Chapter-1

INTRODUCTION

Human health has been such a wide and complex subject that it is difficult to find simple solutions to every problem of the society regarding its well being. As remaining healthy is the cumulative effect of social, economic and political factors on the behaviour of an individual. The situation becomes more complex in a country like India, where people of varied social practices, economic backgrounds and political thoughts jostle to find a space in this unique canvas of human creation. The policy makers in India, from the very beginning, emphasised on providing the health services on a mass sale free or at a reasonable cost to the masses by the government. The Bhore Committee in 1946 emphasised that the health services should be placed as close to the people as possible in order to ensure the maximum benefit to the communities to be served. Since then a lot of planning, efforts and public expenditure have gone into improving health both in rural and urban India. Despite concerted efforts, however, India continues to be among the many developing countries of the world with high levels of morbidity. The goal of ‘Health for all’ by 2000, accepted by Indian policy makers in 1978 at Alma Ata could not have been achieved.

The National Health Policy, 2002, announced recently, 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. The last
policy was formulated in 1983 and since then the health scene has changed dramatically requiring a more exhaustive approach. The major drawback of our health policy has been the neglect of traditional medical systems. Even today one half of the treatment are being provided by private clinics (National Council of Applied Economic Research, 1995). Most of them are run by traditional medical practitioners. The need of the hour is to incorporate the benefits of traditional medical systems and make them part of the realm of policy making. For this the comprehensive knowledge of the health services provided by these traditional medical systems is necessary so that their exact role in the policy draft can be demarcated.

In the new National Health Policy 2002, the traditional system of medicine—Ayurveda, Unani, Siddha, Naturopathy and Yoga, Amchi and Homeopathy have been included in the wider framework of health services. The traditional systems will draw upon the substantial untapped potential of India as one of the eight global centres for plant diversity in medicinal and aromatic plants. As per the present scenario, in India 70% of the population use traditional medicine for primary health care (WHO, 2002). The situation is no different in most of the developing countries. Even in developed countries, the use of alternative medicine has been steadily increasing. These trends clearly show the reach and dependence, if not necessarily the efficacy, of traditional medicines.

In different countries of the world, the health policy makers have been forced to think about the safety, efficacy, quality, availability, preservation and further development of traditional medicines. To assess the present situation and addressing these issues, World Health Organisation has defined its role for better use of traditional medicine by formulating “Traditional Medicine Strategy 2002–2005”. Facilitating integration of traditional medicines into
national health care systems by helping member states to develop their own national policies on traditional medicines is one of the goal envisaged in the WHO strategy.

In a developing country like India, where at present only 0.9 percent of the GDP is being spent on health sector by the Government, it is still difficult to provide all the facilities of proper health-care to the vast population of the country. This makes imperative to use the services of already existing traditional medical practitioners, by enhancing their skills and incorporating them into health care programmes. In addition, the failure of the previous health policies, depending solely on the biomedicine, has enhanced the importance of traditional system of medicine to fill the lacunae. But for making an effective and comprehensive policy, it is required to specify the efficacy and scope of traditional medicines vis-à-vis biomedical or modern system. Another requirement is the study of the utilisation pattern of these health services by the population both in case of traditional as well as modern medical systems. The present study deals with this aspect and is concerned with the type of health care services being provided in Ayurveda and their utilisation by the population.

MEDICAL ANTHROPOLOGY- A SUBFIELD OF STUDY

A social anthropologist generally views the field of medicine in two main aspects: (a) As a cultural complex, i.e., a complex of material objects, tools, techniques, knowledge, ideas and values; and (b) As a part of social structure and organisation i.e., a network of relations between groups, castes, classes and categories of persons. In both these aspects the interest is in medicine, just as in other aspects of social life such as religion or economy. Medicine, like these other subjects, is amendable to systematic study and analysis by sociologists and anthropologists. What is even more important is
that the knowledge of these two aspects of medicine, in itself and in relation to other fields of social life such as economy, religion, magic and law, is becoming increasingly necessary for a real comprehensive understanding of society. Medical anthropology, as a sub field of enquiry deals with the study of people’s point of view in medicine. In its goals, it is not merely limited to the extent of assisting medical sciences in health care delivery but it also covers a much broader spectra of enquiries.

Interest in social and cultural dimensions of illness reached a peak in the West during the nineteenth century, stimulated by public health problems associated with the Industrial Revolution (Dubos 1959). This was the period of an impressive development of social medicine, led by such figures as Villerme in France and Virchow in Germany (Dubos 1959, 1965; Rosen 1963). But in latter part of nineteenth century, the interest in the social and cultural context of medicine declined, because of the preoccupation of the researchers with the direct, immediate causes of disease, such as the effect of microbes on body tissue. Again in the mid twentieth century, since World War II, medical anthropology as a discipline has shown greater development than the previous years. A good idea of the scope and volume of research during what might loosely be considered the first decade of substantial growth in medical anthropology can be gained from excellent review articles by Polgar (1962) and Scotch (1963). A cogent summary and analysis of developments in subsequent years is provided by Fabrega (1972).

In anthropology, the renewed interest in the socio-cultural aspect of health and disease has been stimulated by problems connected with western medical programs in developing areas and by current trends in western medicine itself (Scotch 1963). Health and disease are fundamentally connected with the survival of the society. It is basically the social values and the systems in which they are
practised, affect the perceptions of these phenomena. In this perspective, medical anthropology is not only a way of viewing the states of health and disease in society, but a way of viewing society itself (Lieban 1974).

Fabrega (1972) in a definition of medical anthropology has expressed that a medical anthropological inquiry will be defined as one "that elucidates the factors, mechanisms, and processes that play a role on or influence the way in which the people respond illness and disease. It also examines these problems with an emphasis on patterns of behaviour". The classification given by Lieban (1974) divided medical anthropology into four major areas: ecology and epidemiology, (ii) ethnomedicine, (iii) medical aspects of social system, and (iv) medicine and culture change.

The social and cultural aspects of health and illness have also been tackled in the discipline of medical sociology. Strauss (1957) and Kendall (1963) see the field of medical sociology is composed of two branches: sociology in medicine and sociology of medicine. As Kendall describes them, the first of these distinctions emphasises the contributions of sociological knowledge to the diagnosis and treatment of disease, while the second "concerns itself with sociological study of the medical profession". Foster (1974) concluded that the anthropologist is more interested in culture and the sociologist is oriented towards society. However Hasan (1975) states the medical anthropology is much broader than envisaged by Foster, as it combines in one discipline the approaches of the biological sciences, the social sciences and the humanities. Thus the main thrust is one having a holistic approach towards finding the interrelationship between the social values and medical beliefs of the people, which ultimately affects their response to the diseased condition.
MEDICAL PLURALISM

In the developing societies, the attention is being focused by the researchers on the prevalence of ‘Medical Pluralism’, the coexistence of different medical traditions within a common social settings. The emphasis is being paid on their description, survival value and comparative analysis of variety of forms of health care. An initial focus among applied anthropologists was local responses to biomedicine in non-western settings and putative conflicts between different conceptual systems produced by the encounter (Lambert, 1996).

Pluralistic health care arenas offer those with the means to access them a variety of alternative medical systems. They range from home care with grandmother’s remedies and patent medicines to the services of herbalists, homeopaths, acupuncturists, chiropractors, psychotherapists, vaidas and biomedical super specialists to the existence of spirit medicines, astrologers, diviners, shamans and exorcists. The concept of medical pluralism in anthropology adopts an integrative approach to understand how both the healers and the system in which they are involved and the patients, think and act concerning the care of their body, prevention and cure of the disease. It is not just the efficacy of any particular system which helps it in its survival, but its capacity to integrate itself in the social framework of that society. As Ohnuki-Tierney (1984) pointed out, while studying illness and disease in Japan, that the most important factor in the success of medical pluralism in Japan today is that each system has become so thoroughly embedded in Japanese culture and society. Each system is a part of the total subcultural system. In a way, the study of medical pluralism leads to the understanding of that particular society in which it exists.

