Health is the most basic and primary need of an individual. It is the supreme foundation of virtue, wealth, enjoyment and salvation for members in many societies (Lele, 1986). If health is the supreme foundation of life, illness is considered to be the greatest impediment to the progress of humanity. Every society develops means to cope with this impediment by evolving a unique health culture.

Different communities develop their health culture in line with the overall ways of life and in response to the health problems encountered by them. Health culture of any community consists of preventive, promotive, and curative components.

The preventive and promotive component of health culture consist of activities undertaken to promote one's health and prevent the onset of illness. It may include measures such as maintenance of personal and social hygiene, welfare measures like rejuvenation activities (Park 1977).

The main function of the curative component is to restore the health of the individual when he is affected with an illness. Every society evolves certain institutional mechanisms and contains specific roles to deal with or negotiate illness. However, this process of seeking care is also influenced by the perceptions and evaluation of symptoms by the ill persons or their
families. Thus, broad gamut of topics like etiology, illness behaviour, sick role and choice of therapy are covered under this aspect.

The present study deals with the curative component, in the field of traditional system of medicine, thus the study is guided by the conceptual and theoretical frameworks evolved with the area of medical pluralism and health decision models. The relevant literature in this regard is reviewed following a discussion on Medical pluralism and Traditional medicine with specific reference in the Indian context.

MEDICAL PLURALISM

Medical pluralism is defined as the co-existence of more than one model of prevention, diagnosis and cure, or an active policy of a government to promote the integration of traditional medicine into biomedical practice. (Miller.D.Barbara et al, 2004).

A variety of health care options co-exist in most cultures, even in those in which one medical system enjoys dominance. They range from home care with grandmother remedies and patent medicines to the services of specialists of traditional system of medicine and biomedical super specialists to the expertise of spirit medium, shamans, and exorcists.

The emergence of alternative therapies in the west is somewhat a response to the limitation faced in biomedicine and to escape from negative side effects of the modern therapies. On the other hand in the developing world it is more or less the failure of the health policies based solely on the
biomedical system to fulfil the needs of their population more effectively that led to the perpetuation of varied forms of traditional medical beliefs.

Kleinman. A (1980) provides a classification for healing activities in plural medical systems. According to Kleinman the model can be applied to research in developed and developing societies that contain both high order, literate (or classical) and low order, oral (or folk) indigenous healing tradition. In this model, health care is described as a local cultural system composed of three over lapping parts: the popular, professional and folk sector.

**Popular health sector:** It is the largest part, within which healing acts depend on a general body of knowledge available to the populace. It is the lay, non-professional, non-specialist care, present in all societies. The majority of sickness episodes are managed entirely within this sector often at the household level and under the supervision of mother or other women.

**Professional health sector:** The second sector is the professional sector, comprising the organized healing professions. In most societies, this is simply modern scientific medicine. But in certain societies e.g. Chinese, Indian and Muslim, communities there are also professionalized indigenous medical systems. The traditional Chinese medicine, Ayurvedic medicine and the Unani medicine or Galenic Arabic medicine that have professionalized along lines similar to those of the modern medical profession. Some of the defining characteristics of this sector are (1) standardized and formal training based on an organized body of knowledge (2) credential or licenses required to practice (3) structured relationships among those in the
profession (e.g. mutual referrals, specialization) and (4) Organization that enforces standard of practice, share knowledge and protect the profession.

Folk health sector: In an intermediate position between the popular and professional sectors, is a folk sector, in which healing is performed by "non professional, non-bureaucratic, specialist". Folk healers typically undergo a non-formal education, often by apprenticeship, to learn their curing art. Healing roles in the folk sector lack the defining features of a healing profession.

According to Maureen. D.L. (1984), studies in pluralistic settings reveal two basic patterns of resort to healers which include (a) Multiple therapeutic use and (b) Illness specific use.

Multiple therapeutic use imply that clients use more than one therapeutic system during a single illness episode, either simultaneously or in succession. This pattern has been reported by various authors Janzen (1978) in lower Zaire, Nichter (1978) in Karnataka India, Gonzalez (1966) in Guatemala.

The second pattern i.e. illness specific implies that clients classify disorders as amenable to different types of therapy and seek care accordingly. This behaviour has been reported as early as in (1965) by Gould his study in North Indian villages.
BENEFICIAL ASPECTS OF MEDICAL PLURALISM

Pluralistic health settings helps the afflicted and healers in different ways. The presence of alternative health care systems offers the afflicted and their kin multiple lines of treatment. It also helps to generate illness scenarios around which personal narratives may be developed and instantiated in contexts in which they are contested (Nichter et al 1996).

For the practitioner the multiple systems provide avenues of referral and alternative means to explain the ill health of patients following treatment efforts. Leslie (1983) while highlighting the benefits of medical pluralism for health care planning insists that pluralism in medicine should be recognised and advocated not only in the third world but also in the industrial west.

TRADITIONAL SYSTEM OF MEDICINE

As observed by Oyeneye O.Y. (1985) there is no community that has not developed its own traditional systems of health care.

According to World Health Organisation (2004) the term "traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercise, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well being". Traditional medicine is also referred as indigenous medicine (Banerji, 1981) alternative
medicine (Hasan.M, 2000) Fredrick Dunn. L. (1979) refers traditional system of medicine as regional medical system in the book Asian medical systems edited by Leslie.C (1976). The National centre for complementary and Alternative medicine (USA 2002) terms it as Complementary and Alternative medicine. According to WHO (2003) complementary and alternative medicine are used interchangeably with traditional medicine only in some countries. They are referred to as health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system.

During the last two decades, because of issues on population, ageing, changes in patterns of common diseases and for other reasons, the use of traditional medicine has increased world wide (WHO 2002).

In China, traditional medicine accounts for around 40% of all health care delivered. In Chile 71% of the population, and in Colombia 40% of the population have used such medicine. In India, 65% of the population in rural areas use Ayurveda to help meet their primary health care needs. In Malaysia, it is estimated that about US $ 500 million in spent annually on traditional medicine, compared to about US $ 300 million on conventional medical practice (WHO 2001). In a report by the Secretariat of WHO in the 56th world health assembly (2003) it was reported that traditional medicines are popular in developed countries. The percentage of the population that has used traditional medicine at least once is 48% in Australia, 31% in Belgium, 70% in Canada, 49% in France and 42% in USA.
Traditional medicine often plays an important role in the development of nationalistic pride, since it may symbolise the antiquity of the country concerned, and the high levels to which culture had evolved in ancient time (Foster G. 1978). Practices of traditional medicine may vary with country and region as they are influenced by factors such as culture, history, personal attitude and philosophy. The traditional Chinese medicine is guided by the 'dual forces of Yin and Yang, whose continuous interaction lies behind all natural phenomena, including the constitution and functioning of the human body' (Croizier 1968). The proper balance within the body of Yin and Yang is essential for good health.

In the Ayurvedic medicine in India good health exist when the "three dosha' or humours are in equilibrium in the human body, ill health manifests itself when one or more of the 'dosha' are not functioning properly (Leslie 1959). In Unani system of medicine that traces its origin from Greece, the human body contain blood, phlegm, yellow bile and black bile. Health is primarily that state in which these constituent substances are in the correct proportion to each other. The Unani medicine is found in many Muslim countries and other South Western Asian countries. Humoural pathology underlies much folk medicine in Malaysia, Java and Philippines (Foster 1978). Traditional Kampo medicine in Japan is an adaptation of Chinese medicine but herbal medicine also prevails in Japan. Traditional medicine in Thailand and Vietnam derives from Chinese and Indian traditions.
REGULATIONS FOR TRADITIONAL MEDICINE

In countries with ancient documented medical systems there is frequently an urge to elevate the traditional system of medicine to 'separate but equal' status with contemporary western medicine basing the argument, both on the antiquity of medical knowledge in the country concerned and the putative effectiveness of traditional treatments.

According to Nigenda, G (2001) there are three major tendencies for the existence of national medicine in a country. It includes (a) Integration (b) Co-existence (c) Tolerance. Integration is referred to the process where traditional medicine is integrated into the health system. This situation is found in China where traditional medicine in China is integrated with the modern medicine (Kleinman 1980). This is also found in Korea and Vietnam where traditional doctors are recognised and can be employed in public-health institution. They share clinical decision making with doctors trained under the scientific biomedical model.

