

# Integrating folk healers in India's public health: acceptance, legitimacy and emancipation

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## Abstract

Indian medicine comes in two forms. On the one hand there are almost 600,000 practitioners of Indian medicine with an officially sanctioned degree. On the other we have one to two million local herbal healers who have a semi legal status. Though their expertise and services are in demand these health care providers are under pressure due to their semi-legal status, the aggressive marketing of biomedical drugs, and biomedicine's social prestige. The article wants to give the reader an insight into the diversity of village healers (*gram vaidyas*) in South India. Who are these folk healers? Which patients do they attract and for what reasons? What are the push and pull factors for patients to make use of them? How can their skills be evaluated and improved upon? What recent initiatives have been taken in this respect? Does the sharing of a local moral world between patients and healers contribute to the effectiveness of treatments? Do local health practices contribute to Universal Health Coverage as defined by the World Health Organization?

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## Introduction

Traditional medicine and Complementary and Alternative Medicine (CAM) are not confined to the private sector. The public health care systems of countries like China, India, and the United Kingdom testify this. India is witnessing a recent upsurge in efforts to integrate Indian medical systems such as ayurveda, unani tibb and siddha in public health (see Priya & Shweta 2011).<sup>2</sup> To understand what is happening here it is pivotal to distinguish between two forms of Indian medicine. On the one hand there are 537,012 registered practitioners of ayurveda, unani tibb and siddha who possess at least a college degree.<sup>3</sup> Their training consists of a mix of Indian medical notions and biomedical theories and practices (see Wujastyk 2008). On the other hand there are approximately one and a half million providers of folk medicine who deliver health care to nine hundred million Indians living in rural areas.<sup>4</sup> They do not have a certified medical degree and therefore practice a form of non-state or vernacular Indi-

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<sup>2</sup>Public health care in India is good for 25% of health care delivery. In 2005 health expenditure in India was 5.1 % of the BNP out of which just 0.9% was public expenditure. In the UK these figures are respectively 7.6% and 6.2%; in the USA 13.9% and 6.2%; and in Brazil – like India a fast growing and increasingly prominent economy - 7.6% and 3.2 %.

<sup>3</sup>The figures come from the website of AYUSH, India's department of traditional medicine under the Ministry of Health and Family Welfare. The data are from April 2010. See [www.indianmedicine.nic.in](http://www.indianmedicine.nic.in) (accessed May 2014). Out of these 537,012 there are 478,750 ayurvedic physicians. The vast majority among these graduates practice a hybrid form of Indian medicine marked by biomedical diagnostics and disease categories, biomedical pharmaceuticals, and industrial ayurvedic, unani and siddha medicines. Only a small minority of these degree holders - probably not more than ten thousand - practice a form of Indian medicine, mainly ayurveda, in which the tenets of Indian classical medicine have the upper hand in steering diagnosis and treatment (see Bode 2012, Bode 2013b).

<sup>4</sup>This group must not be confused with untrained medical practitioners who prescribe biomedical drugs and those with a medical degree who practice 'cross prescribing', i.e. those who prescribe biomedical drugs, but have a degree in one of India's medical traditions (Berman 1998). The focus in this article is on village healers who prescribe herbal or herbal-mineral medicines and demand minimally payment or no payment at all. A decade ago Shankar (2004) estimated that in South India alone there are at least 760,000 local practitioners of vernacular medicine. Among them are 500,000 midwives who apart from deliveries treat post-partum ailments, menstrual problems, and common female complaints such as leucorrhea.

an medicine (Hardiman and Mukharji 2012). These folk healers, or vernacular medical practitioners, are the focus of this article.

Folk healers are a very heterogeneous group.<sup>5</sup> Among them are specialists like snake bite healers, bone setters, jaundice healers, midwives, etc. as well as those who treat a spectrum of common and chronic ailments. Most of the healers belong to an oral tradition, but family manuscripts also play a part in the transmission of knowledge. Village healers (gram vaidyas) are generally well integrated in their communities and for most of them healing is a part time occupation (see for example Sujatha 2003, 2007; Bodeker and Burford 2007; Sheikh and George 2010; Sujatha and Abraham 2012). Because they share a common ethos with their patients they are equipped to deliver social-cultural sensitive health care (see for example Nichter and Nordstrom 1989, Sujatha 2009).<sup>6</sup>