Every society has its own concept of illness and disease, and
thus distinguish requirements for remaining healthy. It has been found that social beliefs often influence the medical beliefs and the development of entirely new kinds of healthcare systems. The expansion and diversification of regional health care arenas are the result of a complex of cultural, socioeconomic, political, epidemiological, and demographic factors. (Nickter and Quintero, 1996). Anthropologists have pointed to a number of other factors that have a direct bearing on pluralistic health care. As cultural values, social change, relations of power, responses to human suffering, and issues of ethnic and self identity determine the health behaviour and the healing process. Therapeutic systems are not ideologically neutral. All systems of therapy are ethnomedical, in the sense that they are closely tied to cultural values that impact on what is deemed natural and normal, as well as on what is measured and monitored, privileged and discouraged. Each system is involved in the production of truths in a context in which knowledge entails power and ideology is embodied during health care seeking and practice (Nichter and Quintero, 1996).

The forces of globalisation with improved communication and education; migration, urbanisation and industrialisation world–system market expansion within the medical and pharmaceutical sectors; and changes in the availability of natural and technological resources has opened a wider range of alternative health care options. It is not that medical pluralism exist only in the developing societies which have their own traditional medical system along with the western medical system or biomedical system. Even the advanced western societies are now interacting with the traditional medical beliefs of ancient societies like India and China. It is now the reverse flow of beliefs and health care practices. A variety of health care option coexist in most cultures, even in those in which one medical system enjoys dominance as a result of political patronage and state regulation. For
example, in the United States the biomedical system is clearly dominant, but in 1993 it was estimated that about one third of all U.S. residents used unconventional (non-biomedical) medical treatments. The study also found that a quarter of those sampled used unconventional methods of treatments as self-care, and approximately 30 percent of those consulting a doctor (for a medical complaint) also used alternative forms of treatment. (Eisenberg and others 1993). World Health Organisation has used the term ‘complementary and alternative medicine’ (CAM) for non-biomedical treatments, in case when they are used in developed countries, as they act as an additional and alternative source of health care. The percentage of the population which has used CAM at least once is 48% in Australia, 70% in Canada, 42% in USA, 38% in Belgium and 75% in France (WHO, 2002).

The emergence of alternative therapies in the West, is somewhat a response to the limitations 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 their health policies based solely on the biomedical system to fulfill the needs of their populations more effectively, that led to the perpetuation of varied forms of traditional medical beliefs. Even though the reach of the biomedicine in the developing countries is limited but in most cases the system could not conform to the social beliefs of the population in these particular societies.

EMERGENCE OF MEDICAL PLURALISM IN INDIA

India is among the few countries in the world which has such a diverse range of ethnic groups, religious beliefs, linguistic traditions and social customs. So the occurrence of variable medical systems with their own traditions of diagnosis and cure, within the common geographic limits is not surprising. Moreover, it was inevitable for the
Development of pluralistic medical beliefs, after the assimilation in large number of so many social groups into this unique Indian cultural mosaic. The origin of the knowledge of health care goes as far back as the origin of the Indian civilization as such i.e. the Indus valley civilisation. All other known cultures of the past—Egyptian, Babylonian, Jewish and Greek etc. had their own equally glorious and useful systems of medicine and health care.

During the second half of the fourth and the early part of the third millennium B.C. developments took place around the course of the Indus river that were to lead to the mature Indus civilisation, which flourished during the middle and later third millennium. The period of mature Indus civilisation shows us an evolved urban society with clearly drawn class divisions and roles. No doubt healers of some type existed, perhaps coinciding with the religious functionaries. It certainly seems that hygiene was highly regarded, since the houses in Harappa, Mohonjo-daro, and Lothal often had separate bathrooms with drainage to covered culverts that run beneath the city streets. But while the Indus script remains unread, well-proven archeological facts to tell the exact nature of health care practices are not available.

During the latter part of the second millennium B.C., with the settlement of Indo-European people, started a new period of completely different social beliefs, religious practices and customs, which is known as ‘Vedic Period’. In this time period were produced the great Indian philosophical texts, Vedas, which are considered to be the repositories of recorded Indian culture. The knowledge of variety of forms of human ailments and known herbs for their cure, has been recorded in these texts. Several deities were ascribed particular healing powers, diseases were explained as caused by evil spirits or by external accident, and rituals involving incantations (mantra), penances and prayers were used to placate the superhuman beings. Poisons were classified and used. This
knowledge has played so important a part in the development of a proper medical system that it has been documented in an integrated form in Vedas which are considered to have been originated from gods. This system has been more precisely known as Ayurveda. But Ayurveda as it is practiced today is the result of work done through ages, from the fourth century BC up to the end of first millennium AD. Most of this mythological and medico-religious genesis of Ayurveda is even today shrouded in the mist of antiquity.

Meanwhile, in South India a completely different type of medical system evolved which became the magnificent feature of the Dravidian culture. Known as Siddha medicine, this was—and is—primarily an esoteric alchemical and magical system, apparently strongly influenced by tantric thought and Ayurveda. Its origin has been treated as far back as the Indus valley civilisation. It has been found that there was a strong interaction and mutual borrowing between Siddha and Ayurveda in the formative periods.

The attribution of the cause of disease to the influence of celestial demons has been an acceptable thing since the ancient times. Even today, most of the people in India believe that planetary motions (Graha disha) affects the course of the life. Astrological medicine, is another aspect of Indian medical beliefs (Wujastyk 1993). A work exemplifying the close relationship between medicine and astrology as therapeutic system is the Virasimhavaloka by Virasimha, composed in AD 1383, probably in Gwalior. The parts of the body are conceptually equated with the constellation and planets in a complex scheme of relationships and influences, and the astrologer reads this structure of symbols in order to understand the patient’s problems and to suggest such remedies as amulets, penances, and prayers, as well as herbal decoctions (Pugh, 1984).

In northern and north-eastern Himalayan regions of India,
bordering Tibet, *Amchi* system of medicine is being practised. *Amchi* system traces its origin to Ayurvedic system and is in vogue in Ladakh district (J & K), Lahaul (H.P), Arunachal Pradesh, and Sikkim. This system of medicine is now more closer to the Tibetan system of medicine. The medical system since its delivery by Lord Buddha, while meditating near Bodh-Gaya, in course of time, had accumulated a huge literature and *Amchis* of great fame and repute were produced.

At the end of first millennium AD, with the Arab invasion, introduced another medical system known as ‘*Unani* system of medicine’. *Unani* system originated in Greece. It was further enriched and developed by Arabs and Persians. The great contributors to this system were Hippocrates, Aristotle, Herophilus, Erasistratus, Ibn Sina (avicenna), Dioscoridee, Galen, Al Mamum Ibn Masswayh, Rhazee, Ibn Ishaq, Ibn Al Baitar and others. In India, this system flourished with the royal patronage given in the Sultanat and latter in the Mughal periods. In 20\textsuperscript{th} century, this system was further enriched and brought to prominence by the research work done in developing new medicine and translating original texts by great Indian scholars like Hakim Ajmal Khan, Hakim Kabirudin Saheb and Hakim Abdul Razaque.

The British arrived in India at the beginning of the 17\textsuperscript{th} century, in the form of East India Company. Although there were other European trading companies doing business in India like Dutch, Portuguese and French, but the credit for introducing biomedicine goes to the British, as they emerged as the major political power controlling almost the entire geographical area of the subcontinent. At that time *Unani* and *Ayurvedic* systems were widespread in their use. British colonial rulers gave preference to their own medical system over these indigenous traditional medical systems, while formulating the policies for health care and education. Earlier in the 18\textsuperscript{th} century
the biomedicines were confined to the British military cantonments, civil lines and some of the Indian royals. But subsequently in the 19th and then in early 20th century its reach was enhanced by establishing Indian Medical Service in 1897 for catering to the general public also. The setting up of medical colleges in Calcutta (Kolkata) in 1835, Madras (Chennai) in 1837, and Bombay (Mumbai) in 1845 was an important landmark in the spread of biomedicines. British policy of making health care totally rely upon the biomedical system was continued even after the independence. Bhore Committee, set up by the British colonial authorities (1943), based its recommendations for the future health policy by selecting biomedical system as the primary source of health care. This report, to this day, is regarded as an authoritative document.

