Parts used	Leaves		
Medicinal use	Leaf juice used as purgative, diuretic and healing wounds.		
17. Kopak	Kach kol		*Musa paradisiaca* L. (Musaceae)
Parts used	Leaves, fruits		
Medicinal use	Fruits are used for chronic dysentery.		
18. Piro	Nal Khagari	Wild reed	*Phragmites karka* (Retz.) Trin.ex Steud. (Poaceae)
Parts used	whole plant, root		
Medicinal use	Roots are cooling, diuretic and very useful in Diabetes.		
19. Mudhuri	Madhuriam;	Guava tree	*Psidium guajava* L. (Myrtaceae)
Parts used	Tender leaves.		
Medicinal	Tender leaves are used in Amoebic dysentery		

use			
20.	Bhuin Komora	Indian Kudzu	*Pueraria tuberose* (Roxb.ex Willd.)DC (Papilionaceae)
Parts used	Tuberous roots		
Medicinal use	Tubers are used for fever.		
21. Ombe	Mesaki	Duggal fibre tree	. *Sarcochlamys pulcherrima* (Roxb.) Gaud. (Urticaceae)
Parts used	Leaves		
Medicinal use	Leaves are useful for diarrhea and dysentery, they are carminative and digestive.		
22.	Seni bon	Sweet broomweed	*Scoparia dulcis* L. (Scrophulariaceae)
Parts used	Leaves.		
Medicinal use	Leaves are used for fever, cough and diabetes.		
23. Marsang	Jati malkathi	Brazil cress, Toothache plant	*Spilanthes paniculata* Wall.ex DC (Asteraceae)
Parts used	Whole plant, flower		
Medicinal use	The inflorescence relives toothache, bronchial trouble and ulcers inside the mouth, it has strong local anaesthetization and also used for dysentery.		
24. Ruktak			*Thelypteris angustifolia* (Willd.)Proctor (Thelypteridaceae)
Parts used	Whole plant, rhizome		
Medicinal use	Juice of the rhizome about four teaspoons three times a day given for indigestion or any stomach problem.		
25. Tezmooi	Tezmooi	Toothache tree	*Zanthoxylum nitidum* (Roxb.) DC (Rutaceae)
Parts used	Leaf, stem bark		
Medicinal use	Stem bark is used for toothache or any gum problem, it is carminative and stomachic.		
26. Aambín	Chawual	Grain	*Oryza sativa* L. (Poaceae)
Parts used	Seed		
Medicinal use	Rice-wash water (water used to wash rice before cooking) is used in diarrhea and dysentery		

27. Skin problem	Pochotia pat

(For identification of scientific names, English and Assamese names of some of the plants, help was received from Silapathar Science College, Botany Department.)

Table 3.3 shows some of the important medicinal plants used by Mishings with local name, Assamese and English equivalents and their scientific names. It also mentions the parts of the plants used in treatment of various ailments.

3.7: Rabha Traditional Health Care System

Rabha religion, like all other tribes of Assam and elsewhere appears to be intimately intertwined with their medical beliefs and practices. It involves supernatural forces –both personalized and impersonal. But belief in witchcraft and sorcery is quite strong among the Rabhas than the other tribal communities taken up for the present study.

As noted in Chapter Two, the Rabhas are divided into several sub tribes which show different degrees of acculturation with their neighbours, mostly Hindu communities. The Garos, Hajong and Koch also have close affinity with the Rabhas. Tantric influences may be observed. The processes of Hinduisation and Sanskritization are quite strong among the Pati Rabhas. They have even lost their dialect and speak a form of pidgin known as "*lema*" or Rabhamese (Hakasakam :2006:25).

The finding of the present study reveals an interesting blend between Hinduism –both lay or folk and tantric and the traditional Rabha animistic faith. *Hakasam* has referred that during the early forties of 20th century, a "strong movement for hinduisation took place among the Rabhas. This movement was led by some hindu and rabha leaders and some village

demagogues of the region among the rabha people , and the rabhas in general show a keen interest in accepting Hinduism. A movement for Christianization also took place with the advent of the twentieth century. The doctrine of Christianity were published by the British foreign and bible society in the dialect of the rongdania in 1909; which has not been done by the hindu preachers of different sects. During that time, a few rabha people were converted to Christianity,but after some years they again returned to their ancestral religion. At present a strong movement for conversion to Christianity has been going on under the guidance of Christian missionaries. Still, most of the rabha people are of animistic character." (Rajen Rabha: 186)

As an animistic faith, Rabha world view is full of benevolent and malevolent deities who are under the control of their supreme being referred to as Risi,(Allen,BC 1903 pp232) or Langadeu by different sections. All other gods, goddesses, deities' ghosts and spirits have their own activities and functions dwell in different localities. Their concept of soul is extended to both animate and inanimate objects. These supernatural forces and powers control the everyday existence of human beings more importantly their health care practices.

Rabhas attribute illness, sickness and miseries to the whims and fancies of innumerable invisible ghosts, spirits and deities. The list is very long and it varies from place to place and from informant to informant. Second important character that marks their health care system is their strong belief in witchcraft and sorcery. Impact of witchcraft and sorcery, in reality, could be observed in their daily lives. In the light of Evans-

Pritchard, it may be said that all notion of witchcraft and sorcery explains all unfortunate events.(Evans-Pritchard, 1937). It is true that all the tribal communities studied here have shown the presence of witchcraft but it is among the Rabhas that these are very commonly cited as causes of illness and death.

It has already been mentioned that all communities have some forms of rituals in addressing their health problems which could be classified into two broad categories. The first category of rituals are of some broad based all inclusive community rituals, worship and festivals that are regularly observed by the community for their all-round wellbeing including safe crop and freedom from famine and illness or sickness. The second category includes those rituals and worships that are performed by individual families in order to cure particular cases of illness.

Interestingly, Rabhas have two different terms for these two types of rituals or worship. *Bay-Dhankay* and *Bay Thakai or Kakkai. The meaning of the word bay in Rabha dialects is Deity. Bay Dhankay* refers to the first sets of community worships that are performed for the general welfare of the community at large . *Khoksi Puja, Langadeo Puja* and *Bay-kho* are examples of such Pujas among the Rabhas that are performed by the villagers amidst great festivity and are truly communal in nature. These are benevolent deities. Bay thakkai worships are never performed inside the villages. Each Rabha village, has a permanent place for conducting worship of the deities belonging to bay thakkai category. These places known as bay-than are generally chosen inside deep forests.

Bay –thakkai on the other hand are performed by individual families in order to cure patients suffering from attacks of some ghosts, evil- spirits or witchcraft and sorcery. These are curing rituals in the real sense. According to Rabha faith, *Bay thakkai* are malevolent supernatural beings who have to be appeased as means for immediate solution for individual cases of sickness or misfortune whenever the need arises.

In case of Bay-*Thakkai,* first stage is to identify the cause of illness –whether it is caused by some ghosts, evil spirit, deity or the result of some witchcraft. This is done by divination by diviners or soothsayers. Soothsayers are termed as *tima china krikokay kay* in Rabha . After determination of the cause of illness, the priest (ojha or deuri or bayofang) perform the worship and offer sacrifices. He is helped *by tokbra* or the assistant deuri . Formerly priesthood was confined to a few families and succession to priesthood was transmitted patrilineally. Today the scenario has changed. At present, they are selected from a few eligible and interested persons who have the requisite knowledge of the traditional lore.

It is significant to note that among the Rabhas two types of rituals are in vogue according to the nature and types of ailment. In one category, all the spells and prayers are done in Rabha dialect and fowl and pig are the major items for sacrifice. Blood, head, entrails and feathers of the sacrificial animals and birds are offered at the altar. In some cases, goats and ducks may be required. These are referred to as *rabha bayo or rabha deo puja.*

The second category of *pujas* are conducted generally in Rabhamese, Assamese or in some Aryan language . These worships may have been incorporated due to the process of acculturation resulting out of prolonged continuous contact with their Hindu neighbours. In these pujas, pigs and fowls are not used at all. Only ducks and goats are sacrificed or in many cases set free alive in the name of Gods which is called *Dharam dhenkay* .

Bay- dhankay : Among the community worships, Khoksi puja, Baykho puja and Langa deu puja are performed by different sections of the Rabhas. While different animals are sacrificed to appease different deities, rice-beer is a must in all these deities except in case of a few deities.

Langa deu : langa deu is the principal deity of the Rabhas and He is worshipped by the Pati, Rongdai and Bitlia group. Tis worship belongs to the Bay Dhankai category of community worship to attain general wellbing of the village community. It is preformed in the month of Bohag or Jeth (April -May) in the forest or on a river bank. Along with Langa deu many other deities are also worshipped. These minor deities vary from place to place and from different sections of the Rabhas. In the study area, the informants have referred to *kubir, khoksi, Phool kumar , dudh kumar thakurani*. Of these deities, thakurani is worshiped first and sacrifice a pair of pigeons and a goat in her name. the goat must not be castrated. Next, *langa deu* is worshipped with a sacrifice of a pig or a fowl followed by sacrifice to *dhan kuber* (a pair of red fowl) and *Khoksi*(a pair of fowl of any colour). All these are cooked in the form of curry and offered to the deity. However, it must be mentioned that sometimes, the sacrificial animal

may vary from place to place or among different sections of the Rabhas so also the names of the deities. For example, among some sections, deities that are worshipped along with langa are Lakhar, Chamar-dang, Lohardang etc

Baykho : At present Baykho worship is considered to be the national festival of the Rabhas.(Hakasam) Formerly this worship was confined to the Maitory section only. This worship is also done inside deep forests where there happens to be a permanent site for baykho puja.

Hachang : This worship may be considered as a new version of Bay-kho and Khoksi worship. Hachang puja has more or less replaced the traditional Baykho Puja and Khoksi Puja among the Rangdani Rabhas due to various reasons. Hachang is a community worship performed annually during the months of April-May (*Jeth* in Assamese lunar month). Each village has a fixed place earmarked for this festival. About twelve Gods and Goddesses are worshipped in Hachang Puja where fowls,ducks goats and pigs are sacrificed in the name of different deities. However, Hachang puja has no direct bearing with the health care system of the community.Its aim is to bring about economic prosperity in general.

Kachai khaiti : Kachai khaiti is another form of Mother Goddess . Rabhas believe that Goddess *Kechai khaiti* in her *Ranachandi* (warrior) incarnation fights all the illness, epidemic and all misfortune and drives these away from the village. Therefore, every year, Kechai khaiti is worshipped along with *Langa deu.* The word Kacha means unripe and *Khaiti* mean an eater – usually a female one. Hence, *kechai khati* literally

means a person who devours raw food. Therefore, *kechai khati* is offered raw unripe fruits like jackfruit, mango, cucumber along with different types of sweets and cake made of rice-powder. In some areas a pair of fowls is also sacrificed in the name of *Kechai-khati.* Rice beer must be prepared at the priest's house beforehand. At the end of sacrifices all the villagers pray by kneeling down in front of Kechai khati. In the meantime, village youth make a craft out of banana trunk in the shape of a tortoise where all the offerings meant for kechai khati and other deities are arranged beautifully.