In other countries traditional medicine has only achieved the level of co-existence with official medicine, based on a well-established legal framework, which has permitted a certain level of integration in the official health system. Some of examples of this are India, Pakistan, Burma and Bangladesh. Finally there are countries where the practise of traditional medicine is only tolerated. There is no legislative framework for regulating the practice of doctors who use traditional medicine. Countries in this situation include Mali, Malaysia and Latin American countries.
Murray last article on the 'Professionalisation of indigenous healers' in Medical anthropology (1996) ed by Sargent F.C. et al talks about three broad types of regulatory systems that help to determine politically the nature of a state medical culture and with it the organisational possibilities for indigenous practitioners. Murray highlights three types of systems which include exclusive systems which is prevalent in Soviet Union, France and America, tolerant systems which include the British model and German model. The Integrated system is prevalent in India and China.

TRADITIONAL MEDICINE IN INDIA

In India different medical systems have existed for centuries throughout the country. India has a plural health setting where, more than two systems of traditional medicine co-exist with the modern system of medicine. In the history of medical system in India, traditional medicine has not been static but has continually evolved and progressed even in urban setting (Ramesh, et al 1981).

HISTORY OF TRADITIONAL MEDICINE IN INDIA

The history of the traditional medical systems in India has passed through phases of stagnation and growth. This has been revealed in studies by Banerji (1981), Jefferey (1982).

It has been noted that during the colonial rule policies that were created affected the growth of traditional medicine. In 1835 Macauley's
Minute on Educational policy, argued that European culture should provide the curriculum of schools and colleges. In medical education it meant that the Calcutta 'Native medical Institution" founded in 1822, would no longer teach aspects of Ayurveda or of Unani (Jeffery R. 1982). This shifted the state patronage from the traditional systems of medicine to western system of medicine during the British period.

It was not until in the early 20th century that traditional medicine became more and more important among Indian Nationalists. In 1920, the Indian National Congress passed a resolution to the effect that "having regard to the widely prevalent and generally accepted utility of the Ayurvedic and Unani systems of medicine in India, earnest efforts should be made by the people of India to popularize schools, colleges and hospitals for instruction and treatment in accordance with these indigenous system" (Udupa 1975). Subsequently schools of Indian medicine were opened in Madras, Bombay, Delhi and Bengal.

It was in 1946, in the health minister's conference, the resolution was passed to promote and develop the traditional system of medicine along with modern medicine (Ministry of Health GOI 1948). The government of India in 1969 constituted the central council of research in Indian medicines and homeopathy with four sub councils.

1) Ayurveda and Siddha
2) Unani Medicine
3) Homeopathy
4) Yoga and naturopathy.
In the new National health policy 2002, the traditional systems of medicine Ayurveda, Unani, Siddha, Naturopathy and Yoga, Homeopathy have been included in the wide framework of health services. The policy aims at reviving the ailing health system and increasing the primary health sector outlay to ensure a more equitable access to health services across the social and geographical expanse of the country.

PRACTICE OF TRADITIONAL SYSTEM OF MEDICINE IN INDIA

Ayurveda, Siddha, Unani and Yoga medicine is referred to Indian system of medicine or traditional system of medicine. Charles Leslie (1979) classifies Ayurveda and Unani as "great tradition" medicine, a term derived from Robert Redfields work on the comparative study of civilisations (Redfield 1956). Homeopathy and Naturopathy are grouped under the modern imported system that appeals to humoural concepts of healthcare.

Ayurveda is practised all over the country (Jaggi 1981). Siddha is practised in the southern states of Tamilnadu and neighbouring states. The Unani system is used predominantly in areas of Muslim culture (Izhar 1990). Homeopathy is popular throughout India and most prominent in the North and Northeast. According to Izhar (1990) Naturopathy is an urban middle class practise of limited scope. If the study would be conducted on all the traditional systems of medicine the scope of the study would be large and the quality affected so the study was restricted to Ayurveda and Unani in Hyderabad.
Besides these great traditions of medicine there has been a number of lesser traditions known as little traditions of medicine, which flourished under their shadow. There is a large number of shamans and folk healers in modern India, and it is certain that such practices have been common since earliest time (Kakar, 1984). These Folk traditions trace their origin from great traditions of medicine. Today in addition to the established medical system, there are Traditional bonesetters. Faith healers, Massage therapists. Herbalists and traditional midwives.

LITERATURE REVIEW

Patterns of practice and utilisation of health services have always been an important area of research in both developed and developing countries. The literature reviewed will be broadly classified under two subheadings studies related to the practice of traditional medicine and utilisation of traditional medicine. The researcher has tried to segregate the studies based on the main focus of the study i.e. if the study focused on the patients it was classified under studies on utilisation of traditional medicine and if the study focused on the practitioners it was classified under studies relating to practice of traditional medicine.

During the review it was found that utilisation studies outnumbered the studies relating to the practice of traditional medicine. But it is also important to note that utilisation and practice of a health service are two related concepts, which means that when utilisation of a health services has occurred, it also means that the particular health service was also practised in the particular setting.
STUDIES ON UTILISATION OF TRADITIONAL MEDICINE

While trying to understand utilisation patterns it is important to know the frameworks that have been developed in the area of health seeking and illness behaviour.

Different models showed how people enter the role and make choices regarding the use or non-use of different kinds of health services based on varied conception of health, as well as conceptions of cause, cure, treatment and diagnoses of different diseases (Suchman (1965), Fabrega (1972) Chrisman (1977), and Igun (1979). These models are known as pathway models (Kroeger A. 1983). Suchman's model separates the illness experience into five stages. The stages include:

1) Symptom experience (2) Assumption of the sick role (3) Medical care contact (4) Dependent patient role and recovery and rehabilitation.

In the first stage the whole medical care process begins with the individuals perception that 'some thing is wrong'. This perception may include awareness of physical change, an evaluation of to change as to its degree of severity and some kind of emotional response attached to the evaluation. The responses may range from denial or a "flight into health" to acceptance in which the individual decides he or she is sick and assumes the sick role and enter into the second stage. Once the symptoms persist the individual decides to adopt the sick role and seek to obtain "provisional
validation" for that claim. The illness becomes a social phenomenon because the sick person seeks agreement from significant others that he or she is sick and should be excused from regular duties. Many individuals seek professional help at once, others continue self-treatment and try various remedies suggested by others concerned for the individual health. The provisional validation of the sick role by the family leads into the third stage the medical care contact stage. In the third stage the sick person leaves the lay care system and enters the professional care system. Here the individual is seeking authoritative validation for the claim to the sick role as well as treatment. It is in this stage Suchman brings out a phenomenon called 'shopping'. The patient goes to different physicians until the diagnoses wanted is achieved. The sick person and the doctor may agree that the former is ill, thus providing legitimisation for the sick role and enters into the next stage. The next stage is the dependent patient role where the sick person becomes a patient. Different behaviours characterise this stage, which include adherence to treatment, increasing resistance to the treatment regimen by the patient and go 'shopping' or logically the patients and physicians work together and commence a recovery of the normal physical state and subsequent resumption of normal roles. The last stage is the recovery and rehabilitation stage. The recovery time may be different for different ailments. Patients who cannot effectively leave the sick role may take on the chronic sick role. At the other extreme is the achievement of a cure and the patient once again joins the ranks of the well.

Extending the scope of Suchman's stage of illness behaviour and at the same time providing greater precision for predicting behaviour, Fabrega suggested nine stages. Further the focus is on decision-making, which takes
into account judgements by the individual as to the degree of 'danger' implied by symptoms, weighing costs against anticipated benefits, and choice of behaviour based on previous experiences with illness.

Like Suchman's model, this one starts with identification and labelling of a problem as illness (stage I) and an evaluation of the presumed danger or degree of disability (stage II). The action to be taken include selecting from a range of available treatment options, assessing the potential outcomes based on previous experience, and making a judgement of expected benefits against potential costs (social as well as economic). These stages represents stage III to VII. The patient then selects a treatment plan (stage VIII) and evaluates the outcome. This information becomes part of memory system for subsequent experience (stage IX).

