Journal of North East India Studies
Vol. 2, No. 1, Jan.-Jun. 2012, pp. 22-39.

Perception of Health Care Option and Therapy Seeking Behaviour of Tangkhul Nagas

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Despite increasing attempts to centralised Folk Medicine and integrating with the mainstream medical system, this un-professionalised medical system is miles away to be accepted as a significant healing method in urban based modern society and among biomedical practitioners. Traditional Medicine (TM) in India under the acronym "AYUSH" have tried to make its presence felt in the global market. But as TM is restricted to AYUSH, this has overlooked a major underlying substratum of Folk Medicine that largely invokes natural and supernatural agents as the cause of illness. This calls for further investigation on the scholarship of alternative medicine in India.

Keywords: Folk-medicine, Ayurveda, Allopathy.

Qualitative assessment of health care in traditional societies is fraught with errors of omission since various elements that purists would grade as non-traditional are partly defining characteristics in many traditional societies. In this age of globalisation no characteristics such as the economy, culture and lifestyles are devoid of scientific or modern explanation which we otherwise presumed as traditional. In this backdrop it is important that societies are viewed in relation with changing scenario of post-modern foundation. Competition and change in economy and social relation occupies an important subject in the analysis of traditional folk medicine. The subject of traditional medicine (henceforth as TM) intersects along traditional and modern junction. This is one unique practice i.e. TM that brought us to foreground the various norms and values traditional societies are defined. TM therefore is not confined only to the process of diagnosing symptoms, curing and healing of illness, but is webbed into a complicated fabric of societal functions and relations. Norms and values in marriages, child birth and other social changes are inescapable from the explanation of TM. In other words we can say that TM is associated with all these social change and events. An example can be cited from the angle of marriage which is the most important component of social change and relation. Belief in supernatural aetiology of illnesses such as the evil eye, witchcraft, sorcery, etc. determined selection of bride and groom. Person who possesses occult power that can cast

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ISSN 2278-1455 (print)/ISSN 2277-6869 (online)

http://www.jneis.com

evil-eye or practising witchcraft are considered evil in the present Christian traditional societies and therefore are not the choice for marriages. It is perceived that this evil thing was brought from the past[1] and have been transferred from generation to generation. There is a clear identification among villagers that a particular family is born with and thus will try to avoid from having any conjugal/filial relationship. Therefore, TM conveyed "holism" that consider various cultural components in its operation. It is therefore in this context that we attempt to analyse the significance of traditional and allopathic medicine[2] (AM) among the Tangkhuls.

The Tangkhul is a Naga tribe living in the Indo-Burma border area occupying the Ukhrul district in Manipur, India and the Somra tract in Upper Burma. Ukhrul District is bounded by Myanmar in the East, Chandel District in the South, Imphal East and Senapati Districts in the West and Nagaland State in the North. The terrain of the district is hilly with varying heights of 913 m to 3114 m (MSL). The district Head Quarter—Ukhrul is linked with Imphal, the state capital, by NH-150 about 84 Km. The climate of the district is of temperate nature with a minimum and maximum degrees of 3° C to 33° C. The average annual rainfall is 1,763.7 mm (1991). The exact location of the district in the globe is 24N - 25.41 N and 94 E - 94.47 E. The rainy season in the district is from May to beginning of October broadly but Winter is chilly. The terrain of the district is rippled with small ranges and striped by few rivers. According to Census of India 2011, Ukhrul district has a population of 183,115. The district has a population density of 40 inhabitants per square kilometre (100/sq. mi.). Its population growth rate over the decade 2001-2011 was 30.07 percent. Ukhrul has a sex ratio of 948 females for every 1000 males, and a literacy rate of 81.87 percent.

Research Methodology

According to Lobiondo-wood and Harber (1994), research design is influenced by both the research objectives and the conceptual framework. Polit and Hunger (1993) state that this process entails the gathering and analysing of data. The basic unit of research is the village. Three villages with total households of 428 and population of 2414 persons represent the Tangkhuls for the study. The research in fact is oriented more to the case study approach. Selection of sample village is rational, and on the other hand selection of sample population of the selected villages is difficult. Therefore, the research is based on the information provided by the "head of the household". Case study approach is used in the study of any unit (be it tribe, a caste, a family, etc.). The approach concentrates on the wholeness of the unit chosen for the study. The selection of such units in case study approach may not have been based on statistical considerations of the representatives. Hence, the question of sampling does not arise.

Data Collection: Descriptive case studies are not limited to any one method of data collection, hence relevant information and data for the research are collected by employing different tools and techniques. The respondents of the present research are, head of the household (especially male), in absence of the male head of the household the oldest male member are chosen as the respondents, and in case of disability of head, the eldest member irrespective of male/female are the respondents.

Survey methodology includes household questionnaire, Group Discussion (GD)

and indepth interview. Although equal emphasis are given on all the three methods, household questionnaire forms the basic input for statistical analysis. This is not meant for the exclusion of GD and interview in the analysis, but the strength of numbers is primarily drawn from household questionnaire. GD and interview are qualitative and can generate a richer response and ideas because individuals are made to speak for themselves rather than use pre-specified measures which are the case of household questionnaire. No doubt, the methods have the strength and weakness and therefore data collection incorporates all the three methods.