A ceremonial procession takes place, and the craft is being carried by two youths to a nearby river bank. The procession consists of the priest, youths, drummers and a few women. On reaching the river-bank, an earthen heap is prepared as an alter where the float is placed upon it. Sixty plates made out of bamboo bark are arranged where unripe fruits and cakes are placed. Rice beer is also poured into these plates. Ritual is then performed. . Thereafter the craft is being floated in the river or stream.

One of the significant aspects of this puja is the act of driving away all the evil spirits that might be hiding in some nook and corner of every household waiting to inflict sickness or to cause harm to the family members. For this purpose, a group of men beat each and every house so that all the evil spirits may flee from their hidings. Besides, they attempt some sort of ceremonial theft by stealing any fowl, duck, pigeon or unripe fruits from each household and offer these to the evil spirits. This part of the *Kechaikhaiti puja* is known popularly as *Haol Kheda.* Thus by performing *Haol kheda,* the Rabhas believe that they have successfully

driven away all the evil-spirits –the source of all ill health and other misfortune.

Bhagabati : Bhagabati is worshipped when some family members are suffering from small pox. It is preformed at home of the patient. According to Dr. Rajen Rabha, "eighteen plates of food containing fragrant rice, malbhog banana, milk, basil and betel leaves and areca nuts etc: are offered by the priest in the honour of Bhagabati. No sacrifice is performed for this powerful deity. A group of village women gathers and sings devotional folk prayers known as *Aai Naam* or Bhagabati Naam glorifying the qualities of *Aai Bhagabati* or Mother Bhagabati.

Bira-Bay: *Bira* is the name of a spirit who can do "all impossible works. Some of the Rabhas say that they have seen the *Bira* deity. They describe that *bira* can become long, short or fat, even out of sight of the men. Unexpectedly, he can break down the banyan trees, the cluster of bhaluka bamboo and other gigantic things. He has long hands and feet. His body is covered with long hair but no man has seen his face. The belief of the rabha is that his abode is on the great banyan tree or in the cluster of *bhaluka* bamboo"(Rabha: ibid :205).

During the present study, it was found that there are more than 12 to 15 types of bira *deity*. Some ojha or medicine man subjugates bira by performing some complex and gruesome magical ritual and keeps under his control. However, no one could actually describe the ritual which involves the use of human corpse on a dark night. When the ritual is successful and

the *bira* deity is under his control, the *ojha* can perform any impossible work through the *bira.*

How the action of *bira* is determined: Sudden insane behaviour like attempt to climb trees, or a hilltop, or to jump in a well or a river are generally attributed to be the action of *biras* . in such cases, the patient has to be kept tied up with ropes in order to avoid fatal accidents. Sometimes, the ojha or the keeper or master of the *biras* uses its supernatural powers by pelting stone incessantly on the house of an enemy. Many anecdotes are circulating about the activities of the *biras*. When it is confirmed to be a direct or an indirect act of the biras, 3 to5 priests perform a puja outside the village where a goat or in some places a white fowl is sacrificed.

Tikkar or Daini : *Tikar* or *Daini* is a female evil spirit of supposedly human origin. According to the Rabhas, a woman can convert herself into a *Daini* or witch if she so wishes. Many description of a *Daini* is in vogue among the Rabha peasants. Accordingly it was observed that high fever accompanied by severe pain in the stomach making the patient senseless are considered as confirmed symptoms of a *Daini* attack.

Mode of treatment : the medicine man immediately cover the patient with a fishing or other net and ties securely the little fingers and little toes and joins them together with an un boiled cotton thread continually uttering some magical charm. In this way he ensures that the *daini* cannot escape from the body of the patient. Leaves of *nak dangra* tree and pig's ordure are unbearable to the *daini* . Therefore, as soon as the leaves are placed on the patient's body and a small amount of pig's

ordure is put in front of the patient to smell, the patient becomes restless. At that time as soon as the ojha asks the *daini* her name and address, the *tikkar* or the *daini* speaking through the patient confess its real identity and the cause of enmity with the patient. However, the process is not that simple and it is quite time consuming. The *tikkar* at first does not reveal her real identity fiends innocence and blames others. The ojha has to take recourse to some drastic steps like piercing the body of the patient with some sharp object like hog's teeth. It is only after much cajoling and efforts the *ojha* compels the *daini* to leave the body of the patient. Before leaving the patient, the evil spirit swears on a coin that she will leave some visible proof of her exit by making any noise or breaking a tree in the compound. It is reported that the patient slowly recovers after the *daini* departs.

Sometimes, an *ojha* has to perform another more powerful ritual and use stronger incantination. For this purpose a big goat or a pig has to be sacrificed and curry is prepared out of one fourth of its flesh using other vegetables and rice. All the offerings are offered on a bamboo platform and an earthen heap is made in front of the platform where the vein and stomach of the sacrificed animal is placed. . Rice beer is also offered. It is believed that the *daini* will devour the offering in the guise of a jackal or a dog. Remaining meat is shared by the priest s and the family members with rice beer.

Jhakua or jarang or bakrabay is worshipped when a person suffers from incessant fever, headache and body pain including joint pain at the knee. Worship of this deity starts at the house of the patient where all the villagers gather in the afternoon. Eight fowls, a goat, a pig, a fish or a

tortoise are offered as sacrifice. An earthen alter is made, beside which an image of a horse made with plantain tree is kept. On the altar, pictures of different things are made with rice powder. The chief priest plays a lyre made out of a gourd shell and his attendant plays the cymbal singing aloud the spells or hymn in a musical way. No one can sleep on that night. The songs are mostly in rabhamese. The meaning of the hymn is given below : " Oh pain: descend from head to throat, from thought to breast, from barest to belly, from belly to waist, from waist to knee, from knee to the sole of the foot and so on (Rabha : ibid 210).

Next, the alter is broken and the image of the horse is thrown away to a distant place away from the residence of the patient. The entire courtyard and the house is cleaned by smearing cowdung and all takes a ceremonial bath. Finally, the family of the patient offers a feast to all those who are present. The priests are honoured with cloths and betelnuts and leaves.

CHAPTER – IV

SOCIO-ECONOMIC BACKGROUND OF THE RESPONDENTS

4.1: Depending on the information collected from the revenue offices of the various districts, villages for this study were chosen. This has been elaborately described in the Chapter-I under the title Methodology. The villages were initially visited for testing the questionnaires. A total of seven districts were taken up which are predominantly inhabited by the selected tribal communities. These districts are Kamrup, Karbi Anglong, Dima Hasao, Goalpara, Dhemaji, and Morigaon. The details of the samples corresponding to the tribes and districts are shown in the following Table –4.1

A total of four villages were taken up for study in respect of each tribe. However, for Bodo and Mishing tribes, six and five villages respectively were taken up for this study in order to cover a broader area. Thus, altogether 27 villages were covered under this study.

During the fieldwork, a total of 954 individuals were interviewed covering wide areas concerning health, common health problems, traditional remedial measures, methods and attitude towards western methods of treatment of diseases and ailments. This consists of four categories of respondents. First category was taken up from the cross section of the population of the target areas; they provided vital data

relating to their health care practices, type of ailments commonly faced by the villagers, treatments preferred by the villagers etc.

Table-4.1: Details of the Samples

Tribe	District	Nos of villages covered	Nos of cross section of population covered (Sample-I)	Nos of Persons covered who suffered from illness/ sickness /ailments during the last two years at least once(None belong to Col-4) (Sample-II)	Nos of traditional Healers covered (None belong to Col-4) (Sample-III)	Nos of MBBS + AYUS doctors covered (None belong to Col-4) (Sample-IV)	Total
1	2	3	4	5	6	7	8
Karbi	Karbi Anglong	4	72 (15.48)	68 (16.62)	11 (25.00)	7 (19.44)	158
Dimasa	Dima Hasao	4	84 (18.06)	77 (18.83)	3 (06.82)	2 (05.56)	166
Rabha	Kamrup & Goalpara	4	62 (13.33)	54 (13.20)	6 (13.64)	7 (19.44)	129
Bodo	Kamrup & Bongaigaon	6	82 (17.64)	79 (19.32)	8 (18.18)	11 (30.55)	180
Mishing	Dhemaji	5	87 (18.71)	71 (17.36)	9 (20.45)	6 (16.67)	173
Tiwa	Morigaon	4	78 (16.78)	60 (14.67)	7 (15.91)	3 (08.33)	148
	Total	**27**	**465 (100.00)**	**409 (100.00)**	**44 (100.00)**	**36 (100.00)**	**954**

Note: Figures within the parentheses indicates percentages to the column total.

. The second category is the current patients – they are the persons who have visited health care practitioners – whether, doctors *Kabirajs* (tradition healers, etc) at least once during the last two years (only the latest visit has been recorded). The third category consists of traditional healers of the respective communities. It was also found that two healers are serving one village. From them, collected the accounts relating to healing methods pertaining to various diseases and their views on the prevailing

health care practices by the villagers. The last category constitutes the MBBS and /or AYUS doctors working in the localities wither in government or private hospitals. They provided insight into the attitudes of the villagers towards western system of medicines and their views relating to the practices of the local people and frequency of the visits to the health care units and the frequency of occurrences of various types of diseases.

4.2: Socio-Demographic Analysis:

This Chapter is devoted to the analysis of the respondents in their demographic and socio-economic aspects of the of the respondents of the two major samples namely i) Sample-I consisting of the respondents taken from the cross section of the population from target areas and ii) Sample-II consisting of the respondents who fell ill at least once during the last two years. For simplicity the samples are indicated as Sample I and Sample II respectively. For demographic analysis, age-sex distribution, type of families in which they live in, their marital status, and their educational level have been considered. These demographic factors have great bearing in deciding which system of medicines one should adopt during illness. Similarly, in the socio-economic front, the occupation of the respondents, their incomes are considered for analysis.

4.2.1: Age-sex distribution of the respondents:

In the following table-4,2.1, age-sex distribution of the Sample-I is shown. This sample I consist of the respondents taken from the cross section of the population of the selected villages. Table reveals that majority of the population (283/465= 60.86%) is within the age group of

45-75. 45 is the age at which people start confronting health hazards – that is why the age of 45 is said to be linked to a decline in health, with people reporting that they suffer from joint pain, having high blood pressure, and experiencing shortness of breath. This is the age at which people becoming concern about ailments including heart disease, dementia and stroke.

Almost all these people interviewed during the survey, can be said to be healthy –as they have not reported of having any serious ailments or diseases during the last two years despite the fact that there are considerable numbers of persons in the age group 65-75 and 75+ (25.59%).

Lets us now have a look at the persons who suffered for ailments or diseases during the preceding two years of survey.