The association with Europeans not only brought the biomedicine (allopathy) to India, but another very effective system, developed in the West—Homeopathy. The homeopathic way of healing was devised by the great German physician Dr. Christian Frederick Samuel Hahnemann in late 18th century. This system was first introduced in India in 1839 by Dr. John Martin Honigberger. During his visit to India he cured Maharaja Ranjit Singh of Punjab for paralysis of the vocal cord and edema, though native physicians failed to do that. The homeopathic system of treatment spread successfully not only among the poor people but also among the civil and military personnel throughout the country.

India's great medical tradition Ayurveda not only influenced other medical systems, but some of its components were further developed and propagated as separate entities. The system of Yoga is one of them. It was in the first millennium BC when Patanjali propounded it in a systematic form. Yoga has been gaining popularity and in the West it has become quite a rage. Another system which is closely allied to Ayurveda so far as fundamental principles are
concerned is Naturopathy. Naturopathy is not only a system of treatment but a way of life. There are two schools of thought regarding the approach of naturopathy. One group believes in the ancient Indian methods of diet control while the other mainly adopts western methods which are more akin to modern physiotherapy. Naturopathy as a health care system, got support from some of the great Indian leaders like Mahatma Gandhi. After independence, Morarji Desai, a former Prime minister of India provided his full support and guidance for propagating this system.

Besides these Greater Traditions of medicine, there has been a number of lesser traditions, known as Little Traditions of medicine, which flourished under their shadow unrestrictly. There is a large number of shaministic and folk healers in modern India, and it is certain that such practices have been common there since earliest time (Kakar, 1984). These folk traditions trace their origin from the Greater traditions of Ayurveda. Today, in addition to the established medical systems like Ayurveda, Unani, Biomedicine (Allopathy), Homeopathy, Naturopathy and Yoga, there are traditional bone-setters, massage and enema therapists, faith-healers, famous Gurus, traditional midwives, and the wandering specialists who remove wax from ears.

ESTABLISHED MEDICAL SYSTEMS IN INDIA

At present, policy makers in India has incorporated both the biomedicine as well as the traditional systems of medicine in the National Health Care policy. It has been felt that traditional systems of medicine cannot be ignored, as they have wider reach even in the remote areas of the country. This recognition has paved the way for the organised development of traditional systems along with the biomedicine, each on the basis of its own individual philosophy, merit and strength.
The Union Ministry of Health and Family Welfare has established two separate departments, one for biomedicine and other for traditional systems of medicine, each headed by a secretary. In addition, there are Statutory Regulatory Councils, Research Councils, National Institutes, Pharmacopeial Laboratories and drug manufacturing units.

The major role and responsibility for health care has been provided to the biomedical system of medicine. The traditional systems which are recognised by the Government, and are clubbed together under the Department of Indian System of Medicine & Homeopathy include Ayurveda, Unani system, Siddha system, Naturopathy and Yoga, Homeopathy and Amchi system of medicine. Thus at present, Government has been providing health care facilities in seven medical systems. The basic ideology and treatment methods of each of these seven systems differ from each other, as they are explained here.

**Biomedicine or Modern System of Medicine**

This system of medicine has been the corner stone of Indian health care policy. It is considered as most technologically advanced and scientifically proved system. The basic principle of the biomedicine is to induce a reaction in the body, by using drugs or other means, that will counteract and therefore relieve the symptoms of the disease. As in this system drugs are mainly used to oppose the symptoms as well as the causes of the ailment, that is why the term ‘Allopathy’ was formerly used for this system.

The basis of this system is anatomy (the structure and form of the body) and physiology (the study of the body’s functions). The drugs used are mainly chemically prepared, with variety of forms of dispensation. Inoculation (use of syringes for injecting the drug
directly into the blood) is an important part of disease control, and has been widely used only in this therapy. Biomedicine has been in the forefront of using advanced instrumental technologies in diagnosis and treatment of the diseases. Surgical treatment has been used with great dexterity in curing anatomical disorders. In Biomedicine, health care is provided by many kinds of health professionals in addition to doctors who are specialised in particular field of treatment.

Indian System of Medicine & Homeopathy

**Ayurveda**: Ayurvedic system is the most developed and comprehensive health care system among all the traditional systems of medicine in India. Prevention of disease is an important aspect with emphasis on hygiene, Yoga and exercise. Based on the theory of humours, Ayurveda defined three humours – *Vata, Pitta and Kapha*. In a healthy person these are in functional equilibrium and loss of it leads to sickness.

The treatment of disease generally consists in avoiding factors responsible for causing disequilibrium of the body matrix or of any of its constituents part, through use of medicines, suitable diet, activity and regimen for restoring the balance.

**Unani System of Medicine**: Like Ayurveda, Unani system is also based on the humoural theory, recognising the presence of four humours namely – *Dam* (blood), *Balgam* (phlegm), *Safra* (yellow bile) and *Sauda* (black bile) in the body. Each person has unique humoural balance. The correct diet and digestion maintain the humoural balance. Its main emphasis is on diagnosis of a disease through *Nabz* (pulse), *Baul* (urine), *Baraz* (stool) etc. It has laid down six essentials, prerequisite for the prevention of disease. They are known as *Asbab-e-sitte Zarooriya* viz. air drinks, foods, bodily movement and repose, psychic movement and repose, sleep and
wakefulness, excretion and retention. The modes of treatment include—

i) *Illaj bil – Tadbeer* (Regimental Therapy)
ii) *Illaj bil Ghija* (Dietotherapy)
iii) *Illaj bil Dawa* (Pharmacotherapy)
iv) *Jarhat* (Surgery)

**Siddha System of Medicine** : The Siddha system is largely therapeutic in nature. It is marked by greater use of metals, in particular mercury, and holds particular reverence for a substance called *muppu*, which is believed to hold potent powers for both physical and spiritual transformation. (Zvelebil, 1979). Taking the pulse is more prominent as a diagnostic procedure in Siddha medicine. It has been suggested that Ayurvedic pulse diagnosis – which was not common before the late 13th century was borrowed from Siddha medicine (Valentine Daniel, 1984). This system also deals with the concept of salvation in life. It is emphasised in this system that the achievement of this state is possible by medicine and meditation.

**Amchi System of Medicine** : Therapy under this system is divided into treatment by herbs, minerals, animal organs, spring and mineral water, moxibustion and by mysticism and spiritual power.

**Naturopathy and Yoga** : The concept of remaining healthy in this system is by leading a balanced life. It is often referred to as drugless treatment of diseases. That is why particular attention is paid to eating and living habits. In addition there is an adoption of purificatory measures, use of hydrotherapy, cold packs, mud packs, baths, massage and a variety of methods based on their innovative talents. According to this system, if life is properly organised and if one does not retaliate, one can get the bounties of energy, health and happiness from the benevolent nature.
The system of Yoga, comprises a well defined postures and exercises for keeping the body as well as mind in good condition. It consists of eight components namely restraint, observance of austerity, physical postures, breathing exercise, restraining of sense organs, contemplation, mediation and samadhi. These steps in the practice of Yoga have potential in improvement of social behaviour, improvement of better circulation of oxygenated blood in body, restraining the sense organs and thereby the mind and in inducing tranquility and serenity of mind.

**Homeopathy**: This system is based on the law of ‘Similia Similibus Curentur’ or ‘Let likes be treated by likes’. This concept is employed to cure the natural sufferings of person by the administration of drugs which have been experimentally proved to possess power of producing similar artificial suffering or symptoms of disease in healthy human being.

In homeopathy the primary emphasis is on therapeutics. It takes a holistic approach towards the sick individual and treats his disturbances on the physical, emotional and mental levels at the same time, by stimulating and strengthening his body’s defence mechanism. The drugs given are mainly in the form of small white sweet pills.