Chrisman's (1977) model is a step further in the illness behaviour studies. He identified components of health seeking, which include 'symptom definition', 'Illness - related shift in role behaviour', 'May consultation and referral' 'treatment action and adherence'. The significance of this framework is the integration of cultural and social factors into the framework.

Igun (1979) demarcated ten stages from 'symptom experience' to 'recovery and rehabilitation'. This models the logically possible stages through which health seeking as a process might go. Iguns model not only gives a descriptive account of the sequence of events and actions associated with health seeking, but also explains why patients may move from one source of care to another.
Once the decision to seek medical care has been made the 'determinant models' come into action. These models focus on a set of 'explanatory variables' or determinants, which are associated with the choice of different forms of health services.

Anderson's R. (1968) 'behavioural model of health service use' explained how and why individuals and families use health services. This was a three-stage model consisting of predisposing, enabling and need component. Use is dependent on: (1) the predisposition of the family to use services (2) their ability to secure services (3) their need for such services.

Each component of the model includes sub-components. The model can be diagrammatically represented as
The first set of factors is the predisposing (demographical and social structural) characteristics such as the consumer's age, sex, colour and education. These factors precede the onset of any specific illness episode and reflect the greater propensity of some individuals to engage in utilization and as a result, patient practitioner relationships (Wolinsky D. Fetal 1982).

The health beliefs of diseases, physicians and medical care constitute a third sub component of predisposing conditions. Like the demographical and social structural characteristics, health beliefs are not considered to be a direct reason for using services but do result in difference in inclination towards use of health service.

For example, families who strongly believe in the efficiency of treatment of their doctors might seek a physician sooner and use more services than families with less faith in the results of treatment.

The second sets of factors are enabling characteristics. Even though families may be predisposed to use health services, some means must be available for them to do so. According to Anderson's model enabling factors are measured by family resources and health service resources of the community in which the family lives.

Family resources: The family's ability to obtain services for its members is assessed largely by the extent of their economic resource and source of medical care. Measures include family income, family savings, health insurance, and regular source of care.
Community resources: The characteristic of the community in which the family lives also enable the use of services. One such characteristic is the availability of health services.

Assuming the presence of predisposing and enabling conditions, the family must perceive illness or its possibility among its members for use of health services to take place. Need can be measured in a variety of ways, self perceived health status (e.g. excellent, good, fair, poor) frequency of pains, number of symptom, restricted activity days and disability days are some of the most common methods. Need in defined not only in terms of perception of illness. Some families may not respond to illness or disability, by seeking medical care. Response is examined by two variables seeing doctor for symptoms and regular physical examination.

Patient satisfaction is important since the ultimate validation of the quality of care is its effectiveness in achieving or producing health and satisfaction (Fiedler J.L. 1981). In Anderson's generic access model, consumer satisfaction with previous physician encounter influences the subsequent use of health services, those who have been satisfied in the past use more services in the future than those who have not been satisfied, regardless of their need (Wolinsky, 1982).

There are a variety of survey instruments for assessing patient satisfaction. The major satisfaction dimension constructed by Ware and his associates (1978) include, art of care (humanness or the amount of 'caring' shown toward patients), technical quality of care, accessibility / convenience, finances, physical environment, availability / provider -
Different authors like Ludwig et al (1969), Unshuld (1975), and Shuval, R (1981) have proposed "recognition and significance attached to symptoms" "degree of difficulty in seeking care" "faith in medical systems" "economic factors" "communication gaps" as some of the factors determining the utilisation of service. Different approaches have been advocated to study the different factors influencing the utilisation of health service. One approach suggested that the predisposing and enabling characteristics might be subsumed under the general heading of social network variable. The argument is that the kinship, friendship, organisation and referral network are too closely enmeshed is the socio-economic matrix to permit useful desegregation.

The International Collaborative Study on health care (1976) modified the model suggested by Anderson. The explanatory variables governing the use of care are classified as (i) predisposing factors which include demographic characteristic, household and family composition, education, attitudes, responsibility for health related decision (ii) enabling factor include accessibility of regular source of care, health insurance, income security (iii) health services system factors refers to the structure of the health care system and its link to a country's social and political macro system.
To summarise it can be understood that the interaction of sets of characteristics, those of the family or individual and those of the health care delivery system play an important role in the utilisation of health services.

Anderson's model is still extensively being used in utilisation studies (Fosu 1994, Kang J. T. et al 1994, Fernandez Mayorlas et al 2000, Pillai K.R et al 2003). According to Fosu (1994), this model has been successfully applied to explain the use of other prominent health care services in developing countries such as traditional healers and folk health care.

Benyoussef and Wessen (1974) were among the first to point out that medical care utilization in developing countries is different from that in developed countries. This view was supported by Kroeger (1983) who reported that additional factors are operating such as the continuing process of cultural change, which brings about a change of illness concepts and health behaviour. There also exists a wide range of health services, both in quality and quantity as well as in socio-economic conditions.

Kroeger A (1983) included the characteristic of the disorders and their perception and reported that aetiological concepts and world views should also be considered in order to delineate the factors intervening in the choice of health care. The variable elucidated by Kroeger is presented in the form a simple integrated framework.
FIGURE 1.2: THE CHOICE OF HEALER IN RELATION TO VARIOUS POSSIBLE EXPLANATORY VARIABLE - KROEGER, A 1983

Explanatory variables (interrelated)

- Characteristics of the subject (Predisposing factors)
  - Age, Sex
  - Marital Status, status in household, household size
  - Formal education
  - Ethnic group
  - Occupation
  - Interaction with Family Innovators

- Characteristics of the disorder and their perceptions
  - Chronic or acute
  - Severe or trivial
  - Aetiological model
  - Expected benefits of treatment
  - Psychosomatic vs. somatic disorders

- Characteristics of the health service (health service system factors, enabling factors)
  - Accessibility
  - Appeal
  - Acceptability, quality, communication
  - Costs

Dependent variable

- Traditional Healer
- Modern Healer
- Drug Seller
- Self Treatment or No Treatment

Perceived morbidity interacts with

CHOICE OF HEALTH CARE RESOURCE
Based on these frameworks reviewed it can be understood that it is more or less the same factors that influence the use and non-use of health services.

But it was Kroeger's model, which emphasised on the aetiological concepts and this aspect is an important aspect of medical anthropology in general and illness behaviour studies in particular.

Based on Kroeger's A. (1983) framework, different studies reviewed will be presented under three broad areas: (1) Characteristics of the subject (Predisposing factors), (2) Characteristics of the disorders and their perception, (3) Characteristic of the services (enabling factors).

CHARACTERISTICS OF THE SUBJECT

Age

Mac Lean C.M.U (1965) in a health opinion survey in Ibadan Nigeria reported that the elderly most frequently consulted the traditional practitioner. Similar finding were reported by Baker et al (1967) in Taiwan, Franken berg et al (1976) in Lusaka. The same was supported by Klienman (1980) in Taiwan Nakar. S. et al (2001) reported that a significant percentage of elderly Yemenite immigrants in Israel used traditional Yemenite medicine. Increasing age with the use of complementary and alternative medicine was reported by Oldendick et al (2000) in a survey in Carolina U.S. Korean elderly in America reported the use of traditional Korean medicine and this was dependent on health insurance status of the elderly, this was found in a study by Kim. M. et al (2002).

These studies though reported the use of traditional medicine among different age groups, never, accounted the reasons why traditional medicine was used by these groups and not preferred by other age groups.

Sex

Female morbidity rates are greater than the males around the world. Therefore one would anticipate females to be predisposed i.e. more susceptible and therefore greater utilisation of medical care. Studies have documented users of traditional medicine to be women.

Stella (1999) report that women use traditional medicine for menopausal symptoms. Gotay (1999) also reported that cancer patients who reported the use of traditional medicine were mostly women in Hawaii. They approached traditional medicine after approaching modern medicine and it was done to improve the quality of life. A similar finding was reported by Henderson et al (2004).