The above table reveals that majority of the respondents (24.69%) belongs to the age group 55-65 while highest nos of respondents are between age band 45-75 (66.77%). This is indicative of the fact that more and more people face health hazards with the increase in ages beyond 45.

Table-4.2.1 Age sex distribution of the respondents of Sample I

Age group	Karbi		Dimasa		Rabha		Bodo		Mishing		Tiwa 41		Total279	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
15-25	3 (07.14)	4 (13.33)	4 (08.69)	5 (13.16)	4 (13.33)	5 (15.62)	4 (08.51)	5 (14.29)	2 (04.35)	6 (14.63)	3 (06.67)	4 (12.12)	20 (07.81)	29 (13.88)
25-35	4 (09.52)	5 (16.67)	5 (10.87)	4 (10.53)	4 (13.33)	4 (12.5)	4 (08.51)	3 (08.57)	2 (04.35)	4 (09.76)	5 (11.11)	3 (09.90)	24 (09.38)	23 (11.00)
35-45	5 (11.90)	4 (13.33)	8 (17.39)	8 (21.05)	3 (10.00)	3 (09.38)	4 (08.51)	5 (14.29)	6 (13.04)	6 (14.63)	7 (15.56)	2 (06.06)	33 (12.89)	28 (13.40)
45-55	8 (19.05)	5 (16.67)	8 (17.39)	5 (13.16)	5 (16.67)	6 (18.75)	10 (21.28)	7 (20.00)	1 (02.17)	9 (21.95)	7 (15.56)	7 (21.21)	49 (19.14)	39 (18.66)
55-65	12 (28.57)	6 (20.00)	9 (19.57)	9 (23.68)	3 (10.00)	4 (12.5)	11 (23.40)	8 (22.86)	9 (19.57)	11 (26.83)	10 (22.22)	9 (27.27)	54 (21.09)	47 (22.49)
65-75	7 (16.67)	4 (13.33)	8 (17.39)	6 (15.79)	9 (30.00)	8 (25.00)	10 (21.28)	5 (14.29)	13 (28.26)	5 (12.19)*	12 (26.67)	7 (21.21)	59 (23.06)	35 (16.75)
75+	3 (07.14)	2 (06.67)	4 (08.69)	1 (02.63)	2 (06.67)	2 06.25)	4 (08.51)	2 (05.71)	3 (06.52)	0 (00.00)	1 (02.22)	1 (03.03)	17 (06.64)	8 (03.83)
Total	42(100)	30(100)	46(100)	38(100)	30(100)	32(100)	47(100)	35(100)	46(100)	41(100)	45(100)	33(100)	256(100)	209(100)

Note:- Figures within the parentheses indicate percentage to the respective column total.

Table-4.2.2: Age sex distribution of the respondents of the Sample-II

Age group	Karbi		Dimasa		Rabha		Bodo		Mishing		Tiwa		Total
	M	F	M	F	M	F	M	F	M	F	M	F	
15-25	3(07.32)	3(11.11)	3(06.82)	4(12.12)	2(07.14)	3(11.54)	3(06.81)	4(11.43)	2(05.28)	4(12.5)	3(08.11)	2(08.70)	36 (08.80)
25-35	3(07.32)	4(14.81)	3(06.82)	3(09.09)	3(10.71)	3(11.54)	3(06.81)	2(05.71)	2(05.28)	2(06.25)	3(08.11)	2(08.70)	33 (08.07)
35-45	4(09.76)	5(18.52)	5(11.36)	4(12.12)	3(10.71)	2(07.92)	6(13.64)	3(08.57)	4(10.26)	3(09.38)	4(10.81)	1(04.35)	44 (10.76)
45-55	9(21.95)	4(14.81)	9(20.45)	6(18.18)	4(14.29)	6(23.08)	9(20.45)	8(22.86)	8(20.51)	8(25.00)	6(16.22)	6(26.09)	83 (20.29)
55-65	11(26.83)	5(18.52)	10(22.73)	9(27.27)	6(21.43)	5(19.23)	11(25.00)	9(25.71)	10(25.64)	10(31.25)	9(24.32)	6(26.09)	101 (24.69)
65-75	8(19.51)	4(14.81)	9(20.45)	7(21.21)	8(28.57)	6(23.08)	9(20.45)	7(20.00)	11(28.21)	5(15.63)	10(27.03)	5(21.74)	89 (21.79)
75+	3(07.32)	2(07.41)	5(11.36)	0(00.00)	2(07.14)	1(03.85)	3(06.81)	2(05.71)	2(05.28)	0(00.00)	2(05.41)	1(04.35)	23 (05.62)
Total	41(100)	27(100)	44(100)	33(100)	28(100)	26(100)	44(100)	35(100)	39(100)	32(100)	37(100)	23(100)	409(100)

Note:- Figures within the parentheses indicate percentage to the respective column total.

4.3: Type of families of the Respondents

Information relating to type of families of the respondents is presented in the following Tables 4.3.1 and 4.3.2. The Table 4.3.1 shows that although majority of the respondents taken from the cross section of the population belongs to joint families, yet the difference between prevalence of joint and nuclear families among the respondents is not very prominent- rather negligible (53.12 and 46.88 per cent)

4.3.1: Type of families of the Respondents in Sample-I

Tribe	Joint/ Extended Family		Nuclear Family		Total	
	Nos	PC	Nos	PC	Nos	PC
Karbi	40	55.56	32	44.44	72	100.00
Dimasa	45	53.57	39	46.43	84	100.00
Rabha	34	54.84	28	45.16	62	100.00
Bodo	42	51.22	40	48.78	82	100.00
Mishing	45	51.42	42	48.28	87	100.00
Tiwa	**41**	**52.56**	**37**	**47.44**	78	100.00
Total	247	53.12	218	46.88	**465**	100.00

Similar trend is visible in case of Sample II also where joint families constitute 51.59 percent of the sample as against nuclear families which is prevailing among 48.40 percent of the sample.

4.3.2: Type of families of the Respondents in Sample-II

Tribe	Joint/ Extended Family		Nuclear Family		Total	
	Nos	PC	Nos	PC	Nos	PC
Karbi	37	54.41	31	45.59	68	100.00
Dimasa	40	51.95	37	48.05	77	100.00
Rabha	26	48.15	28	51.85	54	100.00
Bodo	41	51.90	38	48.10	79	100.00
Mishing	35	49.30	36	50.70	71	100.00
Tiwa	**32**	**53.33**	**28**	**46.67**	60	100.00
Total	211	51.59	198	48.40	**409**	100.00

It may also be observed from the above table that among the Rabhas and the Mishings percentage of nuclear families is more than the joint families. This may also be due to sampling fluctuation. On the other hand, there is a considerable

difference between existence of extended/ joint families (54.41%) and nuclear families (45.59%) among the Karbis.

4.4: Marital Status of the Respondents:

Marital status of the respondents is significant because of the fact that this criterion also influences the decision making on health care in the family. When a patient has a family behind him/ her to support, he/ she normally gains confidence which also helps in his recovery. While single member family or unmarried person fell ill there may not be anybody to look after him.

Table 4.4.1 presents the details of the marital status of Sample-I. These respondents are mainly married slightly more than 51 percent in case of male and female respondents followed by unmarried respondents. Numbers of separated respondents are negligible while far more negligible is the divorcee respondents. Only in case of Bodos, two divorcee males were recorded.

Similarly, the details of marital status of the sample-II are shown in Table-4.4.2. The table shows that in their case percentage of married respondents is more while percentage of separated respondents is lesser than that of the Sample I. In this case however no divorcee was recorded.

Table: 4.4.1: Marital Status of the Respondents in the Sample-I

Age group	Karbi		Dimasa		Rabha		Bodo		Mishing		Tiwa		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Currently married	22 (52.38)	18 (60.00)	26 (56.52)	16 (42.11)	13 (43.33)	12 (37.50)	23 (48.94)	14 (40.00)	27 (58.70)	31 (75.61)	22 (48.89)	16 (48.48)	133 (51.95)	107 (51.20)
unmarried	09 (21.43)	07 (23.33)	11 (23.91)	10 (26.32)	11 (36.67)	08 (25.00)	09 (19.15)	06 (17.14)	08 (17.39)	10 (24.39)	11 (24.44)	07 (21.21)	59 (23.05)	48 (22.97)
Widow/widower	11 (26.19)	5 (16.67)	09 (19.57)	12 (31.58)	06 (20.00)	09 (28.12)	09 (19.15)	11 (31.43)	07 (15.22)	-	08 (17.78)	06 (18.18)	50 (19.53)	43 (20.57)
separated	-	-	-	-	-	03 (09.38)	04 (08.51)	04 (11.43)	04 (08.70)	-	04 (08.89)	04 (12.12)	12 (04.69)	11 (05.26)
divorcee	-	-	-	-	-	-	02 (04.25)	-	-	-	-	-	02 (00.78)	-
Total	42 (100)	30 (100)	46 (100)	38 (100)	30 (100)	32 (100)	47 (100)	35 (100)	46 (100)	41 (100)	45 (100)	33 (100)	256 (100)	209 (100)

Note:- Figures within the parentheses indicate percentage to the respective column total.

Table: 4.4.2: Marital Status of the Respondents in the Sample - II

Age group	Karbi		Dimasa		Rabha		Bodo		Mishing		Tiwa		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Currently married	25 (60.98)	19 (70.37)	24 (54.55)	12 (36.36)	14 (50.00)	16 (61.54)	25 (56.82)	18 (51.43)	23 (58.97)	19 59.38)	18 (48.65)	13 (56.52)	129 (55.36)	97 (55.11)
unmarried	05 (12.20)	05 (18.52)	09 20.45)	08 (24.24)	09 (32.14)	04 (15.38)	11 (25.00)	04 (11.43)	05 (12.82)	08 (25.00)	09 (24.32)	07 (30.43)	48 (20.60)	36 (20.45)
Widow/widower	07 (17.07)	02 (07.41)	11 (25.00)	07 21.21)	04 14.29)	06 (23.08)	05 (11.36)	08 (22.86)	08 (20.51)	05 (15.62)	06 (16.22)	03 (13.04)	41 (17.60)	31 (17.61)
separated	04 (09.76)	01 (03.70)	-	06 (18.18)	01 03.57)	-	03 (06.82)	05 (14.29)	03 (07.69)	-	04 (10.81)	-	15 (06.43)	12 (06.82)
divorcee	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	41 (100)	27 (100)	44 (100)	33 (100)	28 (100)	26 (100)	44 (100)	35 (100)	39 (100)	32 (100)	37 (100)	23 (100)	233 (100)	176 (100)

Note:- Figures within the parentheses indicate percentage to the respective column total.

4.5: Primary Occupation of the Respondents:

Primary occupation of a person indicates his/ her economic independency and social status in the society. It also indicates the nature of occupation and the health hazard faced by the person. Apart from the income derived from the occupation, primary occupation also determinants of a person's eligibility to afford health care facilities. In order to see the influences of primary occupation on a respondent's decision of choosing health care facilities, data relating to respondents primary occupation was collected.