**TRADITIONAL MEDICINE AND MEDICAL ANTHROPOLOGY: A REVIEW OF LITERATURE**

Medical anthropology as a subfield developed to judge the medical beliefs from the perspective of social beliefs. The concept of disease and its cure changes with every society and its geographical location. Most of the medical systems of the world have magico–religious origins with a strong socio–cultural influence of the professing societies. This in turn implies that different people do not behave in a similar manner while seeking remedies for the
discomfortable conditions of illness. Moreover, occurrence of different medical systems for cure in the same social milieu further produce complexities in the understanding of health care arena. How and why a particular medical belief originated? What is its rationale of existence? How and under what conditions it is being utilised? And how does it cope with other medical beliefs of completely different or even opposite ideologies? These are some of the interesting questions whose answers have been continuously sought by medical anthropologists in order to understand and frame more effective health care plans. In recent years, biomedicine (Western or modern medicine) has clearly failed to live up to its almighty image, even in the western societies where it originated. Public demand for alternative health care has placed considerable pressure on the medical profession. Medical anthropologists have been assigned the role of providing information on alternative medical systems elsewhere in the world, especially in the third world. As a result, there is growing body of anthropological literature on medical systems in other societies (Ohnuki–Tierney, 1984).

The social aspect of medicine, has been the subject of research in the field of medical anthropology, because of its effects on human ecology and the course of human evolution. The human behaviour in any society towards health and disease, cannot be understood by only the biological aspects of the whole situation. As the basic concepts of illness vary in different societies, so would their remedies. In this regard medical anthropologists have done a lot of research work on the inter–relationship between medical and social sciences. Rivers (1924) wrote *Medicine, Magic and Religion*, pointing out that indigenous medical systems are social institutions to be studied in the same way as kinship, politics or other institutions. Evans Pritchard (1937) in *Witchcraft, Oracles and Magic Among the Azande*, studied the African concept of disease, death and other
misfortune as caused by witchcraft. He concluded, that given the initial premise that harm can be caused by thoughts of envy, greed, malice etc., then the rest of the beliefs follow logically. A number of other valuable studies which appeared during this period include: Field’s (1937) study on the Religion and Medicine of the Ga People; Spencer’s (1941) study of Disease Religion and Society of the Fizi Island and Horley’s (1941) study of Mono of Liberia.

Ackerknecht (1942), a medical historian, contributed a series of papers on ‘primitive medicine’. He said that ‘primitive medicine’ is ‘magic medicine’. He (1947) defines the situation as, “disease and its treatment are only in the abstract purely biological processes…… such facts as whether a person gets sick at all, what kinds of disease he acquires and what kind of treatment he receives depend largely on social factors”.

Mead (1947) and Henry (1949) discussed the general relationship of anthropology with psycho–somatic medicine. Hall (1951) outlined the progress of sociological research in the field of medicine. Sigerist (1951), Jaco (1958) explained the studies done by anthropologists in the field of indigenous medicines.

Gonzales (1966) mentioned the phenomenon of medical pluralism and finds that in the Guatemalan groups, people very often seek help for the same illness from both the indigenous curer and the physician. The utilisation pattern, however, depends upon the socio-cultural influences. One cognitive approach to the problem of alternation between modern medicine and indigenous medicine has emphasised the importance of the type of disease as an influence on the choice made. Observers have pointed out that people in developing areas tend to distinguish the kinds of illness that can be cured by the physician from those that will respond only to the therapy of local healers (e.g., Erasmus 1952; Simmons 1955; Foster
1958, 1962; Goodenough 1963), The course of an illness, the outcome of previous treatment for the same condition, and a variety of other factors may cause the patient to redefine it and shift from one medical system to the other (Lieban, 1967).

Polgar (1962) has distinguished professional health culture of medical practitioners from the ‘popular health culture’ of unspecialised lay practitioners. But Leslie (1967) has contrasted ‘popular’ and ‘professional health cultures’ on a different basis. He has used the term ‘professional health cultures’ to refer to realms of practitioners in both indigenous and modern systems of medicine but has kept the medical sphere of folk specialists out of this category. Hughes (1968) focussed on the study of indigenous medicine and the modern medical system.

Maclean (1971) in Magical Medicine, has reported a study on the practice of African medicine. In the Handbook of Medical Sociology, Freeman (1972) stated about the social nature of the medicine along with the biological basis. That is why the social customs and beliefs affect the utilisation of health services by the public. According to Lieban (1973), medical anthropologists encompasses the study of medical phenomena as they are influenced by social and cultural features and also social and cultural phenomena as they are illuminated by their medical aspects.

Ndeti (1976) showed the relevance of traditional medical practitioners in different African societies. He stated: “In view of its activities, powers, limitations and the very nature of the subject, modern medicine must accept and recognize the reality of the native doctor. He is a very important part of the medical scene and possesses legitimate knowledge essential for medical science. Therapies and treatments performed by witch doctors should be examined critically and the relevant elements should be
adopted into modern education”.

Dingwall (1976) focussed his studies on the patterns of social conduct that are associated with illness behaviour. Bannermann (1977) emphasised the need of medical anthropological studies as the World Health Organisation has given recognition to the traditional and indigenous systems of medicine. Mechanic (1978) has strongly felt that traditional societies are likely to have different orientations towards the social and cultural aspects of health and disease than the modern advanced societies.

Bannermann (1983) opined that traditional medicine have a definite role in the health care. But the need is to change the worldview about traditional medicine. Canary (1983) emphasised on the mutual beneficial relationship of the modern and traditional medicines. For providing the adequate health services, both these arenas of health care should be explored (c.f. Banerjee and Jalota, 1988).

Ohnuki-Tierney (1984) studied medical pluralism along with describing specific medical systems and general health care systems of contemporary Japan, and demonstrated how they are embedded in the Japanese socio-cultural milieu, especially in their value systems and their pattern of interpersonal relationships. He stated that “importation of any alien medical system goes through a profound transformation in the recipient culture before it becomes a viable cultural institution”.

Banerjee and Jalota (1988) conducted study on the Dhimars, a caste group of fishermen and palanquin bearers, in Mandla district of Madhya Pradesh. The study concluded that the efficacy of a system is sought after in terms of financing of care, accessibility of medical resources and respect with regard to one’s cultural traditions.
Majumder (1993) studied the status of traditional medicine in Bangladesh and opined that physicians of all disciplines should serve on a coordinated platform for the success of total health care programme "Health for all". Larson (1993) did his research on the scientific basis of some of the traditional medicine and theories. He stated: "a world desperate for cures for global diseases of disastrous proportions should reach back with open minds and fresh inquiry to reinvestigate ancient knowledge and procedures".

The character of medical pluralism and the place of alternative forms of therapy within western industrial societies is another topic of growing interest among medical anthropologists. Park (1994) compared the status and role of Korean traditional medicines in Korea and United States, one is the newly industrialized Asian economy and other is the most advanced capitalist western economy. He concluded that the strengthened professional power of traditional medicine and the public's strong support of it can, make changes in state policies, and put some control over the organisational forces of cosmopolitan (modern or western) medical providers, and thus raise the status of indigenous medicine. Owoahene Stephen (1994) studied about the western understanding and practices of medicine versus those of the traditional cultures in Ghana, using indigenous medical systems and practitioners as immediate case of reference. This work shows the dominant attitude of the western world towards Ghanians and other peoples of developing societies and the perpetuation of the western ideological interests by some western educated Ghanian. Gesler (1991) stated that data from developed countries indicate that majority of people frequently consult personnel such as chiropractors, massage therapists, and homeopaths who are usually not considered part of the formal or legitimate system of health care.

Lambert (1996) stated that the ethnographic investigation of
indigenous modes of healing and their relationship to underlying conceptualisations of schemes and health as part of a particular worldview has continued to be one of the major orientations historically identifiable in medical anthropology. Tovey (1997), while studying the legitimacy of alternative practitioners in United Kingdom, found that there is a schism within orthodoxy on their professional legitimacy of alternative practitioners, and that schism is occupationally based at the extremes, consultants remain characteristically dismissive of them or overwhelmingly enthusiastic.

Regarding the reach and utility of traditional medicine, Van Rensburg and Benator (2001) stated that despite the pervasiveness of western influences, traditional healers survived and play an increasing role in some countries. For example, while there are about 25,000 western trained medical practitioners in South Africa, and western medicine has a powerful foothold in this middle income country, over 200,000 traditional healers carry out a thriving trade. According to World Health Report 2000, even without new medical technologies important advances can be made in health outcomes—just by improving the way currently available health interventions are organised and delivered. Fogel and Lee (2002) studied the factors responsible for the disparity in assessing the health care facilities in developing as well as developed world.