Medical Pluralism: Health Care Options in Traditional Settings

Modern, western, biomedicine, allopath medicine express the same meaning in this paper although they may vary in concise literary exercise. Traditional Medicine here includes the institutionalised Ayurveda, Chinese acupuncture, Homeopathy, Siddha, Yoga, the Humoural theory, etc. and the un-institutionalised or the un-professionalised folk medicine that is practised far away from the expertise of clinical and pharmaceutical geniuses. However we are more concerned on the folk type of medicine which is not institutionalised but are most significant in Tangkhul society. Allopath or Modern health care services is profound in Tangkhul society. With the introduction of three tier system of medical services by the government, the importance given to allopathic health care in Tangkhul society is remarkable in terms of quantity. However, the qualitative aspect may indicate a less successful programme; nevertheless we are aware of the operation of allopath medicine and how it functioned in traditional societies. Cases of professionalised allopath practitioner unreported in Primary Health Centres (PHCs) is not surprising. Unavailability of medical kits recommended for PHCs, poor infrastructure, etc. have further added to the woes of people and have dwindled the popularity of allopathy rendered by the PHC. Therefore, in this background, we placed TM as the most important choice of health care services among Tangkhuls. "Medical pluralism is the character of health care options where options are available both within a relatively formal structure, such as a government health centre or a traditional healer's clinic; and in more informal ways such as through medicaments often purchased, with accompanying advice, from pharmacists or medicine sellers, and self care by the people themselves" (Heggenhougen, 1991: 133).

Medical pluralism is a fact in many societies. Services dispensed from PHC and folk healers are also the character of health care in Tangkhul region (Ukhrul district). In remote villages where coverage of PHC is nil and where communication facilities is almost absent, allopathic medical care have little or no relevance because it is over taken by Folk Medicine (FM). The urban based Tangkhuls does not deviate much from the rural counterparts despite the improved network of allopathic or modern health care services. Relevance of medical pluralism and choice of TM in many cases are not only confined to healing process but are framed in a larger context of social set-up. Belief systems paddling around TM can be identified holistically and this concept of "holism" added superiority over modern allopath medicine.

In table 1 given below the quantitative aspect of research where medical choice between TM and allopath/modern medicine are studied. The table largely indicates that people respond to the type of healer according to illness defined largely in their own

Table 1: Traditional Medicine versus Allopathic Medicine/PHC

	Choice between PHC and TM			Is Clinic or PHC Cheaper than TM	
Age of the Head of Household (HH)	TH	Clinic	Depends on treatment Needed	Same	More Expensive
15-25	31.3		68.8		100
26-35			100.0	20	80
36-45		13.2	86.8		100
46-55	16.7	11.5	71.8		100
56-65			100.0	15	85
66+	33.3		66.7		100
Total	7.8	8.6	83.5	4.2	95.8
Educational Level of Head of HH					
No schooling	6.5		93.5		100
Completed standard 5	31.0		69.0		100
Completed standard 8	5.5	5.5	89.1		100
Completed standard 10	6.1	22.0	72.0		100
Completed a diploma or degree			100.0	25.6	74.4
Total	7.8	8.6	83.5	4.2	95.8
Type of Occupation of Head of HH					
Not working	80		20.0		100
Cultivator	3.6	12.9	83.5		100
Clerical	50.0	25.0	25.0		100
Services			100.0	26.3	73.7
Skilled manual			100.0		100
Others			100.0		100
Total	7.8	8.6	83.5	4.2	95.8

Source: Primary Field Survey

framework. This obviously meant that consultation of illness experienced are initially subjected to home treatment or referred to the traditional healer. This can be proved from the response of the respondents where the choice of treatment depends on treatment needed. 83.5 percent of the sample population reported that choice between AM and TM largely depends on treatment needed. A meagre 7.8 percent choose TM and this is highest among the "non working" class with 80 percent. Fifty percent of the respondents with clerical profession choose TM. In terms of educational qualification, 31 percent of respondents who completed their fifth standard choose TM. 31.3 percent of the respondents belonging to the age group 15-25 years of the sample population choose TM. On the question of the cost of treatment received from AM and TM, it is reported that majority of the sample population endorsed PHC/AM to be much more expensive.

There has been a persistent problem among health administrators and practitioners in extending health care services to people in rural areas. Policies and programmes have failed in many areas and this may be partly because of the distrust people have in doctors and partly because of poor infrastructure on the public administration. Allopathic doctors are ignorant of the cultural conception of illness which had been long recognised by the rural people. Language barriers and customary traditions can be an obstacle for the doctors to convince people about scientific health concept. Many societies have their

own concept of health like the aborigines of Australia (Wiminydji and Peile, 1978) and the Tangkhuls. But doctors are ignorant to this fact. The inexperience practitioner is therefore encountered with cultural, linguistic and educational difficulties in eliciting the actual history and causes of disease.