Table – 4.5.1: Primary Occupation of the Respondents taken from cross section

Occupation	No. of Males	% of males	No. of female	% of female	Total	Total%
Nil (dependent)	51	19.92	27	12.92	78	16.77
Housewife	0	00.00	109	52.15	109	23.44
Agriculture	117	45.70	17	08.13	134	28.82
Service	12	04.69	02	0.96	14	03.01
Weaving	0	00.00	19	09.90	19	04.09
Wage Labour	33	12.89	0	00.00	33	07.10
HAR making	0	00.00	23	11.00	23	04.95
Contractor	14	05.47	1	0.48	15	03.23
Other business	29	11.33	11	05.26	40	08.60
TOTAL	**256**	**100.00**	**209**	**100.00**	**465**	**100.00**

Note:- Figures within the parentheses indicate percentage to the respective column total.

The table above shows that majority of the respondents are engaged in agriculture (28.82%). However, taken together (40.22%), the numbers of dependents and housewives surpass the agricultural category.

The Table-4.5.2 presents occupational pattern of the respondents who fell ill. In this case also, occupational pattern is more or less similar to the former category discussed above. The Table indicates that majority is

engaged in agriculture (33.98%) followed by other business (11.00%) and wage labourers (10.02%).

Table – 4.5.2: Primary Occupation of the Respondents who fell ill

Occupation	No. of Males	% of males	No. of female	% of female	Total	Total%
Nil (dependent)	42	18.03	21	11.93	63	**15.40**
Housewife	0	00.00	76	43.18	76	**18.58**
Agriculture	103	44.21	18	10.23	139	33.99
Service	10	04.29	02	11.36	12	02.93
Weaving	0	00.00	27	15.34	27	06.60
Wage Labour	41	17.60	0	00.00	41	10.02
HAR making	0	00.00	13	07.39	13	03.18
Contractor	11	04.72	0	00.00	11	02.69
Other business	26	11.16	19	10.80	45	11.00
TOTAL	**233**	**100.00**	**176**	**100.00**	**409**	**100.00**

Note:- Figures within the parentheses indicate percentage to the respective column total.

4.6: Income status of the respondents:

Income directly affects the decision of a respondent in the matter of choosing a particular health care provision. It also shapes the attitude of the respondents about prevailing and effectiveness of health care practices in the locality. That is why the income range of the respondents was studied during the survey. The following table gives the details of the income of the cross section respondents.

Table-4.6.1: Monthly Income Status of the Respondents of Sample-I

Sl No	Income Status (Monthly income)	Nos of respondents		Total	Percent
		Male	Female		
1	Nil (dependent)	51 (19.92)	27 (12.92)	078	16.77
2	Housewife	-	109 (52.15)	109	23.44
3	5000-8000	69 (26.95)	34 (16.27)	103	22.15
4	8000-11000	48 (18.75)	22 (10.53)	070	15.05
5	11000-14000	42 (16.40)	11 (05.26)	053	11.40
6	14000-17000	30 (11.72)	05 (02.39)	035	07.53
7	17000-20000	16 (06.25)	01 (0048)	017	03.66
	Total	256 (100)	209 (100)	465	100.00

It appears from the table that majority (62.37%) of the respondents either dependents, or housewives or in the range of Rs 5000-8000 monthly income earners. None of the respondents earn a monthly income more than Rs 20000. Number of respondents in the highest income earning bracket is only 17 constituting only 3.66 per cent of the total respondents.

Similarly, income status of the respondents of the Sample-II was also recorded and presented in the following Table – 4.6.2. The trend in this case is also similar to that of trend of the Sample-I respondents. In this case however, the family incomes of the dependents and housewives have been collected and shown in the table. This is done with a view to give an idea about the about the economic status of the families of these unemployed.

Table- 4.6.2: Income status of the respondents of Sample-II

Sl No	Income Status	Nos of respondents		Total	Family income
		Male	Female		
1	Nil (dependent)	42	21	63	05000-08000=24 08000-11000=29 11000-14000=04 14000-17000=06
2	Housewife	0	76	76	05000-08000=14 08000-11000=28 11000-14000=19 14000-17000=12 17000-20000=03
3	5000-8000	58	29	87	
4	8000-11000	61	32	93	
5	11000-14000	36	09	45	
6	14000-17000	27	07	34	
7	17000-20000	09	02	11	
	Total	233	176	409	

The above Table-4 indicates that majority i.e.22.74 percent of the informants earn income between Rs 8000 – Rs 11,000. This is followed by those 21.27 percent informants who earn incomes between Rs 5000- 8000.

4.7: Educational background:

Besides income, the level of education plays an important role in deciding the type of health care facilities to be availed by the respondents. Accordingly data relating to the level of education of the respondents was collected. The following table presents the educational level of the respondents from cross section of the population.

Table-4.7.1: Educational levels of the respondents taken from cross section of the population

Sl No	Educational status	Nos of respondents		Total	PC
		Male	Female		
1	Illiterate	48(18.75)	27(12.92)	75(16.13)	16.13
2	LP level	74(28.91)	63(30.14)	137(29.46)	29.46
3	ME level	47(18.36)	21(10.05)	68(14.62)	14.62
4	High School (Class-VIII-X)	32(12.5)	32(15.31)	64(13.76)	13.76
5	HS Level	23(08.98)	30(14.35)	53(11.40)	11.40
6	HS Pass	19(07.42)	12(05.74)	31(06.67)	06.67
7	Graduate level	06(02.34)	9(04.31)	15(03.22)	03.23
8	Graduate	0(00.00)	3(01.44)	3(0.65)	00.65
9	P.G Level	0(00.00)	1(0.48)	1(0.22)	00.22
10	Professional	7(02.73)	11(05.26)	18(03.87)	03.87
	Total	256	209	465	100.00

Among these respondents, education up to Lower Primary level appears to be most common level. This constitutes 29.46 percent of the total respondents which is followed by ME level. From LP level there has been gradual fall in the number of respondents up to PG level. IT may be

observed from the table that more women have done higher education than men.

Table-4.7.2: Educational levels of the respondents taken from cross section of the population

Sl No	Educational status	Nos of respondents		Total	PC
		Male	Female		
1	Illiterate	39(16.74)	23(13.07)	62(15.16)	15.16
2	LP level	67(28.76)	56(31.82)	123(30.07)	30.07
3	ME level	52(22.32)	17(09.66)	69(16.87)	16.87
4	High School (Class-VIII-X)	31(13.30)	19(10.80)	50(12.22)	12.22
5	HS Level	21(09.01)	23(13.07)	44(10.76)	10.75
6	HS Pass	11(04.72)	12(06.82)	23(05.62)	05.62
7	Graduate level	04(01.72)	11(06.25)	15(03.67)	03.67
8	Graduate	2(0.86)	7(03.98)	9(02.20)	02.20
9	P.G Level	0(00.00)	3(01.70)	3(0.73)	00.73
10	Professional	6(02.58)	05(02.84)	11(02.69)	02.69
	Total	233	176	409	

Educational level of the respondents having ailments shows almost the similar trend like that of the previous category of respondents. A negligible percentage (06.60%) of respondents are found to be in the graduate and above level (professionals are not taken into account).

4.8: Morbidity Conditions:

The respondents in the Sample-I have not suffered any ailments or diseases etc since last two years. They were asked in case of any such eventualities which health care system they would choose. The results of the responses are presented in the Table-4.8 below.

Table-4.8.: Views of the Respondents in Sample-I on Selection of Health Care facilities.

Tribes	Traditional healers/ *Kabiraj*		Govt Hospitals/ Nursing Homes		Homeo/ Ayurvedic		Others		Total
	Nos	PC	Nos	PC	Nos	PC	Nos	PC	
Karbi	05	06.94	52	72.22	13	18.05	2	02.78	72
Dimasa	13	15.48	59	70.24	8	09.52	4	04.76	84
Rabha	34	54.83	24	38.71	4	06.45	-	-	62
Bodo	12	14.63	65	79.27	5	06.10	-		82
Mishing	09	10.34	71	81.61	2	02.30	5	05.75	87
Tiwa	16	20.51	57	73.08	1	01.28	4	05.13	78
Total	89	19.14	328	70.53	33	07.10	15	03.23	465

The above table presents a positive picture in respect of western medicinal system. Except for the Rabhs, the majority of all other tribes have expressed their first preference selection in favour of allopathic medicinal system. Thus, we have 70.53 per cent respondents have expressed their first preference to go for allopathic doctors. Only 19.14 percent would prefer to go to the traditional healers at the first place. It is indeed significant that even today at least one fifth of the respondents still have faith in the traditional healing system.

4.8.1: Reasons behind First Preferences:

The next question in the row was to state the reasons for giving first preference to any of the systems. The results of the processed data are shown in the table below:

Table-4.8.1: Reasons behind giving First Preference

Reasons	Traditional Healers	Allopathic Medicines	Homeo /Ayurvedic	Others
Quick & easy Steps	-	127 (38.72)	16 (48.48)	-
Quick healing	-	89 (27.13)	04 (12.12)	-
Cheap	27 (30.33)	51 (15.55)	-	-
Easy to reach	-	35 (10.67)	09 (27.27)	-
Doctors are educated persons	-	26 (07.93)	-	-
God Gifted	38 (42.70)	-	-	-
No side effect	14 (15.73)	-	04 (12.12)	-
God will be annoyed	05 (05.62)	-	-	-
No response	05 (05.62)			15(100)
Total	**89 (100)**	**328 (100)**	**33 (100)**	15 (100)

The above table shows that reasons of preferences are very simple. They act in the very simple way they think. 42.70% of the respondents who would prefer to go to the traditional healers believe that the craft acquired by the traditional healers is god gifted and thus cure is certain. Again 05.62 percent of them think that in times of health crises, if they do not go to traditional healers , God will be annoyed and that is why they prefer to visit village Doctors first.

But side by side these peoples, there are also the others whose first preference is treatment through allopathic doctors – if there is a PHC or civil hospital nearby or through doctor who sits in Pharmacies of the localities.. They know the differences between undergoing treatment in a government hospital and a private nursing home. They also know the difference between going to the traditional healers and Doctors. Many of them believe that there is no bar going to traditional healers even after taking medicines from doctors.

From the table it is clear that majority of the respondents prefer going to Doctors because they get immediate action which is easy also- just purchase the tablet and gulp it (38.72%) and quick relief(27.13%) .As many as 15.55 percent of this group say that medicines prescribed by the doctors are cheap and easily available in the market while medicines prescribed by the traditional healers are not easily available. Moreover, in most cases before prescribing a medicine, the village medicine man conducts a *puja* to satisfy the ruling deities - which involves a considerable cost.