Research work done in Indian cultural settings in the field of medical Anthropology mainly revolves around villages and tribal studies. Studies have also been conducted taking hospitals as the single units of observations. Marriott (1955) focussed his study on the perception of rural community of North Indian village towards the western medicine and its comparison with acceptability of the traditional folk medicines. He found that in rural settings, western medicine was handicapped by the villager’s perception of such things as its emphasis on privacy and individual responsibility, its utilisation...
of written prescriptions, and the democratic nature of its expectation of interpersonal trust—all features incongruent with village experience and attitudes.

Carstairs (1955) opined that the patient’s own ideas of illness and cure affects his behaviour of utilising a particular kind of medical system, despite, the availability of best facilities in western system at his disposal. There must be a common bond of perception about the disease between the practitioner and the patient. Sometimes, the type of disease also guide the patient to go to a particular type of a healer.

Gould (1957) made systematic analysis of the nature and effects of this kind of dichotomy in a community in Northern India. There he discovered that modern medicine tended be utilised for critical incapacitating dysfunctions (such as pneumonia, typhoid fever, and very severe hernia), while patients were inclined to go to indigenous healers for treatment of chronic non-incapacitating dysfunctions such as enlarged liver, asthma, and rheumatism). Leslie (1967) found evidence in India corroborating the kind of distinction found by Gould in the village he studied. In a later paper, based on subsequent research in this community, Gould (1965) modified some of his original conclusions and concluded that personal relationships also affects the making of medical choices.

Ahluwalia (1974) observed that despite the differences in the medical systems, people belonging to all sections of the society, including the most westernised; simultaneously utilise the services of these varied systems.

Karna (1976) has described the traditional attitudes relating to the causation of diseases which may not be necessarily based upon the scientific reasons. It has also been indicated that in the village
situation, people’s beliefs about illness are derived from six sources: (i) family of orientation, (ii) parents-in-law, (iii) indigenous midwives, (iv) elderly women, (v) folk and indigenous medical practitioners and (vi) government health functionaries. (Kakar, 1977).

Bhowmick and Roy Chowdhury (1977) studied the sociocultural barriers which stand in the way of introducing a technological change to a community of rural West Bengal. The study was conducted on the acceptance of allopathic medicine by the Muslims in a rural region of lower Bengal.

Lieban (1960) concludes that “despite the increasing utilisation of modern medicine in developing areas with consequent reduction in morbidity and mortality, traditional medical systems still persist and exert a significant influence on the state of health and on medical decision and outcomes in developing societies”. This can be easily supported by various studies done in India, particularly on the role of practitioners of indigenous and modern systems of medicine (Kakar, 1976; Banerji, 1975; Hockings, 1980; Madan, 1980).

Kurian and Bhanu (1980) have focussed upon the folk medicines, their magico-religious connection and have revealed that every culture develops a system of medicine.

Sengupta (1983) has reflected upon the importance of traditional medicines in a villager’s health care system. Chopra (1984) in his study on four villages of Haryana, concluded that the beliefs, attitudes and values of a community strongly influence people’s interpretations of the symptoms and the techniques for their treatment.

Joshi (1985) emphasised upon the more constructive role of medical Anthropology in the field of ethnomedicine healers, health-care programmes and herbal medicines etc. Chaudhuri (1985), while
focussing on the tribal health problems, has shown the socio-cultural dimensions of health interaction of traditional and modern systems, and the constraints of acceptance of modern system.

Kakar (1988) explained the role played by traditional medical practitioners in the primary health care and the factors that guide the people to avail of these services. Yesudian (1988) conducted a study on the effect of social and economic status on the pattern of utilisation of medical services in the metropolitan area.

Joshi (1990) suggested a modern approach in the field of health care services. In a situation of multiplicity of options (medical pluralism) modern action should be of the kind which appropriately suit the local conditions. Mehta and Lamba (1990) has compared the indigenous tribal and modern medicine for finding their respective effectiveness and suggested, "we need to evolve is a system that blends traditional with modern, whether it is in the field of experimenting and prevalent drugs, or establishing and adapting a self propagating set of close healer–patient relations, or involves the imbibing of stabilised faith and confidence in the abilities of the curer". Shobha Devi (1990) has demarcated the discrepancies in the existing health services and the important factors which have greater impact on the health status of the people.

Tripathi (1993) has tried to find out the possibility of co-existence of traditional and modern medicine. He stated: "The traditional systems possibly have an edge over modern medicines in all other respects except in the total empiricism with which the traditionalists use their drugs. It is here that the scientific tenets of modern drug developments can be utilised with a view to rationalise the empiric traditional practices". Warrier (1993) emphasised on the necessity of restudy and popularisation of traditional techniques as pluralistic medicines are the need of the times.

Prakashan (1995) conducted the study to find out the utilisation pattern of the rural population of primary health care services in Guntur district of Andhra Pradesh.

Chopra and Mathiyazhagan (1997) listed the factors which attracts the people in Gwalior district of Madhya Pradesh towards the utilization of the services of indigenous system of medicine.

Tribhuwan (1998), while studying the tribal beliefs on health and disease in Maharashtra, India, suggested that health services can be strengthened so as to prevent illness if traditional practitioners are properly trained and utilised. According to him, “The traditional medical practitioners are a valuable resource for providing primary care to communities. They are respected and more readily accepted by their own people than the health workers and allopathic doctors”.

Anandhi, Nagraj and Kumar (1999) conducted a study in rural area Haryana to find out the role of indigenous private medical practitioners (IMPs) in reproductive health of the population. They concluded that the common mode of treatment being followed is the combination of allopathic and ayurvedic treatment and emphasised on the need for including the IMPs in delivering reproductive health through training them adequately.

Hausman (2002) studied the changing perceptions towards Homeopathy while developing the medical education policy in Tamilnadu state of South India. He situates homeopathy in South India within the context of shifting relations between scientific and indigenous systems of medicine.
Padmaja (2002) noted the relationship between the total expenditure on health by the common people and the condition of the Government healthcare facilities. He has advocated the idea of charging a reasonable amount from those who can afford to pay as this could lead to the improvement in public healthcare institutions.

The World Health Organisation (WHO) has been consistently emphasising the need for anthropological studies of traditional medical practitioners. In fact, it has initiated a profitable dialogue on the domain of ethnomedicine which has also been referred to as 'popular medicine' or popular health culture’. WHO has emphasised the need to assess the contributions of traditional medical practitioners in the primary health care. WHO *Traditional Medicines Strategy 2002–2005* reviews the status of traditional medicine (TM)/Complementary and alternative medicine (CAM) globally, and outlines WHO’s own role and activities in TM/CAM. But more importantly it provides a framework for action for WHO and its partners, aimed at enabling TM/CAM to play a far greater role in reducing excess mortality and morbidity, especially among impoverished populations.

THEORETICAL CONSIDERATION

The social context in which an individual exist, determines the characteristic pattern of his behaviour. Role Theory basically deals with these behaviour patterns or we may call them ‘roles’. It explains that within a social context, a person has recognized social identities (or positions) and there are ‘expectations’ of his own as well as other members of that social setup, which results in establishing a set behaviour of the concerned person in that setting. Its vocabulary and concerns are popular among both social scientists and practitioners, and role concepts have generated both theory and a good deal of research.
The concept of role theory started developing in the early 1930s. There were three major contributors in this period, who worked on this concept but with somewhat different agenda. Ralph Linton, considered roles as “the dynamic aspects” of societally recognized social positions (or “statuses”), and he used role theory as a means for analyzing social systems. George Herbert Mead opined that ‘social interactions’ are the main originator of ‘roles’, which different individuals develop as the coping strategies in their respective social setups. While Jacob Morendo, a psychologist, saw roles as the habitual tactics adopted by the persons in their social relations and new roles are thus learned through imitations for which he used the term “role playing”.