The importance of TM is well recognised and because of this the WHO recommended for the integration of MM (modern medicine) and TM. But the problem lies in the distrust between the allopathic doctors and the traditional healers (Romero-Daza, 2002). There are various problems for the integration of MM and TM. In this regard De Zoysa and Palitharatna (1992) mentioned that: "unfortunately western medical practitioners in Sri Lanka with a few exceptions do not consider Ayurveda (TM) to be a useful knowledge system and often dismiss it without study". They have attributed such attitudes to a "neo-colonialistic" cultural attitude. Wanninayake (1982) sums up the difficulties facing synthesis which are (1) fundamental differences between the concepts of life, health and diseases, (2) intransigent, exclusive attitudes of both TM and MM practitioners, and (3) isolationist attitudes for preserving traditional values on the part of TM practitioners. Nevertheless, the importance of TM reigns over these limitations. In 1978 the WHO along with UNICEF urged its member states to foster collaborations between traditional and allopathic systems of care as a means to achieve the goals of the primary health care initiative (WHO, 1990). The recommendation resulted from the recognition of TM as the main source of health care in many areas of the developing world, its community centered nature, and its holistic approach to health (Morris, 2001; Roberts, 2001; Van der Gest, 1997; Zhang, 1996). Lord Hailey in his African survey in 1939 also put forward that "not all the practitioners of native medicine could be called witch doctors and proposed a study of herbs used by some of them, so that they could be incorporated in a list of remedies used by western doctors" (Beck, 1979). Indeed his proposal has been realised by many research institutions and companies. Biomedicines have now turned to TM, mainly the use of plants as a source for new drugs. Researchers use ethno-botanical information as the "clue to which plants are prime candidates for further screening and chemical analysis" (Farnsworth, 1993). "Traditional medical knowledge is important not only for its potential contribution to drug development and market values, but also for people's health care in the past, present and future" (Sheng-ji 2001). Although TM and AM are distinct from each other, recently there has been an increasing incorporation of elements of one into the other. There are examples of acupuncture in allopathic clinics or the use of antibiotic injections by traditional healers to improve their attractiveness to potential clients (Burghart, 1987) or the TBA referring to western trained midwife in case of twins (Rubel et al., 1971). Since TM is most significant for the local population because of its culturally-influenced perception on aetiology, means to integrate the two is a must exercise.

In the Tangkhul region there is an impressive array of medical pluralism. Allopath medical care to be successful lies with the State, but we also see the operation of folk healers occupying an important space in traditional health care system. Since Ayurveda and Siddha are closely related to Hindu and Muslim religion the popularity of such Traditional medicine is practically absent or un-utilised in this Christian dominated Tangkhul society. However, we see folk and religious healers (both treated as traditional folk medi-

cine/healers) such as the chiropractor, mid-wife, sorcerer, priest or pastors, shaman, exorcist, bone setter and herbalist and even homeopathy operating successfully. The types of healers as mentioned reflect types of illness under consideration. Illness such as malaria, typhoid, and tuberculosis if diagnosed and believed by the population as it is, then it will only give way for allopath practitioners to perform their job. But it is known that these kinds of illness have been firstly diagnosed and treated by traditional healers and only when they cannot put a cure that they bring to hospital at an acute stage. However, it is worthy to mention the role of folk and religious healers in treating various chronic illnesses such as anaemia, fractures, spinal problem, flatulence dog bite, snake bite and supernatural illnesses such as evil-eye, witchcraft, sorcery, demonic possession etc. with simplicity, affordability and with efficacy. Let us analyse how and what are the underlying factors in the choice of traditional medicine and allopathic medicine in Tangkhul region.

Determinants on the Choice of Health Care Services

Various factors are seen in the behavioural aspects of societal relation, reformation, transformation, change and perception, and utilisation of health care services in traditional societies. There are certain socio-cultural and physical factors for one's choice in health care services among the available options. Microscopic view of social structure in traditional societies relates us that various social elements in the society cannot be studied independently as these elements are dynamically interacting in social space. Therefore, choice is not random or fortuitous, but are governed and propelled by various factors that meet social norms and regulation. Individual opinion in rural parochial societies cannot function without the knowledge of other members of the society. This is one of the impediments in progress and development of societies. The undisputed leadership of elders and headman of the village keep at bay modern scientific medicinal knowledge as the learned younger generation cannot exercise their knowledge. For example, a couple cannot terminate pregnancy, which in the eyes of bio-medical practitioners is desirable and run risk such as deformity or chances of the mother survival is less when not performed. But understood on the lines of religious view or values and norms the population embrace such as destroying the embryo is equivalent to murder, only strengthen the orthodox, superstitious and dangerous gamut of choice the society have. Therefore, the choice of health care options in such societies is multifaceted which needs to be meticulously observed and analysed.

Firstly, let us fit the physical background of the Tangkhuls and its choice of health care. In spatial studies, i.e. locational or the geographical space, communication network that defines accessibility receives special attention on health care options. This, however, cannot be de-linked from various other factors interplayed in such cultures. Accessibility is one that defines health care options and various other structures of the society. Tangkhuls are mostly hill people inhabiting the remotest part of climatic and physiographic space in the country. Around 80 percent Tangkhuls are found in the hilly Ukhrul district of Manipur state and in the Somra track of Myanmar. The rest can be roughly estimated to be scattered in an around Imphal valley and along the trough of Thoubal river of Manipur. The Tangkhul villages are recognised by poor medical facilities and communication infrastructure. Absence of allopathic doctors and medical kits in PHC

in these villages, and transport for ferrying a sick person, the role of traditional medicine confers the highest position in societies of medical pluralism.

Tangkhul region which falls under the administration of Manipur Government is no exception to policies and programmes implemented by the State. Establishment of PHC in accordance with the norms and eligibility set by the Government, viz. population of 20000—30000 per PHC which varies depending on the physical landscape and 4 PHC under one Community Health Centre (CHC) have indeed touch parts of Tangkhul region, but quality dispense of service is largely debatable. Subjecting assessment of the health care picture in traditional societies such as the current study population deviate far away from what is written in the statute book and in the field. The low quality of service of biomedicine is one major factor that parochial societies moved away from and hence created a system of their own where health care are met inexpensively from folk or native medicine. The physiographic region of the study population is characterised by rough terrain, deep gorges, forested and loose lateritic soil. During Asiatic south-west monsoon where incessant rainfall is experienced, the region is marked with thick undergrowth of cane and weeds, and regular landslides and mudflow. It therefore logically reveals that without proper construction of coal tar road, the community will remain isolated from the outside world. The reality of the region is no less than true from poor infrastructure such as communication network, educational and health care facilities. Locational factors, specifically concern with accessibility, therefore are important determinants to the study of behavioural pattern of the population as regard to the quest and choice of health care services. Secondly, aetiology repertoire and the semantic interpretation of types of ailments as categorised under strict and deep philosophical exercises deserve attention with regard to choice of health care in traditional societies.