The study by Cappuccio et al (2001) in London on the use of alternative medicine reported that women of African origin mostly used the system of medicine. In a study by Gray et al (2002) it was found that Traditional medicine users were mostly female, younger and better educated. Melchart et al (2003) study in Germany on the utilisation of traditional Chinese medicine showed that almost three fourth of the users are women. This was done to evaluate the quality of a medical provider.
In an article by Christine A.Court et al, in Women Health ed. by Waller.D (2003) it was reported that women's usage of complementary medicine is generally found to excel that of men.

The disease specific studies using traditional medicine by women reported the reasons why traditional medicine was used but other studies never reported why women preferred using traditional medicine.

**Education**

It is reported formal education negatively influences the utilisation of traditional medicine. This has been revealed by different studies conducted in Taiwan, Korea and Thailand by Kleinman (1980), Rhi B. J (1973) and Hindeling P (1973) respectively (Kroeger.A1983).

Fromm et al (1970) reported that the educated did not utilise traditional methods of healing in Mexico. Similar findings were reported by Benyoussef et al (1974) in Tunisia. Ramesh et al (1981) study in Madras city of India on traditional Indian medicine revealed that half of the clients had no formal schooling and nearly 20% had only primary schooling.

**Ethnic group and Religion**

In a study by Kang et al (1994) it was found religion was one of the factor related to the choice of Chinese traditional medicine, it was found that folk religion believed and favoured traditional Chinese medicine. There has been a dearth of studies relating to religion as a factor for choosing traditional medicine, the reason maybe that Anderson model (1968) does not include religion as a factor for choice of a particular system of medicine.

Studies related to use of traditional medicine among ethnic groups showed that ethnic groups had no influence on the use of traditional medicine. Pachters (1998) study among families for the treatment of common cold among children showed no preference practices among mother from ethnic minorities of African, American, Puerto Rican and West Indian Caribbean heritage's to traditional medicine. Mackenzie et al (2003) study showed that use of traditional medicine did not differ by ethnicity in a national probability survey of Complementary and Alternative Medicine users. Kakai et al (2003) studied the choice of health information among cancer patient using complementary and alternative medicine among three ethnic groups. Study revealed that Caucasian patients preferred objective scientific information from journal or newsletters from research institution and the Internet. Japanese patients relied on medicine and commercial sources including print and electronic media and provider. Asians and Pacific islanders used information sources involving person-to-person communication with their physician, social groups and cancer patients. This was related to education levels and it was reported that effect of patients ethnicity overrides their educational level in shaping their choices of health information. It was found that Caucasian females used traditional medicine.
Study by Reeve M.E (2000) among the Caboclo community of the Lower Amazon reported that traditional medicine for these people is a salient mark of ethnic identity. In a study by Cappuccio et al (2001) Black people of African origin were more likely to use alternative medicine than the whites. Najm et al (2003) study among the elderly of three ethnic groups of Asians, Hispanics and White non-Hispanic showed that Asians were higher users of traditional medicine.

Lasker N. J. (1981) in 'Choosing among therapies: Illness behaviour in the Ivory Coast', reviewed a wide variety of medical systems available to the inhabitants of Ivory Coast. It was reported that ethnicity, religion and occupation are important individual characteristics, which predict choice of therapy. It was revealed that in the village ethnicity played a role 'gouro' (people indigenous to study area) were more likely to use the traditional system first as compared to others.

**Income and Occupation**

Source of income was found to influence the use of traditional medicine. HoS et al (1984) study on the role of Chinese traditional medical practice in Singapore revealed that patients belonged to the lower income group and were mostly unskilled labours. Djurfeld G et al (1973) study in a rural South Indian town revealed that social class was positively correlated with the use of allopathic practitioner (Kroeger.A1983).

But studies by Blais et al (1997), Eisenberg et al (1998), Furnham and Bhagrath (1993), Kelner and Wellman (1997), showed that use of traditional medicine was related to higher incomes. The latter can be explained by the
fact that they usually have to pay for traditional medicine from their own pocket, which might not be affordable for poorer patients (Kelner and Wellman 1997). This can be applicable in developed countries as studies in developing countries showed that use of traditional medicine was related to the lower income group. Study by K. Pillai et al (2003) in Kerala showed that the families who chose traditional medicine belonged to lower economic status.

There has been a dearth of studies, which showed that occupation is a direct determinant of use of traditional medicine. A study by Lee P.R (1981) on the factors related to choice of traditional Chinese medicine showed that farmers and businessman favoured traditional medicine.

Family Size

The size of the family with relation to the use of traditional medicine has been under researched. The family size might affect the predisposition of its individual members to use health services. It has been found that for large families greater are the levels of utilisation. According to Fiedler (1981) this is due to two interrelated factors, increasing family size increases the probability of introduction of infection. It also increases the probability of over crowding, implying closer physical contact which tends to enhance the spread of infection. This in turn increases the incidence of illness and so greater level of utilisation. But there has been no study to support this view. It is also reported that extended families can behave more traditionally than nuclear families. But this has to be studied farther and this particular study will try covering this aspect.
CHARACTERISTICS OF THE DISORDERS AND THEIR PERCEPTION

Research into the aetiology of disease in a particular setting is one door by which anthropology enters the field.

Chronic or Acute

The more chronic the condition the more time has the complainant to recourse the different curing facilities (Kroeger A. 1983). Evidence points to the fact that chronic diseases are usually treated by traditional healing methods.

In India (1965), rural Nigeria (1979), Korea (1973) and urban Zambia (1976) traditional healers treated particularly chronic conditions. 90% of patients of traditional healers 'suffered from chronic self limited and marked minor psychological disorder in Taiwan' Lieban's (1967) study in Cebu reports that Cebunos resort to 'mananbal' (indigenous healers) for supernaturally caused illness. Blais et al, (1997), Eisenberg et al (1998), Kelnar et al (1997), Murray and Shepherd (1993) and Vincent Furnhan 1996 reported that traditional medicine is used for chronic condition. Kersnik J’s. (2000) study in Slovenia revealed that traditional medicine was used for a chronic condition. Similar Findings was also reported by Astin (1998), Gordon.et al (1998) and Sharma (1992).

Severe or Trivial

Severe diseases seem to be treated predominantly by modern health practitioners, wherever possible.
Kleinman's (1980) study in Taiwan listed the various determinants of health care seeking. It was revealed that 'perceived' severity of sickness by family members appears to dominate. All the sickness episodes labelled by families as 'severe' received treatment from professional or folk practitioners.

In rural Mexico (1981) 21 persons with grave illnesses resorted to the modern system and eight to the traditional one. In most parts of rural Equador people with severe diseases resorted predominately to the modern system. However 71% of children under five years of age with terminal illnesses were presented to traditional medicine.

Kloos (1990) reported disease severity as an important determining factor for the utilization of health service. In a study among the elderly Mexican Americans by Apple white S.L. (1995) reported that though participants relied on modern medicine to treat serious injuries and major health problems, they still considered traditional folk healing in situation where modern health care was unsatisfactory or ineffective. Mitz dorf et al (1999) exploratory study evaluated patient's reasons far taking treatment in a hospital practicing traditional Chinese medicine. It was reported that disease severity was an important factor (long duration acute progression) along with other reasons to choose traditional medicine. Disease severity depended on the socio-economic status of the family for choosing the system of medicine for children affected with respiratory problems and diathrea in India (2003).
Aetiological concept

The aetiological concept among different communities was believed to influence the utilisation of traditional medicine.

Simmon's O.G. (1955) study among the Mestizo communities of coastal Peru and Chile revealed that the aetiology was important for the choice of healers. Foster (1958) called this as folk dichotomy. It was reported (1966) reported that rural Guatemalans went to the doctor to gain relief from symptoms and to the folk healers to remove the cause of the disease. Djurfeld and Lindberg (1975) observed in an Indian town a 'bewildering and confusing variety of view on medical subject' and concluded people's concepts of disease aetiology contributed substantially to choice of health services (Kroeger.A1983). In Taiwan (1979) people with mental illness resorted more particularly to traditional healers. In rural Nigeria (1975) conditions like worry and sleeplessness were predominantly treated by traditional healers, where as infectious diseases were treated by modern facilities. In a study (1976) in rural Tanzania some people with folk diseases preferred to resort to traditional healers. In a study in rural Ghana it was revealed that modern medicine was mainly used for infections and digestive condition while traditional medicine was mainly used for musculo skeletal problems. In urban Ecuador (1981) illnesses with deemed supernatural causes, were treated by folk specialist while infection was treated at home.