For some authors the term ‘role’ refers only to the concept of social position, for others it designates the behaviour characteristics of social position members, and for still others it denotes shared expectations held for the behaviour of position members. Despite, these differences, role theorists tend to share a basic vocabulary, an interest in the fact that human behaviour is contextually differentiated and is associated with the social position of the actor, and the assumption that behaviour is generated (in part) by expectations that are held by the actor and others.

One of the early perspective of the role theory reflected functionalism. Talcott Parsons is the main proponent of this thought, who explains that ‘role’ is the shared expectations for behaviour for the actor, who performs them in order to accomplish certain functions. Functionalist theory was concerned with the problem of explaining social order. This approach to ‘role theory’ was also advocated by Bates and Harvey (1975).

Another approach developed to interpret the role theory was in the form of organisational analysis. To study the stability of an
organisation and the behaviour of individuals within it, another term “role conflict” was applied. Role conflict (i.e. opposing norms that were held for actors by powerful others) posed problems for both the actors and the organisations in which they appeared, and that strategies for coping with or “resolving” role conflict could be studied. Further, role concept was applied to organizational analysis and many studies of role conflict and role conflict resolution in organisational context were done (Van de Vliert 1979; Van Sell and others 1981; Fisher and Gitelson 1983). The concept of role conflict was also applied on disempowered persons, particularly married woman who must cope with the opposing demands of the workplace, home maintenance, and support for their husbands (Stryker and Macke 1978; Lopata 1980; Skinner 1980).

The structuralist approach defines roles as sets of behavioural prescriptions attached to positions in organisations and statuses in society. R. Merton (1957) introduced a more dynamic version of structural theory in which the incumbent of any position is said to play somewhat different roles in response to the varied expectations of different significant others, e.g. A teacher must simultaneously take into account the somewhat different expectations of parents, administrators, students, and fellow teachers. These several roles linked to any given position are called a role-set.

Interest in role theory has also appeared among symbolic interactionists who think of a role as a line of action that is pursued by the individual within a given context. Roles are affected by various forces, including preexisting norms applying to the social position of the actor, beliefs and attitudes that the actor holds, the actor’s conception and portrayal of self, and the “definition” of the situation’ that evolves as the actor and others interact. These concepts have been applied by symbolic interactionists to a host of interesting concerns (Scheilbe, 1979; Gordon and Gordon 1982; Ickes and
and a continuing and useful contribution has flowed from Ralph Turner's interest in the internal dynamics of roles and the fact that roles tend to evolve over time (1979, 1990).

Empirical research in role theory has been carried out by cognitive social psychologists representing several traditions (Biddle 1986). Some of this work has focused on role playing, some of it has concerned the impact of groups norms, some of it has studied the effects of anticipatory role expectations, and some of it has examined role taking. These studies suggest that roles are often generated by two or more modes of expectational thought, and several models have also appeared from cognitive theorists reflecting this insight (Bank and others 1985).

Recent Trends in Role Theory

In some of the recent works role does not appear by itself as a major concept but rather is likely to be discussed in such topics as "the self", "groups", "institutions", and "role taking". The latest work of Forsyth (1999), an entire chapter is devoted to "norms", "roles", and related issues. Joann Keyton (1999) focuses a major chapter on "group member roles", group norms" and associated materials.

Role concepts have also been used for discussing social relations within a specific institution or for portraying the lives of those who share an occupational identity. For example, Biddle (1997) provides an extensive overview of recent research on "the role of the school teacher". The term "role" normally has been used to refer to differentiated behaviours, whereas notions about behaviours that are thought to be appropriate for roles are normally termed as "norms" or "role expectations".

The interpretation of gender difference is another area where
role theory has been applied as in the work of Alice Eagly (1987, 1995). Eagly asserts that such differences appear as a result of structural forces in societies—hence may differ among countries—but are sustained and reproduced because men and women develop role-appropriate expectations for those behaviour.

Some versions of role theory are applied for generating insights or resolving problems in cognate fields.

A recent article by James Montgomery (1998), dealt with the long-term social interactions and the factors that govern them. By citing the work of Granovetter (1985) and March (1994), Montgomery argues that in long-term interactions, persons make assumptions about social identities which are based upon the shared expectations about behaviour among the interacting individuals. These expectations of the social identities guide the person’s behaviour in a social set-up.

Role Theory in Medical Anthropology

The inability of modern or western system of medicine to reach every strata of the population has forced the makers of health policies to consider the role of indigenous medical systems in providing the health services. As the field of medical anthropology deals with the study of human health and disease, health care systems, and biocultural adaptations, so it was inevitable that anthropologists focused their study on the traditional medical systems or ethnomedicine. William H.R. Rivers (1924), a physician, is considered to be the first ethnologist of non-western medical practices. Early theoretical work by Forrest E. Clements (1932) and Erwin H. Ackerknecht (1942, 1946) also attempted to systematise primitive medical beliefs and practices. Since the 1940’s anthropologists have helped health care providers understand cultural
differences in health behaviour, as shown in Benjamin D. Paul's edited volume, *Health, Culture and community: Case Studies of Public reactions to Health Programs* (1955), one of the first medical anthropology texts.

In 1960's anthropologists did a considerable work on the concept of role (Barth 1963, 1955; Banton 1965; Benedict 1969; Coult 1964; Freilich 1964, 1968; Goodenough 1965; Keesing 1970). In social sciences, the role concept has been defined as primarily structural functional in use (Biddle and Thomas 1966; Sarbin and Allen 1968). The process of role change is like the socialisation process. It is primarily a chronological modifications occurring, when person assumes new roles as he reaches new age grades and new social horizons. So far the concept of role change has been defined in terms of conflict and strain. But David Landy (1974) tried to explain that role change in response to contact with superior or technologically more advanced culture may sometimes prove beneficial for curer and help in strengthening his status in his own society. Goode (1960) in his role strain theory concluded that all individuals in any sociocultural systems are confronted with 'overdemanding' total role obligations, but must manage to equilibrate role relationships and consensuses with other actors in the system and consequently reduce role strain.

Landy (1974) attempted to examine the effects on the curer’s role of the contest between indigenous systems of medicine and the western system of medicine. Adaptation of the curing role under acculturation and change in a series of selected societies is considered and types are derived for curer’s role, which is called as ‘adaptive’ type, ‘emergent’ and ‘attenuated’. He is the first person who used the concept of ‘role adaptation’ in medical anthropology, which he developed from the model of role strain, suggested by the sociologist William Goode.
The process of acculturation does not completely vanish the role of traditional curers. This shows the inner strength of their beliefs as well as the inseparable nature from their particular sociocultural setup. Fogelson (1961) did his study on the Cherokee Indians of south eastern United States. Cherokees are highly acculturated people. He found a strong persistence of traditional medical beliefs and practices compounded with many Christian elements, and the role of the conjurer-curer still surprisingly viable. Similarly, Jahoda’s (1961) study in Southern Ghana depicts that despite some utilisation of western medicine and hospitals, indigenous healers are handling the bulk of ailments, physical and mental, in all social classes. But their persistence in the society does not come without any change, which we may called as ‘role adaptation’ which is clear in Jahoda’s study (1961). He told that a new type has emerged involving the adoption of some of the external trappings of the western medical man and pharmacists who dispenses herbal remedies in an affectively neutral manner and tends not to become as closely involved with the patient as the traditional healer. Hes (1964) pointed out that even under great stress of modernisation and immigration, the Yemenite Jewish ‘Mor’i persists. Their healing role is adapted to changed socio-cultural scenario, though in somewhat narrowed orbit. Not only this, but division of responsibility has also been observed as beneficial factors in defining the role of traditional curer in the changed scenario. Gould (1957) observed a division of role in the village of Sherupur in North India. In addition, Gould made a significant contribution to the study of comparative medical systems by indicating the need to differentiate the technical from the scientific since they do not necessarily coexist. Several studies provide an insight into this concept of role change or role adaptation. Leighton and Leighton (1945) gave detailed descriptions of the role of Navaho singers, diagnosticians and herbalists as well as of the reactions of the Navaho to modern medical practice. Alland (1970) conducted
investigation of the Abron medical system and its several curing roles and compared their fate vis-à-vis western medical practitioners.