Morbidity has been defined as "any departure, subjective or objective, from a state of physiological well being. The term is used equivalent to such terms as sickness, illness disability WHO Expert committee on Health Statistics noted on its 6th Report that morbidity could be measured in terms of 3 units. (i) Person who were ill, (ii) the illnesses (provides of spells of illness) that these persons experienced and (iii) the duration (days, weeks etc) of these illnesses. The aged population has special health problems that are basically different from those of adult or young. Most diseases in aged are chronic in nature – cardiovascular, arthritis stroke, cataract, deafness, cancer, chronic infections etc. Disease process is usually multiple 37. Morbidity pattern among the elderly varied from country to country. Chronic conditions which produced infirmity and disability became more common in old age.

In order to assess morbidity condition of the tribes under study, all the respondents were asked about their family health conditions. Number of members fell ill during the last year, type of ailment or diseases suffered and approximate number of days they suffered and impact of illness. In the

process data in respect of 5681 persons are available. The data processed in terms of no of times a particular person fell ill in a particular disease (frequency). Thus, accordingly we could have an idea about the prevalence of diseases/ ailments in the study area. This data than matched with the available hospital records.

Table- 4.8.2: Pattern of Morbidity: Primary Reporting Vs Hospital Records

category	Type of illness / disease	Frequency of occurrence of illness	Average Nos of days suffered	Hospital's record 1st June 2012- 1st June 2013
Man	Fever	2346	4	725
	Diarrhea	1897	4	37
2142	Asthma	89	2	18
	TB	21	6months	21
	arthritis	45	18 months	89
	Skin infection	789	7 months	870
	ARI	47	5 months	26
	Gastritis	1782	3 months	1268
Women	Leucorrhea	878		211
1668	Anaemia	1287	Chronic	349
	Backache	567	-do-	56
	Menstrual problem	768	-do-	23
	UTI	756	-do-	188
Children	ARI	21		
1871	Skin infection	463	13	523
	Malnutrition	668	chronic	
	Worm infestation	792	one month	234
	Diarrhea	1297	2 days	1034
	allergy	543	3 days	32

The above table signifies how grave the health situation in the rural areas is. Primary reporting in respect of fever outnumbers total male strength. This proves frequent occurrence of fever and in some cases twice or more than twice within a year. The table makes it amply clear that

common fever, Diarrhea. Skin infection, anaemia backache menstrual problem, urinary tract infection malnutrition worm infestation and allergy are the most frequently occurring diseases among the tribal population. Majority of these diseases occur due to unhygienic surrounding, non availability of pure potable water and lack of nutritious food.

Another significant fact worth noting here is that there is a large gap between the data concerning primary reporting and secondary reporting. Out of the 2346 fever cases only 725 were reported in the concerned hospitals. This implies that huge numbers of fever cases were never reported. They either take recourse to various other systems of medicines or do not go for any treatment. These discrepancies can be visualized in most cases. However, in case of skin disease of male and children, hospital records show more cases (870 as against reported 789 for males and 523 as against reported 463 for children) than the actual reporting. Similar is the cases with arthritis of men.

4.9: Socio-Economic Factors Affecting Health Condition of the Tribes

Empirical Researches has shown that within the same group of people there prevail the inequalities in health status. Basic indicators like inequalities in income, housing and employment status contribute to inequalities in health. It is our common experience that those who are from lower social classes, who are least educated, who have least money and least material resources are the most likely to experience poor health.

4.9.1: Income & Poverty as a Factor

The discussion made above has amply shown that majority of the respondents under study live in absolute poverty. Their highest income level is only Rs 20,000 per month with which they have to support a big family. Moreover, there are only a few handful families who earn this scale of income others earn less than this income. Thus, per capita income of the respondents under consideration will be much less then what is state's per capita income i.e. Rs 44000 . With this extreme poverty, people bound to suffer a condition of poor health as can be visible from the table- . Poverty affects the elderly and infants, disabled and unemployed people alike. Unfortunately number of these people is more in the society. Because of the poverty they cannot make their choices - choice of where to live, what to eat and what to do. People can only choose what they can afford, not what they want or feel is best. They have to be content with what they could afford and as a result they suffer in poor nutrition- which results in deteriorating general health condition – inviting innumerable infectious diseases to shelter in the body and finally due to lack of money, they surrender to their fate - die their death without any treatment. This is the vicious cycle of poverty and health.

4.9.2:Education as a factor

Another basic socio-economic condition that affects the health condition is the level of education. Better educated people have lower morbidity rates from the most common acute and chronic diseases. Education equips a person with the knowledge about its own body and the

method how to maintain the body, measures to be taken for good health and during illness. Education for the people living at subsistence level therefore very essential because they have limited resources to make choices for good health conditions. But unfortunately people in such society have lesser chances to pursue their education due to resource constrains. As a result poor health status continues to overpower such society.

In the present study we have seen above the level of education of the respondents. The situation is more or less similar all over Assam. Mere increase in literacy rate does not go well with the level of education. In the present case we have seen that educational level of the respondents of of both Sample –I and Sample –II is pathetically poor. In both the cases, 74 percent of the respondents have educational level less than class X. So long as their traditional knowledge supports their living condition they live healthily but once they fell ill, they become vulnerable. This contributes greatly in expanding health hazards to further areas.

Findings regarding high influence of higher education levels of women on the use of maternal health services are consistent with other studies in India and other countries; the better educated women are, more aware about their health, know more about availability of maternal health care services and use this awareness and information in accessing the health care services. Education of husband might be playing a similar role in supporting the women's access to the health services. In the rural areas of the state, maternal health services are delivered through government run CHCs, PHCs and Sub Health Centres. In urban areas, these services are rendered by

medical colleges, district and civil hospitals and urban health posts. Maternal health services from private hospitals, nursing homes, health centers and private practitioners are also availed in rural and urban areas. Access to and availability of health care services is expected to be greater in the urban areas.

4.9.3: Unemployment as a factor:

When the extreme upper and lower strata of the population which usually remain dependent are larger than the size of the productive population group, economic life in such a society becomes burdensome. Unable to cope with the demands of the daily life, they resort to borrowing which in turn leads them to further poverty for not being able to repay the borrowed amounts. One regular income earner therefore is an essential requirement in a family.

Among the tribes we have seen more than 40 percent of the respondents in Sample-I are dependent while in case of Sample II it is 33 percent. While agriculture is the main occupation of the respondents (28.34% in case of Sample-I and 34% in case of Sample II), it doesn't a give a stable income always.. There is also considerable proportion of respondents who depends on daily wages. State sponsored agricultural insurance has not reached these localities. Thus they continue to rely on such vulnerable occupation having no social security measures. In times of illness therefore they do not have any resources to pay for good health care system.

4.9.4:Poor Housing as a factor

Housing condition in rural Assam is pathetic. This is the fall out of poverty. Average houses are built unhygienically with no adequate arrangement for air and light. Due to inadequate drainage system, water logging near the house is a common scene. These are the sources of various diseases. Mosquitoes and flies and other insects expend their families in such water logged areas and carry germs easily. Once any inmate in such houses fell sick, the house itself becomes the source of germs of such diseases and they continue to suffer in the same disease repeatedly. Due to lack of knowledge about keeping the house adequate for hygienic living and lack of resources, the poor health condition continues.

4.9.5: Environment as Factor:

There are numerous factors in the physical and social environment that can affect the health and well-being of people. Environmental pollution can seriously affect the health of adults and children equally. According to WHO "every minute, five children in developing countries die from malaria or diarrhea. Every hour, 100 children die as a result of exposure to indoor smoke from solid fuels. Every day, nearly 1,800 people in developing cities die as a result of exposure to urban air pollution. Every month, nearly 19,000 people in developing countries die from unintentional poisonings."[1]

[1] Source: Health and Environment: Tools for Effective Decision-Making: the WHO/UNEP Health and Environment Linkages Initiative Review of Initial Findings, 2004.

This is equally true in the context of the target group under this study. People in the remote rural localities due to lack of awareness and education fail to realize the gradual degradation of environment around them. This degradation occurs in many ways including mining, earth removing, establishment of heavy industrial units and Jhuming by themselves not to speak of air and water pollution. Even with strict government controls, pollution seems to be an increasing problem with a rise in car exhaust fumes, industrial waste, noise and litter. Some pollutants have been linked to delay in cognitive development, some are said to be carcinogenic and others are blamed for congenital deformities. Pollution can also act as a trigger for asthma and other respiratory disorders.

4.9.6: Location of Health Care Centre as a factor:

Location of the health centre is an important factor that may either promote or degrade the centre. Health centres located in an accessible area with better connectivity flourish. Doctors also visit such centers regularly as the journey to and from is not time consuming. Many sub-centers however are set up in remote areas due lack availability of land. Doctors rarely visit such sub-centres regularly. Care need to be taken to oversee this problem.

CHAPTER – V

EXISTING HEALTH CARE PRACTICES: THE FINDINGS

Use of traditional and modern medical system for treatment

5.1: In this Chapter a detailed discussion have been made focusing on the health care practices as availed by the tribes under study. The discussion will be based on both the primary data collected from field and the secondary data available from various monographs, accounts, reports on the tribes.

Table-5.1 shows the details of the persons who suffered from illness/ sickness /ailments since last two years at least once. This category has been divided into 5 separate categories depending on the last remedial measures taken by them. These include, patients who visited the health care centers- either government of private, patents who visited traditional healers, thirdly the patients who have not consulted any doctor but took medicine on the their own. The fourth category is the respondents who consulted ayurvedic and/or homeopathic doctors for treatment of their diseases/ ailments and finally the fifth category constitutes respondents who did not go for any treatment. It may be mentioned that only the last visit is recorded after which the patients either got relief from the ailments or finally decided not to pursue any treatment.

It may be observed from the table that majority of the patients finally opted the western health care system which consist of 68.22 percent. Some respondents of this group had earlier tried traditional or homeo but finally visited Doctors.

Table-5.1: Details of the Persons who suffered from illness/ sickness /ailments since last two years at least once

Tribe	Total	Persons who suffered from illness/ sickness /ailments since last two years at least once	Of the Col-3 Persons who visited Public health centre at the last	Of the Col-3 Persons who Visited traditional healers at the last	Of the Col-3 Persons who Took allopathic medicine on their own	Of the Col-3 Persons who consulted Ayurvedic / Homeopathic doctors at the last	Of the Col-3 Persons who did not take any treatment
1	2	3	4	5	6	7	8
Karbi		68 (100)	43 (63.24)	7 (10.29)	0	8 (11.76)	10 (14.71)
Dimasa		77 (100)	52 (67.53)	4 (05.19)	7 (09.09)	5 (06.49)	09 (11.69)
Rabha		54 (100)	23 (42.59)	11 (20.37)	12 (22.22)	7 (12.96)	01 (01.85)
Bodo		79 (100)	53 (67.08)	2 (02.53)	11 (13.92)	7 (08.86)	6 (07.59)
Mishing		71 (100)	67 (94.37)	0	0	0	4 (05.63)
Tiwa		60 (100)	41 (68.33)	4 (06.67)	5 (08.33)	0	10 (16.67)
Total		409 (100)	279 (68.22)	28 (06.84)	35 (08.56)	27 (06.60)	40 (09.78)

Note:- Figures within the parentheses indicate percentage to the corresponding figure of col-3

The table reveals that a group of respondents took allopathic medicines on their own or as suggested by their kins and got relief from the ailments (08.56%). Similarly, a considerable numbers of respondents

(09.78%) desist themselves from taking any treatment for their ailment/ diseases.

