Traditional Healers in North India

A Study

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IF we are to accomplish the objective of health for all by the year 2000 A.D. we have a Herculian problem to resolve in the development of appropriate health manpower in terms of numbers alone. There is little point in training a multiplicity of frontline workers if we are unable to provide the supportive and referral chain with both personnel and facilities. Fendall[1] offers two main approaches to increase the number of primary health care workers: one is to train ab initio; and the other is to reinforce existing personnel with traditional healers.

The Alma-Ata conference on Primary Health Care did well to recommend that governments should give higher priority to the full utilization of human resources by defining the technical role, supportive skills and attitudes required for each category of health workers, according to the functions that need to be carried out to ensure effective Primary Health Care; and by developing teams composed of Community Health Workers, other developmental workers, intermedidate personnel, nurses, midwives, physicians, and, where applicable, traditional practitioners and traditional birth attendants.[2]

India today has 1,60,000 Ayurvedic registered practitioners, 25,000 Unani practitioners and 15,000 Siddha practitioners. In addition, there are, 1,10,000 Homoeopaths and nearly 500,000 folk practitioners. This makes a grand total of 950,000 trained as well as untrained traditional practitioners.

With such a vast potential reservoir of health personnel, for Primary Health Care, India can ill afford not to utilize their services or to keep them out of the centrally-sponsored health care system. Yet despite the fact that the practitioners of traditional medicine represent a valuable human reservoir outside the centrally-sponsored health care system, very little is known about their diverse practices. Needless to say if traditional medicine has to be integrated with cosmopolitan medicine, it would be necessary to learn more about the role of different types of traditional healers in different parts of the country. There have been relatively few studies of sickness behaviour and the role of traditional healers in India, although the anthropological literature does contain numerous descriptions of the details of primitive and traditional medicine in certain tribal and rural areas.

The Present Study

In a way the present study is an extension of an earlier study done in Punjab[12] where the author had an opportunity to study the role of indigenous medicine practitioners for a number of years. In this study, which was conducted during 1976-80, we were able to make a much more vigorous and intensive effort to study the role of indigenous medicine practitioners in a Community Development Block of Haryana. Elsewhere, we have given a fairly detailed description of the characteristics of this Community Development Block.[13]

The main concern of the present study was to determine the role of indigenous medicine practitioners in providing medical care to the people and to identify factors influencing continuity of their practice. We had identified all traditional healers, practising in the Community Development Block, with the help of local influentials and medical doctors. We succeeded in establishing a good rapport with them through frequent visits to their homes and clinics. It was during these visits that we were in a position to explain to them the objectives of our study and we assured them that no part of the information gathered from them, on any aspect of their practice, would ever be misused. For the collection of data we used a specially prepared interview schedule but we also relied on the technique of 'participant observation'. In brief, our interviews were not hurried affairs; rather, these were systematically planned and conducted in an atmosphere of mutual trust, understanding and cooperation. In fact, we had prepared detailed case studies of practically all practitioners studied by us. All of these data, including selected information on practitioner-patient interactions have appeared in a separate monograph under preparation[14]. In the present survey, only a few selected findings are proffered.

Findings of the Study

Sixtyfour registered indigenous medicine practitioners were found to be practising in a Community Development Block with a total population of 18,000. Only 9 of them were fully-institutionally qualified, i.e., they possessed an ayurvedic degree like GAMS or BIMS. Of the rest, only 10 were partially-institutionally qualified,

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i.e., they had either a diploma or a certificate in Ayurvedic or Unani medicine and the remaining 45 were all non-institutionally qualified. These 45 RIMPS had no formal training in indigenous medicine but they all had served apprenticeships to established practitioners in different areas. The duration of apprenticeship had generally been four to five years. Age-wise, 3 of them were less than 25 years of age, 22 were in the age-group '25-34', 7 in the age-group '34-44', and the remaining 2 were above 55 years of age. Caste-wise, 22 of them were Brahmins, 18 Khatris, 17 Vaishs, 4 Harijans and 3 belonged to other caste groups. Interestingly, 44 of them were practising both allopathic and ayurvedic systems of medicine. Only two of them were 'pure' ayurveds. As regards their registration, 27 of them were registered with the State of Haryana, 29 with the State of Punjab, 5 with the Union Territory of Chandigarh and the rest 3 with other states. Income-wise, barring two who had had a monthly income up to Rs. 400 only, the rest all earned more than Rs. 1000 per month. In fact, four of them had a monthly income of more than Rs. 2000.

The value of the stock of drugs maintained by them, ranged from Rs. 500 to 2,500. Barring three, all were engaged in full-time practice. As most of the RIMPs had their clinics on the main roads, they were easily accessible to their clients. Nearly three-fourths of them had 'non-residential clinics' and the rest practised in their own homes. But most of them had only one-room clinics. Furnishings usually included a wooden table and chair and a couple of benches for waiting clients. Most of them displayed a large number of medicinal bottles in the open shelves in their clinics. Some of them also displayed their framed certificates. However, all of them kept their clinics open both during the day and in the evening.

