Chapter-1

1.1 Introduction

Health is an important elementary need of human life. The WHO charter defines good health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. It is generally believed that Medicine is the science and practice of the diagnosis, treatment and prevention of disease. Medical system and clinical practices vary across the world due to the regional differences in culture, knowledge and technology. Modern medicine (MM) or Biomedicine (BM) or Western Medicine (WM) dominates the global health system while in developing countries of Asia, Africa and Latin America most of the population still rely on Traditional medicine(TM), Complementary Medicine (CM), Folk Medicine (FM) or Alternative Medicine (AM).

Public Health is always a debatable issue and it has always been neglected in India. It received low priority in the central and state budgets. It is evident that there is a huge urban bias characterising health policies and investment strategies in India. More than 75% of the resources and infrastructure of health are concentrated in the urban India. But the conditions of public health facilities and infrastructure in rural India are very chronic and deteriorating with every passing day. People lack basic primary healthcare facilities in their region. To address this alarming situation the government of India has initiated several programmes and policies among which the NFHS, NRHM and DNHP are the important ones. The National Family Health Survey (NFHS) was carried out as a principal activity of a collaborative project to strengthen the research capabilities of the Population Research Centres (PRCs) in India, initiated by the Ministry of Health and Family Welfare (MOHFW), Government of India and coordinated by the International Institute of Population Science (IIPS) Bombay. The main objective of the survey was to collect reliable and up- to -date information on health, family planning, fertility, mortality and maternal and child health. Government has conducted four NFHS by in a holistic manner viz, NFHS-1, NHFS-2, NHFS -3 and NHFS-4 in the following years 1992-1993, 1998-1999, 2005-2006 and 2015-2016 respectively. It is revealed from the reports of all four NFHS, that there are huge differences in the health, nutrition, mortality and fertility among the states of India. Some states are performing very well such as Andhra Pradesh, Goa, Karnataka and Kerala but the performances of some states like U.P., Bihar, M.P. Orissa and W.B. are not very satisfactory. The reports also stated that there has been a considerable growth in the awareness level, health facilities, family planning, education etc in every successive survey report. It is further notified that poor nutrition is less common. Anaemia has also declined throughout the years but still remains widespread. It is also evident from the report that more than half the children are anaemic in ten of the 15 States/UTs. Similarly, more than half the women are anaemic in 11 States/ UTs. Over nutrition continues to be a great health issue for adults. At least 3 in ten women are obese or overweight. (Ministry of Health and family Welfare, 1992-1993, 1998-1999, 2005-2006, 2015-2016). (NRHM) National Rural Health Mission was introduced by the UPA

government in the year 2005. The primary objective of this mission was to "carry out necessary architectural correction in the basic health delivery system...to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor women and children". To attain the stated objective three tiered public health system was introduced to provide the proper healthcare facilities to the rural people in the name of Sub Centres (SCs), Primary Health Centres (PHCs) and Community Health Centre (CHCs) units. However, the outcome of the scheme as envisaged above was not achieved in a satisfactory manner because it has faced several setbacks such as deficiencies in physical infrastructure which involves a lack of electricity supply to SCs in some States, scarcity of beds for patients in many PHCs, poor condition of sanitary provision in PHCs and CHCs etc. It is also noted that shortage of equipments and medicine in all three units in several states was another lack of the scheme. The evaluation reports have also highlighted the scarcity of manpower in all three units in many states. Moreover, the NRHM envisages that every village must have an ASHA (Accredited Social Health Activist) who are selected by the village panchayat. The main task of ASHA is to act as the interface between the community and the public health system. On the basis of the norms for recruiting ASHAS, it is stated that they have been selected as per the recommendation of ANMs, anganwadi workers and the panchayat head but in most of the cases it is seen that they have been recruited from the people of influential families, relatives of local leaders or the persons backed by the politicians. In some cases even the wives of community health workers were appointed. It is also evident that the training of the health activists and the availability of kits in many health centres are also very worrisome. There is no regular and frequent training of health activists, the quality of training also widely varies from state to state. Hence, the ultimate goal of NRHM to deliver the proper healthcare facilities to rural masses has fallen far away in reality. (Hussain, Jan 22, 2011) Similarly, the Draft National Health Policy 2015 was also introduced by the government to provide highest possible level of good health and wellbeing through a preventive and promotive health care orientation in all developmental policies. The policy prescribes that the harmony of purpose between the public and private healthcare delivery system to achieve the goal of "universal healthcare", infact facilitated the unconcerted growth of private intervention in the health delivery system in the country. This policy seeks to deliver a comprehensive set of preventive, promotive, curative and rehabilative services through the sub centres and PHCs but at the same time it also initiates the "package of services". Hence, the very idea of comprehensive and the package system is contradicting each other. The DNHP also emphasised on the holistic approach and cross sectoral convergence in addressing social determinants of health. It further stressed on planned and adequately financed institutional mechanisms to achieve the stated goals. But in reality, except for the Swacha Bharat Abhiyan and the Integrated Child Development Services no other initiatives have been made in this regard. Moreover, The health professionals, academicians, health activists and the members of civil society strongly oppose and condemn the pro-business formulation of DNHP (Mohan Rao, April 25, 2015) On the other hand, the picture of urban health in India is also in an alarming condition. Over 70% of urban population is suffering from obesity, it is a chronic medical state characterised by too much body fat