Hielscher et al (1985) study on the concepts of illness and utilisation of health care services in rural Malian village reveals that it's the cause of illness that decides the utilisation of medical service in a pluralist medical setting. Steen T. W. et al study (1999) in Botswana on the health seeking
behaviour among T.B patients reported that T. B may be regarded as 'European disease' or as Tswana disease and this has implication for treatment seeking. Patients who regard TB as Tswana diseases may use modern medicine for symptom relief but traditional medicine to treat what they consider the cause of the disease. In a study among the Caboclo community of Lower Amazon (2000) it was reported that understanding belief concerning disease aetiology is critical for individual treatment choices in a plural medical system. Bernstein el al (2002) reported that in Mongolia that patient's specific illness is important in deciding what type of treatment he will seek. Mishra et al (2003) study among the Samoans revealed that utilisation of the traditional healer or 'fofo' were based on aetiology i.e. Samoans used 'fofo' for biomedically defined muskulo keletal, neurological problems and Samoans sicknesses (ma samoa).

CHARACTERISTICS OF THE SERVICE

These are labelled as the enabling factors i.e. the factors which facilitate the use of particular health services. Geographical Accessibility, communication between healers and patients, quality of care and costs are major enabling factors in the choice of services available.

Geographical Accessibility

The low degree of accessibility of modern health services in supposed to be major argument for the use of traditional resources in the health care delivery. The geographical accessibility of a health service can be measured by the distance travelled, travel time and travel costs.
In a study by Srivastava et al (1974) on the utilisation and pattern of demand for the CGAHS Ayurvedic dispensaries in Delhi reported that long distances and waiting time were major reasons for not using allopathic dispensaries. In rural Tanzania (1977), Ethiopia (1980), Ivory Coast (1981) accessibility of modern services was one of the major determinants in the abandonment of traditional services.

In Bangladesh (1981) it is revealed that traditional practitioner had a much better coverage than allopathic ones. Paul C. Y Chen (1981) while studying the use of traditional and modern medicine in Malaysia revealed that rural people often have to depend upon traditional medical care as it is within their geographical and economic reach.

The study by Ramachandran et al ((1983) on the movement for medical movement in Karnataka revealed that there are no significant differences in the distance travelled among various occupational groups but there was an association between the places visited for treatment and the places of contacts through visits to relatives. This suggests that long distance movement is not a matter of travel costs but essentially of overhead costs at the place of treatment. Kloos (1990) and Bender et al (1993) reported that rural families use alternate care because modern care is less available to them.

In a study by Adera T. D. (2003) in a Kisshe settlement area in Ethiopia on traditional treatment of malaria revealed that, traditional medicine was used due to greater accessibility. In a study by Pillai et al (2003) it was reported that rural families in Kerala used alternative care
more often because Allopathic care is less available to them that their urban counterparts. Hill et al (2003) in a study in Ghana among children reported that accessibility was one of the reasons for preferring traditional medicine.

**Appeal acceptability / Doctor - Patient interaction**

The interaction between doctor or healer and his patients and the latter's family, friends, peoples previous experiences with services as well as factors ranging from waiting time all contribute to increase or reduce the appeal of particular services (Kroeger A. 1983).

Studies showed that causes for communication barriers between the population and western trained physician was the cultures specific classification, which does not fit in the doctor's paradigm. This was reported in Tunisia (1977) and Nepal (1977).

Studies related to this aspect will be dealt in detail subsequently in the chapter titled patient practitioner interaction

**Costs and Fees**

High costs are frequently asserted to be major barriers to modern health facilities, where as traditional treatment is supposed to be cheap and within reach of poor. This was reported by Bharadwaj (1975) while studying the attitude towards different system of medicine in North India.

Wolinsky et al (1982) in a study of the salient issues in choosing new doctor selected socio-economic status and access as two variants while describing the important factors influencing the choice of new doctors. It was revealed that the individuals with lower socio-economic status but better access to medical care focus on the cost of an office visit.
The dynamics of payment for therapy to traditional healers has been studied by Nichter.M (1983) in rural south India. It was revealed payment to traditional practitioners involve the ideal of moral bonding. Ho. S et al (1984) has also revealed that cheaper cost of Chinese traditional medicine was a major reason. Aaron's (1999) and Applewhite (1995) reported that in developing countries traditional medication are used frequently both by those who cannot afford treatment by physicians trained in the biomedical tradition. In a study by Messerli (1999) in Switzerland it was found that non-compliance in modern medicine was a result of the high costs.

The above studies reviewed reveal that utilisation of traditional medicine is determined by predisposing, enabling and aetiological factors. But some areas need further understanding like the income of the utilisers with relation to the cost of treatment availed.

DOCUMENTED USE OF TRADITIONAL MEDICINE

Other than the numerous studies conducted around the world on the factors that lead to the utilisation of traditional medicine there are also studies, which have documented the use of traditional medicine.

Charles Leslie (1976) and Klienman's (1978) study in Asian Medical System have been notable contribution in the field of medical pluralism. The use of traditional or indigenous medicine in the African continent has been studied extensively by different authors Oyebola (1980), Oyeneye(1985) etc Cosminsky et al (1980) provides evidence of utilisation of humoural medicine in Guatemala. Heggenhougen (1980) reveals that traditional medicine is used in Malaysia. The use of traditional medicine has also been
reported among the Asian community in Britain. Bhopal. R. S. (1986) has reported that traditional medicine was found to play a modest but not insignificant role within the context of total health care among the Asian community.


Adiputra N. (1992) study on Balineese traditional medicine revealed the reason why Balineise use traditional medicine. He reported that traditional healers practice traditional medicine within the cultural framework of his group / community. Secondly the diagnostic techniques are familiar in the areas. Lastly the curative materials are taken from the familiar resources or environment. R. Frank (2002) article on the relationship between the patient and homeopathic physicians revealed that homeopathic medicine is used in Germany. Maimbolwa M.D (2003) reported that traditional medicine was used by women to facilitate childbirth.

The recent trend in utilisation studies of traditional medicine is to study its use with specific diseases. Ernst (2000) and Ben-Arye (2003) studies the use of traditional medicine among dermatological patients. This study report that complementary medicine is being used by the patients, with a belief to do everything to heal the disease. Studies by Kakai (2002), (2003)
and Henderson (2004) reported the use of complementary medicine among cancer patients. The use of complementary medicine was used in conjunction with modern medicine. It was used to enhance the overall quality of life, to reduce stress and strengthen the immune system.

Studies by Eisenberg et al (1993, 2000) among patients affected with HIV revealed that patients had used Complementary and Alternative Medicine for HIV related problems, which included dermatological problems, nausea, depression, insomnia and weakness. The patients reported 'feeling better' 'feeling in control' and increased coping. These studies warrant further research into the area of traditional medicine on the efficacy of the traditional drugs.

HOME FRONT - INDIA

India with its rich tradition of multiple medical systems is known for the studies carried out by different author in the 1970's Banerji (1974-75), Bhatia et al (1975), Bhardwaj (1975) and Minocha (1980).

Tabor CD. (1981) has studied about the concepts of Ayurvedic medicine, which expresses the notion of health sickness in South Gujarat. Egnor M.T. (1983) study in Tamil Nadu of Southern India examines four different healing traditions practised in the region. This study revealed that the mythical and philosophical bases of this tradition share some common premises and communicates to the patients a common message concerning the nature of life.
Bhattacharyya D.P. (1983) examines the pluralistic nature of the psychiatric domain in Bengal, India. The paper critically analyses the concept of medical pluralism. Three varieties of pluralism are identified: the social institutional pluralism of the diverse specialists, the cognitive pluralism of clients conceptual frameworks, and the pluralism resulting from the divergent perspectives of the client and specialist. The paper argues that all the three forms of pluralism is conceptualised in terms of actors structuring activities and thus it is an emergent product of social interaction.