Which patients do they attract and for what ailments? We will give two examples from South India. The first example discusses the practice of a private South Indian folk healer while the second case study deals with the integration of Indian medicine in a Public Health Centre (PHC) in Karnataka (South India). Then we ask why patients make use of them. What are the push and pull factors for consulting folk practitioners? Next we discuss a recent initiative by

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<sup>5</sup>There exists a body of knowledge on different aspects of Indian folk medicine see Nichter 1981, 1982, 1989, 1991, 2008; Lambert 1992, 2012; Trawick 1992; Obeyesekere 1992; Langford 2003; Sujatha 2003, 2007, 2009; Shankar and Unnikrishnan 2004; Barrett 2008; Sax 2009; Sheikh and George 2010; Sujatha and Abraham 2012; Quack 2012; Sadgopal 2013, Sébastia 2013, Priya 2013. The social prestige and practices of these healers, who are not sanctioned by the state, differ widely. Some practice a form of herbal medicine while others are spiritual healers; some are illiterate while others are scholarly; some belong to the upper castes while others are at the bottom of the social hierarchy. For scholarly ayurvedic practitioners who base their practices on family traditions and are not necessarily sanctioned by the state - the Ashtavaidyas of Kerala - see Yamashita and Ram Manohar 2009-2013.

<sup>6</sup>Quacks are also among these semi-legal practitioners of Indian medicine (see Van Holten 2005). However, quackery can also be found among state sanctioned medical practitioners like biomedical physicians and government sanctioned practitioners of Indian medicine. Medical practitioners who practice another system than the one in which they are trained can be considered as quacks. However, these 'quacks' offer medical treatment in places where officially sanctioned practitioners do not work. See Barua 2014 for the practice of a 'homeopath' in a Delhi slum. Weak professional organizations and lack of law enforcement are probably reasons for this state of affairs (see Jeffery 1977, 1988).

the Indian government to integrate Indian medicine in public health. Finally we discuss the related issues of Universal Health Coverage, legitimacy and acceptance.

### **Folk medicine in private and public practice: two case studies**

In this section we discuss the medical practices, ethics, and social background of a folk healer who practices in a village near Shimoga, a city in Northern Karnataka. The first author met Shadashivaiah in 2009 within the context of a healers' exchange program in which healers from South and Middle America, Africa and Asia, met with their Indian counterparts (see Institute of Ayurveda and Integrative Medicine 2011). For the occasion Shadashivaiah had assembled hundreds of his patients and their family members on a central square in his village. He told us that he sees around three hundred patients every week and that ninety per cent of them did so after biomedical treatment had failed, turned out to be too expensive, or was unaffordable from the start. Patients suffered from ailments such as the consequences of a stroke, kidney and liver failure, disabling inflammation of the joints, psoriasis and other skin ailments, diabetes, leucorrhoea, dysmenorrhoea, and various forms of cancer. The healer, who in 2011 was in the beginning of his forties, started his practice in 2005. Natural medicines made with fresh botanical materials the healer and his assistant collect in the wild and which his wife converts into powders, are the backbone of his treatments. Sometimes minerals and metals are added to these herbal powders which are then consumed by themselves or in combination with cow products such as ghee and milk. Food prescriptions, moral guidelines and the healer's blessing potentiate these medicines. The healer comes from a locally respected family and owns a good measure of land. The fact that his father was the head of the village council (*panchayat*), testifies his social status. Shadashivaiah had started his career as a healer relatively late in life. Till 2005 business and farming were his main occupations. He now sees his profession as a calling and considers himself as the successor of his grandfather who was a healer too. Prayers, *pujas* (offerings), and prophetic dreams are an integral part of his practice. Dreams in which religious figures tell him what medicines to use for specific patients and where to find the natural ingredients are important sources of information. The healer also claims to be clairvoyant, which he illustrates with an anecdote about a car accident he had foreseen and therefore escaped.