which has resulted 10% of couples in the country infertile. The incidence of obesity in India has been rising very rapidly. Women are at a high risk of pregnancy complication due to obesity. Dr. Shobha Gupta, medical director and IVF specialist from Mother Lap IVF centre, said "I see 20 patients coming to me for infertility, of which 4 to 5 % are obese" (Statesman) .

If we look back to the history of medicine in India, it is evident that before the advent of the British in India the total health care system was dominated by the traditional healthcare practices or indigenous healthcare medicines. But during the British reign in India, they introduced modern or western medical system to deal with different communicable and non-communicable diseases. Thus, the modern medical system was not a choice rather an imposition by the British in India. Further, it was a biased and class based medical system where only the people from higher classes and government officials were entitled to access the modern medical facilities whereas the bulk of poor Indian masses were forbidden from such medical facilities. But gradually the western medical system gained momentum in India and it became accessible to all irrespective of class, caste and creed. It is also evidenced from the sources that the public healthcare facilities of pre-independent India were much better than the existing public health facilities in India. It is a fact that the British were very much conscious about the provision of sanitation which they considered as the root cause of any disease. So, during their reign high attention and focus were given to the sanitary measures such as proper drainage and sewage system, cleanliness, availability of doctors and dispensaries in every rural area. They appointed officials in each villages of the entire nation who submitted their reports annually regarding the public health of their region. Of course, they had their personal interest in doing so, but truly they maintained a well systematic public health provision for the nation. But after independence, the public health in India has become a highly debatable issue. Despite the fact that the government is constantly dealing with the problems and diseases in regard to public health like communicable and non-communicable disease, vector borne disease etc. with innovative ideas, policies and programmes , but there is still a long run to go ahead to meet the desired end. (Gupta M. D., 2005) Many writers have commented that it is the governmental failure to provide good health facilities in India. There is high absenteeism, low quality in clinical care, low satisfaction level and rampant corruption in public health services in India which led to the mistrust in the system. It is further argued that there is a wide mismatch in the policy formulation its implementation and its action in regard to public health in India, which is again fuelled with the intervention of elite classes and politicians in this matter. It is interesting to mention here that a considerable portion of health budget is spent for medical training and other intermediary purposes and very little amount is really spent for public health purposes and primary health services. Again, the Central government is taking only the responsibility of formulating public health policies and programmes after which it passes its responsibilities in the hands of the State for its implementation and State has nothing to say but to accept and ignore. As a result, there is a wide range of health disparities State-wise in India. There is no provision for making any training programme for the workers of rural public health in different States of India. So, most of

the time health workers retire without knowing what his actual duties or functions were. Further, the State government is least bothered about the public health service; actually, most of the posts of public health services are always lying vacant; no one bothers about immediate recruitment. Not only that, there is no such provision to have an authentic report regarding the public health in India. It is very interesting to know that the Tamilnadu government produced its Public Health Act in 1999 which was the photocopy of the Act of 1939, Madras Presidency's Public Health Act. There is no centralised Public Health Act in India. The government of India had developed a model of Public Health Act in 1950 which was revised in 1987, but it did not influence the states. So, public health in India is hanging around in between the Centre and the State government. Thus, it is somehow much neglected. Not only that health system in India is highly class based which was prevailed in England in early 17th century that the college of physicist had to confer the membership for medical practices in England, those who don't have membership they are not entitled to practice in medical institution. The same is the case in the Indian medical practices today; the candidates from elite classes, politicians and influential families get first priorities in the practices of medical institutions. This is further fuelled with the public private partnership of health system under the banner of Structural adjustment Programme in India. Candidates who can afford big amount of donation get the first priority for medical practice in any private medical institutions. The entire scenario of Indian Health System is further aggravated with the process of economic liberalisation, politicization and other various factors, which paves the way for the further deterioration of the health situation in India. (Jeffery Hammer, 2007)