In his role adaptation to culture change, the traditional healer not only incorporates, but elaborates, western elements. The indigenous curing role may exist in complementarity to the scientific medical system in a variety of ways, from almost complete isolation to almost total interaction. But adaptation for role preservation consists in selecting only those changes that will preserve his role while at the same time minimally disturbing his already intruded culture (Landy, 1974).

It has been shown in many studies by anthropologists that in a competition to more technologically advanced medical system or simply by interacting with them, sometimes new roles are established for the traditional curers. In a way a new lease of life is provided to the indigenous medical systems. It is well illustrated by Mead (1930, 1961) among the Manus, a technologically primitive people of New Guinea. The study shows that in a socio-cultural system in which apparently there had been no traditional curing specialists, the impact of western medicine in fact seemed to give rise to them, a new synthesis both of sociocultural system and of curing role, which begins to appear, with western medicine fertilizing, rather than starving the emerging practitioner’s role. As McCorkle (1961) noted that a healer may invent or discover a revolutionary new medical method that places him in a potently competitive position vis-à-vis modern medicine. His study of chiropractic technique in rural Iowa, which was discovered by one D.D. Palmer (a general storekeeper and magnetic healer), explain this new kind of roles for the traditional curers. Press (1971) in his very useful study of curers in an urban south American city calls attention not only to basic differences in the curing role in rural and urban peasant communities as contrasted with urban ones, but the fact that the culture and multiplex social
organisation of cities provide opportunities for a wide variety of curers to flourish. Landy (1974) typed this phenomenon of development of a role as 'emergent curing roles'.

Role adaptation not only creates a space for the traditional curers but sometimes results in diminishing their role in the society. Landy (1958) created a new term, 'attenuated curing roles', to explain the process of this type of role adaptation. While studying Tuscarora curers from Niagara Falls and Buffalo regions, he concluded: "As the powerful scientific medical and economic system spreads its influence, the curers may choose to continue in his traditional role and ignore the attrition in clientele due to competitive services. This implies, in effect, his voluntary acceptance of diminished prestige because he now yields his influence to render his own role completely obsolete". A similar case of role deterioration is reported by Messenger (1959) among the Anang, an Ibibio group of southeastern Nigeria. Mongeau, Smith and Maney (1961) reported decline in the role of Negro midwife in parts of the rural southern United States. Thus, in case of role attenuation, role strain and role conflict follow, and the curer's status may become so hopelessly compromised that role adaptation is impossible of fulfillment and the status of curer becomes marginal and headed for extinction (Landy, 1974).

To determine the role of traditional curers in this era of globalisation, it is necessary to know how they adjust themselves to the varied demands of health needs vis-à-vis technologically advanced biomedical system. Many a times traditional healer not only incorporates, but elaborates, western elements. But only those changes are accepted that would create a space for the curer in the changed social set-up, and at the same time do not alter his identity as a traditional curer. In socioculture change we see that those value and principles will be most easily transferred which are most
consonant with the ideology and behavioural standards of the host culture. As Alland (1970) hypothesises that those impinging new roles for which ‘analogue roles’ exist in the host culture will be most easily accepted. Landy considered role adaptation is such a formulation which could be used to understand the changing role of the traditional curer in the confrontation between the ‘markedly contrasting social matrices’.

OBJECTIVES OF THE STUDY

The main aim of the present study is to find out the scope of Ayurvedic system of medicine in the filed of health care services and people’s perceptions towards the utilisation of these services. The study is based upon the findings from Ayurvedic practitioners, the patients undergoing treatment and other persons or employees who are associated with this system of treatment. The objectives of the study are:

1. To probe into the particular type of health needs for which the services of Ayurvedic medicine have been sought by the patients.

2. To find out the various kinds of health services that are being received from different health centres.

3. Also are the services provided by the Ayurvedic centres (the quality of treatment and its scope) perform satisfactorily by really helping the patients.

4. Regarding the myths and beliefs of the people towards the Ayurvedic system of medicine, do people have faith in the system, or do they simply treat it as an alternative way of cure?

5. The factors that influence the people’s thinking in
approaching the system.

6. The scope of improvement of the existing health services.

HYPOETHESES

The present study is based upon the following assumptions, these hypotheses have paved the way and guided the present study:

i) The popular perception for the traditional system of medicine is that they have a limited scope of cure. The health services in Ayurveda are not as widespread and advanced as in the case of biomedicine.

ii) There is a significant difference in the dispensation of services in Ayurvedic system as compared to the biomedicine. In Ayurveda, more traditional methods are used for providing relief, which are laborious and complex.

iii) Majority of health services providers in Ayurvedic system are in the private sector. They are traditional medical practitioners like Vaidas who have been practising Ayurveda for generations. There is still no widespread network of Government hospitals and dispensaries built on the basis of modern requirements as in the case of biomedicine.

iv) In order to utilise the services available in field of health care, Ayurvedic system of medicine has been considered as the second choice. The first option has always been biomedicine. This is possibly because of some misconceptions about the validity of Ayurvedic system.

v) The present status of Ayurveda in the people's mind is just like any other system of primary health care. For chronic and serious cases, the biomedicine is preferred. Although
Ayurveda is the oldest system of medicine in India, its development and propagation of this system has not proceeded properly. Lack of knowledge and information about the system prevents people from using this system outrightly and benefit from it.

vi) The healing and cure from any disease mean an immediate and quick relief from the uneasy condition. That is what people expect from a medical system when they go to a physician. This is the major factor that guides the people to utilise the health services available in a particular system.

TECHNIQUES AND METHODOLOGY

In view of the scope of present study, a holistic approach was adopted so as to cope up with the descriptive approach of a piece of research. It would be an endeavour to seek a vivid description of the situation by using interview schedules. The piece of research work depends upon a well founded set of hypotheses mentioned earlier. Its principal objective is to provide an insightful understanding of the adoption of medical care. This understanding has ultimately brought into focus problem areas and illuminate alternative paths of action with an estimate of their costs and consequences.

UNIVERSE OF STUDY

The most important aspect of any piece of research is to find out and select the specific area from which enough information could be collected about the field of study. In the present case the study has been conducted on the traditional health care system – Ayurveda and the utilisation pattern of general population towards this system. The investigator decided to conduct the fieldwork for the proposed study in the Union Territory of Chandigarh.
The city of Chandigarh was selected for this study because it is a prominent modern urban centre of North India. As most of the studies on the traditional systems of medicine were conducted on rural areas, nothing or very little material has been published about the role of these traditional health care systems in the urban settings, where the biomedicine health care system (Allopathy) has been practised widely, and modern technology is available, for the benefit of people. In Chandigarh, the health care facilities relating to different types of medical systems, viz., Biomedicine (Allopathy), Ayurveda, Homeopathy and Unani, are available to its residents. So they have a wider choice in terms of utilisation of health services. How and when the people generally decide to utilise the services of Ayurvedic system of medicine? Is the occurrence of multiple medical systems offer any added advantage to the people in general? These were some of the questions which led the investigator to select the universe of study. Another factor for the selection is that the population of the city is more enlightened and informed, the literacy rate being fairly high (81.6%, Census 2001). The situation is thus conducive to assess the status of Ayurvedic system of medicine in an urban society vis–a–vis other existing systems of health care. Further, researcher knows the layout of the city well and being a Punjabi and a resident of the city proved helpful in communicating well with the respondents in their own language.

For the present study, Pt. Kedarnath Memorial Ayurvedic Hospital in Sector 46-B of the city was selected as the primary source of data collection. This hospital is attached to Shri Dhanwantry Ayurvedic College. Because of its status as a hospital attached to a medical college, it provides most of the medical care facilities that can be made available to the patients in Ayurvedic system of medicine. Besides this, it is also possible to know the possibilities of future improvement in the existing health care facilities from the
practitioners who are serving in this hospital.

All the Government Ayurvedic Health Centres of the union territory, which are total six in number, were also selected as primary source of data collection. These health centres are present in different sectors of the city and one of them is located in rural area of the union territory. Thus, they provide Ayurvedic health care services to the wider proportion of the population, which have helped in collecting the necessary information from diverse sections of the society, covering different parts of the city.

**SOURCES OF INFORMATION**

The information about the research topic has been obtained from two types of sources: (i) Primary or Field sources and (ii) Secondary or Documentary sources.