When the first author visited Shadashivaiah again in March 2011 the healer

had moved to a recently built new house in the same village.<sup>7</sup> Though it was a holiday (Shivaratri) around twenty patients showed up, most of them at the request of Shadashivaiah. Among them were patients suffering from the consequences of one or more strokes. They had placed themselves under Shadashivaiah's treatment as they phrased it. According to the patients and their companions their health had improved since then. There is, however, no way to check this as Shadashivaiah does not keep patients' files. The symptoms and illness histories presented by the patients and their companions, the results of biomedical tests carried by them, *nadi pariksha* (pulse diagnosis), provided the healer with the needed information. When asked what the reasons were for treatment failure he mentioned ignoring dietary and behaviour advices, immoral behaviour such as illegitimate sex and drinking alcohol, and failing to perform the prescribed *pujas* (offerings) and rituals. Shadashivaiah emphasized that patients only had to pay a minimal charge to cover the costs of the medicines. During the same visit the first author accompanied Shadashivaiah to a temple in a nearby village where he occasionally treated patients. When the healer arrived in his jeep about sixty villagers, all males, were already waiting outside the temple. They immediately stood up and touched Shadashivaiah's feet. This gesture illustrates their great esteem for him. When the healer entered the temple devoted to the local deity Basaveshwara they respectfully followed him into the temple. Then the patient, a girl of eight with a severe skin ailment, entered together with her mother. Shortly the healing ceremony started. A statue of the local deity was carried by two men while another man asked the deity questions about what herbs were needed and for how long they had to be taken. The three men were obviously in trance. Through them Basaveshwara answered questions about the treatment by tapping on the healer's hands, through 'writings' on the inner temple walls, and by pointing at dates on the temple calendar. During this divination the patient was repeatedly blessed by the deity. Herbal therapy and religious divination went hand in hand. It seems that Shadashivaiah's status as a religious man, who is close to Lord Shiva and his social prestige as the grandson of a village leader cum healer, potentiates his medicines. The healer's medicines are sacraments in the sense that supernatural powers play a role in their selection, application, and effect. This defies the distinction between rational and symbolic use of medicines. The healer's medicines might work because they contain active ingredients as defined by modern pharmacology.

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<sup>7</sup>The first author wants to thank the healer and his wife for the hospitality extended to him. He also thanks Mr. Joy, at that time staff member of the section Local Health Traditions Unit, FRLHT, Bangalore, for translating and showing him the way in the geographical sense of the word.

They are also vehicles of meaning and have effects because the human body reacts to meaning.

Around the same time a pilot public-private partnership project of the government and the Karuna (lit. compassion) Trust, a South Indian NGO, tried to integrate Indian medicine in the Primary Health Centre located at the South Indian village of Segunahalli. When the first author visited this health centre in November 2009 there was an ethnobotanical garden which is part of the Home Herbal Garden project run by the Foundation for the Revitalization of Local Health Traditions (FRLHT), another South Indian NGO (see Hariramamurthi, Venkatasubramanian, Unnikrishnan & Shankar 2007). Herbal medicines made of plants, flowers, shrubs and trees from this garden supplemented the PHC's biomedical drugs. A college educated ayurvedic practitioner was in charge of the PHC. This is a common situation in rural PHCs all over India as biomedical physicians generally shun jobs in rural areas. As is generally the case, though trained as an ayurvedic doctor, the young head of the PHC mainly distributed biomedical pharmaceuticals. Herbal medicines were the domain of a young woman with the title *arogyamitra* (lit. friend of health). The medicines she prescribed to her patients partly consisted of ingredients that came from the PHC's ethnobotanical garden. The *arogyamitra* was the daughter of a local farmer-practitioner with a medical practice of over forty years and was well integrated in the local community. The father, who got his knowledge from his grandmother, told the first author that he was a 5th generation healer specialized in the treatment of children's ailments, skin diseases, and respiratory and digestive infections. This is how he described his practice:

*Healer:* My diagnosis is through eyes, tongue and pulse. I usually give 9 doses to a patient; they have to take it 3 times a day, for 3 days. Patients determine themselves what they want to give in exchange. First time I give patients medicine and explain about its content and preparation. Then the next time they can make it themselves. It is like giving them training. I also learn them to prepare herbal medicines themselves. Allopaths give an injection when patients have a fever. Then they look cured, but the fever easily returns. I use *neem*, cinnamon etc. to make *kashayams* (decoctions); then the patient perspires and there is a long lasting cure, for half a year there is no fever. I use a root of a plant for treating skin allergies and patches and itching. It also helps to make a garlic paste and put it on the itchy areas. Food restrictions are a must; what not to take and what to take. Without the gods we cannot do anything; whatever I treat I do this in the name of the god. Before picking plants and giving medicines I pray. I attribute my successes and failures in healing to god; nothing happens without god. I pray to the local

god and to Atman (Brahma), Shiva, and Rama. Before there were enough medical plants and it was easy to pick them in the nearby forest. Because of environmental degradation this has become a problem now. The FRLHT Herbal Garden Project of this PHC is helpful in this respect. Now my medicines come from this garden and the forest.