5.2: Type of Ailments of the Respondents who visited Primary Health Centres

Lets us now examine the type of ailments / diseases suffered by the respondents in Sample II before going to the Doctors. This is presented in the Table 5.2 .

Table- 5.2: Type of Ailments for which the respondents visited Primary Health care Centres/ sub-centers

Type of disorder	Ailments	Karbi	Dimasa	Rabha	Bodo	Mishing	Tiwa	Total
Respiratory disease	Difficulty in breathing	2	1	1	3	2	1	10 (03.58)
	Attacks of coughing	0	3	0	1	2	0	6 (02.15)
	Excessive sneezing due to allergies/ Asthma	0	0	0	3	3	3	9 (03.23)
	Cough with sputum	1	0	0	0	0	0	1 (00.36)
Cardio-Vascular disease	Palpitation on exertion	0	2	0	0	1	0	3 (01.08)
	Shortness of breath	0	0	1	2	0	2	5 (01.79)
	Chest pain	2	3	1	2	3	0	11 (03.94)
	Attack on fainting	0	2	1	1	0	0	4 (01.43)
	High blood pressure	0	4	0	1	5	2	12 (04.30)
	Loss of consciousness	1	0	0	0	2	0	3 (01.08)
Gastro-Intestinal disorder	Poor appetite	0	0	0	0	0	0	0
	Difficulty in chewing	0	0	0	0	0	0	00
	Difficulty in swallowing	0	0	0	0	2	0	2 (00.72)
	Heart burn	0	0	2	2	2	0	6 (02.15)
	Excessive belching	0	0	0	1	0	0	1 (00.36)
	Abdominal distension	0	0	0	0	0	0	0
	Gastritis	2	3	0	1	3	3	12

								(04.30)
	Change in bowl habits	0	0	0	0	0	0	0
	Diarrhea	14	09	8	10	13	11	65 (23.30)
	Constipation	0	2	1	3	2	0	8 (02.87)
	Bleeding piles	0	2	1	2	1	2	08 (02.87)
	Painful defecation	0	0	1	2	0	0	3 (01.08)
Nervous System disorder	Forgetfulness	0	0	0	0	0	0	0
	Disorientation in time, people & place	0	0	0	0	0	0	0
	Numbness in hands/feet	3	0	0	1	1	1	6 (02.15)
	Shaky hands while doing routine activities	0	2	0	1	1	0	4 (01.43)
	Disturbed sleep	0	0	0	0	0	0	0
Gynaecological disorder	When coughing feeling of something coming out from vagina	0	2	0	0	0	0	2 (00.72)
	Presence of Leucorrhoea	2	0	0	2	0	0	4 (01.43)
	DNC/DNE/Miscarriage	1	0	1	3	3	2	10 (03.58)
Uro-genital disorder	Difficulty in passing urine	0	1	0	0	1	1	3 (01.08)
	Passing blood in urine	0	0	0	1	2	1	4 (01.43)
	Cloth wetting	0	0	0	0	0	0	0
	Increased frequency of passing urine at night	0	0	0	0	0	0	0
	Excessive thirst, urination and desire to eat	0	0	0	0	0	0	0
Fever	Of all types	8	7	9	5	8	8	45 (16.12)
Musculo-skeletal diseases	Painful joints	3	3	0	0	3	3	12 (04.30)
	Difficulty in moving about independently	0	2	0	0	0	0	2 (00.72)
	Muscle twitching/ cramps	0	0	0	0	2	0	2 (00.72)
	Alteration in gait	0	0	0	0	0	0	0
	Skeletal deformities	0	0	0	0	0	0	0
	Fracture	2	3	1	3	2	2	13 (04.66)

	Locomotors Arms	0	1	0	0	0	0	1 (00.36)
	Locomotors Legs	0	0	0	1	1	0	2 (00.72)
	Total	41	52	28	51	65	42	279 (100)

. Note:- Figures within the parentheses indicate percentage to the respective column total.

It may be observed that among the respiratory diseases, difficulty in breathing (3.58%) is prominent followed by asthma (3.23%). Among the cardio vascular diseases, high blood pressure (4.30%) and chest pain (3.94%) are prominent. Similarly, among the Gastro-Intestinal disorder, gastritis (4.30%) and diarrhea (23.30) appears to be the most common disease. In fact diarrhea is the most occurred disease among this group of respondents. Miscarriage (3.58%), fever (16.12%) and fracture of bones (4.66%) are other common diseases.

5.3: Age structure of the Respondents who visited Health Centres

The age structure of the respondents who had attended health centres for their treatment of diseases, presented in the Table-5.3. The table shows that majority of the respondents belong to the ages between 35 and 75 consisting of 83.87% in case of males and 83.86% in case of females.

This age range is the productive age range and therefore social usefulness is accounted at highest during this period. Their life is valuable to the family as well as society. Therefore society is not ready to take any risk on their life. It is because of this reason that when the traditional medicines / Indian medicines stopped working, they were taken to the hospital to save their life.

Table-5. 3 : Age sex distribution of the persons who visited Primary Health Centres.

Age group	Karbi		Dimasa		Rabha		Bodo		Mishing		Tiwa		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
15-25	01 (03.13)	0	3 (08.11)	0	0	0	3 (01.11)	1 (06.25)	1 (02.44)	2 (07.69)	0	1 (05.88)	8 (04.30)	04 (04.17)
25-35	3 (09.38)	2 (18.18)	5 (13.51)	1 (06.67)	1 (06.67)	0 (00.00)	0 (00.00)	0 (00.00)	2 (04.88)	2 (07.69)	0 (00.00)	0 (00.00)	11 (06.55)	05 (05.37)
35-45	4 (12.50)	1 (9.09)	7 (18.92)	3 (20.00)	2 (13.33	3 (37.50)	3 (08.110	2 (12.50)	5 (12.20)	4 (15.38)	3 (12.50)	1 (05.88)	24 (12.90)	14 (15.05)
45-55	7 (21.88)	1 (9.09)	6 (16.23)	2 (13.33)	4 (26,67	0	8 (21.62)	5 (31.25)	10) (24.39)	5 (19.23)	4 (16.67)	3 (17.65)	39 (20.97)	16 (17.20)
55-65	10 (31.25)	4 (36.36)	9 (24.32)	5 (33.33)	2 (13.33	2 (25.00)	10 (27.03)	2 (12.50)	9 (21.95)	9 (34.62)	7 (29.17)	5 (29.41)	47 (25.27)	27 (29.03)
65-75	5 (15.63)	2 (18.18)	4 (10.81)	3 (20.00)	6 (40.00	2 (25.00)	9 (24.32)	4 (25.00)	12 (29.27)	4 (15.38)	10 (41.67)	6 (35.29)	46 (24.73)	21 (22.58)
75+	2 (06.25)	1 (09.09)	3 (08.11)	1 (06.67)	0	1 (12.50)	4 (10.81)	2 (12.50)	2 (04.88)	0 (00.00)	0 (00.00)	1 (05.88)	11 (05.41)	06 (06.45)
Total	32 (100)	11 (100)	37 (100)	15 (100)	15 (100)	8 (100)	37 (100)	16 (100)	41 (100)	26 (100)	24 (100)	17 (100)	186 (100)	93 (100)

Note:- Figures within the parentheses indicate percentage to the respective column total.

5.4: Reasons for going to Primary Health Centers:

The respondents were asked about the reasons for going to health centres. The cited reasons are shown in Table 5.4:

Table- 5.4: Reasons for going to Public Health Centers

Sl No	The main Reason cited	Nos of Respondent	PC
1	Condition was gradually deteriorating	73	26.16
2	Hospital was nearby	58	20.79
3	ANM & ASHA advised	44	15.77
4	Due to serious type of disease	36	12.90
5	Hospital Doctor came to see me at home	21	07.53
6	Cured earlier in the same hospital	15	05.38
7	Advice of the elders	14	05.02
8	Village healer (*kabiraj)* was not present in the village	09	03.23
9	Habituated to go to Doc when any illness occurs	09	03.23
	Total	279	100.00

The table above shows that majority of the patients had chosen the hospital because their health condition was deteriorating (26.16%). Many of these respondents earlier tried the traditional medicines but without any result. Some of them also tried medicines offered by traditional healers of a nearby village. But finally when nothing worked- as a last resort they were shifted to nearby hospitals and finally got cured. Such incidents bring hospital services in good impression of the villagers and start gaining trust on the medicine system.

Slightly more than one fifth of the respondents had opted for the hospital because it was nearby. This again is good indicator for spread or

growth of medical services in rural areas. When people fell ill and suffer, their ultimate objective was to get relief from the sufferings. When they find that a curing

5.5: Monthly Income Status of the Respondents who had visited Health Centres

An analysis of the income status of the respondents who had taken treatment in the Hospitals shows that majority of the respondents belong to middle income earners or belong to middle income earning families which is Rs 8000/ per month and above.

Table-5.5: Monthly income Status of the respondents who visited health care centres

Sl No	Income Status	Nos of respondents		Total	Family income
		Male	Female		
1	Nil (dependent)	21	8(08.60)	29 (10.39)	05000-08000=04 08000-11000=18 11000-14000=07
2	Housewife	0	51 (54.84)	51 (18.28)	05000-08000=11 08000-11000=27 11000-14000=06 14000-17000=04 17000-20000=03
3	5000-8000	37 (19.89)	080(8.60)	45 (16.13)	
4	8000-11000	53(28.49)	11(11.83)	64 (22.94)	
5	11000-14000	47 (25.27)	09 (09.68)	56 20.07)	
6	14000-17000	19 (10.22)	05 (05.38)	24 (08.60)	
7	17000-20000	09 (04.84)	01(01.08)	10 (03.58)	
	Total	186 (100.00)	93(100.00)	279 (100.00)	

Of the total of 279 respondents, as many as 209 belong to this medium income range giving a percentage of 74.91. Thus there is scope to believe that income level of these respondents has a bearing on the decision

to going for treatment at the health care centres. During the survey it is gathered that treatment even at the Public Health Centres and Civil Hospitals, is very costly.

5.6: Educational Level of the Respondents who had visited Health Centres

The educational level of the respondents is presented in the Table 5.6. The table shows that for majority (80.64%) of the respondents, educational level is only class X or less than that.