Accessibility is an important factor determining the attitude and behaviour of population with regard to choice and utilisation of health care services. Various studies report that rural population generally prefer traditional medicine/healer because of its cheaper treatment cost, proximate distance (accessibility), reliability and social relationship especially between the traditional healer and the patient. Distance of the population to the traditional healer or traditional health care services can be observed by questioning the mode of travel. 82 percent of the sample population reported "walking" and this varies according to socio-economic background of the respondents. The distance taken is 10 to 20 minutes for 65.1 percent of the sample population indicating that traditional healer may be available within the village or proximity to it. On the other hand, distance to allopath clinic or PHC may have been far since the majority (70.6 percent) reported travelling by bus to the doctor. This hypothetically concludes the absence of any referral PHC or allopathic practitioner nearby. However, on this very aspect we cannot ignore the locational or situational feature of the three villages especially selected for the analysis with regard to its distance from the PHC. Only 13.9 percent of the respondents reported that they "walk" to the PHC despite the availability of PHC in the two villages namely Yainganpokpi and Phungyar. To unveil this paradox we ultimately deduced the non-functioning of the PHC in the said villages. 70.6 percent of the sample population reported to use the "bus service" for travelling to the PHC and a few 13 percent used the "taxi" service. Renting a

taxi in these villages is costly compared to the income of the population and this is necessary only in case of emergency. It is reported that a high 90 percent response walking to the PHC will take more than 20 minutes which further proved the absence or non-functioning of any PHC in the said villages.

Table 2: Accessibility

	How do you travel to a TM				If Walk how long does it take to the TM			How to Travel to a PHC				If walk how long to the PHC		
	Walk	Taxi	Bus	other	Less than 10 Minutes	10-20 Minutes	More than 20 Minutes	Walk	Taxi	Bus	Other	Less than 10 Minutes	10-20 Minutes	More than 20 Minutes
Age of the Head of Household														
15-25	43.8	25.0	31.3		18.2	72.7	9.1		37.5	62.5		11.1	33.3	55.6
26-35	96.7		3.3		30.0	53.3	16.7		23.3	76.7				100.0
36-45	82.6	8.1	9.3		10.1	64.6	25.3	13.1	3.6	83.3				100.0
46-55	84.6	1.3	7.7	6.4		77.9	22.1	21.8	14.1	56.4	7.7		16.4	83.6
56-65	95.0			5.0		35.0	65.0	20.0	5.0	75.0			21.4	78.6
66+		66.7	33.3				100.0		66.7	33.3				100.0
Total	82.4	6.0	9.0	2.6	8.7	65.1	26.1	13.9	13.0	70.6	2.6	0.5	9.3	90.1
Educational level of Head of HH														
No Schooling	96.8	3.2			33.3	10	56.7	16.1	16.1	48.4	19.4	5.9		94.1
Completed Standard 5	66.7	8.3	4.2	20.8		45.5	54.5	27.6	27.6	44.8			44.4	55.6
Completed Standard 8	98.2			1.8	3.6	83.6	12.7	16.4	1.8	81.8			6.1	93.9
Completed Standard 10	68.8	5.2	26.0			70.8	29.2	9.1	20.8	70.1			5.1	94.9
Completed a Diploma or Degree	84.8	15.2			17.9	82.1		7.7		92.3			7.7	92.3
Total	82.4	6.0	9.0	2.6	8.7	65.1	26.1	13.9	13.0	70.6	2.6	0.5	9.3	90.1
Type Of Occupation Of Head Of HH														
Not Working	80	20				100.0		80	20				80	20
Cultivator	88.4	3.9	7.0	0.8	7.8	65.6	26.6	13.4	12.7	69.4	4.5		2.9	97.1
Clerical	50.0		50.0			85.7	14.3	25.0		75.0			42.9	57.1
Services	84.2		15.8		18.4	65.8	15.8	7.9	13.2	78.9			9.1	90.9
Skilled Manual	83.3			16.7	6.7	40.0	53.3		16.7	83.3				100.0
Others	50.0	50.0				100.0			14.3	85.7		14.3		85.7
Total	82.4	6.0	9.0	2.6	8.7	65.1	26.1	13.9	13.0	70.6	2.6	0.5	9.3	90.1

Source: Primary field survey

Furthermore, we also captured information regarding the significance of TM by posing the question “if allopath clinic is closer to your home would you still use TM more often?” 61 percent responded that it depends on the nature of illness and its treatment, followed by 26.3 percent reporting the “same as before”. This again varies according to socio-economic and demographic background of the population.