On the other side, the oldest texts in oriental countries like China, India and Middle East reflect various facts on the health care practice and medicines formulations. Among all the treatises, *Athervaveda* could be considered as one of the oldest and '*Ayurveda'*, the science of life, is the oldest *Meteria Medica*. Most of the ancient diseases referred to are from microbe originated e.g. *Kustha rog* (Leprosy), Jaundice, Tuberculosis etc. Indian medical heritage flows in two different streams a) Classical Codified System and b) Oral Folk System. There are more than 50,000 herbal formulations documented in Indian medical texts whereas modern medicine has only 4000 odd drugs representing the sum total of world's pharmacopoeia. But after the advent and popularization of so called scientific Western Medicine (WM) or Bio Medicine (BM), both the systems in India started crumbling down. During the colonial and post colonial period, the growth of BM for commercial purpose took a rapid pace. However, there has been an attempt to revitalize the codified system of medicine with the establishment of department/ministry of AYUSH. The scientific validities, research, efficacy and legitimacy of the above codified system is on, at all levels of stakeholders but there isn't any organized process to document the oral folk system of medicine commonly called Local Health Tradition (LHT). It is estimated that there exists more than 1, 00,000 herbal healers in India. These folk systems of medical practices are now- a-days considered unscientific. But there exists cases of scientific validities and knowledge base in the practice of such local Health Tradition LHT. The standardization, regulation and legitimacy of Traditional Medicine (TM) are still questionable in the modern medical sciences. ***(Unnikrishnan, 2004)*** This

concept of uncodifed health care system did exist among the ethnic communities of Darjeeling Hills in India, *viz. Magar, Tamang, Gurung, Rai, Limbu, Lepcha* etc. and the sole health care system before the advent of the British colony in these hills was dominated by such an un-codified healthcare system. Among the local faith-healers, *Dhami* and *Jhankri* are common among the hill-tribes and *Vaidha* and *Ojha* in the lower hills. Among the Gorkha and Nepali community, *Jhankri* is a common term of social status. He may be an ordinary person of any caste having spiritual power who acts as an intermediary between man and supernatural powers. Still in modern age, people of Darjeeling especially in the rural areas, have the legacy of faith- healers (Jhankris) in all communities. Basically there are two types of healers (Jhankris) in Darjeeling, one type of healer is trained by a guru i.e. a normal human being having good knowledge of healing system but there is another type of healer who is trained by *ban jhankri. Ban Jhankri* is the natural deity who lives in a forest. Further, it is also evident from the preliminary study that similar kind of traditional healthcare system is also practised in some parts of Kerala in the name of *Vaidhya* Sytem. Moreover, the place is also popular for practising the renowned traditional healthcare system known as *Asthavaidya* System and the man associated with this system is known as *vaidya*. Hence, it is imperative to have an integrative approach combining both the Traditional Codified and Un-codified System of Medicines. It has been observed that integration of TM with that of BM in Korea as Traditional Korean Medicine (TKM) can be treated as a lesson in this regard. But in the Indian context, due to diversified cultural practices and unorganised profile of traditional practitioners, there is every possibility of this folk system of medicine being eroded while integrating the medical systems. To safeguard this knowledge base, it is needed that a suitable contemporary approach be made to strengthen the medical pluralism in India where the interest of local health tradition should be taken into consideration.

On the basis of the review of literature, it is revealed that there are various works which have been carried out by different researchers regarding the 'Public Health and Traditional Medicine' in India and outside India. But very few and limited works have been done by researchers on Traditional Healers and Healing Practices, the uncodified traditional health practices and the Public Health System in India and outside India. It has also been found that ample of works have also been done in regard to public health and politics in India and abroad but very few or limited works have been done in regard to Uncodified Traditional Health System particularly healing practices and politics in India as well as abroad. Further, it is also noteworthy to mention that the government, while formulating the health policies and programmes for the people has not given due recognition to these kinds of system. Whether it is due to lack of sufficient data collection in the hands of government or it is the disbelief of the government towards uncodified health system, this research sincerely tries to analyse that gap. Moreover, most of the works in this area have been carried out by the people from the discipline of sociology, anthropology and some public health practitioners. Further, no such kind of systematic research has been carried out in Darjeeling Hills regarding faith healing *(Jhankri)* system and the status of general public health in Darjeeling. Further, it is also evident that similar

kind of healthcare system is also present in some parts of Kerala known as *Vaidhya* or *Asthavaidya* System. So, being a student from political science background the researcher sincerely tries to bridge that gap and attempts to analyse the practices of informal Traditional Healthcare System viz. *(Jhankri system*) and *(Vaidya system)* within the larger framework of Public Health System in India in general and Darjeeling Hills, West Bengal and Kottayam, Kerala in particular.

1.2 Definition of Key Concepts/Terms:

Public Health is the general health condition of the people of a particular nation. It also includes the health policies and programmes formulated and implemented by the government to its general public. It also covers the health facilities provided by the government and enjoyed by the people of a particular region.

Traditional Health Practices is contrasted to modern health practices. It is the oldest form of health care system in India and many other Asian countries and often regarded as Indigenous Medical System. There are two kinds of Traditional Health Practices in India (1) Codified (2) Uncodified. **Codified** is a documentized health practice in which the knowledge of health care system is passing through a written document from one to another and it has also got recognition in India by the government in the name of AYUSH. **Uncodified** health practices on the other hand lacks documentation, it passes on verbally from one man to another like the health care practices of local healers, ojhas, folk medical practitioners etc.