Table-5.6: Educational Status of the respondents who visited health centres/ health care centres

Sl No	Educational Status	Nos of respondents		Total	PC to Total
		Male	Female		
1	Illiterate	18 (09.68)	10 (10.75)	28	10.04
2	Up to primary level	37 (19.89)	32 (34.41)	69	24.73
3	ME Level (Cl-7)	43 (23.12)	18 (19.35)	61	21.86
4	High school level (Class-8-10)	54 (29.03)	13 (13.98)	67	24.01
5	HSLC passed	13 (06.99)	07 (07.53)	20	07.17
6	HSSLC level	14 (07.53)	11 (11.83)	25	08.96
7	BA level	07 (03.76)	-	7	02.51
	Professional	-	2 (02.15)	2	00.72
	Total	186 (100)	93 (100)	279	100.00

Thus, in this context educational level of the respondents cannot be said to be a factor in the decision making.

5.7: Monthly Income Status of the Respondents who had visited Traditional Healers:

In Table 5.7 the income status of the respondents who had visited the traditional healers have been shown.

Table : 5.7: Monthly incomes Status of the respondents who visited Traditional healers

Sl No	Income Status	Nos of respondents		Total	Family income
		Male	Female		
1	Nil (dependent)	03(30.00)	03(16.67)	06 (21.43)	05000-08000=03 08000-11000=02 11000-14000=01
2	Housewife	00	07(38.89)	07 (25.00)	05000-08000=00 08000-11000=03 11000-14000=04
3	5000-8000	04(40.00)	04(22.22)	08(28.57)	
4	8000-11000	03(30.00)	04 (22.22)	07(25.00)	
	Total	10(100)	18(100)	28(100)	

It may be observed that income status of the respondents is very poor. Majority of them is in the income range of 5000-8000. Only 25 percent earn an income between Rs 8000-11000. There is scope to infer that income level may have an impact on the decision to go to the traditional healers.

5.8: Type of ailments of the respondents who visited traditional healers:

An attempt was made to discover whether the type of ailment has anything to do with the decision of the respondents to go to the traditional healers. The findings are tabulated in Table 5.8

Table- 5.8 : Type of Ailments for which the respondents visited Traditional Healers

Type of disorder	Ailments	Karbi	Dimasa	Rabha	Bodo	Mishing	Tiwa	Total
Respiratory disease	Excessive sneezing due to allergies/ Asthma	1	0	1	0		0	2
Cardio-Vascular disease	Shortness of breath	0	0	1	0		0	1
	Attack on fainting	0	1	1	1		0	3
	Loss of consciousness	1	0	1	1		0	3
Gastro-Intestinal disorder	Diarrhea	0	0	0	0		1	1
	Constipation	0	1	0	0		0	1
	Bleeding piles	0	1	2	0		1	4
Nervous System disorder	Forgetfulness	0	0	0	0		0	0
	Disorientation in time, people & place	1	0	1	0		0	2
	Numbness in hands/feet	1	0	0	0		0	1
Gynaecological disorder	DNC/DNE/Miscarriage	1	0	2	0		0	3
Uro-genital disorder	Passing blood in urine	0	1	0	0		1	2
	Cloth wetting	1	0	0	0		0	1
Fever	Any type	1	0	2	0		1	4
	Total	07	04	11	02		04	28

Note:- Figures within the parentheses indicate percentage to the respective column total

. It may seen that fever and constipation are the major diseases occurred among this set of respondents followed by fainting and loss of consciousness. There is scope to believe that since the ailments are not of very serious nature, the respondents opted to go to the traditional healers.

CHAPTER - VI

Challenges to Health Programmes & Government Interventions

6.1: One of the objectives of this study is to examine the problems and challenges of the health programmes implemented by Government in the rural tribal areas and the Doctors and other government functionary's role in pursuing it. These two objectives will be discussed in this Chapter.

6.2: During the survey, a total of 36 doctors were interviewed and obtained their views on the existing system of health care and the problems and prospects as they visualize it. The details of the Doctors are shown in the table-1. It may be observed that majority of the doctors interviewed were doctors of PHCs and CHCs followed by doctors sitting in the private nursing homes nearby or having their chamber in the rural Pharmacy.

Table-6.2: Details of the Doctors interviewed

Sl No	Doctors in the stream of	No of Doctors	PC	Government or private
1	Allopathic Doctor	15	41.67	Government (medical Officer)
2	Allopathic Doctor	13	36.11	Private Nursing Home and Pharmacy, chambers in teagarden areas
3	Homeopathic Doctor	4	11.11	Private, Chamber
4	Ayurvedic Doctor	4	11.11	Private
	Total	36	100.00	

6.3: Main Problems:

During the survey, a total of 11 PHCs and 3 CHCs were visited and doctors in-charges were interviewed on the matter of problems and prospects of the health care programmes in the tribal localities. The result of the interview is shown in the tables below.

Table-6.3: : Main Problems As Sorted out by the Government Doctors in implementing policy

Sl NO	Type of Problems
1	Inadequate Staff strength
2	Inadequate infrastructure
3	Scarcity of water
4	Inadequate logistics
5	Unmanageable patients
6	Scarcity of hospital items
7	No ambulance
8	Scarcity of medicine
9	Poor Road condition

The main complaint against Doctors is that they are rarely willing to come to rural services. Due to shortage of doctors, one doctor has to attend all the patients. Sometimes one doctor has to attend two hospitals also. This is herculean task. Five of the doctors are working in the same hospital for more than nine years as the Government is unable to provide replacement. According to them, the present programme inducted by Government for rural health is most aspiring and scientifically designed programme. But for its effective implementation the problems indicated above shall have to be resolved first.

6.4: Views about Traditional healing system:

The doctors' view about the traditional medicine is significant. According to them the magical part of the system is just to exert psychological pressure on the patient. This is the same as what doctors do while talking to the patient. Since the magical healers also have a responsibility of keep the system going they make some part of the performance ornamental. Apart from the magical part of the system, the herbal part is quite significant. Some of the herbal medicines like those they use for dysentery, diarrhea, tooth ache, work very quickly while some other herbs work slowly but their result is almost certain. Medicines of all the systems of medicine work slowly on the drug addict or alchoholics,so there is no reason why the system should be blamed for this.

6.5: Government Intervention: challenges to Health care programmes:

The National Rural Health Mission is the only currently operational mission mode project on rural health. It was launched on 12th April 2005 by the Prime Minister of India to improve the status of health services in India. It has now been extended till 2017. This Misson mode project is based on the understanding that under the prevailing circumstances, States required additional funds and technical and institutional support from the Centre to improve the health status of their population. The stated aim of the NRHM was to provide accessible, affordable and accountable quality services to rural population with concentration on 18 'Special Focus States' and the

poor. These States include the Empowered Action Group States, States of the North-East, Jammu & Kashmir and Himachal Pradesh[1] . Despite its implementation since last eight years, the NRHM has not achieved its desired objectives.

6.5.1: : The goals of the NRHM:

1. Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR);
2. Universal access to integrated comprehensive public health services;
3. Child health, Water, Sanitation and Hygiene;
4. Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
5. Population stabilization, gender, and demographic balance;
6. Revitalization of local health traditions and main-stream Ayurvedic, Yoga, Unani, Siddha, and Homeopathy Systems of Health (AYUSH);
7. Promotion of healthy lifestyles.

6.5.2: The strategies to achieve the goals include: 1. Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services; 2. Health plan for each village through Village Health Committee of the Panchayat; 3. Strengthening sub-centre through an untied fund of Rs.10000 for local action and planning. This Fund will be deposited in a joint Bank Account of the ANM and Sarpanch and operated by the ANM, in consultation with the Village Health Committee, and more Multi Purpose Workers (MPWs); 4. Provision of 24 hour service in 50 per cent PHCs by addressing shortage of doctors, especially in high focus

[1] (http://www.mohfw.nic.in/NRHM/Documents/NRHM_The_Progress_so_far.pdf).

states, through mainstreaming AYUSH manpower; 5. Preparation and implementation of an intersectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation, and hygiene and nutrition; 6. Integrating vertical Health and Family Welfare programs at National, State, Block, & District levels.

6.6: Challenges:

6.6.1: Infrastructure related

The healthcare in rural areas has been developed as a three tier structure based on predetermined population norms The sub-centre is the most peripheral institution and the first contact point between the primary healthcare system and the community. Each sub-centre is manned by one Auxiliary Nurse Midwife (ANM) and one male Multi-purpose Worker [MPW(M)]. A Lady Health Worker (LHV) is in charge of six sub-centres each of which

Primary Health Centres (PHCs) comprise the second tier in rural healthcare structure envisaged to provide integrated curative and preventive healthcare to the rural population with emphasis on preventive and promotive aspects. (Promotive activities include promotion of better health and hygiene practices, tetanus inoculation of pregnant women, intake of IFA tablets and institutional deliveries.) PHCs are established and maintained by State Governments under the Minimum Needs Programme (MNP)/Basic Minimum Services Programme (BMS). A medical officer is in charge of the PHC supported by fourteen paramedical and other staff. It acts as a referral unit for six sub-centres.

Community Health Centres (CHC) forming the uppermost tier are established and maintained by the State Government under the MNP/BMS programme. Four medical specialists including Surgeon, Physician, Gynaecologist, and Paediatrician supported by twenty-one paramedical and other staff are supposed to staff each CHC.

Many of the sub centres are still running in the rural areas from rented houses with inadequate spaces. Data on facilities within these centres are not available. Most reports and evaluation studies point to the lack of equipment, poor or absence of repairs, improper functioning, or lack of complementary facilities such as 24-hour running water, electricity back-ups, and so on. But conditions being what they are, unreliable electricity and water supplies also take their toll on the performance of these centres.

6.6.2: Shortage of Manpower

Making basic health care accessible to all is a big challenge in India. PHC is the first contact point between the village community and the Medical Officer. The dearth of trained doctors, lab technicians and pharmacists is acutely felt . To confront this challenge, doctors need to be deployed in rural health care institutions in sufficient number. Sufficient number of positions should be created for young doctors in the public health system so that they can make an impact on population health. There is a need to mediate between the 'interests' of the medical profession and that of the society so as create an environment that enables young doctors to achieve their full potential along with making contribution to rural health service. There also exists shortfall across all cadres in the posts of MPW(F)/ANM,

MPW(M), Health Assistant (Female)/LHV,and that of Health Assistant (Male). The large shortfall in Male Health Workers has resulted in poor male participation in Family Welfare and other health programmes and overburdening of the ANMs. This shortage is despite government efforts to train health workers through various training programmes throughout the country for more effective and systematic service delivery.

6.6.3: Road connectivity

One of the basic requirements for accessing the health care infrastructure is the road connectivity and adequate transport services. Many of the healthcare facilities, public or private, are not accessible throughout the year to about a third of the villages. Private and government hospitals are relatively more accessible as they are typically located in areas well connected by metalled roads.

6.6.4: IT for Accessible Healthcare Provisioning

It is well known that many doctors are not willing to serve in the rural areas due to lack of facilities even if they are paid high salaries. However, as telecom network is spreading swiftly and the government is keen to provide broadband connectivity to all parts of the country, information technology can be effectively harnessed to improve the delivery of health services.