*Bode:* do you also give preventive medications:

*Healer:* yes, *neem*, *tulsi* to be taken twice a week. To improve the quality of the milk and prevent the child of becoming ill mothers who give breast milk must adhere to food restrictions.

*Bode:* is there enough support and respect for you in this village; can traditional healers bind the community and prevent young people to go to a big city?

*Healer:* yes I have local support. I do not need to ask for money because I have my own farm land. The young generation however is not interested in my healing practice.

*Bode:* do you need a healers association?

*Healer:* There should be recognition and we need training. Now we are scattered. We need an association to teach the healers how to update their knowledge. If we do not support traditional medicine it will degrade further, but we depend on it for our health. We need to protect this knowledge and nature because our medicines come from there.<sup>8</sup>

This interview illustrates a few markers of vernacular medicine in India: the strong relation between medicines and food, the intertwining of herbal medicine and religious practice, the dependency of medical practice on the state of the local ecology, the potential to emancipate villagers in matters of health, the need for training and mobilization of medical practitioners, and the dwindling of local support and the related difficulty of finding young people taking up the profession.

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<sup>8</sup>Interview Segunahalli, November 2009. Mr. J. Nagendra was the translator during the interview.

### Why do people consult village healers?

In this section we ask why rural South Indians make use of vernacular medicine. We start with a discussion of the factors that push people towards folk medical practitioners. Lack of access to biomedical treatments of good quality certainly is a factor. In rural areas biomedical facilities are often not to be found within a reasonable distance and if they are available they are often of bad quality or not affordable. Figures show that half of India's population has no access to life saving drugs and many get into financial problems due to disease (Horton and Das 2011). Public health facilities hardly offer an alternative because they are notorious for the non-availability of essential drugs, absence of physicians, corruption, and insulting social treatment. Frequently patients are not listened to, do not get the respect they are entitled to, and are financially exploited when they are pressed to undergo unnecessary biomedical tests and to buy pointless biomedical drugs (Pinto 2004, Priya & Shweta 2010, Sudarshan 2011, Priya 2012). These negative factors only partly explain why Indian villagers make use of the services of folk healers. Ethnographic cases descriptions suggest that their treatments offer patients hope and mitigate despair. It is also reasonable to assume that the herbs and foods they prescribe have healing potential. Indian medicine also provides people with a metaphysical perspective on disease, suffering and death (see for example Trawick 1992, Sax 2009, Valiathan 2009). They have another advantage too. Due to the fact that they are an integral part of the local social and moral world they are in a position to take the illness perceptions of patients and the economic and social-cultural realities of their lives into account (Priya 1995, Nichter 2008, Sujatha 2009). An example hereof is the treatment of a young woman from Karnataka who earned her money as a bidi (local cigarette) roller by a local ayurvedic *pandit*, a term referring to a relatively high status (Nichter 1981).<sup>9</sup> The woman came to this charismatic healer with the somatic and psychological signs of a major depression (weakness, lethargy, leucorrhoea, back pain, poor sleep, lack of interest in her work, loss of appetite). Though she was of marriageable age her family had not arranged for her marriage due to the fact that her earnings were crucial for the income of her native home. She could therefore not save for her dowry, a necessity in the culture to which she belongs. By using a directive interviewing

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<sup>9</sup>Nichter and Nordstrom (1989) coined the term 'medicine answering'. The term draws attention to the fact that traditional healers focus on the illness experiences of their patients. It would be wrong, however, to assume that this is always the case. We need more research to determine how common 'medicine answering' is among traditional practitioners.