Formal Healing System is a kind of healthcare practice which is often recognized by the government and practised in an institutionalised form. The knowledge and techniques of health care system are documented hence it is codified healthcare practices.

Informal Healing System is uncodified healthcare system which is neither recognized by the government nor is its practices institutionalised. The validity of the same is recognised only by the community or local social system. This healthcare system lacks both documentation and legitimization. The healing practices of *Kabiraj, Vaidyas* and *Jhankris* are some informal healing systems in India.

Jhankri Practice: The flagship bearer of Informal healing system among the Nepalese is known as *Jhankri*. The local health tradition practised by them in a diaspora could be termed as *Jhankri Practice.* It is in vogue in Nepal, Bhutan, Darjeeling, Sikkim, Duars and the North East.

Asthavaidya: In Kerala**,** there is a unique healthcare system called *Asthavaidhya* which is an interface between codified and uncodified system. Practitioners of this healthcare system are known as ***vaidhyas***.

1.3 Definition of the Research Problem:

The problem to be investigated by this research is based on the multiplicity of healing systems, coexistence of informal healing systems such as Jhankri system, Vaidhya or Asthavaidhya system with formal bio medical systems, while the latter is the predominant form of healing system patronised by the state and the legal support system including insurance system. The former still continues and though not actively supported by the state is tolerated. Even within formal codified health system public health policy often accommodates less trained healthcare personnel particularly in case of rural healthcare, for instance using parademics for certain functions of doctors. This role of state with regard to healing system needs to be understood in our research.

1.3.1 Rationale

The nature of human life is beyond science, as it is believed in the Hindu philosophy that life is constituted by the five elements of nature called *"Panchamahabhutta"* i.e. *earth*, *sky*, *water*, *air* and *fire*. The proper balance of all these five elements in human body is often considered as healthy body and mind. Further, the explanation of these five elements in our body is stated in the *Vedas* - the earth is the source of minerals, the sky the source of consciousness, water the source of thirst, air the source of respiration and fire the source of energy. It is believed that the imbalance of any of the elements of *'panchamahabhutta'* in human body leads to the causation of sickness in the form of imbalances of three basic elements of human body i.e, *Kaffa*, *batta*, and *pitta* that is blood, pituit, black bile and yellow bile. In India, *Atharvaveda*, the sacred text of Hinduism is considered as first book of knowledge in medicine. The school of health care, *Charaka*, that of medicine and *Sushruta*, that of surgery are the first medical practitioners who formally introduced the health care practices in this globe. These two foundations lead to the birth of *Ayurveda*, the science of life where many branches of medicines are described. *(Unnikrishnan, 2004)* The explanation of modern science in this regard is quite different and argues that the root cause of sickness of human body is due to an attack of external forces such as external virus or bacteria in human body which creates sickness. Whatsoever the reason for the causation of sickness of human body, there are two schematically available treatments Western Bio-Medicine and Indigenous Traditional Medicine. Again, this Indigenous traditional medicine flow in two distinct streams one is codified traditional medicine and another is uncodified traditional health practices. In India we have both codified and uncodified health practices. But the codified traditional medical practices have been recognised by the government in the name of *AYUSH*. Whereas the uncodified health practices are very much present in the society but no one is bothered about its preservation and legalisation. One of such practices is *"Jhankri System or Vaidya System"* an uncodified healthcare system in various parts of the country. Darjeeling Hills is also not an exception in that matter, this faith healing system occupies an important place in the society, particularly in the rural society of Darjeeling. In many instances we have also seen the hill politicians encouraging this faith healing system. Whether they have any political motive or they simply want to preserve the traditional cultural heritage of faith healing system is still a big question. Further, it is

