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Existing of Medical Pluralism in Era of Globalisation: A Study in North West Himalayas

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Abstract: ***Today's era is so called scientific centaury where western Bio-medicine is so popularised in the world through globalisation, virtual medical where it has been proved scientifically by the eminent scientist. But there is also a world where people are using medical pluralism. This paper will highlight the study of medical pluralism; there is ethno-medicine, religious healing and folk medicine in village of Himachal Pradesh. Objective of the study was to study to explore medical pluralism, local specialist, in a village Various methods have been used like unstructured and structured interview, life history, case studies, observation, participation. Yet no study has specifically characterized medical pluralism through an anthropologist perspective in Himachal Pradesh.***

Keywords: Medical Pluralism, ethno-medicine, local Specialist, indigenous knowledge, local healers

1. Introduction

Medical pluralism where numbers of alternative medicines used by the patient. when they don't get effect from one medicine so they look to other alternatives. Such alternatives included like homeopathy, Ayurveda, local healers or specialist.

The level of acceptance of a therapy or a medicine to the broader society is of the utmost importance for the relevant practitioners and consumers. Therefore, medical pluralism is more than a phenomenon of the mix of traditional and modern medicine; it is rather, a function of political economy and cultural hegemony[1,2] and a result of complex factors within medical and other systems which are intertwined. A major issue often discussed in the study of medical pluralism is the role of the State. In the Third World, State support for non-orthodox medicine tends to encourage anti-imperialist feeling. However, when members of the upper class require serious medical attention, they seek help from orthodox care [3]. In pluralistic medical systems, a set of signs is liable to multiple interpretations, and different sickness labels. As[4]mentions,'social forces help to determine which people get which sickness.Symbols of healing are simultaneously symbols of power and medical practices are simultaneously ideological practices' [6][7]. Irrespective of whether or not non-orthodox medicine receives necessary financial and legal support to survive, both from the government and the public, the State's interest is to keep it alive, so that non-orthodox doctors take some burden off the orthodox ones [5].

According to cultural explanations which stress cultural factors, patients may consult non-orthodox healers because they do not always agree with unfavourable comments made about them by orthodox medical doctors. Non-orthodox healers may be more easily accessible geographically and financially[8]. People may be interested to take up any health services available in the hope that they may provide relief [9,10]. What makes medical pluralism possible from the viewpoints of cultural explanations? According to [11]the medical plurality is related to the freedom of choice that serves to place the patient in control of his environment, to give him options to strike what seems the best course for himself.

Area of the Study: The fieldwork was carried out in a small village called 'Sawrakoti' in Shimla district of Himachal Pradesh. The village was decided after we reached the place of our temporary residence. Thus, three categories of respondents were interviewed, namely-

- The local people of the village who may not know about medical pluralism,
- Elders people who having knowledge of indigenous knowledge.
- And people like tantric, pujari were interviewed.

Individuals from these categories constituted the ultimate units of enquiry. In addition to these a considerable number of case studies were conducted in order to attain substantial level of authenticity.

Objective of the study:

- To explore indigenous medicine, health and local healers involved.

Sources of Data

In fieldwork both primary and secondary sources were used for the data collection.

- Secondary data- was obtained through literature review, formal and voluntary institutions.
- Primary data- was collected through a variety of research techniques employed in social science research viz. interviews, observations, case histories, life histories, etc.

2. Materials and Methods

For gathering information on indigenous knowledge of the area, initially with the help of some elderly people, several local folk-healers, people and farmers were approached and requested to share their knowledge on use methods and treating different ailments and health problems .By establishing a good rapport with them. Available key informant were also accompanied to the field to approaching different species for curing and healing the suffering people.

To gather the first hand information and confirmation of responses from local people for validity extensive field work

done for the 15 days. Information were gather from different local respondent included both gender and younger people were taken into confidence to get their knowledge awareness and interest in traditional practice.

To conduct fieldwork. I used indigenous approach and historical approach to collect my data for topic "Medical pluralism". I used mostly primary sources to collect from the area of study and also used some secondary sources like going through journals, article books to know the information related to my topic. And by using the technique I came to know the view of local people and about their progressing because most of them still having faith and belief in indigenous medicine, local specialist like shamans and tantric, pujari, whenever they don't get results from the Bio-medicine they go to local specialist.Cannot depend only the one informant for the information so I collected the information respondent from the village with whom I have established a very good rapport conducting interview from one person home to another person. And also used some methods like Genealogy, Case study, life history.