technique the healer revealed the root of the matter and convinced the woman's relatives that she needed to get married. Next to this directive form of counseling, the healer's approach consisted of prescriptions for making medicines and healthy foods based on locally available medical materials. In contrast to what is known of biomedical settings in India the young woman's feelings of shame in relation to reproduction and sexuality were taken seriously. The healer's wife did part of the physical examination when she took the young woman apart and advised her on how to tackle her leucorrhoea and treat her deranged menstrual cycle. This thorough treatment addressed the 'heart of what's the matter' and acknowledged 'what was at stake' for the patient. Because the healer and his wife were an integral part of the local culture they could recognize and respond to the woman's idiom of distress. Treatments based on local logics also have their advantage when it comes to infamous diseases and ailments such as tuberculosis, vitiligo, infertility, Aids, leprosy, and elephantiasis, to mention just a few (see Barrett 2008; Bodeker, Burford & Dvorak-Little Carter 2009).

Empirical research also suggests that providers of traditional medicine are consulted because of positive outcome perceptions (see for example Diallo et al. 2006, Sujatha 2007, Giovannini et al. 2011, Orr 2012, Vandebroek et al. 2011, Hardon & Dilger 2011, Mathez-Stiefel, Vandebroek & Rist 2012, Quack 2012, Beerenfenger 2012). The popularity of Complementary and Alternative Medicine (CAM) in the West and among the middle class of developing countries also implies that lack of access to modern health care does only partly explain the continued use of traditional medicine and CAM.<sup>10</sup> The poor increasingly suffer from what is known as the 'double diseases burden'. Apart from infectious diseases, chronic ailments like diabetes, respiratory difficulties, rheumatic complaints, overweight, etc., ailments for which patients in the developed countries are increasingly turning to forms of CAM, affect the poor in countries like India. It would be sad if the health practices the affluent increasingly use become unaffordable to the financially poor in developing countries like India.

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<sup>10</sup>It is common usage to apply the term 'CAM' for commodified forms of traditional medicine practiced outside their countries of origin. This term is also used for medical logics such as homeopathy and anthroposophy, which are based on notions of a single individual, respectively Hahnemann and Steiner.

Bodeker and Burford (2007) speak of Traditional, Complementary and Alternative Medicine (TCAM). Here 'TCAM' is an umbrella term that includes highly different treatment modalities such as codified Asian traditions like the medicines of India and China, rational forms of herbal medicine, and spiritual therapies. The term 'TCAM' has its shortcomings because it is too much like biomedicine and the rest.

### **The National Rural Health Mission: Integrating Indian medicine in public health**

Already in the 1920s efforts were made to integrate Indian medicine into health care (see for example Banerji 1973, Minocha 1980, Banerji 1981, Jeffery 1982, 1988, Leslie 1989, Shankar 1992, Wujastyk 2008, and Berger 2013). One way of doing this is the professionalization, regulation and standardization of Indian medicine through the establishment of ayurvedic, unani and siddha colleges and universities. This has resulted in 304 ayurvedic, unani and siddha colleges with a yearly admission capacity of 15.345 students. However, the large majority of these graduates work in private practice where most of them apply a hybrid form of medicine marked by biomedical diagnosis, biomedical drugs, and industrial Indian medicines. Those who work in Primary Health Centers (PHC) and District Hospitals (DH) - roughly twenty per cent of those graduated from the colleges of Indian medicine - mainly practice biomedicine as many of them fill the places of biomedical physicians who shun work in rural areas. They fill the seats in PHCs and DHs for which graduates in biomedicine seldom apply (Kamat 1995, Priya and Shweta 2010). We can conclude that though the number of 537.012 college educated ayurvedic, unani and siddha physicians looks very impressive it does not indicate the integration of Indian medicine in public health. In contrast, private health care in India is highly pluralistic (see for example Khare 1996). When we take the patterns of resort of patients as an indication for what kind of health care people want, public medicine in India does not accommodate this. In the past efforts to integrate vernacular medical practitioners in public health as Community Health Workers has failed largely. Probably because their practices were ignored and most of them were positioned at the lowest tier of India's hierarchical health system. Their inclusion had to make the delivery of biomedicine more effective. The objective was not to give patients a choice of medical treatments (see Jeffery 1982, 1988, Leslie 1988, Quack 2012).