Table 3. Response to Traditional Medicine

	Did family members visit TM		Number of Visiting TM in the last one year				Visiting TM have change in the last 5 years because of					
Age of the head of household	No	Yes	None	Once	2-3 times	4-6 times	More than 6 times	Allopathic services available	Better transport services to reach health centers	TM not effective	Illness not allocated for TM or AM	Others
15-25	68.8	31.3	25.0	18.8	56.3				16.7			83.3
26-35	51.4	48.6	60.0	5.7	31.4	2.9						100.0
36-45	4.7	95.3	34.1	9.9	30.8	6.6	18.7	34.3			8.6	57.1
46-55	42.3	57.7	35.9	19.2	32.1	6.4	6.4	19.4		35.5	29.0	16.1
56-65	15.0	85.0	30.0	55.0	15.0						22.2	77.8
66+	33.3	66.7			100.0							100.0
Total	29.4	70.6	37.0	16.5	32.5	4.9	9.1	20.5	1.1	12.5	15.9	50.0
Education of HH												
No schooling		100	3.2	22.6	74.2				5.9		11.8	82.4
completed standard 5	31.0	69.0	20.7	24.1	37.9		17.2					100
completed standard 8	40	60	52.7	25.5	10.9	10.9				45.8	29.2	25
completed standard 10	41.4	58.5	29.3	3.7	47.6	7.3	12.2	45			12.5	42.5
completed a diploma or degree	15.2	84.8	65.2	19.6			15.2					
Total	29.4	70.6	37.0	16.5	32.5	4.9	9.1	20.5	1.1	12.5	15.9	50
Type of occupation of HH												
not working		100			100							
cultivator	26.9	73.1	30.2	20.86	36.7	5.0	7.2	29.0		17.74	17.7	35.5
clerical	75.0	25.0	50.0		50							100.0
services	39.5	60.5	86.8			13.2						100.0
skilled manual	33.3	66.7	10.0	36.67	36.7		16.7				21.4	78.6
others		100.0	42.9		7.1		50.0		100			
Total	29.4	70.6	37.0	16.46	32.5	4.9	9.1	20.5	1.1	12.5	15.9	50

Source: Primary field survey

Table 3 indicates that 70.6 percent of the respondents reported family members visiting TM. This varies according to the socio-economic background of sample population. According to age-group of the respondents, we see that 95.3 percent of the family visit TM followed by 85.0 and 66.7 percent in the age group 56-65 and 66 plus respectively. According to educational background it is reported that 100 percent of the population deprived of any qualification visit the TM, followed by 84.8 and 69 percent of the respondents educated with “Completed a Diploma or Degree” and “Completed Standard 5” respectively. According to the type of occupation, 100 percent of family members visiting TM are respondents with no occupation. Cultivators, Skilled Manual and Services have a share of 73.1, 66.7, and 60.5 percent respectively. 65 percent in the higher age-group of 56-65 reported to use the “same as before” although if allopath clinic is closer to their home. According to educational level of the head of household, 55.2 percent in the educational

level of "completed standard 5" reported to use the "same as before" despite availability of allopath clinic to their home. No significant relationship between educational level and the utilisation of TM in this regard could be ascertained since respondents with "no schooling" composed of only 25.8 percent in the category responded "same as before".

Cross-classified according to type of occupation of the head of household, 100 percent reporting "not working" response that recourse to types of health practitioners depend on the nature of illness and treatment, despite the availability of allopath clinic proximate to their village/home. 86.8 percent in the "services" category and 93 percent in the "others" category reported to use TM depending on the nature of illness. Type of occupation with "skilled manual" and "cultivator" composed of 40 percent each to use "same as before". Since only a small fragment of the population (3.3 percent) is believed to use TM more often despite the availability of allopath health care services, this crudely indicates the diminishing popularity of TM because of allopathic medicine.

To validate further on the importance of TM we posed the question to the head of household that "*would you used more or less TM in the future*?" To this we found out that 57.6 percent reported to use the "same", 9 percent to used "more" and a meagre 6 percent to used "less" in the future. 27 percent of the respondents are confused on this subject. There is a paradox on this subject confusing the researcher as well. In the first analysis we figured out the diminishing popularity of TM, but on the other hand there is still the observation of the importance of TM in near future. Respondents with educational level "completed standard 5" are of the judgment to use the "same" as before in the future. In this context we observed the inverse relationship between increasing educational level and utilisation of TM. As educational level of the respondents increase the percentage to response the option "same" decrease, and on the other hand percentage in "Don't Know" category increases. With higher educational level we felt that there arises more confusion regarding the use of TM in the coming future.

According to type of occupation, we observed that 20 percent of the non-working respondents replied that they do not have opinion on it. The percentage in "DK" category is 6.5, 25, and 86.8 percent for cultivator, clerical and tertiary services respectively. This suggests that respondents with higher occupational status have lesser interest in the utilisation of TM in the future.

Analysing further on the significance of TM, the cost factor is also taken into consideration. Hypothetically, we expect that in rural societies the population will prefer cheaper rate provided that there is an option. Cost of any commodity or services is an important determinant to understand the complex behaviour of rural population. The question "*if TM is more expensive would you use them?*" which is posed to the respondents reveal us that 14 percent reported to use less, 21 percent to use more, 15.6 percent to use the same as before, and 50 percent to use depending on the nature of illness and its treatment. A high figure of 28.2 percent in the age-group 46-55 years reported to use "less" if TM is more expensive. On the contrary, 55 percent in the age-group 65-65 years reported to use TM "more" although it is more expensive. A significant 65.9 and 66.7 percent of respondents in the age-group 36-45 and 66+ years respond "depending on what treatment they needed". According to educational level of the Head of Household, 20 percent of the respondents who have "completed standard 8" reported to use less if TM is more