(i) **Primary or Field Sources:** The information have been collected from the individuals, who are directly associated with the Ayurvedic system of medicine. There were two types of such respondents – a) The persons who are responsible for providing the health care services in this system – Ayurvedic medical practitioners, paramedical staff and Government officials of health department; b) the persons who are utilising the health care services – the patients.

(ii) **Secondary or Documentary Sources:** This included the information collected from the statistical records of Indian Government, the Economic Survey for the financial year of 2002–2003, official websites of Ministry of Health and Family Welfare – Department of Indian system of Medicine and Homeopathy; Chandigarh Administration; and World Health Organisation. The official records of the Ayurvedic hospital and Government health centres (which have also provided the valuable information about the strength of incoming patients, their ailments and duration of
treatment. Besides some research abstracts, like dissertation abstract international, journals and encyclopedias have also been consulted in order to study the earlier research work on the behavioural pattern of the population towards their health needs and available health services.

SAMPLE SIZE

The respondents belonged to two distinct categories with a great difference in their numbers. The first category of respondents – the health services providers, were not large in numbers. In this category the primary source of information were the doctors working in the single hospital and six dispensaries of the union territory. In Ayurvedic medical college and hospital, the medical officers were thirteen in number, and in addition there was a single visiting vaidya, who heads the newly opened—Clinical Research Unit. Thus the total strength of doctors in the hospital was 14. In the six Ayurvedic dispensaries, there were six Ayurvedic medical officers, which makes the total number of responding doctors in this category to 20. Then there were members of paramedical staff – nurses, pharmacists, helpers and masseurs, who made the second group of respondents in this category. The total strength of paramedical staff in Ayurvedic Hospital and Government dispensaries was twenty–eight. The third type of respondents were Government officials of the U.T. Health Department. As far as possible, all these personnels were decided to be interviewed and no particular sample was chosen in this category for collecting necessary information for the present study.

The second category belongs to the health services utilisers i.e. the patients, were comparatively large in numbers. So, it was necessary to select a representative sample for collecting the data. Thus, a sample size of 200 patients was selected following simple random sampling method. No prior preferences were made, while
selecting the respondents for the sample, as the idea was to find out the exact nature of the section of population, in terms of sex, age, literacy level, economic status, types of ailments and distance of approach, which is utilizing the services of Ayurvedic system of medicine.

COLLECTION OF DATA

The field work was conducted from November 2001 to December 2002, covering all six dispensaries and the hospital. Information were collected from the respondents by using the techniques of a) schedules, b) personal interview, c) observation and d) Case study.

a) Schedules – Two separate schedules, each with some similar as well as different set of questions covering the entire range of the topic of study were prepared, one for the Ayurvedic medical practitioners and other for the patients. As they are the individuals, who are mainly responsible for the proper functioning of any health care system. The schedules were both close ended and open-ended. The information collected from the paramedical staff and the Government health officials, was according to the requirement of the study, as and when it was felt necessary, in order to corroborate the facts and figures about the availability and nature of Ayurvedic health care services in the U.T. So no definite schedules were prepared for these personnel.

b) The method of interview was used for the data collection, as the schedules were both closed and open ended. So, to get the valid information, the face to face conversation was necessary. Though the medical practitioners could easily understand questions and the purpose of the required information, but all of them were reluctant to fill the schedules themselves, so in order to overcome this problem,
this method was used. In case of the patients, it was not possible for the investigator to obtain the necessary information by simply using the technique of filling up the proforma since majority of the patients were ailing and were old, some of them illiterate or they could not understand the language of the questionnaire. In this type of situation interviews helped a lot.

There are three important phases in the interview – rapport building, probing and recording of responses. Rapport building refers to the capacity of the interviewer to motivate the respondent to communicate. In any type of social interaction, the conversation with free mind is required. By helping all this in mind, the process of data collection was completed in the six dispensaries and one hospital, without any major hindrance. The fieldwork was started first by meeting the Deputy Director (ISM & H) of the U.T., who himself is a practising ayurvedic doctor in one of the six Government health centres in the city. The purpose of the meeting was to get his permission for conducting the fieldwork in the Government dispensaries and obtaining detailed information about the status of Ayurvedic health services on the U.T. area. The concerned gentleman was found to be a die hard supporter of Ayurveda as a system of medicine and was very much enthusiastic about any type of research work on this particular system. Thus it was a very encouraging beginning of the research work. The other medical officers in the remaining dispensaries were also quite helpful and provided valuable information about their work and system of medicine. But, some probing had to be done in cases of one or two doctors, as they were somewhat reluctant, being government servants themselves, express their views more candidly regarding the Government policy, support towards Ayurveda and the status of Ayurvedic health care facilities in Chandigarh. Otherwise, the entire work completed very smoothly. Similar was the case with the doctors
working in the Ayurvedic college and hospital. The data collection was started by getting necessary permission from the Principal of the medical college and reporting to the Chief medical officer of the hospital. Majority of the doctors offered their full cooperation for the research work. In case of some female medical officers, some explanation had to be given in order to convince them about the rationale of some questions and easy nature of the interview work, as they were apprehensive that it would take a very long period and would put hindrance in their routine work of examining the patients. But later on they obliged and provided their honest and clear views on each and every inquiry. The paramedical staff in the hospital as well as in the dispensaries had provided complete information about the concerned health centre, and necessary data about the patients from their daily attendance registers and other official papers.

In case of patients, it was already expected that all the selected patients would not necessarily agree to talk and discuss. As these people are already in an uncomfortable conditions and have came for getting relief, are not in a position to answer every question of a stranger, who has suddenly come in front of them from nowhere. Here the rapport building process helped a lot and it proved quite successful, with almost 95% of the responding patients answering all the queries without any hiccups. Little difficulty was faced only in case of some educated patients, as they were very much interrogative about all aspects of the field work, right from my identity to the purpose of the research. But after satisfying them with my explanations, they provided all necessary information which were required. In fact, unstructured form of interview method was used, so as to allow the flexibility in the interview and information conversation. On the whole the research work was completed with the great help provided by medical officers, paramedical staff, government officials and of course, the patients.
c) The third technique used was **Observation**. In the present study, controlled observation method was used and mechanical appliance like ‘camera’ helped in capturing the unique aspects of Ayurvedic medical system. Observation method was used only in the limited cases, such as, while studying the procedure of treatment of the patients, the patients’ general behaviour and reactions towards the treatment, and the facial expressions and gestures of the out-patients, while they were consulting the doctors.

d) **Case Studies**: Case study approach was followed to extract information about the practical applicability of Ayurveda as a viable health care system. For this, some doctors as well as patients were selected, depending upon their individual merits, regarding the utility of information they provide for the study.

**DATA ANALYSIS**

In the present study the data has been treated as under:

i) **Measurement Scale**

There are two scales that has been used in measuring the data – (a) Nominal scale (b) Ordinal scale

a) **Nominal scale** – It means the simple categories of things i.e. grouping of data into discrete categories e.g. sex (male or female).

b) **Ordinal Scale** – It means ranking of objects on some basis e.g. social class (low, medium, high). The questions regarding types of illness and quality of drugs etc fall in this category.

ii) **Description of variables**

Most of the data is quantitative in nature. Therefore, each
variable has been listed in the form of numbers, which is called frequency distribution. Wherever necessary, frequencies have been converted into percentages.

TECHNIQUES OF DATA ANALYSIS

In the research work, most of the data would reveal the causing factors that affects the utilisation pattern of the health services, quality of services and individual response to these services. All the variables are interdependent. Therefore, the data analysis has been done in such a way so as to find the relationship between these variables. For this purpose, the 'Bivariate analysis' technique is considered most appropriate. In this analysis, two variables are examined in relations to each other. For this, a cross-tabulation has been used i.e., a joint frequency distribution of two variables. It would show whether the variables are associated or not.

DATA DISPLAY

Different forms of graphical representation have been used to display data for better understanding. Most of the data is represented in tabular form. As we have used nominal as well as ordinal scale, it was easy and appropriate to represent the data as bar graphs in some cases. The second form which has been used is pie charts to detect the percentile distribution.