believed that hill people are basically nature worshippers who believe in nature worshipping. There are many instances where this nature worshipping was organised in Darjeeling by G.N.L.F. supremo late Subash Ghising in the name of "*dhunga ko puja* i.e. stone worshipping", "*khola ko puja* i.e. river worshipping", "*jungle ko puja*" i.e. worshipping of the jungle, etc. Jhankri dance (healer dance) had been organised in different parts of Darjeeling in the name of nature worshipping. Whether it is to attain some political objective or it is an action of cultural preservation or it tries to show that the hill peoples are basically tribal people remains a big mystery. Similar type of healthcare system is also present in some rural parts of Kerala in the name of *Asthavaidya* System. In Kerala these local uncodified healthcare practioners are called Vaidyas. Again, this faith healing system has a very age old origin. It is the oldest form of medicine. It is rooted in the human existence. According to history of medicine, there are four successive stages of medicine - instinctive stage, theological stage, metaphysical stage and scientific stage. Instinctive stage is a primitive stage or the first stage of human civilization where people save themselves by their instinct or by practising the use of different herbs for different diseases as well as worshipping the different gods. The second stage is theological stage which gives the ample of instances that the primitive people had the practices of faith healing because they believed in the existence of supernatural powers and they also believed that the diseases occur due to the unhappiness of these powers so they worshipped different natural gods and also made different sacrifices to calm down the wrath of these supernatural powers. Third one is metaphysical which states that the diseases occurs due to the imbalances of humours in human body that is blood, pituit, black bile, and yellow bile. The man associated with this idea is a well known philosopher Hippocrates. After these stages we enter in the last stage that is present stage or the scientific stage. If we come to the Hindu philosophy of medicine, the most ancient document of the Indo Aryan race is Veda. There are four *Vedas - Rig Veda, Sama Veda, Yajur Veda and Atharva Veda*. But we can find the details of medicine in *Atharva Veda*. Hindu philosophy states that there is a direct relation between god and disease. We can find the origin of all recognised traditional medicine in *Atharva Veda*. According to this philosophy the first medical practitioner or the doctor in modern term are *Charaka and Susruta,* former is the expertise of medicine and the latter is the expertise of surgery. (Cumston, 1999) But simultaneously in this age also we have ample of instances of the practices of healing, sorcery, black magic and the use of negative forces. Emile Durkheim, the famous sociologist argues that there are two categories of things in the world- sacred and profane. Things which are held in respect are sacred and therefore related to supernatural and things which are items of utility are profane and related to worldly activities. Thus sacred is religious and profane is worldly. From the religious point of view, there are two forms of religion viz. *Oral Religion and Religion of the book*. *Oral religion* is the one whose theory and beliefs about the religion are not written in any language or in any document. Tribes all over the country have oral language .Religion of Book on the other hand is the documented theory like *Gita, Veda, Bible, Quran* etc. Oral religion is characterised by their local relevance, relative lack of dogmas etc. The primitive and tribal groups invariably have an oral language like Bhil tribe of Western India. Further there are four theories of religion viz. *Animism,*

Polytheism, Monotheism and Naturalism. Animism is the existence of intangible, non material or spiritual being. *Polytheism* is to have belief in more than one spiritual power or deity. *Monotheism* is to have belief in one deity and *Naturalism* deals with nature worshipping. According to 'People of India', project of K.S. Singh, 45.9% out of 461 tribal groups still practice animism. According to social anthropologists like Durkheim and Parsons, religion is the belief and rituals are mechanism through which beliefs are fulfilled. They further argued that rituals are the part of religion. It is an ingredient of religion. Therefore rituals are termed as practices of religious actions. All these theories of religion and their practices followed by the ritual healing system are very much prevalent in almost every part of rural India. ***(Jain, 2011)*** On the other side, public health is always in a questionable premise in India. So, the present study is an attempt to analyse the uncodified traditional healthcare system such as *Jhankri* System and *Asthavaidya* System in India by placing it on the larger public health scenario of the nation.

1.3.2 Scope and Delimitation of the Problem

a. Scope: This study will make a detailed analysis about the codified and uncodified traditional healthcare practices such as *Jhankri System* and *Vaidhya* or *Asthavaidya System* and the current public health scenario of India in general and Darjeeling Hills, West Bengal and Kottayam district, Kerala in particular. It also explores the idea of the growing commercialization of public health facilities in India and the interventions of state and private agencies.
b. Delimitation: For the present purpose of study only the *Jhankri* practices of Darjeeling Hills and *Vaidhya* or *Asthavadya* practices of Kottayam district of Kerala have been taken into consideration which denotes an existence of ethnic traditional healthcare system of two different regions.

1.4 Statement of the Research Problem

India being the fastest growing economy of the world has a very appaling picture in regard to rural health facilities. There is a wide disparity between rural and urban health facilities in India. Technological medicine, specialists, super specialists, health infrastructure in urban India has been very impressive and it almost matches the global health standard. But the picture of rural health scenario is lamentable. Rural people even don't have a basic primary health facility in their region. According to National Family Health Survey of 1998 and 1999, half of all adult women suffered from anaemia, 30% of all children had regular fever. The 1992 and 1998 round of the Family Health Survey (International Institute of Population Studies 1994 and 2000) revealed that India is among the countries having the highest rates of maternal mortality. This disparity between rural and urban health facilities are further aggravated with the process of privatisation which resulted in the corporatization of medical facilities in the country. As a consequence, it is only the rich and the elite people who can have an access of medical facilities in India. To narrow down this disparity the government of India has initiated so many programmes and policies such as NHRM National Rural Health Mission in 2005, under which there are three tier health facilities in rural India viz. Primary Health Centre at the village level,

