Abstract

The present study is an attempt to analyse the uncodified and informal traditional healthcare system such as *Jhankri or Vaidya System* in India by placing it on the larger public health scenario of the nation. Further, the study is about the comparative analysis between formal and informal healthcare practises of Darjeeling district of West Bengal and Kottayam district of Kerala. It is evident from the different national health reports along with NFHS reports 1,2,3 and 4 that the state of Kerala has been performing very well in regard to public healthcare facilities as compared to the state of West Bengal. Still alternative healthcare practices such as *'Vaidhya'* and '*Asthavaiya System'* is very much prevalent in Kerala. So, the primary concern of the study is to find out whether it is a matter of accessibility, affordability or efficacy, or it is the loopholes of the concerned administration to provide good health facilities in the region, or it is the culturally rooted belief system that the general masses of India accept these alternative healthcare practitioners *(jhankris or vaidyas)* as their health care provider and the large number of people believe, follow and practice these kinds of healing tradition. Hence, the problem of the present investigation is stated as *"**Public Health Policy and the Coexistence of Formal and Informal Healing Systems in India: A Study of two States".***

Objectives of the Study

i. To examine Public Health Policy in India.

ii. To analyse the state responses and interventions regarding the Traditional Medical Practices in India.

iii. To examine the Rural Health scenario in India.

iv. To analyse the nature and practices of faith healing system in India.

v. To account for medical pluralism or coexistence of formal and informal health system.

Some Research Questions:

i. What is the nature of health policies and programmes in India?
ii. What is the condition of Public Health in Darjeeling and Kottayam?
iii. What is the status of these faith healing Systems?
iv. How to account for coexistence of codified and uncodified healing systems in India?

Hypotheses:

On the basis of the theoretical framework and formulation of research problem the following hypotheses have been designed.

1. There is an inverse relationship between growing accessibility and affordability of mainstream health service and the dependence of people on informal and traditional healing system in Indian Society.
2. To what extent formal health infrastructure is inadequate in rural areas. People in rural areas tend to depend more on the practices of traditional health system including *Jhankri* System.
3. The co-presence of formal health infrastructure and traditional informal healing system such as faith healing will reveal socio-economic patterns of people's dependence on either of them. In other words, the bulk of poor and illiterate people would resort to traditional healing system as a rule. Whereas the affluent and the educated sections tend to depend on formal public and private health infrastructure.
4. There may be cases where the affluent and the educated depend on informal and traditional health systems including faith healing system for strong cultural and community orientations.
5. While the public health policy has been and will be functional for the development of formal healthcare system in a condition of active political society, such policy would be tolerant and permissive of the traditional healing system such as *Jhankri* System. It is likely that there will be political nexus between the local level politicians and practitioners of faith healing system where they are prevalent under the condition of limited accessibility to formal public health facilities for the bulk of the people.

THEORETICAL FRAMEWORK

India, politics included, has been a land of fascinating dualism. The old coinage of *India* versus *Bharat* is one of the familiar constructions about the heterogeneity of time and space. More popularly one may refer to the coexistence of tradition and modernity in India. Many Indian scholars have tried to capture this duality in relation to the policies pursued by State. One of the well known scholars in this respect has been Prof. Partha Chatterjee. Before we return to the views of Prof. Chatterjee, let us note the ambivalence of the public health policies in India in its approach to traditional and more particularly uncodified health regimes. *"Jhankri System"* and "*Vaidhya System"* is one such uncodified health practice in India. These systems involve a distinct ethno-cultural and religious belief, rituals, customs and treatment of different diseases; a large number of rural populations are associated with this system in India. This system often violates the rules and regulations of the states and is generally practised by the unprivileged, underprivileged and marginalised populations of rural India, who play an important role

in the functioning of Indian representative democracy in broad manner, the real ' Politics of the Governed' as advocated by Prof. Chatterjee.

Prof. Chatterjee in his book, 'The Politics of the Governed' has drawn attention to popular politics in India and some other similar places of the world. He has drawn a vast literature on the differences between State and civil society relationship in the north and those in the south. He has disagreed with the proposition of Benedict Anderson that nation lives in homogenous empty time. Chatterjee argues that in most of the post colonial world there is a presence of a dense and heterogeneous time and there is a tension between the homogenous time of capital and the real space constituted by the heterogeneous time of governmentality. Within this tension State often tolerates the particular claims of marginal population groups even if they are grounded in violations of the law. In other words, there has to be a continuous mediation between the formal and informal, legal and illegal. The mediators are often local level politicians connected with political parties. In fact this represents the active element in the "political society" having place in the general political culture and helping the procedures of governmentality. The governmental process tends to be formal and legal. As the health system stands in India, governmentality is expressed through increasing regulatory frameworks for health regime licence and permits. New norms come up, new regulatory bodies come up. Codified health systems are formally encouraged and supported but, political society which is full of people unaware of their rights and entitlement and compelling reasons to go for the uncodified ensures that violations from norms are tolerated at the local level at least, one term says, blind eye to a quack substituting for a registered medical practitioner.