Izhar (1990) studied the users of Unani medicine in a clinic in Aligarh town in India. This study revealed that two thirds of the patients patronised the clinic after going to the modern medicine. This study revealed that educated utilised the system of medicine.


Chacko (2003) studied the use of Ayurveda among diabetic patients in an urban setting in Kerala. This study revealed that 40% of the patients used Ayurvedic medicine for the treatment of diabetes. Ayurvedic medicine and folk tribal remedies were used as supplements to biomedicine. This study is different from other studies as it tries to understand the local medical knowledge and regional remedies, which have been tried and tested in the background of cultural capital, an area founded by Pierre Bordieu (1988).
Pugh. F. (2003) study in New Delhi provides a descriptive account of rheumatic disorders in India's Ayurvedic and Unani medical traditions. Data was collected from texts and secondary sources and highlights their congruent concepts of arthritis, related somatic concepts, aetiologies and treatments in the two systems of medicine. It reveals the parallels in the clinical practices of practitioners of both system of medicines and identifies a broadly shared model of arthritis that circulates between the practitioner and the clients. Pillai K. et al (2003) study in Kerala applied Anderson's model to understand the factors affecting decision to seek treatment in the alternate system of medicine for women affected with acute respiratory infection and diarrhoea. The studies in India reveal that traditional Indian system of medicine finds patronage in urban setting.

Based on the review the researcher support Izhar (1990) statement that there is a dearth of studies in Great tradition medicine in India even after a decade.

Apart from Izhar's study on the usage of Unani medicine in 1990 and practice of traditional medicine in Madras in 1981 by Ramesh et al there are no studies to specifically understand the patterns of Utilisation and Practise of traditional medicine.

This study tries to be different in a way that it ventures into two great tradition medicines i.e. Ayurveda and Unani in Hyderabad simultaneously. The study tries to capture both the practice and Utilisation of two systems of medicine. The studies the researcher came across during the review found that both the concept of utilisation and practice has been understood from a
single homogenous group i.e. either the practitioner or utilizers\clients but this study tries to analyse both the practitioners and patient with respect to belief frames and factors responsible for the utilisation and practice of the two system of medicine.

**STUDIES ON PRACTISE OF TRADITIONAL MEDICINE**

As mentioned earlier by the researcher it is indeed a thin line that separates studies on practice and utilisation of traditional medicine, as they are two related concepts.

Studies reviewed will be presented under two main sub-heading studies conducted on the practice of traditional medicine worldwide and studies conducted on the practice of traditional medicine in India.

**PRACTICE OF TRADITIONAL MEDICINE WORLD WIDE**

Jaspen (1976) studied the social organisation of Indigenous practices among the Rejangs of Sumatra. Jaspen's study included the folk doctors of Sumatra. The study included the occupational professionalisation, the medical examination, the diagnosis and treatment, the pathology involved for diagnosis among the folk doctors. The study revealed that the folk doctors were not full time professional workers who depended for their livelihood on the practice of medicine. They were primarily farmers but enjoyed "high social status" in the community due to this medical training. The diagnosis depended on the 'hot' 'cold' dichotomy and treatment was followed based on this pathology other than the doctors own active and
devoted concern for the patient. The conscious understanding and efforts of patient, relatives and friends are a vital factor in the therapeutic process.

It was found that, it was a custom for a Rejang doctor to train one of his own sons or nephews in his an of medicine, if he had the right personality and a sense of dedication or calling. One of the holistic attributes according to Jaspen was the 'transparency' the Rejang folk doctors maintained in the practice.

Otsuka.Y (1976) study of Kanpo medicine, Chinese traditional medicine in Japan revealed that the increasing incidence of serious side effects from synthetic drugs, the analytic nature of modern medicine and disregard of patients complaints in modern medicine are factors that promote the development of Kanpo medicine in Japan. Yasuo studied the preferences of Kanpo practitioner and academicians of Kanpo medicine. The study also reported the concerns shared by the respondents, which included continued drug supply, standardisation of drug quality, and objectification of diagnostics, co-operation of Western and Kanpo medicine, modification of health insurance to include traditional treatment, education and reassessments of important classics and initiation of large scale research institutes of Kanpo medicine.

Weisberg. H Daniel (1982) while studying the Northern Thai health care alternatives in Sri Muang Town reported about the presence of two spheres of health care discernible solely on type of medical technology or modern traditional dichotomies. The practitioner in the medical systems have been divided into the locally sanctioned and officially sanctioned
sphere on three bases (1) how a particular healer is validated as a practitioner
(2) the form of organisation within a healer group, including the method of
training and the manner in which healers interrelate and perhaps co-operate
and (3) the style of interaction between the healer and the patient and family.
Weisberg reveals that in the locally sanctioned sphere which constitute of
herbalists and diviners jealousies are quite common between them but
relationship are cordial. They however do not share esoteric information and
formulas.

Duncan et al (1983) study on traditional medicine in Equador
identifies the structural and operational characteristics of non-formal health
systems, in terms of resources, terminologies, diagnostics, preventive and
the therapeutic procedure. Data was gathered on the socio-demographic
profile of the traditional healer and based on the information healers were
classified into different types. It was revealed that the fathers influence is
decisive in the initiation and training of the healer. Dreams and Oneiric
experiences had also been reported in the initiation, training and practice of
healing. The training and training process was through his life and daily
practices. No fixed time frame is reported for the completion of
apprenticeship. It was reported that the healer's clientele comes from the
same ethnic groups with the same ideology and interpretation of disease.

The traditional healers in Swaziland were studied by Edward green et
al (1984) to explore possibilities for specific types of co-operation between
modern and traditional health sectors. Edward Green et al distinguishes
between the two varieties of healers that include the divine healer and the
herbalist. The characteristics of the healers were studied, the training
background for both varieties of healers was looked into and the reasons for taking up the profession were also looked into. It was revealed that there is a certain amount of competition and mistrust among the healers and only 62% healers engaged in any sort of mutual referrals.

Coburn.D. et al (1986) article on Chiropractic in Canada describes and analyses the social history of the Chiropractic in Canada. It reports that while the Chiro practice in Canada has gained acceptance and recognition it has sacrificed many of its earliest claims to be an alternative healing art and to some degree chiro practice has become medicalised. This has in turn affected the scope of practice by moving toward a situation of limited mandate and this is being done for increased legitimisation. The Chiropractic is quite willing to refer any problems beyond their competence to regular medicine and is not against some of the therapies of regular medicine such as injection drugs and surgery as they once were.

Anderson R. (1984) exploratory study of a Mexican (Sabador) bonesetter covered three main issues i.e. (1) what does the Sabador treat (2) what methods are used (3) what success is achieved. The study revealed that the practice was limited to musculo skeletal pain or stiffness, cuts and bruises exclusively and used massage frequently as the method of treatment. It was found that on the whole the Sabador is a safe practitioner who provides at least some relief to nearly all his patients.

Ooi. G. L. (1991) study on the persistence of Chinese medicine in Georgetown a city in the state of Penang in Malaysia revealed that there was a reorganisation of traditional Chinese medical practice. Institutional
developments and adjustments observed among the traditional Chinese medical practitioners have created diversity. Such diversity is evident by comparing the practices that are based in shops and those which are Clinic based but also the newer and older practices.

Joralemon. D. et al (1993) study among the 'Curendero' in Northern Peru dealt with the lives and curing "metaphysics" of shamans (Curendero). The text also explores pre-hispanic and colonial sources for the symbolism of the rituals performed by shamans and the relationship between the shaman's practices and contemporary social reality.


Frank R (2002) study among the homeopathy physicians in Germany revealed three distinct patterns of homeopathic practice. In included segregating the patients into categories of homeopathic and biomedical patients (a) complementing a predominantly homeopathic practice with few biomedical strategies for diagnostics (b) focusing on homeopathy and condemning biomedicine with the exception of emergency medicine and surgery. The physician perspective on efficiency of homeopathy was collected. The study revealed that homeopathic physicians do not sacrifice central aspects of homeopathic concepts in order to gain legitimacy.