Rapport establishment: Itis a very major aspect of the field work. To gather the correct information the researcher needs to get the trust of the people. Co-operation of the people is must. As we went in a group, at the very first day we could see that the villagers were very anxious to know out the purpose of coming to their village..The news of arrival spread over the village within very short period of time .It helped us in some aspects, especially to establish ourrapport.

3. Results

Villagers of Himachal Pradesh used to consume varieties of food in summer and winter season to keep them healthy. In winters they mostly consumed like goat meat, red kidney beans,dry fruits to keep them healthy. It has been shown in table 1.

Table 1

Summers	Winters
Gourd (bitter and sweet),cucumber, pumpkin, maize, wheat, split green gram, split red gram, split red lentil, cauliflower, cabbage, eggplant, potatoes, lady's finger, capsicum, underground tuber (*lingdā*), black lentil, curd, *lassi*, tomatoes, peas, English cucumber *Kadhi*. Fruits like oranges, banana, mangoes, pear, apricot, plum, apple, grapes, peach, and guava.	Radish, spinach, mustard, coriander, *jow* (a type of grass),split black lentil, red kidney beans, potatoes, chickpea, goat meat (no other type of meat is allowed), green vegetables, carrot, maize, apricot oil, fenugreek leaves, corn, split red lentil, *gaundā*(boiled water, flour, sugar/jiggery), *sidku*(uneven flour bread with stuffing of black lentil inside).

Now a days rural also having almost same life style as urban they consume same as urban -hite do. Like in snacks chips, wafers, Kurkure, cold drinks. Table no.2 has shown

Table 2

Sweets	*Snacks*
Vermicelli,*kheer*,*halwa*, *gajak* (sesame candy), *jalebi* (orange coloured, fried sweet), *gulabjamun* (milk dumplings,deepfried), *pateesa* (gramflour sweet), *barfi* (sweet made from condensed milk), *rasgullā* (a cheese based syrupy sweet), custard, *khoya* (prepared from dried whole milk or thickened milk).	Maggie, chowmein, *samosa*, *pakora*, biscuits, peanuts (during winters), popcorn, bread, *kurkure* (rice based wafers), *alookeparanthe* (wheat flour with potato stuffing cooked in ghee), coldrinks, chips, momos (steamed dumplings), fruits like bananas, oranges, mangoes, chewing gum, *muda* (a mixture of maize, rice, apricot seeds, almonds, a preparation from the cannabis plant, and roast it).

Health, in Sawrakoti, referred to as *sehat* has a physical and socio-psychological/psycho-social aspect to it.
Health as socio-psychological/psycho-social :For their daily routines , almost all the respondents, in one way or another, have mentioned the interaction with others, be it in the form of gossiping, going to the market, or the strolls in groups. The individual linkage with group acts as a cushion during times of stress. The daily routines of the males and females clearly indicate the division of labour, except for one or two cases. Most of the responsibilities befall on women due to which they suffer from greater psychological problems since the expectations of the society from them are much greater.
Health as physical: With the agriculture now but a rudiment compared to in the past, it is affecting the physical fitness of the villagers. Sure enough money has brought with it comforts and luxuries, but it has also given rise to a more sedentary life style, which the elders fear will be the root of many problems in the future.

Being healthy and maintaining it, for most of the respondents, begins at home. The first line of treatment is usually self medication which, if it does not work out, is followed by seeking other methods ranging from visiting a doctor to performing rituals at the temple. Following are a few examples of home remedies associated with curing cough and cold:

Table 3

S.No	Home Remedy	Raw Materials used	Usage
1.	*Eyun*	Mountain ice, *pudinā*(mint), *dhaniyā*(coriander), *chullukiguthli*(apricot seeds), red chilies, sugar, salt.	Forwarmth during winters.
2.	*Kādhā*	*Banakshā* flowers (small white flowers), clove, small cardamom, black pepper.	To treat cough and cold.
3.	*Kūt*(herb)	-	For treating cold.
4.	*Joshāndā*(herb)	-	For curing cough.
5.	*Kakad*(herb)	-	Used in treating cough.