The framework that Chatterjee uses to contrast a civil society and a political society help us in understanding India's public health policy. So, we can perceive the local uncodified health system like *'Jhankri' and 'Vaidya'* coexisting with the licensed and codified health regimes through mediations of political society with the civil society.

Methodology

The researcher has used the standard tools and techniques of field research including the use of SPSS. The data has been collected through surveys, observation and interviews on the basis of stratified random sampling of the patients in all the study areas. However there are major components of interviews, snowball samplings of the traditional faith healers, local healers *(Jhankris and Vaidyas),* and local level politicians and so on. A self-made questionnaire was administered for gathering information. The attitudinal component has been measured through scaling. For the use of SPSS schedules have been administered as per sampling procedures with appropriate coding. Since the subject of our study was dominated by the attitudinal components of patients, collection of information prior to designing the schedule and formulating relevant questions for the purpose of interview was necessary. The first phase of data collection had begun with several case studies of patients who have been depending on traditional health practices such as

Jhankri and *Vaidhya* System. However the uses of SPSS represent the second stage of preferred methods. The first stage has been oriented towards case studies. Primary sources of the study include Government Reports, official records, news papers, healers, *Ojhas, Vaidhyas,* doctors, ANMs, political leaders, political thinkers, elderly experienced people having vast knowledge of life, natural phenomenon, traditions of the society. All this information will come to the investigator's help for understanding the remote past. Secondary sources include books, journals, magazines etc. The data collection has been processed in a meaningful way involving Classification of Data, Coding of Data, Tabulation of Data and Pictorial representation of Data. The researcher then analysed the processed data for testing the significance of the hypotheses framed and also in order to discover inherent facts by following the SPSS method. Finally, the researcher tried to logically and critically examine the results obtained after analysis, keeping in view the limitations of the sample chosen, the tools selected and used in the study.

The present study has been classified into the following chapters:

Chapter 1- Introduction

This chapter involves the nature of healthcare practices in India, the statement of the problem and rationale of the present study, objectives, research questions, theoretical frameworks and methodology.

Chapter 2- Review of Related Literature

Chapter 3- Public Health Policies and Programs in India: State and Private Agencies

This chapter thoroughly elaborates the different healthcare policies and programmes in India pre and post independence. It also involves the nature, role and relation of State and Private Agencies in healthcare system in India.

Chapter 4-Traditional Codified and Uncodified Healthcare System in India

This chapter deals with the nature and scope of Traditional Indigenous Healthcare System both Codified Formal Healthcare and Uncodified Informal Healthcare System in India.

Chapter 5- Practices of Informal Healing System in India

This chapter states about the prevalence of diversified informal healthcare practices in different parts of India. It also extends the position of state about these kinds of uncodified healthcare regime.

Chapter 6- Case Study on Jhankri System in Darjeeling District of West Bengal and Vaidhya System in the Kottayam District of Kerala

This chapter deals with the detailed analysis of Jhankri System of Darjeeling Hills of West Bengal and Vaidhya and Asthavaidhya System of Kottayam district of Kerala.

Chapter 7- Data Analysis/ Interpretation, Findings, Recommendations & Conclusion

This chapter states about data analysis, findings, recommendations and conclusion.

Summary and Findings

It is evident from the present study that both the districts of two distinct states witness the existence of alternative healthcare system in the name of '*Jhankri* and *Vaidhya'* system. Both healthcare systems are based on the traditionally culturally rooted belief system and the habits of the people of concerned areas. In both the cases, it is found that health providers are easily accessible, affordable and efficacious in their healing practice. However, it is revealed from the study that, in case of Darjeeling the public healthcare facilities provided by the government in rural areas are not up to the mark. But, in case of Kottayam district of Kerala, it is very good and people are fully satisfied with the healthcare facilities provided by the government. Further, it is very wrong to assert that the lack of proper healthcare facilities provided by the concerned government in the region is responsible for the existence of alternative healthcare system. Because, in case of the state of Kerala, the public healthcare facilities in Kottayam district of Kerala are excellent, still people follow the alternative healthcare system in the name of *Vaidhya* practice. Similarly, in case of education and income, it is a well evident fact that the district of Kottayam in Kerala is famous for the high rate of literacy. From the survey conducted in the region, it is revealed that the education levels of the respondents are very good. Maximum numbers of respondents are highly educated in the district. Very few respondents are intermediary educated or Madhyamik passed. It is revealed from the study that there isn't any illiterate respondent found in the entire samples. The survey report also reveals that majority of the local people have very good monthly income and only minor sections of people have moderate monthly earning. Hence, it is not only the matter of healthcare provisions provided by the concerned authority and the economic wellbeing or educational advancement rather it is the beliefs, practices and the habits of the definite ethnic communities which ultimately plays a pivotal role for the existence and survival of these kinds of healthcare systems in the society. Further, it is also evident from the statistical analysis such as t-test and chi-square that despite all the differences of educational status, income and healthcare facilities between Darjeeling and Kottayam, alternative healthcare system such as *Jhankri* and *Vaidhya* System exist in both societies and the people are abundantly following the same with immense faith and belief.