Community Health Centre at the block level and Health Centre at the district level. The Draft National Health Policy 2015 was also initiated by the government to provide highest possible level of good health and wellbeing through a preventive and promotive health care orientation in all developmental policies. The government has also initiated the National Family Health Survey i. e, NFHS-1, NFHC-2, NFHS-3 and NFHS-4 starting from early 1990s to find out and cope up the health problems of the masses. But the health disparity between urban and rural and the rich and the poor are not diminishing rather increasing day by day. Darjeeling district of West Bengal is also witnessing the same, though there are Primary Health Centre, Community Health Centre and Health Centre and many other speciality and super speciality hospitals but the rural people still prefer to visit the healers first in their illnesses and any other social problems. Similarly, Kerala, being a highly ranked state in regard to public health facilities and health infrastructure is also not free from this kind of uncodified healthcare system. The current health status and healthcare facilities in the state of Kerala and West Bengal has been given below:

1.4.1 Comparisons of Health Facilities and Provisions in the State of West Bengal and Kerala on the basis NFHS-4 Fact Sheet- State Findings (2015-2016)

Table-1.1

	Kerala		West Bengal	
Indicators	**Urban**	**Rural**	**Urban**	**Rural**
Population and Household Profile/ Characteristics of Adults/ Marriage and Fertility/ Infant and Child Mortality etc.				
Men who are literate (age 15-49) (%)	98.8	98.6	83.9	79.7
Women who are literate (age 15-49) (%)	98.4	97.3	79.4	66.9
Population (female) age 6 years and above who ever attended school %	96.5	94.5	81.5	70.4
Population below age 15 years (%)	20.3	20.1	22.6	26.8
Percent of households with an improved drinking water source	95.7	93.0	93.5	95.1
Households using improved sanitation facility (%)	98.7	97.5	62.0	45.5
Households with electricity	99.5	98.9	97.2	92.0
Household using clean fuel for cooking	65.2	50.6	61.8	11.3

Total fertility rate (children per women)	1.6	1.6	1.6	1.9
Women age 20-24 years married before age 18 years (%)	7.7	7.5	27.7	46.3
Men age 25-29 years married before age 21 years (%)	1.8	3.8	19.7	26.5
Total unmet need	14.3	13.2	8.4	7.1
Infant mortality rate	6	5	16	32
Under five mortality	8	6	16	38
Maternity and Child Health/ Delivery care/ Child Immunization etc.				
Mothers who had antenatal check-up in the first trimester (%)	96.2	94.2	58.9	53.3
Mothers full antenatal care (%)	63.1	59.5	25.2	20.4
Mothers received postnatal care from a doctor/nurse/ANM(%)	87.7	89.6	68.6	58.1
Mother who received financial assistance under Janani Suraksha Yojana %	19.1	21.5	17.3	34.0
Children who received health check after birth from a doctor/nurse/ ANM (%)	48.1	50.1	26.2	26.9
Institutional Birth (%)	99.9	99.9	83.7	71.9
Births assisted by doctor /nurse	100	100	88.5	79.0
Children fully immunized (age 12-23months) (%)	82.2	82.0	77.7	87.1
Received 3 doses of polio vaccine (%)	89.6	87.6	82.5	90.1
Received 3 doses of DPT	90.5	90.3	87.8	94.7

vaccine (%)				
Exclusively breast feeding (age 0-6months)	55.0	51.3	61.1	49.6
Children Under weight 5 Yrs (%)	15.5	16.7	26.2	33.6
Stunted (%)	19.8	19.5	28.5	34.0
Wasted (%)	16.0	15.5	16.7	21.6
Nutritional Status, Blood sugar level, Hypertension /Knowledge of HIV/AIDS among adults etc				
Women who are overweight (%)	33.5	31.5	30.6	15.0
Men who are overweight (%)	31.1	26.3	20.7	11.2
Children age 6-59 months anaemic (%)	35.5	35.7	55.6	53.7
Women age 15-49 anaemic	36.3	32.4	58.2	64.4
Men age 15-49 anaemic	12.4	10.4	26.9	31.9
Women Blood sugar very high (%) (age 15-49)	4.8	4.8	4.2	3.2
Men blood sugar very high (%)(age 15-49)	4.7	7.7	7.2	5.3
Hypertension very high women (%)(age 15-49)	0.6	0.5	0.8	0.7
Comprehensive knowledge of HIV among Women (%)	42.5	43.6	23.9	16.1
Comprehensive knowledge of HIV among men (%)	51.8	49.8	37.2	20.2
Women age 15-24 who use hygienic methods of protection during their menstrual period (%)	91.7	88.5	73.0	47.6
Married women who usually participate in household decision	92.1	89.0	91.7	92.4
Women consume alcohol (%)	2.4	0.9	0.7	0.9