Apart from self-medication are local specialists who are distinct from the doctors since they do not follow the same treatment procedure as the professional specialists and often have people coming to them for cures the doctors will not have or if allopathic treatment has been unsuccessful. The local specialists people go to, reside in the two villages of Arwas and Sawrakoti. These include:

- Healers who cure using a person's horoscope;
- Those that undergo trance and act a medium for the local deity (Hateshwari Mata) to communicate with the villagers, similar to shamans;

- And those who have received training in certain ancient system of knowledge through texts (Tantric Veda) and a formal training making them similar to priests.

The local term for shaman in the region is *gurmāli*, the person performing this role helps out at the Hateshwari Mata temple and meets people who want his help within the temple premises itself. Most of the people come to him for problems at a social, rather than individual level.

The other local specialist is the *tantric-pandit* who mostly deals with local categories of illness like evil eye (*nazar panda*), or possession by a deity (*khellagna*). The book which he refers to, containing all the mantra, the problems along with their solutions is known as *sāncha,* written in *tānkri*script.

Apart from the local specialists are the medical practitioners who are located in Arwas, numbering three in total. While one runs a private Ayurveda clinic, in which he also gives allopathic medicines, the other two doctors work at the Primary Health Centre (PHC).

Roughly 60% of the patients came to the private clinic for allopathic treatment while the remaining 40% who choose Ayurvedic treatment are the ones opting for it as their last resort after everything else was unsuccessful. People who stick to Ayurveda are those suffering from chronic illnesses which have lasted some years. These consist of piles, fistula, kidney stones, jaundice, arthritis, a low immunity, dysmenorrhoea (pain during menstrual cycle), white discharge and skin diseases.

The PHC was treated as a first aid centre only and if people were well-off, it was altogether avoided by them. The reason lay in the lack of facilities the people expected the PHC to have and provide them with. The PHC has two doctors, one staff nurse and one sweeper and one female for immunization and maternal child health work. The PHC gives out iron and de-worming tablets and the doctors also go for haemoglobin checkups of adolescent girls to schools. The works carried out by the PHC include immunization for children, family planning, distributing contraceptives like condoms, oral contraceptives (like Mala D), permanent sterilization, copper t insertion (least used method).

Diarrhoea, cough, cold, fever and gastric problems were reported as the common illnesses in the area. The older people mentioned *rakt chap* (blood pressure), joints pain and *madhumej* (diabetes) as a problem. Jaundice had now started coming up in the children. Diabetes; especially the incidence of the non-insulin dependent diabetes (diabetes type II) is increasing. This can be linked with the eating habits, especially the intake of ghee prevalent in the village.

The migrant workers of the hydel project: Persistent problems included chest infections, throat infections (which have the potential to turn into tuberculosis or asthma in the future) and skin diseases (itching). Approximately thirty female patients from the project complained of joint pains and fever which was due to upper respiratory tract infection. The project is expected to give rise to new diseases, especially due to the migrant workers who are coming from varying geographical conditions and trying to adjust in a new area.

4. Discussion

Higher education and poor health status continue to predict use of these approaches to healthcare in national studies that include both genders[12–15]and also in studies of women,[17,18]as they did in my sample. Higher levels of education probably indicate a greater ability to navigate available resources, openness to a variety of approaches to health, and empowered information seeking and decision making, factors that may be independent of income. Income was a predictor for Complementary and Alternative Medicine(CAM) use only when spirituality, religion, or prayer was excluded from the CAM measure. Religion, spirituality, and prayer for health are widely used across income strata, and these practices are not usually associated with specific treatments or healthcare costs. The influence of spirituality, religion, and prayer on health behaviours within cultural contexts should be further studied.

Although having insurance predicts CAM use, the relationship of insurance status to CAM use is complex, as many CAM treatments are not reimbursable. As insurance status is likely to influence treatment patterns, more research is needed in the context of medical pluralism. The population of the uninsured is diverse and includes those who have limited access to health services of any kind and those who are young and healthy and may not often use health services.

