CHAPTER I

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“OUM SARBE BHAVANTU SUKHINAH
SARBE SANTU NIRAMAYAH
SARBE BHADRANIPASHYANTU
MAA KACHCHIDUHKHA BHAGA BHAVET.”

May all be Happy;
May all be without disease;
May all have well-being;
May none have misery of any sort.

(Brihadranyaka Upanishad 1.4.14)

This is an ancient popular saying of Indian Philosophers, which means,
“May all men be free from disease and may all be healthy. This concept of
happiness has its roots in the ancient philosophy of life, which conceived the oneness at unity of all people wherever they be healthy. From time immemorial, men have been interested in trying to control disease. The medicine men, the priests, the herbalists and the magicians, all undertook in various ways to cure man's disease and/or to bring relief to the sick (Park 2007).

Health is the first and most important form of wealth. Health – the physical, mental and social health of an entire population is a nation's fundamental natural resource. If health is ignored or wasted, farms will wither, mines will close, factory engines will slow their production, families will break up and children's laughter will no longer be seen throughout the community. If health becomes only the province of the wealthy, that nation will have an ominous future. The poor will struggle for equity and even the wealthy, by feeling isolated or disabled or in fear, will stop enjoying their riches (Jenkins 2005).

The World Health Organization (1948) defined health as “a state of physical, mental and social well being and not merely the absence of disease or infirmity”. The broad meaning of this definition is holistic, considering the multidimensional aspect of health. This definition sets out the standard of positive health. It symbolises the aspiration of the people and represents an over all objective or goal towards which a nation should strive. The 30th World Health Assembly resolved in May, 1977 that “the main social target of the Governments and WHO in the coming decades should be the attainment
by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”. This culminated in the international objective of Health for all by the year 2000 as the social goal of all Governments (WHO 1978). Health for all means that health is to be brought within the reach of every one in a given community. It implies the removal of obstacles to health i.e. elimination of malnutrition, ignorance, diseases, contaminated water supply, unhygienic housing etc. Health for all was a holistic concept calling for effort in agriculture, industry, education, housing and communication just as much as in medicine and in public health.

The primary health care approach was proclaimed as a way to achieve health for all at the International Conference of Alma Ata (USSR) in 1978. The primary health care approach, which seeks to integrate promotive, preventive and curative services, is considered as an integrated part of the country’s plan for socio-economic development. It has all the essential ingredients of health care like (a) Comprehensiveness (b) accessibility (c) acceptability (d) availability at affordable cost and (e) community participation. Acting on the primary health care approach of the international bodies, the Government of India evolved the National health policy in 1983, to reorient and organize the existing rural health infrastructures. As a result both the state and central Govt. have established a vast network of rural and urban health institutions and also have reorganized the existing ones, to provide comprehensive health care services to the people of the country.
The primary health care has also been introduced in rural and tribal areas of Assam and during the last three decades, a vast network of rural health infrastructures like sub-centres, primary health centres and community health centres had been established. Unfortunately, these health centres have not been able to provide the people with good quality of health care in remote areas especially in the tea belts or Adivasi areas. Instead of providing "comprehensive health care" they have emphasized "medical care". Promotive and preventive health services have not received due emphasis and attention, they deserve while rural health services are being developed on a relatively normative pattern. The health workers and para medical staff are often loaded with record maintenance and various health programme launched by the Government of India. They also remain busy with conducting health camps, immunization camps, family planning camps and meetings. Probably because of the above reasons effort is not made for collecting health and nutrition related data on tribals, which are very much essential in planning culturally acceptable health and nutrition programme aimed at improving the health status of the people in general, women and children in particular.

In order to involve the rural population in the process of planning their own welfare measure in 1952, i.e., during the first Five Year Plan period the Community Development Programme was launched on 2\textsuperscript{nd} October, 1952 for all round development of the rural areas, where nearly 80% of the India’s population live. This programme was related with wide spread slogan known as "\textit{Of the people, for the people, by the people}" to eliminate the triple enemies -poverty, ill health and ignorance.
Standard of health varies among societies. Health depends on their culture, social classes, education, age group and ecological conditions. The major contributing factors are the environmental, social, economical and behavioral, which have direct impact on health of the community. Health and diseases are always related to the cultural and biological factors of a particular community. Culture influences the health of a community both positively and negatively. The various cultural “do’s and don’ts” especially in food and drinking habits, pregnancy and childbirth etc., have direct impact on the health of a particular group of people.