Table 4: Validating Traditional Medicine/Folk Medicine

	If Clinic closer to your Home would you used TM more often				Would you used more or less TM in future				If TM is more expensive would you used them			
Age of the head of household	Less	More	Same	Depends on Treatment	More	Less	Same	DK	less	more	Same as Before	Depends on what treatment needed
15-25		31.3	31.3	37.5	50.0	25		25		37.5	31.3	31.3
26-35			37.1	62.9			54.3	45.7		31.4	22.9	45.7
36-45	13.2		18.7	68.1			72.5	27.5	13.2	11.0	9.9	65.9
46-55	14.1	2.6	20.5	62.8	10.3	14.10	57.7	17.9	28.2	16.7	17.9	37.2
56-65			65.0	35.0	25.0		50.0	25.0		55.0	5.0	40.0
66+		33.3		66.7	33.3			66.7			33.3	66.7
Total	9.5	3.3	26.3	60.9	9.1	6.2	57.6	27.2	14.0	21.0	15.6	49.4
Educational level of head of HH												
No schooling		6.5	25.8	67.7	22.6	3.2	71.0	3.2		58.1	22.6	19.4
completed standard 5		3.4	55.2	41.4	3.4		86.2	10.3		37.9	24.1	37.9
completed standard 8	20		34.5	45.5		20.0	69.1	10.9	20	9.1	25.5	45.5
completed standard 10	14.6	6.1	25.6	53.7	17.1	3.7	59.8	19.5	28.0	20.7	12.2	39.0
completed a diploma or degree				100			13.0	87.0				100
Total	9.5	3.3	26.3	60.9	9.1	6.2	57.6	27.2	14.0	21.0	15.6	49.4
Type of occupation of head of HH												
Not working				100			80	20				100
Cultivator	16.5	1.4	30.9	51.1	11.5	10.1	71.9	6.5	20.9	25.9	22.3	30.9
Clerical		50	25	25	50		25	25		41.7	33.3	25
Tertiary Services			13.2	86.8			13.2	86.8	13.2			86.8
Skilled Manual			40	60			60	40		33.3	6.7	60.0
Others			7.1	92.9		7.1	42.9	50			7.1	92.9
Total	9.5	3.3	26.3	60.9	9.1	6.2	57.6	27.2	14.0	21.0	15.6	49.4

Source: Primary Field Survey

expensive. The figure is 28 percent for those who have “completed standard 10”. And on the other hand 58 percent of respondents with no schooling reported to use more even though TM is more expensive. This supplicate the conception that perhaps, cheaper allopathic clinics or PHC are not available within their realm of the world or that allopathy is not effective or that TM is more superior than AM for illiterate or uneducated respondents. The figure for “completed standard 5” is 38 percent in the category “more”. The option “depends on what treatment I need” is 100 percent for respondents with the background of “completed a diploma or degree” indicating a much more rational assessment of TM. Findings based on the “type of occupation” of the respondents’ background, 100 percent of them who are “not working” responded that it depends on what treatment they need if TM is more expensive. A higher figure of 31 percent in the “cultivator” background also respond “depending on treatment” as against 21, 26, and 22.3

percent in the category of "less, more, and same as before" respectively. Respondents with clerical type of occupation favour more even though TM is more expensive. Majority of respondents in the "services" category respond "depending on treatment needed", and a meagre 13.2 reported to use "less" if TM is more expensive. "Skilled Manual" and "others" type of occupation of the respondents reported a high figure depending on treatment if TM is more expensive.

Medical Pluralism in India: NFHS 3.

The National Family Health Survey 3 (2005) conducted in India reported a meagre 0.8 percent or 873 households (out of total 10, 90, 41 households) visit traditional healers generally when they are sick. 98.9 percent of the households visit allopathic practitioners of which 64.5 percent are accounted by private sectors and 34.4 percent by public sector (Jeermison, 2011). The survey in fact relay us nothing about medical pluralism especially about TM despite the official recognition and introduction of AYUSH department in the Ministry of Health and Family Welfare.

The result provided a complete set back to the relevance of TM in India where no significant assessment is worthy enough to be carried out. However, one should not stay rejected and conclude simply because errors and limitation in data is inevitable. The highly praised Ayurvedic component in Kerala where tourism department has taken keen interest is also not reflected in NFHS 3. However, we should also consider on the contrary of why the popularity of TM has significantly diminished.

Traditional Medicine in India may not have lost its credibility to allopathic medicine but its popularity has significantly diminished. Although efforts to established a modern, state-controlled and financed system of education and research in Ayurvedic and Unani medicine began about 70 years ago (Leslie, 1963), these system of medicine is yet to expand and develop as an alternative medical system in India. As seen from the study a very small percentage of households in India received health services from TM. This indicates that most of the health services are provided by allopathic medicine from both private and public sectors. "In China, on the other hand, traditional medicine based on thousands of years of history is still practiced far from the frenzy of pharmaceutical geniuses and their seemingly conflicting cures, and has been able to skirt the expense and profit driven motives of western medical doctors and pharmaceutical industries" (Cooper 2007: 135).

"The classical Chinese pharmacopoeia describes a large number of herbal formulations that are used for the treatment of a wide variety of diseases. This therapeutic approach is ignored by many and considered to be an alternative to conventional medicine by others. The scientific proof and clinical validation of these herbal formulations require a rigorous approach that includes chemical standardization, biological assays, animal models, and clinical trials" (Yaun & Yaun, 2000: 191). Traditional Chinese Medicine (TCM) has developed ultimately into an alternative health care system with great success in clinical experimentation. They have been successful in promoting its therapies with more research and science-based approach, while Ayurveda still needs more extensive scientific research and evidence base (Patwardhan et al., 2005: 465). China has conducted extensive clinical studies in TCM and has found to be potentially useful for treating

Table 5: Percent Distribution of Household Members receiving Health Care from Different Sources. State -wise distribution, India 2005.