The study made it abundantly clear that: (i) cosmopolitan medicine is still favoured by a majority of the rural people; (ii) the traditional healers are approached more for the treatment of chronic non-incapacitating dysfunctions rather than critical incapacitating dysfunctions; (iii) some traditional healers made tall claims of curing barrenness, impotency, venereal disease; and certain chronic diseases: (iv) the traditional healers have often moved from one place to another in the course of their training and practice; (v) most of them kept themselves in touch with doctors practising in towns to acquire knowledge of new remedies; (vi) all kinds of elements of cosmopolitan medicine—injections, patent medicines and pills have been incorporated into the traditional system of medicine; (vii) they maintain constant liaison with traditional birth attendants who practised 'protective medicine'; (viii) much less ill-health reached a Primary Health Centre doctor's attention than that of his traditional counterpart; (ix) the traditional healers frequently fulfilled more than one role, using supernatural methods as well as herbs; and (x) the traditional healers took care of the medical needs of nearly three-fourths of the total population of the block.

Conclusions

It would be clear from the findings of this study that the registered indigenous medicine practitioners capatialized on the malfunctioning of the centrally-sponsored health care system in this Block. The Primary Health Centre in the Block served mostly the people residing within a radius of three to four miles. The health centre had an irregular supply of drugs and it also suffered from numerous other inadequacies. Besides, the doctor incharge, posted at the health centre, showed little interest in building up a good clientele.

In fact, the classic image of doctor-patient relationship has already changed. In the classic image of doctor-patient relationship, the medical practitioner encountered his patients not only in a medical setting and in relation to a specifically medical goal, but also in their homes with their families and in other settings in the community. Thus he was able to obtain his knowledge of human relations during the course of his practice because of his enormous contact with his clientele drawn from a limited locale. He had an easy access to their life styles. He knew their values, their virtues, their weaknesses, their beliefs and attitudes. Thus he could relate their illness behaviour to their way of life. Today, these qualities of the good old doctors of cosmopolitan medicine are increasingly being acquired by the traditional healers.

Not many people realize that medicine is both a bio-scientific and a social endeavour, and that while modern medicine has developed largely along the lines of science and technology, traditional medicine has developed predominantly as a social activity. It needs hardly to be emphasised that as a result of rapid technological developments, the patient has become an unknown quantity. Specialization and super-specialization in different branches of medicine has narrowed the bases of contact between doctor and his patient. No wonder, in such a situation, the traditional healers have drawn maximum benefits. Medical scientists never cease to point out that unless they are trained properly, they may do more damage than good to the society. Thus the sooner we pay attention to these vital issues, the better it would be for all concerned.

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Latest in Cot Death Research

A TEAM of Australian scientists is studying the sleep behavioural patterns of the potoroo, a small marsupial related to the kangaroo, as well as those of babies, to try to unravel the mystery of cot deaths, the biggest killer of infants up to a year old.

At the University of Tasmania in Hobert, capital of the island State of Tasmania, one of the team members, Dr. David Megirian, has been monitoring potoroos' sleep patterns in response to artificially induced changes in oxygen and carbon dioxide levels.

At the same time, another team member. Dr. Naville Newman, Director of Neo-Natology at the Royal Hobart Hospital, has been studying the behaviour of infants whose breathing has been artificially obstructed to temporarily lower the oxygen intake.

Both doctors have found that when oxygen levels are reduced, more time is spent in deep non-dream sleep than normally occurs. It is during this period that the baby faces the greatest risk from cot death or sudden infant death syndrome (SIDS).

Initial research was carried out on rats to study respiratory muscle activity in relation to changing carbon dioxide levels.

"We believe that low oxygen levels in the womb could lead to hypoxia (low oxygen saturation levels in the blood) which could affect an infant's respiratory system in the first few months of life," Dr. Megirian said.

By beginning with potoroos which are almost adults (120 days) and experimenting with ones progressively younger, Dr. Megirian is hoping to determine the exact long-term effect of exposure to low oxygen levels at different pre-natal periods.

The other discovery that Dr. Megirian has made is that with low oxygen levels body temperature falls quite sharply—about 3°C over a six-hour period.

"Once we understand the normal physiological mechanisms, then we can predict when deviations might occur and provide far more intensive care for babies identified at risk," he said.

Premature babies and the siblings of those who have already died from SIDS are among those in this group, and Dr. Newman is now studying these infants to try to establish a recognisable pattern.

Using babies from one week to six months old, Dr. Newman has found response to obstruction differs depending on the age of the infant.

"In the first week the baby's intercostal chest muscles do not respond to a respiratory lead," he said. "From two months they do. For the first three months the baby spends half its time in dream sleep, which then drops to 40 per cent for the next six months."

From the age of nine months, the baby spends only 25 per cent in dream sleep, which sets its behavioural pattern as an adult. However, it is the transition from the amount of time spent in dream sleep at birth to that at three months which interests Dr. Newman.

"The highest incidents of cot deaths occur between two and four months old when the baby is spending more time in non-dream sleep," he said.

"In fact, we are trying to show that, as the baby becomes older, the most dangerous type is non-dream sleep," he said.

Dr. Newman said respiratory failure in babis was caused by a number of factors including larynx, tongue or nasal obstruction, regurgitation of milk, or shallow breathing in non-dream sleep. Social factors, as experiments in some Western countries had shown, also played an important part in the incidence of cot deaths.

"The physical problems are the most difficult to identify and by our research we are hoping to reduce cot deaths to an absolute minimum," he said.