Every culture, irrespective of its simplicity and complexity has its own notion regarding health and health seeking behaviour. The system of medicine in a culture tries to treat the diseases in its own way. That is why the concept of health, disease and types of treatment vary from society to society and culture to culture. Every culture has developed a system of their own medicine. For example, some of the Adivasi communities have magical and religious beliefs on health matters. It has been observed that both magico-religious and herbal treatments are included in the indigenous treatment. Magico-religious approaches are in use as preventive as well as curative one. The Priests from Adivasis are invited by a family to perform Puja to satisfy deities and evil powers, which they believed is responsible for harming the family and community.
It has been observed by the researchers that there is a close relationship between health problems and socio-cultural and socio-economic conditions. Socio-economic conditions always influence human health. Because, health status of a country or community is determined by their level of socio-economic development, education - specially female literacy, nutrition, employment, housing and also the political willpowers of the Country/State etc. Thus Hasan (1967) stated that the importance of social and cultural implications of modern medicine and public health programme could be understood only when medical men and social scientists collaborate with one another.

There are estimated 300 million indigenous people worldwide livings in different continents (Centre for Human Rights, 1997). They comprise about 5000 – 6000 distinct groups distributed over 70 countries, with a diverse range of culture, heritage, language, and many other characteristics. In India, according to the 2001 census, tribal form about 8.74 per cent (967,607,574) of Indian Population. There are over 573 scheduled tribes; major tribal groups being Gonds (14.4%), Bhils (14.3), Santhals (8.3%) and Oran (3.6%). All these have been identified as primitive tribes (2004). In Assam, in the year 1991, tea labourers and their dependent comprises 32.3 percent of the State’s total population, (Census of India, 1991). Undivided Dibrugarh District is largest tea producing district in Assam with 280 Tea Gardens covering an area of 73, 821 hectares of land. There are 2,00,477 of Tea Labour inhabitant in Dibrugarh District (Census of India, 1991, series 4, p.55). At present, Dibrugarh district comprises of 161 tea gardens (Record, Tea Board, 2001)
They are basically tribal people and still maintaining the ethnical character and falling in the dark of backwardness in all sphere of life, i.e., socially, economically and educationally far behind than the other community (Mutharayappa, R. 1954).

Women in the world are about half of the adult population. They constitute one-third of the world's Labour force, expend about two-third of the working hours, earn only one-tenth of the income and own only one percent of the world's property (UN 1975). Women in all over the world in general and India in particular belong to one of the weakest section of the human society. They have been subjected to exploitation, torture and discrimination almost in all walks of life since times immemorial. Even today, in this modern era, the position of the women in rural and tribal area in India remained deplorable and alarming. The social structure, illiteracy, division of labour, ignorance, limited resources, primitive technology, attitudes towards women and above all economic dependence are a few main factors of their miseries. The women, who work hard right from early morning to late night get a little in their account. There is no proper balance between amount of labour put and amount of output received. In India, woman is the shadow and strength of man. She looks after almost all the activities of the family. She is the backbone of family welfare.

The report presented in 1975 by the Parliamentary Committee on the Status of Women – "that women are not inadequate but unacknowledged,
unrecognized & rendered but helpless due to denial of opportunity, subjugation and suppression. In fact, studies reportedly reveal their infinite tenacity, courage, resilience and strength" (Waghmare 1989).

The status of women world wide as analyzed by Dixon (1982), taking into consideration the International Labour Organization, Food and Agricultural Organization and National Population census data, revealed that women constituted 38 percent of agricultural Labour force in developing countries. For South East Asian countries it was estimated to be 45.3 percent.

**Significance of Study**

The women of the Tea Tribes Community working in tea gardens are hard working in nature. They equally work in the tea garden as the male worker works. Besides working in the tea garden, the woman workers have to look after their family affairs. They have to take care of their in-laws, husbands and have to nourish their children. They have to collect fuels and to cook for their family. They have to clean the house and to wash the utensils. It means they have to work from dawn to night taking few hours rest at night and get a little in their account.