Men consume alcohol (%)	32.8	40.8	35.7	25.1

It is evident from the above table that the State of Kerala has been performing very well in regard to public health facilities as compared to the State of West Bengal. As per the Human Development Index ranking (2007-08 and 2014), the state of Kerala has been continuously occupying the 1st position and West Bengal has been in the 10th and 11th position consecutively. The details of which are as follows:

CHART 1

Relative human development ranking of 17 major Indian states

PLAIN FACTS

	HDI RANK		CHANGE
	2007-08*	2014	
Kerala	1	**1**	⇔
Himachal Pradesh	2	**2**	⇔
Tamil Nadu	5	**3**	↑
Maharashtra	4	**4**	⇔
Punjab	3	**5**	↓
Haryana	6	**6**	⇔
Jammu and Kashmir	7	**7**	⇔
Karnataka	9	**8**	↑
Andhra Pradesh	11	**9**	↑
Gujarat	8	**10**	↓
West Bengal	10	**11**	↓
Rajasthan	13	**12**	↑
Odisha	17	**13**	↑
Madhya Pradesh	15	**14**	↑
Assam	12	**15**	↓
Uttar Pradesh	14	**16**	↓
Bihar	16	**17**	↓

*the methodology to calculate 2007-08 HDI was slightly different, owing to data constraints for education, as explained by Mehrotra and Gandhi (2012) here: www.iamrindia.gov.in/IHDR-epw.pdf

Sources: Institute of Applied Manpower Research (for 2007-08 HDI); RBI (for state per capita income); Desai, Sonalde, and Reeve Vanneman. India Human Development Survey-II, 2011-12 (for education indicators); SRS Based Life Tables 2009-13 and Mint calculations

On the other hand, Healers (*Jhankris*), Witches (*Boksi or Dankans*), Supernatural forces (*Devi Devta*) and Nature (*Prakriti*) are important terms in day to day life of the people in many rural areas of India. They also occupy an important position in people's worldview. Nature is responsible for the causes of ill health because of invariable changes in weather but it also provides cures by way of plants and their parts, good air, water etc. Witches or *boksis* are the negative forces or evil spirit present in every community. They wish to control the society by setting various social norms and values. Healers play a crucial role not only in giving medicine to the sick but also through their role as a middle man who makes a communication between physical and spiritual world. He is the one who helps to appease the supernatural forces by performing various rituals to calm down their wrath and anger. He also performs some specific rituals for the wellbeing of overall society. So, the healer (*Jhankri*) or (*Vaidhya*) is a person who ensures good health for people, livestock and crops in the region. Thus, in the Darjeeling Hills of West Bengal and Kottayam district of Kerala in particular and many other rural areas of India in general, the idea about health and illness are based on culturally rooted beliefs and values.

The apparent conclusion that one can derive from the above discussion is that the rural people in particular and the poor in general lack the options to avail formal codified healthcare facilities and consequently the improvement in formal healthcare system would reduce the extend and scope of informal healing systems. But things may not be that simple if we find that despite formal healthcare is both available and affordable to people some of them might opt for traditional healing system by way of preference then, should we also look for cultural aspects other than political-economic aspects to understand co-existing of both formal and informal.

Things would be much more complicated if we want to understand why state tolerates extra legal healing systems after all. A political-economic explanation will suggest that state has constraint to spent more money in providing universal healthcare and yet in a democracy it has to provide something as healthcare facilities to the rural vote banks. But in that case informal healing systems should be banned where adequate health facilities are made available. But does state ever ban extra legal healthcare systems in India? We have little evidence. The alternative explanation may be based on certain contrast between the formal and informal healing systems in India. First, the modern bio-medical system is the domain of high achievers- doctors who were best in physics, chemistry, mathematics and biology and students of few expensive or premier institutions and consequently members of a professional elite community. This constitutes a social gap between the patients and the doctors. By contrast, healers in the informal sector are encumbered in the society of the patients, both know each other well. The lack of social distance and the social bond may sustain on the one hand the challenge of modern medical science and institution to them. Second, people in traditional societies share certain worldview. In case of informal health practices a particular worldview constitutes a bond between the healers and the patients like, Hakims for Muslims, Vaidhys for Hindus, Ojhas and Gungrings for Tribals and so on. In case of modern medical science doctors are trained to treat physiology and anatomical aspect as a rule without any

reference to a worlview of which health is a part. So, we have taken two state one with weak health infrastructure and in other with strong health infrastructure and intend to examine the relationship between formal and informal healing systems there. We would also examine the relative significance of both political-economic and cultural factors explaining our topic. Hence, the probem of present investigation is stated as *"**Public Health Policy and the Coexistence of Formal and Informal Healing System in India: A Study of two States".***

1.5 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.

1.5.1 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?

1.6 Hypotheses:

On the basis of the theoretical framework and formulation of research problem as stated above, the following hypotheses have been designed which will be tested in course of the study.

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 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.