Under the National Rural Health Mission (2005-2014) and the eleventh five year plan (2007-2012), once more efforts were made to integrate Indian medicine in Primary Health Centers and state run hospitals (Priya 2012, 2013a, 2013b). A pilot project of accrediting folk healers under the Delhi based Indira Gandhi National Open University (IGNOU) was part of this. The first author was present at the Second Multi Stakeholders Meeting on Scheme Certification of Prior Learning and Knowledge of Grama [village] Vaidyas held in Shimoga on 4 March 2011. This meeting was sponsored by the department of Indian medicine (AYUSH), the Foundation for the Revitalization of Local Health Traditions (a Bangalore based NGO) and the Paramparica Vidya Parishath Kar-

nataka (Karnataka traditional healers' association).<sup>11</sup> The meeting was a set-up to a projected healers' accreditation project in which the *panchayats* - clusters of around five villages with a total population of approximately three hundred people - were destined to play an important role. A survey among 250 households living in villages without a public health facility was planned as part of this project.<sup>12</sup> The survey had to answer questions such as: For what ailments do patients living in villages without a public health facility turn to folk healers; what is the treatment rationale of traditional healers; do villagers appreciate their services and for what reasons. These community surveys had to provide evidence for the acceptance and perceived effectiveness of Indian medicine.<sup>13</sup> A list of priority diseases for which villagers can safely turn to healers and minimum treatment standards for handling by folk healers of diseases such as cold and cough, fever, anemia, diarrhea, skin ailments, jaundice, rheumatism, diabetes, bone and muscle fractures, menorrhoea, leucorrhoea, pre- and postpartum ailments, was expected to be two other outcomes of these surveys. A healers' accreditation program had to sift the wheat from the chaff. An evaluation committee consisting of medical professionals such as biomedical and ayurvedic physicians, as well as local spiritual authorities and human rights experts, was projected to this end. These committees could also allot a certificate, refuse accreditation, or postpone accreditation till the healer had taken additional training, which had to be offered against an affordable price. The larger goal of the project is to carve out a space for folk practitioners and offer patients a choice between folk practitioners, government sanctioned doctors of Indian medicine, or biomedical physicians. Emancipation in matters of health is an important justification for including Indian medicine in public health.

Around the same time a report was published by the Indian government that evaluates the status and role of forms of Indian medicine in public health (Shweta and Priya 2010). The main findings of the report based on field research in the period 2007-2009 are: high utilization of both syndicated (state sanctioned) and vernacular forms of Indian medicine which made the researchers conclude that both are an integral part of the lives of large sections of the Indian population; valid medical knowledge and rational prescription practices of state sanctioned practitioners of Indian medicine, known as AYUSH doctors, who work in the public health structure of Kerala and Tamil Nadu; two states

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<sup>11</sup> In 2009 this association had approximately 2500 members.

<sup>12</sup> 40,000 out of India's 600,000 villages have a PHC.

<sup>13</sup> The critical medical anthropologist Vincanne Adams (2013) pleads for testing the effectiveness of medical interventions through research designs that take local social and epistemic realities into account.

where AYUSH doctors are not mainly deployed as substitutes for biomedical physicians; ninety per cent of the households were aware of medical plants. Another interesting outcome is that seventy percent of biomedical physicians working in PHCs think positively about state sanctioned Indian medicine and fifty five percent of them have a favourable opinion on Indian folk medicine. The researchers also noticed that their respondents were aware about the validity of home remedies. The report comes with the tentative conclusion that patients want to be offered a choice between biomedicine, syndicated forms of Indian medicine and folk medicines. The South Indian state of Tamil Nadu is seen as a model for integrating both syndicated and vernacular Indian medicine in public health. The authors of the report further recommend: the co-location of these three medical forms in PHCs and DHs; organized supervision and evaluation of the services delivered; guaranteeing the supply of medicines and other necessities such as clean water and good buildings; and a ban on what in India is known as 'cross-prescribing', i.e. medical practitioners prescribing medicines of other 'pathies' than their own. The authors also plead for: better linkages between vernacular medicine and public health facilities; improving the integration of AYUSH doctors in the communities where they practice; the development of referral systems between the different 'pathies'; the establishment of herbal gardens; and providing folk healers with additional training, a legal status, facilities such as good buildings, basic diagnostic equipment, and a regular supply of herbal medicines. The report also signals lack of data on the practices of local healers and therefore recommends the documentation and validation of vernacular health practices. The authors argue that implementing these recommendations will prevent chasing people to the private sector which is badly regulated and profit oriented.