State	Allopath	TM 1	TM 2	Others**
Jammu and Kashmir	99.4	0.1	0.2	0.3
Himachal Pradesh	99.5	0.3	0.5	0
Punjab	99.4	0.3	0.5	0.1
Uttaranchal	98.4	0.3	0.5	1.1
Haryana	99.8	0.1	0.2	0
Delhi	99.6	0.2	0.4	0
Rajasthan	99.5	0.4	0.4	0
Uttar Pradesh	99.1	0.6	0.7	0.2
Bihar	98.9	0.9	1.1	0.1
Sikkim	99.8	0.1	0.1	0.1
Arunachal Pradesh	98.4	0.2	0.9	0.7
Nagaland	96.4	0.6	3.2	0.4
Manipur	99	0.4	0.9	0.1
Mizoram	99	0.3	0.8	0.3
Tripura	98.9	0.5	0.6	0.6
Meghalaya	96.2	0.6	3.4	0.3
Assam	98.9	0.8	0.8	0.3
West Bengal	96.9	2.5	2.6	0.5
Jharkhand	95.7	3.4	3.9	0.4
Orissa	97.1	1.7	2.1	0.8
Chhattisgarh	99.1	0.5	0.7	0.2
Madhya Pradesh	99.4	0.3	0.5	0.1
Gujarat	99.6	0	0.1	0.3
Maharashtra	99.6	0.1	0.2	0.2
Andhra Pradesh	99.5	0.1	0.3	0.2
Karnataka	99.4	0.1	0.3	0.3
Goa	99.3	0.1	0.4	0.3
Kerala	98.2	1.2	1.5	0.3
Tamil Nadu	99.6	0.2	0.3	0.1
Total	98.9	0.7	0.8	0.2

Source: IIPS 2005-06

TM (Traditional medicine) 1 includes treatment received from Vaidya/Hakim/Homeopath and traditional healer and **TM (Traditional medicine) 2** includes Vaidya/Hakim/Homeopath, Traditional healer, DAI and home treatment. ** Others include “other (shop) and Others” as coded in NFHS3.

various ailments. Bao-En Wang (2000) reported that TCM is still being extensively used for treatment of liver disease in China having great potential in the treatment of chronic hepatitis B. Yuan R and Yuan Lin (2000) also examine relevant studies on the use of traditional Chinese medicines for the treatment of such diseases as bronchial asthma,

atopic dermatitis, and irritable bowel syndrome. However, in India there have been consistent problems of the assessment of safety and efficacy. The country is sitting on a gold mine of well-recorded and traditionally well-practised knowledge of herbal medicine (Dubey et al., 2004) but it is not able to utilise and promote traditional system of medical knowledge unlike China because clinical studies in this field have not been undertaken extensively. Research organisations and universities have neglected the study of potential medicinal plants because of lack of facilities. Other factors for the low profile of Indian traditional medicine in the world market are adulteration of herbal products from India and improper harvestation of medicinal plants (ibid.). Plant samples in the market are stored under undesirable conditions over the years, and often contain a mixture of other plant species (Khatoon et al., 1993). Due to this adulteration and altered efficacy, the faith in crude drug promotion has declined (Gupta et al., 1998). This is one of the major causes of decline of ayurveda in India and has also adversely affected the global promotion of Indian herbal products. An example to this is that foreign countries like U.S.A. and Canada took Ayurvedic and Unani medicines off stores and banned their further import after dangerously high levels of heavy metals such as lead, mercury, and arsenic was found in formulations. Unlike China that has several WHO's Collaborating Centres for traditional medicine, India has not been able to set up even a single collaborating centre. A WHO collaborating centre is an institution designated by the Director-General of WHO to form part of an inter-institutional collaborative network set up by WHO in support of its programme at the country, inter-country, regional, interregional and global levels, as appropriate. It participates in thestrengthening of country resources, in terms of information, services, research and training, in support of national health development. Its objectives are to promote research & development of traditional medicine systems; to promote studies of herbal remedies used by traditional practitioners, in their ethno-botanical, medical-anthropological, experimental, pharmacological & chemical & clinical aspects; to collect, document, analyse & disseminate information relating to traditional medicine systems; and to participate with other WHO Collaborating Centres for Traditional Medicine in joint studies aimed at evaluation of national traditional medicine systems. India, therefore need to established its position by joining hands with others for research in the field of traditional medicine. The other areas of TM that has not been given enough attention especially in India are folk healers in rural areas that employed spiritual therapies and magico-religious remedies. In societies aetiology of illness is of paramount importance in the choice of treatment. Most societies identify two major causes of illness; normal/ natural and personalistics/supernatural illness. Witchcraft, demonic possession, evil-eye comes under the supernatural folk classification of illness. In this case folk healers are preferred over allopathic practitioners. Since there are some sections of the population in the country that believe in supernaturalistic explanation of disease, the role of folk healers such as shamans, diviners and DAI gain importance in providing treatment. But as we restrict our discussion of TM in India to AYUSH, we have overlooked a major underlying substratum of "folk" medicine that largely invokes natural and supernatural agents as the cause of illness.