The health condition of woman workers in tea garden is very poor and pathetic. It has been admitted that, age-old tradition, social taboos, superstition, ignorance and poverty prevent the tea garden women to avail the
Fourthly, social atmosphere at labour line (colony) is also one of the reasons of the unhealthy conditions of women.

The women of tea garden are the part and parcel of Assam and Assamese society. The women of Tea Garden are not only constituting a major segment of the labour force of Assam, but also constituting a large part of the women of Assam. It is, therefore, necessary to improve the health status of the women working in the Tea Gardens of Assam. This would also improve the health status of women population of Assam in general as already mentioned. Improvement in health of the woman workers of tea gardens of Assam would in turn improve their productivity as well as aggregate productivity of the working force of Assam. This would lead to rapid socio-economic development and usher into a welfare state in true sense.

Therefore, there is ample scope to study the health practices of women working in the tea gardens of Assam as health practices have important bearing on the health status of the family as well as the community. In this connection it is worth mentioning here the suggestion of The WHO conference in Tokyo in 1986 on “Leadership in Nursing, Health for All”. It reiterated that nursing research should be in support of health care practice. Nurse researchers should select settings in which nursing care is delivered, identify significant problems in those settings and conduct research into these problems and application of research findings into practice. The nursing profession has an obligation to teach health practice of all section of people, which will help individuals maintain good health. Recognition of socio
Women at work in tea garden, Map of Assam and India
cultural forces and ignorance is essential if an established pattern of behavior is to be modified effectively. One of the main objectives of primary health care nursing is to teach people to take care of and to make them responsible for their own health. Nurses can thus play a vital role in reducing the frequent incident of preventable diseases by teaching healthy life style, knowledge, attitudes and healthy practices as well as early diagnoses, treatment and preventive measures. Therefore, there is a need for nurses to conduct research study on health practices, environmental sanitation, and utilization of available resources of health and health services. Keeping all these views in mind, the present study was undertaken to explore various practices related to health by the woman workers of the tea gardens.

In regards to the choice the Dibrugarh District, it is a well-known fact that the Dibrugarh District has the highest concentration of tea gardens and tea gardens population not only in Assam but also in the country. Various castes and tribes whose ancestors were brought by the British Colonial Government in the early part of 19th Century from various parts of Orissa, Bihar (Jharkand), West Bengal, Andhra Pradesh, Madhya Pradesh etc. have contributed the working force of the tea gardens and have settled in the Dibrugarh District for livelihood. These people have inherited the attitudes and beliefs of their ancestors, which largely influence their health practice and behaviour related to health. Because of these reasons Dibrugarh District was selected as a study area for the said study.
Statement of the Problem:

A study on the Health Practices of Tea Garden Woman Workers of Dibrugarh District.

Research Question:

1. What are the existing health practices of woman workers of tea garden?

2. What are the health related knowledge, attitudes, practices and beliefs of woman workers of tea garden?
OBJECTIVES

GENERAL OBJECTIVES

To study the existing health practices of tea garden woman workers.

SPECIFIC OBJECTIVES

1. To identify the prevailing health problems among the women of Tea Tribes Workers.
2. To assess the knowledge of women of Tea Tribes on prevailing health problems and health.
3. To find out the attitude of the Tea Tribes Women towards health and health problems.
4. To find out the existing practices practised by Tea Tribes women in relation to health and health problems.
5. To explore the factors influencing the health practices practised by Tea Tribes Women.
6. To suggest suitable recommendations on the basis of the finding of the study.
The Conceptual framework of the study

The conceptual framework for the present study is based on the concept of health and health belief models. Health always requires the promotion of healthy lifestyle, because there is an association between health and lifestyle of individuals. In developing countries like India most of the people still practises the traditional lifestyle which are connected with lack of sanitation, poor nutrition, poor maintenance in personal hygiene (hardly uses of sanitary latrine), food taboos in pregnancy and lactation, consumption of country liquor and typical customs and cultural patterns. Researcher observes that there is no active involvement of women (respondents) in health matters. They consider life is easy and also easygoing process.

The main aim of this study is to explore the health behavior, their living condition, surrounding and also try to explore the factors responsible for their health practices.

In the present study, the researcher proceeds with the assumption of the following conceptual frameworks –
Conceptual framework of the present study
(Based on Rosenstock's health belief Model adapted in 1974)