### **Universal Health Coverage, Legitimacy, and Emancipation**

In 2011 the opening article of a special issue of the Lancet started with the observation that "(...) a failing health system is India's greatest predicament" (Horton and Das 2011). Not more than 30% of the Indian population is insured against medical costs, often only partly. For most Indians medical treatment is 'out of the pocket payment'. No surprise that medical expenditure is the second reason for Indian families getting into debt. Folk healers might fill the gap by offering affordable treatments at the doorstep of villagers. However they have been largely ignored by policy makers. Though officially their practice is illegal since the Central Medical Council Act of 1970 stated that only college trained ayurvedic, unani and siddha doctors are allowed to practice, folk healers are

generally tolerated till today. It is highly doubtful if the official hierarchy consisting of biomedicine, state-sanctioned Indian Medicine, and folk medicine, reflects their effectiveness for the rural poor. Making good use of folk medicine might be the best strategy for achieving Universal Health Coverage so that "(...) all people can use the preventive, curative, rehabilitative and palliative services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardships".<sup>14</sup>

The WHO definition of Universal Health Coverage has three elements: access, quality and affordability. In India, as elsewhere in the developing world, biomedical health services are lacking in this respect due to non-availability, un-affordability, and un-accessibility, while public health facilities are often of inferior quality. The relatively affluent therefor make seldom use of them. Folk healers might offer a solution for the financially poor. Though systematic research on the effectiveness of traditional medicine is urgently needed we have substantial anecdotic evidence for the health benefits of Indian health practices such as diets, medications, orthopedic technologies, oil baths, fasts, and religious observances (see for example, Shankar & Unnikrishnan 2004, Bodeker & Burford 2007, Sheikh and George 2010, Sujatha & Abraham 2012, Lambert 2012, Payyappalli and Hariramamurthi 2012, Bode and Payyappalimana 2013). There also is a growing body of positivist evidence, though mainly of an in-vitro nature, for the efficacy of the materia medica used by folk healers all over the world.<sup>15</sup>

Social-cultural research suggests that health and the social fabric of rural communities are related (see for example Farmer, Prior & Taylor 2012; Priya 2013b).<sup>16</sup> In this article we have given the reader an impression of what South Indian folk medicine has to offer. Apart from being a first line of resort for the treatment of common diseases, folk healers can contribute to the prevention and treatment of chronic ailments, and the treatment of diseases for which biomedicine has no cure. Folk healers also offer alternatives for biomedical treatments patients cannot afford. Vernacular practitioners share a local moral world with their patients and are therefore in the position to make good use of local values placed on specific persons, objects, and places (Sujatha 2002: Sujatha 2003:14). Their services are generally affordable for people with limited finances. Because folk healers belong to the same village community their ac-

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<sup>14</sup> [http://www.who.int/health\\_financing/universal\\_coverage\\_definition/en/](http://www.who.int/health_financing/universal_coverage_definition/en/) accessed May 2014.

<sup>15</sup> See for example articles in the *Journal of Ethnopharmacology*, *Fitoterapia*, and other peer reviewed scientific magazines.

<sup>16</sup> See Farmer, Prior & Taylor (2012) for a theoretical model that argues the relation between rural health services and community sustainability.

countability might be higher than that of doctors who have been assigned to a public health facility. Empiric research in Tamil Nadu shows that by withholding payment villagers have an instrument to control the quality of folk healers' treatments (Sujatha 2009).

Indian traditional medicine is in demand as its continued use testifies. At the same time its continuity is unsure. Most healers are older than sixty and many are above seventy and even eighty. There are also indications that young people are turning away from folk medicine. Though empirical research is needed factors such as biomedicine's social prestige, the aggressive marketing of biomedical drugs, the semi-legal status of folk practitioners, the absence of substantial financial investments, and lack of studies on the practice and effectiveness of Indian medicine, are probably responsible for the fact that folk medicine in India is under pressure. Though field studies have given some insights in these practices and their uses, a lot remains unstudied and therefore goes unnoticed by those in power. This is a Catch 22 situation for traditional healers who often work at the margins of legitimacy. They are not seen because their practices are not studied, their practices are not studied because they are ignored.

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