Women reported using herbs and vitamins more than any other CAM, which confirms findings from a study based on the 2002 NHIS CAM supplement.[18] The use of biologically based therapies, most likely used without clinical supervision (given the low rates of visits to CAM practitioners who prescribe herbs and the small proportion of doctors who advise about the use of nutritional supplements and herbs), is a public health concern. Information about herbs and dietary supplements from vitamin and health food store personnel, magazines, the internet, product labels, and advertisements is unreliable. Product quality is variable and not easily determined, which is also a major public health concern.

The majority of women who used biologically based therapies used them concurrently with prescription or Over TheCounter (OTC) pharmaceuticals for all the conditions we asked about. Women often used biologically based CAM concurrently with OTC and prescription medications for symptoms relating to pregnancy and menstruation. This approach was less common among women at menopause, perhaps because women who use CAM at menopause may be avoiding hormone replacement therapy. Studies of how patients, especially those on daily medications for chronic conditions, make decisions and communicate with their providers are needed. A better understanding of how to manage the risks of polypharmacy, whether CAM or conventional, is essential to the health of Villagers.

A majority of women in our sample disclosed CAM use to their doctors when consulting them about the same condition

for which they used CAM. We report higher rates of CAM disclosure than other studies [13],[14],[15] Many people may use herbal treatments or vitamin supplements to treat colds and flu, for example, but if they do not see a doctor for the condition and it does not have squeal, they are unlikely to report this use to their doctor during a subsequent medical encounter for another reason. We asked women whether they had told their doctor about their CAM use for the specific condition for which they visited the doctor. Women see doctors more often, ask more questions, and have longer medical encounters when compared with men, and these factors may lead to higher disclosure rates for women.As this and other studies have shown,[16]pragmatism seems to motivate medical pluralism, especially among those with more education, as people seek to solve their health problems with a variety of approaches.Social networks among women and family relationships have been reported as the most common reasons for CAM use. Negative factors related to conventional care (high costs, side effects, and limited efficacy) are not so commonly reported.[18],The majority of women in this sample (61% of CAM users) cited wanting "natural treatments." Although it is unclear what exactly women mean by this, it is often reported as a desired approach to treatment and may refer to practices that are perceived to work with the natural processes of the body, to be non-technological, to have minimal side effects, and to come from natural sources, such as plants. Women in this sample sought care and used treatments pragmatically for their conditions (i.e., chiropractic, manual therapies, and yoga/meditation and taiji for back pain), using a variety of modalities to treat problems or to stay healthy and well.However, in seeking an explanation for the pervasive demand for and supply of alternative health care, it is not only important to go beyond the culture of each kind of health care itself but also to examine the changes occurring at a societal level as well as to examine consequential individual response to the changes [19]. There are some relatively new social conditions that influence the choice of diverse health care methods such as herbal medicine, health foods and what are loosely called New Age therapies. The transformations in the labour market and the global effects of the restructuring of work have led to decreases in job security, work-related stress and pressures on household budgets. These have contributed to broader cultural changes, transformations in subjectivity and a pervasive attitude of 'look after oneself', which reiterates the importance of an underlying mechanism in understanding the recent booming of complementary medicine.[20]Whether the discussion of medical pluralism is anchored to the economics of healthcare, consumer choices, and markets or the discussion is driven by provider-patient relations and clinical concerns, the healthcare system must incorporate an assumption of medical pluralism as a normative, pragmatic approach among Villagers in all sectors. The majority of Villagers engage in a variety of practices for health maintenance or try them when ill. The distinction between CAM and conventional medicine is often an artifact of the research and clinical professions and may no longer be useful for many. The interplay of professional care and self-care, communications within and around encounters between patients and providers, medical charting, referral systems, and professional and patient education trump the usefulness of characterization of modalities as CAM or conventional.

5. Conclusion

The popular use of alternative medicine in part reflects the increasing awareness of the limit of biomedicine or frustration with scientific approaches to health and illness. MP is common in North West Himalayas. Socio-demographic factors, unhealthy lifestyle, use of folk therapy, and living in areas with a high density of Traditional Chinese Medicine (TCM) physicians are all associated with MP. People who had factors associated with the adoption of MP may be at risk for adverse health effects from interactions between TCM herbal medicine and WM pharmaceuticals.Although the predominance of modern scientific medicine, folk tradition and indigenous form of medicine also co-exists. A conscious effort has been made to conclude certain social groups gain access with institutionalised form of medicine (both allopathic and alternative system).

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