Taiwan have reported the integration of modern techniques, which may include diagnostic techniques in the system of practice by practitioner of traditional medicine.

**STUDIES RELATED TO THE KNOWLEDGE, ATTITUDE AND PRACTICE OF TRADITIONAL MEDICINE BY PROFESSIONALS OF MODERN MEDICINE.**

The increased trend in the utilisation of traditional medicine around the world in recent times has prompted research regarding KAP among the professionals of Modern Medicine.

Easthope G. et al (2000) study in Tasmania Australia among general practitioner revealed a favourable attitude toward complementary therapies. Favourable attitudes were attributed to personal experiences of such therapies, patient endorsement and the holistic orientation of complementary medicine. The favourable attitudes were prevalent widely among younger physician who practised singly.

In a study by Perry R. Et al (2000) in Britain to ascertain the use and attitudes towards complementary medicine amongst general practitioner revealed that 13% had treated directly by using a complementary medical activity 31% had referred and 38% had endorsed one or more complementary therapies. Risberg T. et al (2004) study among the oncology professionals in Norway revealed though only a small percentage of physicians had a favourable attitude towards Complementary and Alternative Medicine, paramedics showed a favourable attitude.
Watanabe. S. et al (2001) survey among the doctors belonging to the regional medical association in Japan showed that nearly 73% of doctors practised Kampo (Japanese traditional medicine). Doctors who believed in the efficacy of Kampo tended to believe that other Complementary and alternative Medicine therapies were also effective.

Such studies among the health professional is important as Botting D.A et al (2002) put forward that the medical profession is involved in the political processes affecting legislation governing 'complementary medicine'. Botting D. A. et al (2002) has also made a critical review of published research studies dealing with the knowledge, use and attitudes of doctors to complementary medicine. According to Botting D.A. et al these studies also raise a number of concerns including lack of evidence to demonstrate effectiveness, possible harmful effects, in adequate knowledge of doctors and lack of statutory regulation for most therapies.

This has also been opined by Mukherjee P.K (2001) regarding the evaluation of drugs of traditional medicine of Ayurveda, Siddha and Unani. According to Mukherjee government of India and private sector are exploring all of the possibilities for the prefect evaluation of these system in order to effectively adopt the therapeutic approaches available in the systems of medicine and to help in generating data to put these products on the National health programme.
PRACTICE OF TRADITIONAL MEDICINE: INDIA

Studies on the practice of traditional system of medicine can be dated back to 1970's, which included, Alexander et al study on traditional healer in (1971), Bhatia J.C. et al (1971) on the role of Indigenous medical practitioner in two areas of India, and a latter study by the same author in 1975 on traditional healers and Modern medicine. Chutney C.S. et al (1973) survey of indigenous medical practitioner in rural area of five different states of India.

Basham A. L. article in Charles Leslie book Asian medical system (1978) covers the practice of medicine in ancient and medical India.

Montgomery Edward presented his findings of the study of private medical practitioner in Vellore Tamil Nadu in Asian Medical System (Charles Leslie ed. 1978). This study included the private medical practitioner belonging to modern medicine and traditional medicine. The organisation of practice range of services rendered (which included population of patients) referral services and socio-demographic character was collected. Montgomery proposes a model of a medical system, which constitutes of four variables rate of change in the practitioner population, collective rate of consultation or medical practice, rate of change in the patient population and set of medication.

According to Montgomery the model is intended to encourage studies of the ways in which changes in medical practice are causally related to equally important changes in other aspects of the medical system.
Data was collected from practitioner of two system of medicine i.e. Siddha system of medicine and Ayurveda in Ramesh et al (1981) study on the practice of traditional Indian Medicine in Madras. Information was collected regarding system of practice. Training background, characteristics feature of the patients seen, Diagnostic methods and attitude and opinion. The study revealed that the indigenous medical systems still remain a significant contributor to medical care of the people. The study reported that a number of favourable factors support the Indigenous Medical practitioner even though there is competition from modern practitioner. The factors included low cost factor, location of the centre as it increases demand and many provide dietary prescriptions, which are expelled by people of Indian culture when they are ill.

Kakar S. (1982) book on shamans, mystics and doctors deals with the psychological inquiry into Indian and its healing traditions. Kakar (1988) explained the role played by traditional medical practitioners in the primary health care and the factors that guide the people to avail these services. Anandhi et al (1999) conducted a study in rural area of Haryana to analyse the role of the indigenous private medical practitioners in reproductive health of the population. The authors emphasised the need for including the Indigenous medical practitioners in delivering reproductive health through training them adequately.

During the course of review on the practice of traditional systems of medicine, it was found that barring two or three studies in the great tradition medicine most of the studies were conducted in little tradition medicine or
folk sectors. The review revealed that while studying the practice of a system of medicine various aspects of the practitioner need to be covered which included, organisation of practice, training background. Range of services rendered in terms of diseases treated and population treated and the attitude and opinion of the practitioner towards the system of medicine practised vis-à-vis the modern system of medicine.

It was found that the studies focusing on the practice of traditional system of medicine in India in recent times were scare. The researcher however do not contend the fact that there may be unpublished studies conducted in India, which was not come across by the researcher. Another reason may be that, utilisation studies also try to cover the aspect of practice of the system of medicine. But as the researcher has already mentioned the basis for the segregation of the studies, it was found focused studies on practice were few in number.

OBJECTIVES OF THE STUDY

1. To know the client profile of the users of traditional system of medicine.
2. To explore the factors leading to the use/non use of traditional system of medicine.
3. To understand the strength and contribution of traditional system of medicine in the terms of numbers and range of diseases treated exclusively or as a complementary form of treatment.
4. To know the socio-demographic profile, organisation of practice, services rendered by the practitioner of traditional medicine.

5. To understand the belief frames, perception and opinions of patients and practitioner towards the traditional system of medicine.

6. To analyse the process of practitioner patient interaction and how the doctor and patients view and evaluate each others role.

SIGNIFICANCE OF THE STUDY

The 'quest for therapy' all over the world is an important research issue since it reveals essential elements of peoples social behaviour and provides insights into their perceived needs for different kinds of health services (Kroeger, A. 1983).

Utilisation studies could offer great insights into how best to design and alter the health delivery system so as to improve health care services, which in turn increases utilisation of health care services.

In the recent years the growing need for research in the traditional system of medicine has been recognised by WHO which passed its first resolution in 1977 promoting development of training and research in traditional systems of medicine. There are many reasons cited for the promotion and development of traditional medicine. Its approach is unique and holistic. It's culturally, socially and environmentally close to people. It has a potential for wide application at low cost. Its use local resources, local
technology and labour. It has the potential to contribute to scientific and universal medicine.

The world health assembly has adopted a number of resolutions drawing attention to the fact that most of the population in various developing countries around the world depends on traditional medicine for primary health care. The practitioners for traditional medicine is a potentially important resource for the delivery of health care (WHO 1998).

The world health 'Traditional Medicine Strategy 2002-2003' takes care of the safety, efficacy, quality, availability, preservation and further development of traditional medicines. The strategy also envisages the integration of traditional medicine into national health care systems by facilitating members states to develop their own policies on traditional medicines.

But for making an effective and comprehensive policy involving traditional medicine, it is required to specify the efficacy and scope of traditional medicines vis-a-vis modern medicine. Another requirement is the study of the utilisation pattern of the traditional medicine by different populations to understand the services offered and the attitude, opinions shared by the users of traditional medicine. As this particular study tries to capture the client community and the practitioner of the traditional medicine, it can help the health policy planners to utilize the services of the practitioners in various public health programmes, so that it effectively reaches the clients utilising the traditional medicine.
This study tries to explore the factors leading to the use and non-use of traditional system of medicine. This analysis may contribute to understanding the continuity and change within the Indian society specifically relating to health culture.

METHODOLOGY

STUDY AREA

As has been stated earlier the study has been restricted to only two traditional systems of medicine i.e. Ayurveda and Unani. The present research was conducted in Hyderabad due to the following reasons:

1. The literature survey undertaken by the researcher revealed that the proposed traditional system of medicine i.e. Ayurveda and Unani were practiced and utilized in Hyderabad.