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 would tend to depend on formal public and private health infrastructure.
4. There may be cases where the affluent and the educated may 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.

1.7 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 turn 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"* is also one of such uncodified health practices in India. This system involves 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 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. Darjeeling Hills is also not an exception; the total rural health care system in Darjeeling is dominated by this "Jhankri system". The first choice of the people for the treatment of different diseases is not the doctors rather it is the local healers (Jhankris) in rural Darjeeling. Whether it is the efficacy, affordability or accessibility of the local healers or it is an attempt of an ethnic community to preserve its distinct religio-cultural and folk identity in the larger socio-political framework of the nation is still a big dilemma. The states on the other hand are allowing such kind of practices as because the prohibition of which will create the dissatisfaction among the respective communities which may directly affect their voting behaviour. Or the state is neutral as because they may think that it is an attempt of the marginalised groups to make them noticeable in the

larger social framework. Further, the prospects of traditional medicine have begun to look brighter than they did a few decades ago due to the resurgence of public support in complementary medicine. Attempts have also been made for the revitalization of folk medical traditions in India. Governments are beginning to take note of the public expressions of support. So, it is evident from the above discussion that 'Jhankri System' is an uncodified traditional folk medical system of India. It provides better health care facilities to the millions of rural masses in India.

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 govern mentality. The governmental process tends to be formal and legal. As the health system stands in India, govern mentality is expressed through increasing regulatory frameworks for health regime and 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 atleast, one term say, a 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 helps us in understanding India's public health policy. We think that the local uncodified health system like *'Jhankri'and 'Vaidya'* coexisting with the licensed and codified health regimes can be understood through mediations of political society with the civil society.

Chatterjee's framework of political society may stop explaining state and civil society relationship in the context of healing systems in India at some point where a cultural explanatory framework may be needed to understand state's tolerance of informal healing systems and people's propensity to go for it in a country like India. Though this thesis is not a theoretical battle ground of Marxian and Weberian epistemologies we presume both political-economic and cultural factors can explain our research problem to a satisfactory extend.

1.8 Research Design

Since in Human Sciences the attitudinal and cultural factors are significant we don't propose an experimental research design that includes both control and experimental groups. We would rather depend on a comparative research design trying to find out the most similar systems. While at the same time within the similar system, however, we will be differentiating the rural and urban areas for selecting our areas of study. Hence our study would be broadly ethnographic and comparative. We propose to identify at least two States in India, one with developed formal health system and another with poor formal health infrastructure where faith healing systems are present in some measures. In both the cases we have selected rural areas to test our hypotheses.

1.9 Methodology

The researcher has used the standard tools and techniques of field research including the use of SPSS. The data collection methods have included both survey researches 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, academicians, health activists, patients, subcentres, primary health centres, and so on. 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 we need to collect information prior to designing the schedule and to formulate relevant questions for the purpose of interview. 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.

1.9.1 Tools:

- Questionnaire and Opinionnaire have been prepared with a view to collecting additional information from the persons who have knowledge in this area.
- Interview-scheduled structured interview were employed as another means of collecting data.
- Observation, particularly the participant observation in which the investigator is already witnessing such kind of practices in the region.
- Survey is another tool for collecting data in which particular community or definite region have been taken into consideration.
- Scaling: Scaling is also an important tool for gathering information in this research. Because it is only through scaling we could measure attitude and beliefs of an individual and community.

1.9.2 Sample:

Stratified random sampling has been used in the present study which will constitute the Government Hospitals, Primary Health Centres, Community Health Centres, Health Centres, Local Healers *(Jhankris*) other local health practitioners like Vaidhyas, Ojhas, Doctors, Nurses, ANMs , political thinkers, political leaders, political parties, etc.

1.9.3 Procedure for Data Collection:

The researcher has visited the area of research for data collection by applying interview method as that permits an exchange of ideas and information. The researcher first tried to secure the confidence and cooperation of the subject and tried to establish a rapport. To gather desired information by asking questions in the planned sequence, the researcher had also added stimulating and encouraging comments alongwith necessary explanation and recordings.

1.9.4 Sources of Data

- Primary Sources: Government reports, Official records, News papers, Jhankris, Vaidhyas, doctors, ANMs, Political leaders, political thinkers, elderly experienced people having vast knowledge of life, natural phenomenon, traditions of the society will come to the investigator's help for understanding the remote past etc.
- Secondary Sources: Books, Journals, Magazines etc.

1.9.5 Data Analysis and Interpretation:

- 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.

1.10 Locale:

The locale of the present study is the urban and rural areas of Darjeeling Hills of West Bengal and Kottayam district of Kerala. Rural areas like Tea gardens, Busties and Villages are the focus areas of the research. The researcher has selected the State of Kerala and the State of West Bengal for the present study as because the former has been performing very well in regard to public health facilities and health provisions and the latter has been performing quite moderately.