In Chapter 3 the researcher has presented an analysis of the nature of health policies and programmes in India. In general there is poor health infrastructure in rural India combined with widely different infrastructure in different states. It appeared that policies and programmes announced from time to time have not been implemented efficiously. The conditions of Public Health in Darjeeling and Kottayam have been discussed in Chapter 6 and 7 respectively. In the latter public health infrastructure was found to be much better. Yet the traditional healing systems have survived. In the former poor health infrastructuire was combined with the prevalence of extensive uncodified healing systems primarily due to non-avilability of formal health care facilities and the affordability and popularity of *jhankri* system.

In chapter 4 and 5 the status of the faith healing systems were examined. In Kerala the uncodified system was made a codified system which offers a parallel healing system with modern biomedical healing system which is also highly developed. In Darjeeling the formal health care facilities is in shambles and uncodified faith healing system is widely resorted to. It is not banned for mainly two reasons. First, it requires massive investment to extend formal health care facilities in rural areas which is not possible under current scenario and the faith healers serve as necessary support systems. Second, the cultural proneness of people to the alternative systems makes it politically injudicious to curb it. Hence, the coexistence of codified and uncodified healing systems in India is a product of both politico-economic and cultural factors.

As per the research findings, most of the hypotheses have been corroborated, however we did not find an inverse relationship between growing accessibility and affordability of mainstream health service and the dependence of people on informal and traditional healing system in Indian Society. The Kerala case rules out such a hypothesis. However we found statistical evidence in support of our postulation that to the extent formal health infrastructure is inadequate in rural areas, people in rural areas tend to depend more on the practices of traditional health system including *Jhankri* System. We also found that the co-presence of formal health infrastructure and traditional informal healing system such as faith healing reveals socio-economic patterns of people's dependence on either of them. In other words, the bulk of poor and illiterate people resort to traditional healing system as a rule. However the affluent and the educated sections would not necessarily tend to depend on formal public and private health infrastructure. There have been cases where the affluent and the educated depend on informal and traditional health systems including faith healing system for strong cultural and community orientations.

This study has generally confirmed the hypothesis that while the public health policy has been and will be functional for the development of formal healthcare system, in a condition of active political society where community political leaders support extra-legal healing systems, public health policy would be tolerant and permissive of the traditional healing system such as *Jhankri* System. It was also found that there are political nexus between the local level politicians and practitioners of faith healing system where they are

prevalent under the condition of limited accessibility to formal public health facilities for the bulk of the people.

Conclusion

The study shows that the public healthcare facilities in Darjeeling Hills are very worrisome and questionable which accelerate the wide prevalence of Jhankri practice in different parts of the region and at the same time, it has also been revealed that the people of Darjeeling Hills are practising this *Jhankri* System since centuries. This *Jhankri* practice in Darjeeling Hills is embedded with culture and society. Thus, in the case of Darjeeling Hills, *Jhankri* system stands as an urgent need for mitigating the healthcare emergencies of the people at the same time it also upholds the old age traditional cultural heritage of the Gorkha community. On the other hand, the *Vaidhya* system is more intact with culture and community in the state of Kerala. Because, the public healthcare facilities in Kottayam district of Kerala is very good and the local people are quite satisfied with the healthcare facilities provided by the concerned authority. It is also evident that this *Vaidhya* practice in Kerala is prevalent from time immemorial and people have great faith in it. Further, this *Vaidhya* system of Kerala is very effective and efficient for treating different diseases. Moreover, this alternative healthcare practice in Kerala like *Vaidhya* practice is recognised by the Kerala government as an important traditional indigenous healthcare regime. Hence, it is legal and approved healthcare practice in the state of Kerala in general and the district of Kottayam in particular. But, in case of *Jhankri* system in Darjeeling Hills, the government is nonchalant and considers it as an informal, uncodified and extra-legal healthcare system. But it is well evident from the study that this informal healthcare practice such as *Jhankri* practice plays a pivotal role in catering to the healthcare needs of the general masses of the hills. Hence, it is the responsibility of the government to provide due recognition to all these informal healthcare systems along with these informal health practitioners with legal support and sanctity.