2. The State Board of the Indian System of Medicine and Homeopathy in Andhra Pradesh is located in Hyderabad, which helped the researcher when secondary information about different aspects was required. This also included the sample frame of the practitioners located in Hyderabad.

A brief profile of the organizational structure of the board, the educational facilities and the registration process in the state has been presented in the appendix.
THE UNIVERSE

Hyderabad is the fifth largest city in the country spread out across an area of 217 square kilometers. The total population of Hyderabad is around 37 lakhs consisting of around 19 lakh males and around 18 lakh females. The population growth (decadal) is around +17.18%. The literacy rate is 79.04%. Hyderabad consists of a cosmopolitan profile with people from different states practicing different religions. Some of most prominent religions are Hinduism, Islam and Christianity. Different languages are spoken with the prominent ones being Telugu (the State language), Hindi, Urdu and English.

HEALTH FACILITIES IN HYDERABAD

A list of the government health facilities in different system of medicine available in Hyderabad are presented (Government of Andhra Pradesh, 1998-99).

<table>
<thead>
<tr>
<th>System of Medicine</th>
<th>No. of Hospitals and Dispensaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopathy</td>
<td>82</td>
</tr>
<tr>
<td>Ayurveda</td>
<td>06</td>
</tr>
<tr>
<td>Unani</td>
<td>15</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>09</td>
</tr>
</tbody>
</table>
Other than the government facilities, there are also numerous private and corporate Allopathic hospitals in Hyderabad but the same does not hold true for other systems of medicine.

THE SAMPLE

As the study was concerning both practice and utilization", the sample included practitioners and patients of Ayurveda and Unani system of medicine. The practitioner's sample was selected from the list of institutionally qualified registered practitioners of Ayurveda and Unani. The samples for the patients were selected from the patients utilizing the services of the sampled practitioners.

Sample for Practitioners

The list of registered Institutionally Qualified practitioners for both Ayurveda and Unani system of medicine was collected from the state board of Indian Systems of Medicine and Homeopathy, Hyderabad. This constituted the sample of practitioners within the Telangana* region. From this list the registered practitioners in the study area was short-listed. This consisted of 365 practitioners of Unani and 487 practitioners of Ayurveda in Hyderabad as on 30th October, 2001. As it was decided to choose 10% of the practitioners from Ayurveda and Unani a sample of 50 belonging to

* Utilization in this study is defined as the process where services (which include medicines /physical treatment, etc) are taken by the respondent after approaching a qualified practitioner of traditional system of medicine
Ayurveda, and 40 belonging to Unani were finally selected. As it was intended that the sample should be representative of the universe, the practitioner were selected from different zones of Hyderabad. But during the fieldwork it was found that tracing the practitioners from this sampling frame was not an easy task as only five Ayurvedic and three Unani practitioners were traced from the list. One of the main reasons included the change in the address of the practitioners. So finally the researcher visited the government Ayurvedic and Unani hospitals in Hyderabad and a snowballing technique was used to locate the practitioners in Hyderabad. Each practitioner was asked to identify five practitioners for the study. The researcher ensured that there were no two similar references cited by two practitioners.

**Sample for Patients**

It was decided equal number of patients (i.e. around 100) would be covered for both the Ayurvedic and Unani medicine to understand the utilisation pattern. Patients were selected from practitioner who reported of treating more than five patients per day. This was ascertained during the interviews with doctor by observing the turnout and also going through the registration records whenever possible and wherever maintained. Though greater number of Ayurvedic practitioners reported treating more than five patients per day, patients were selected from only 33 practitioners as only 33 practitioners of Unani reported the same. The patients were selected at the rate of three patients from 33 practitioners of Ayurveda and 33 practitioners of Unani respectively.

* See registration process in appendix 1.
Thereby 99 patients using Unani and 99 patients using Ayurveda were selected. The total sample of 198 patients was selected randomly from each practitioner and only the second patient was selected for the interview.

Efforts were taken by the Researcher to ensure that 50% of patient sample were visiting the health care service for the second time. This was mainly done to capture detailed version regarding utilization behaviour, which included collection of belief frames, factors responsible for effective utilization, perceptions and opinion on traditional system of medicine.

TECHNIQUES OF DATA COLLECTION

Data for the study included both quantitative and qualitative information.

Schedule

Information was collected primarily by means of a semi structured schedule. There were two types of schedules. One was administered to the practitioners of Ayurveda and Unani medicine. The second type was administered to the patients using Ayurveda and Unani medicine. The schedule for the practitioners covered aspects like the socio demographic profile, the training background, the system of practice, Organisation of practice, the range of services rendered which included Patient load, Organisation norms of fees and Compliance behaviour of patients. Details of the patient practitioner interaction was also collected with the help of the schedule. The schedule for patients covered aspects like the client profile, the family particulars which included type of family and the socio-
demographic particulars of each individual of the family. The history of the current illness was collected which included duration of the illness, symptoms suffered, action taken from onset of symptoms and shopping under taken by the patient for treatment. Data was also collected on the health seeking behaviour of the family members. The current health provider patient interaction from the patient's point of view was also collected.

Case studies

Case studies were taken when in depth information was needed. Case study technique was particularly employed to elicit information on the health seeking behaviour and choice of therapy. Case studies proved to be helpful as they substantiate the data that was collected by various other means.

Interviews

Interviews with use of Interview Guides was also conducted. Interviews were conducted for practitioners of Ayurveda and Unani medicine. Interviews among the patients revealed the belief frames, attitudes, knowledge preference practices towards Ayurveda and Unani medicine vis-à-vis biomedicine. Information was also collected on the availability, quality and affordability of drugs in Ayurveda and Unani. The Reasons for choice of therapy and the qualities of Ayurveda and Unani medicine which distinguish it from other system of medicine.
Interviews with practitioners were conducted to elicit information on the attitudes, opinion, beliefs towards the system of medicine practiced, limitations and problems encountered during the practice, quality of drugs produced and the government efforts to uplift the traditional system of medicine. Data was collected on referral patterns, status of the system medicine in terms of changes to keep in pace with modern medicine and role of media in promoting the system of medicine.

LIMITATIONS OF THE STUDY

Tracing the practitioners was one of the major hindrances faced by the researcher as the addresses provided by the State Board of Indian Systems of Medicine and Homeopathy had changed and thereby practitioners were not available. Securing an appointment for the study was another major area of concern. Practitioners were not keen on allocating separate time for the interview. The practitioner wanted the interview to take place during consultation, which was a major hindrance, as the flow of information was obstructed when a patient visited the practitioner.

Collecting information from practitioners was a challenging task the aspect that a non-medical person was 'questioning' a medical person was met with initial resistance, but explanation from the researcher, which included the nature and scope of the study, reduced the resistance. Practitioners were interested to know why the study was conducted only within the Ayurveda and Unani system of medicine.
RECORDING AND VERIFICATION OF DATA

Data was recorded immediately in the schedules for the practitioner. Data collected from the patient were verified with the attendees of patients and from medical records were whenever possible regarding the authenticity of the information provided.

DATA ANALYSIS

Data was analyzed with the SPSS package

CHAPTERIZATION

Apart from a brief introduction dealing with explanations of medical pluralism, Traditional systems of medicine, the history of TSM in India, statement of objectives, detailed literature review and the methodology followed for the study the thesis contains five other chapters.

The second chapter contains a brief profile of Ayurveda and Unani. The third chapter will focus on both the traditional system of medicine and its practitioners. The profile of the practitioners will be dealt. It includes the organisation of practice, the training background, Range of services rendered, attitude and belief of practitioners of both system of medicine vis-à-vis biomedicine.
The fourth chapter will give a detailed account of the factor that lead to the use of both the systems of medicine. The patient profile, reasons for choice of therapy, belief frame, attitude and opinion of the patients will be presented. The health seeking behaviour and shopping for treatment will also be highlighted.

The fifth chapter will be regarding the Patient practitioner interaction. This chapter constitute the findings of patient-practitioner interaction and how each of them evaluates the role of the other. The importance of this aspect in utilisation studies will also be highlighted. This will be followed by the last chapter, which will consist of the summary and conclusions.