Conclusion

The quantitative aspect of the research data collected through household questionnaire

provided us the significance and utilisation of TM of the Tangkhuls having little correlation with socio-economic background of the respondents. In other words we can say that economic conditions and literacy status of the respondents do not affect the relevance and utilisation of TM. Medical pluralism exists and thus recourse to heath care services largely depends on the aetiology of illness. The research reveals that both allopathic medicine and TM are utilised based on cause and effect of illness experienced. Discussions and interviews[3] carried out among the elders on utilisation of TM provided us that wide collections of illnesses are associated with supernatural explanation. This supernatural entity has a clear presence historically, and which is sustaining and explaining even today. They are considered to be a fact rather than being superstitious as claimed by biomedicine. It is said that traditional healers treat a variety of illness, but TM supersede biomedicine over cases such as fractured bones, spinal injury and supernatural causes of illness. Preference given to chiropractor and bone setter is because of its instant healing and low economic cost. From the discussion we found out that fracture of bones and spinal injuries are better treated by TM than biomedicine. Various cases of patients suffering from dislocation and fractured of bones, discharge from the hospital and brought back to the traditional healers are also cited.

The other aspect of the problem is the supernatural causes of illness. This includes evil eye, sorcery and demonic possession. They are translated into epilepsy, schizophrenia and psychological disorder by biomedicine and therefore treatment follows on how it is diagnosed. This is one subject where biomedicine strongly rejected TM on the ground of obscurity and irrationality. But on the contrary, this is also the point where traditional healer/TM reduce the efficiencies and reliability of biomedicine. Supernatural explanation of illness aetiologies are confined not only to the Tangkhuls but with various other societies.

Explanations of supernatural events do vary from society to society. “People are aware of the natural causes of illnesses; they know that bad food can entail stomach cramp and traditional herbal medicine or allopathic drug can stop the pain. But what they also know is that in some cases, drugs and doctors are ineffective, that doctors are unable to treat some diseases. In those cases they do explain, by reference to the supernatural entity” (Deliege 2007: 54). Tangkhuls also never put down every illness to supernatural; they are very much aware of natural causes of illness and thus seek health care from allopath or traditional herbalist.

From the analysis we can infer some information regarding the significance of TM according to socio-economic background of the respondents. Firstly we see respondents with higher educational status moving away from TM in the near future. Secondly, respondents with higher occupational status reported lesser interest in the utilisation of TM in the near future. This is rather confusing as, on the other hand, majority of the respondents reported to used TM depending on treatment needed although it is expensive. This generally gives us an idea that the faith in TM is not yet reduced even with the most educated respondents.

Therefore, we conclude that there are types of illness which are better treated by TM and which can be treated only by TM. The research also confides the presence of medical pluralism in Tangkhul villages and thus recourse to health care are determined by

both supernatural and natural aetiology of illness.

Notes

[1] Before Christianity the real religion Tangkhuls professed is that cult—ancestor-worship. The earliest ancestor worship—"the root of all religion" as Herbert Spen-cer spelt out—was probably coeval with the earliest definite belief in ghosts. The earliest legend in the Tangkhul society did speak of an underworld, where mysterious evil being dwelt in corruption; but this vague world of the dead communicated with the world of living; and the spirit there, though in some sort attached to its decaying envelope could still receive upon earth the homage and the offerings of man. The ghosts of the departed were thought of as constant presence, needing propitiation, and able in some way to share the pleasures and the pains of the living. They required food and drink and light. If honourably sheltered and properly nourished the spirit is pleased, and will aid in maintaining the good fortune of its propitiators. But if refused the sepulchral home, the funeral rites, the offerings of food and fire and drink, the spirit will suffer from hunger and cold, and will act malevolently and contrive misfortune for those by whom it has been neglected (Horam, 1988).

[2] The term "allopathy" was coined in 1842 by C.F.S. Hahnemann to designate the usual practice of medicine as opposed to homeopathy, the system of therapy that he founded based on the concept that disease can be treated with drugs (in minute doses) though capable of producing the same symptoms in healthy people as the disease itself. The term allopathy is derived from Greek *állos*, other, *páthos*, suffering. Therefore allopathy *ipso facto* includes varieties of medical systems practiced apart from homeopathy. However in this article we have separated a section that includes treatment received from vaidya/hakim/homeopath, traditional healers, DAI and home treatment designating as traditional medicine, and allopathy with the assumption that it is largely biomedicine. Therefore, the term allopathy in a strict sense may not correspond with our application.

[3] Discussion with elders of different background was carried out in the month of May 2011. Interview with traditional healers also provide rich input on the subject especially on evil-eye. A traditional healer who has given cure to patients suffering from evil eye gave this account. A girl of seventeen treated by allopathic practitioners without any improvement returns to traditional healer showing symptoms of distended stomach, violent revulsion, extraordinary strength, occurrence of numerous papules and sores in the skin and spasm of muscles . The girl was treated in the clinic by one allopath practitioner of the same community that shares beliefs and concerns with the patient and the family, but was referred subsequently by the doctor to consult a spiritual healer saying that it is the case of possession. It was therefore brought to me for treatment of this supernatural illness by combining herbal treatment and spiritual healing, said the traditional healer. The account narrated... "Dip the ember in a cup of water. The ember in contact with water produces charcoal. Powder the charcoal to ash and mix it up with the water in the cup. Wait for few minutes to dissolve the ash and finally the ash will settle down producing a crystal clear potion. Force the patient to drink the potion. At first the evil spirit (here it is the patient possess by the Evil-eye) will feign that it is going to leave

the patient in peace, but in reality the Evil-eye hides or act as it has become recessive. Do not believe in anything the evil spirit says. Force to drink and repeat the procedure until it leaves the patient". However, he further mentions that anyone who treats a patient should be strong in all respects and courageous, and this is the reason where some treatments go ineffective. On questioning the effectiveness of the potion, the healer responded that certain elements (not chemical compound) of fire helps in driving out the Evil-eye from the person it has possessed. The process indeed bear close semblance with the hot-cold theory of Latino cultures.

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