6.6.5: Participation of Local Self-Governing Bodies:

At present, the NRHM is being seen as a package of schemes but in reality it is a participative programme of different stakeholders like Community, PRIs, government and non-governmental organizations in a

well co-ordinated manner. The involvement of local self-governing bodies therefore seems very limited. NRHM programme can be successful only with the involvement of PRIs. This programme could not achieve the desired results due to petty politics at grassroot level and lack of political will. In tribal villages there are Traditional Manki/Munda/Pahan and village heads without legal or administrative powers of the PRI system. However, PRI participation has not been systematically implemented. There is no clear plan of Action, including capacity building plans on how panchayats should be involved. The PRIs should be given some legal and administrative powers for their active participation in the implementation of this programme. There is need of capacity building of health service providers.

6.6.6: Utilization of Untied Funds:

Civil society engagement has not yet taken place at the state level . Unfortunately, sometimes united funds are not being released at proper time and most of the Medical Officers and ANMs were unaware about the proper utilization of these untied funds. Secondly, due to lack of proper training of Panchayati Raj Institutions, there is lack of clarity on how the fund will be operated. There should be special steps taken to institutionalize civil society participation in NRHM activities, including monitoring at the state and district levels. MNGOs should be selected in consultation with civil society at the state level. The involvement of MNGOs as principal NGO partners in planning and particularly monitoring processes should be reviewed as it can lead to conflict of interests.

6.6.7: Public-Private Partnership:

Public-private partnership processes should not encourage the privatization of health services. Financing should be from public funds so that universal access to services is ensured. Other challenges hampering access to better health services are, hard to reach areas, low acceptance level in some areas, extremist prone areas, quality assurance in strengthening the Village Health Committee and Sahiya training, lack of infra-structure and trained human resources and frequent transfer of health personnel.. Mechanisms for introducing social audits and Jan Sunwai should be drawn up and implemented with care as soon as possible. District level planning has started in several places without village level planning processes being put in place first. This may set a counterproductive precedent. Village level planning should be introduced as soon as possible.

6.6.8: Engagement of Specialists:

NRHM should welcome partnerships with the Non-Governmental Sector in a fully transparent manner to ensure that quality services are available at affordable costs to communities. The Hospital Development Committees at District, Sub-District, CHC, PHC, Hospitals is an opportunity to move towards need based and health facility based engagement of Specialist services. In emergency there should be provision of engagement of some specialist doctors working in the private hospitals under this programme.

6.6.9: Rural Health Insurance

Around 70 per cent of India's population lives in villages. Of this, less than 2 per cent is insured. Though the rural health insurance market is huge, it has so far remained untapped. The private sector is likely to be a significant investor in health care infrastructure in rural areas, as rural incomes increase, and the spread of the road network improves accessibility. Recently, IRDA constituted a committee to chalk out a plan for spreading health insurance in rural areas. Various micro-health insurance schemes are to be studied under the proposed plan. Around 25 such schemes currently run in rural India, most of which are attached to micro-finance institutions.

Lack of awareness about various schemes has been one of the hindrances in spreading rural health insurance. If the government wishes to cover the population for lessening debt burden and promote the cause of poverty reduction, then insurance policy should cover common illnesses for which people take loans. Each of these schemes has its own strengths and shortcomings. For instance, Yeshaswini Insurance Scheme which had 16 lakh farmers enrolled in the first year faced a large dropout in the second year as the scheme covered only surgeries and not routine medical problems. Also the risk is not covered by an insurance company and is subsidized by the government. Experts feel that there should be an insurance company or a separate mechanism to fund the scheme. Others like Healing Fields, though successful, cover only a small section of the population.

6.7: Role of doctors in promoting the health care

Indian Public Health Standards (IPHS) Guidelines for Primary Health Centres at Annexure 7 has laid down detailed guidline about the role to be performed by the Medical officer of the PHCs

The Medical Officer of Primary Health Centre (PHC) is responsible for implementing all activities grouped under Health and Family Welfare delivery system in PHC area. He/she is responsible in his individual capacity, and as over all in charge. It is not possible to enumerate all his tasks. However, by virtue of his designation, it is implied that he will be solely responsible for the proper functioning of the PHC, and activities in relation to RCH, NRHM and other National Programs. The detailed job functions of Medical Officer working in the PHC are as follows:

6.7.1: Curative Work

The Medical Officer will organize the dispensary, outpatient department and will allot duties to the ancillary staff to ensure smooth running of the OPD. He/she will make suitable arrangements for the distribution of work in the treatment of emergency cases which come outside the normal OPD hours. He/she will organize laboratory services for cases where necessary and within the scope of his laboratory for proper diagnosis of doubtful cases. He/she will make arrangements for rendering services for the treatment of minor ailments at community level and at the PHC through the Health Assistants, Health Workers and others.

- He/she will attend to cases referred to him/her by Health Assistants, Health Workers, ASHA/Voluntary Health Workers where applicable, Dais or by the School Teachers.

- He/she will screen cases needing specialized medical attention including dental care and nursing care and refer them to referral institutions.

- He/she will provide guidance to the Health Assistants, Health Workers, Health Guides and School Teachers in the treatment of minor ailments.

- He/she will cooperate and coordinate with other institutions providing medical care services in his/ her area.

- He/she will visit each Sub-Centre in his/her area at least once in a month on a fixed day not only to check the work of the staff but also to provide curative services. This will be possible only if more than one Medical Officer is posted in PHC.

- Organize and participate in the "Village Health and Nutrition Day" at Anganwadi Centre once in a month.

6.7.2: Preventive and Promotive Work

The Medical Officer will ensure that all the members of his/her Health Team are fully conversant with the various National Health & Family Welfare Programs including NRHM to be implemented in the area allotted to each Health functionary. He/she will further supervise their work periodically both in the clinics and in the community setting to give them the necessary guidance and direction.

He/she will prepare operational plans and ensure effective implementation of the same to achieve the laid down targets under different

National Health and Family Welfare Programmes. The MO will provide assistance in the formulation of village health and sanitation plan through the ANMs and coordinate with the PRIs in his/ her PHC area.

He/she will keep close liaison with Block Development Officer and his/her staff, community leaders and various social welfare agencies in his/her area and involve them to the best advantage in the promotion of health programmes in the area. Wherever possible, the MO will conduct field investigations to delineate local health problems for planning changes in the strategy for the effective delivery of Health and Family welfare services. He/she will coordinate and facilitate the functioning of AYUSH doctor in the PHC.

CONCLUSION

All the indigenous tribes of Assam have one thing in common i.e. they accept the personalistic explanation of illness. All of them believe that illness is due to acts or wishes of other people or supernatural beings and forces. They believe that the causes and cures of illness are not to be found only in the natural world. Curers usually must use supernatural means to understand what is wrong with their patients and to return them to health. Typical causes of illness in personalistic medical systems include: i) intrusions of foreign objects into the body by supernatural means, ii) spirit possession and iii) bewitching.

They have their system of healing in place which is based on certain magical performances and sacrifices through which supernatural beings are appeased. As Bourdillon notes, "The physical world is seen and controlled by a hierarchy of spiritual beings, each with its specific functions, and everything is understood in terms of this structured spiritual world."8 Hence, certain illnesses are viewed not only as physical or psychological but as "spiritual sicknesses," and they can only be treated by engaging the spiritual world.

This world of indigenous tribes is unique in the sense that its facts, rules and regulations and tools are confined only to a particular person (*Kabiraj, deo, Baidya* etc) in the village. He is undoubtedly a respected person because he is believed to have the capacity to communicate with the supernatural world on behalf of the patient. But instances are there when, the

despite performances and sacrifices, the patients fails to get any relief and finally decided to shift to hospitals with due permission.

Doctors at the time of their interview disclosed that, they advise the tribal people to perform the rituals connected to a particular disease as quickly as possible and then come to the hospital for resting. But this is not always happening because villagers are not in a position to collect the necessary ingredients for the rituals as they are cash starved. This is a common phenomenon especially when a pig is required for sacrifice. A fully grown-up pig costs Rs 2500-3000 in the village market which can at best be exchanged in terms of 10-15 pairs of pigeons. Thus, for the poor villagers, it is not always easy to do the puja in time while there is the system of making promises to the priest to satisfy the spirit as soon as the patient gets cured. The priest in turn gives the word to the spirit on behalf of the patient's families. So the Priest remains as security for the words of the patient's families till the promise is realized.

One notable difference between the traditional healing system and the western healing system as observed by the villagers is that in the case of former, the supernatural spirit gets its dues only if the patient is cured but in case of the later the payment of fee to the doctors begins well before the treatment is started and they even do not return the cost/ fee if the patient is not cured. This has become a puzzle for them.

The lower middle income earning and the poor tribal villagers are habituated to go to the village *Kabiraj* for the common diseases seeking remedies. But even in these households if someone has the knowledge of

allopathic medicines they take recourse to such medicines as they get quick relief. For dysenteries, medicines like lomotil or lomofens work wonder to the villagers; similarly, for any type of pains, dispirin and Sheridan are the most popular medicines. When any neighbor or relatives go to the town, the elders request them to bring medicines from towns. Such medicines are preserved for bad days – sometimes even beyond the expiry dates. This way some common medicines are in wide circulation among the villagers.

Tribal peasants know it well that allopathic system has a cure for wide range diseases and ailments. They have seen it and experienced it practically. Expansion of TV and mobile network has helped in disseminating information on various diseases and their cures. Those families- poor or rich- whose children studies in towns, invariably takes recourse to allopathic medicines in times of illness at the insistence of the son or daughter. Almost all the villagers today - know the series of inoculations that are to be given to a newborn. An ASHA workers intervention is considered as an important service and they like to hear the ASHAs. They have heard about the 108 emergency services.

The influence of tradition system of healing is gradually losing ground. Tribal people in large numbers today are seen queuing in the local dispensaries, PHCs and CHCs etc for treatment. Two basic reasons why people go to the traditional healers even today are i) no health care services around and ii) poverty. Despite this, traditional system is surviving because it does not consider as a complementary to other medicinal system. People even after getting cured in western system can perform the *pujas* to appease the

local spirits. The fact behind its losing popularity is its undeveloped nature. The Priest and the Kabiraj who are at the centre of the traditional system in most cases are illiterate and they are not aware of the recent development in medicines. Maintaining cleanliness and the matter of accuracy in proportion in herbal medicines is not adhered to always. Shortage of medicinal plants and no special efforts from the villagers to grow them also is one factor adding to this gradual fall. Government intervention in this area is almost nil.

Doctors posted in the remote interior areas are playing a incredible role in serving the simple tribal masses. They have been commanding respect in the villages. They are even invited to various community pujas performed annually to appease the supernatural spirits. Doctors participate in the feasts followed by such pujas. Many doctors admitted that the sense and knowledge of herbal medicines of the village medicine man is tremendous. But for aiding the poor and ailing tribal villagers, large scale expansion of services in the sub centres are an immediate necessity. This can be done by posting more and more doctors and health staff in the remote areas.

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