Chapter 16
Illness, Health and Culture: Anthropological Perspectives on Ethno-Medicine in India

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Concept of Ethno Medicine in Anthropology

Anthropology, since its very inception as an academic discipline has dabbled with the aspects of medical systems of the so-called 'primitive' or non-western people; often, these systems came heavily entwined with systems of religion and magic and found their place even in the earliest monologues as dedicated chapters. W. H. R. Rivers and F. Clements, the earliest pioneers, before the officially known sub-discipline of medical anthropology emerged, effectively owe us the initiation of concepts of disease causation and indigenous medicine. Clements (1932, in Foster and Anderson 1978) in the first comparative worldwide survey of beliefs of disease causation and Rivers (1924, ibid) through magico-religious and naturalistic worldviews of health in his book *Medicine, Magic and Religion*, showed the deeply cultural underpinnings of native understanding of disease and health as also the stereotype that magic and religion are always connected to medicine in indigenous societies.

The ever-strengthening field of medical anthropology has documented and argued for the centrality of culture in every aspect of human illness and health in societies around the world, whether it is at the level of conceptualizing and describing illness, functional v/s experiential nature, causation and etiology, symptoms, treatment seeking, sick-role, patient-healer interaction, notions of efficacy, cure, etc. Remaining true to its roots of the physical anthropology, accounts of native medical systems and mental health and the field of public health, medical anthropology has consistently tried to enquire into the biological as well as cultural and preventive as well as curative aspects of various medical systems at a cross-cultural level.

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The sub-field of ethno-medicine articulates with other sub fields on both a theoretical and applied level. So, whereas the universal occurrence of beliefs in illness and healthcare across societies make ethno-medicine an interesting enterprise to collect data on knowledge and practices of different societies related to psychosocial, physical and functional aspects of health and healthcare, it is also utmost necessary on a practical level to apply this knowledge in a better manner in order to contribute towards a more effective and culturally accepted public health in regions with indigenous populations in increasingly multi-cultural nations.

Most medical anthropologists dealing with ethno-medicine take somewhat of a systems approach in their work. Major areas of study among biological medical anthropologists include diet and nutrition, evolutionary adaptation, genetic and epigenetic aspects of populations, etc. while socio-cultural medical anthropologists show mostly an ethnographic interest in health knowledge, beliefs and medical systems along with the paraphernalia firmly embedded within the cultural nuances of people under study. A mid-way ground sees health ecologists, medical geographers and epidemiologists combining these two approaches.

Ethno-medicine today is broadly understood as 'those beliefs and practices relating to disease which are products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine' (Hughes 1968: 99 in Foster and Anderson 1978). However, it has increasingly been accepted in the academic circles that modern or bio-medicine is also a form of ethno-medicine since it is essentially drawn upon western cultural constructs thereby eluding the gold standard of 'scientific objectivism' previously assigned to it (Lock and Schepher-Hughes 1990; Rhodes 1990). But for the sake of avoiding confusion, ethno-medicine in this chapter should be seen as consistent with the aforementioned definition.

Such terminology also creates some conflicting assumptions about different indigenous medical systems. For example, in Indian context where tribal groups practice their native medicine and health and illness beliefs, the mainstream population following great traditions has its own indigenous health systems viz., Ayurveda, Yoga, Unani, Siddha, which as per the definition above and commonly employed stand different from the cosmopolitan western bio-medicine.

Sometimes, these two diverse types of medical systems are also collectively called traditional medical systems. However, the term ethno-medicine should generally be used for native groups which have undocumented orally perpetuated systems of medicine and healthcare unlike the national medical systems which are codified and documented.

A number of perspectives arise when one thinks of ethno-medicine in India. India being an extremely culturally diverse country is marked by changing cultural connotations every few miles. Not only different communities but also different sections of the same community practice differing sets of practices and belief systems. Added to these are the overarching great traditions which permeate these different sets of beliefs and practices. In relation to the conception of health and illness, beliefs of causation and cure, these complex cultural groundings influence the notions of sickness, disease and treatment in a unique manner (Mutatkar 2013).

The modern medical system or bio-medicine has low outreach and majority of it is concentrated in the urban areas serving a minority of population, thus, leaving a wide chiasm to be filled in by effective understanding and application of ethno-medical practices and beliefs of such areas. Even in a few societies, where modern medical system has been introduced, the efficacy remains low due to non-acceptance of such a healthcare system by the natives, compelling the health scientists and planners to come up with insights on a better suited healthcare system to indigenous people.

Various studies done on different aspects dealing with indigenous beliefs on health and illness, etiologies, epidemiology, traditional medical practitioners, healthcare systems as well as interaction between various medical systems, health policy planning, etc. shed some important insights into anthropological understanding in the field of ethno-medicine. Some of these are discussed as:

Conception of Health and Illness in Indigenous Groups

The conception of health varies from culture to culture and so does that of illness. Most medical anthropologists today distinguish between illness and disease, where former relates to the subjective and lived experiences of people articulated through a common cultural understanding; disease is a pathological concept used to technically narrow down the unit of malfunction from a wider experiential illness description in the bio-medical model of health. As such, the concept of health and subsequent illnesses are grounded in a holistic and inclusive cultural frame in all societies.

Different indigenous communities conceive health in their own culturally rooted manners and have a native conception of body organs and functions called as ethno-anatomy and ethno-physiology which influences their beliefs related to health, body processes and illnesses (Khundongbam et al. 2012). Many a times, contradictory versions of health also appear in native beliefs where bio-medical views on germs and diseases clash with native models like the case of Jaunsar-Bawar, where intestinal worms are looked upon as beneficial to health rather than as a disease (Joshi 1986, 1995).

The ethno-physiology of *jenukuruba* tribe of Karnataka places importance on the liver as the chief organ where food is transformed into blood. Thin and red-coloured blood is a sign of agility and health while thick and blackish red blood is a sign of illness and loss of strength. These are manifested in young and old bodies respectively. Also, health and intelligence is attributed to lean and short-statured body type. As such, various causes, natural or personal, may turn blood thicker and discoloured giving rise to many types of illnesses (Vijayendra and Bhat 2004).

The menstrual beliefs of body among the *andro* community of Manipur (Krishnakumari et al. 2013) relate menstrual blood to be flowing out of a lotus shaped sac in the women's womb, which if encounters male semen is conceived as a baby. Also, the ethno-anatomy of womb is seen as having numerous placentas in the womb which determine the sex of the baby; if conceived on the right side of the womb it is a

male offspring and to the left is a female. Also, various reproductive illnesses (in press) like vaginal discharge, prolapse, menstrual irregularities, etc. are described in terms of ethno-anatomical perception and beliefs on body processes. For example, it is believed among the *andro* women that wearing pads and intra-uterine devices causes obstruction in expelling impure menstrual blood and leads to illness, highlighting the role of folk anatomical and physiological beliefs in healthcare.

As with many ecologically oriented groups, various indigenous communities describe health in functional rather than medical sense of being. As such, disability to perform usual life functions is seen as illness rather than presence of some ailment per se.

The *kamar* of Chhatisgarh describe their health in terms of ability to maintain levels of energy to perform daily tasks and vigour of blood. So, youth is seen as the healthiest stage of life where one's blood is warm and red while due to weakening of blood in old age, a person becomes susceptible to illness (Khatua 2012). Apart from this, other illnesses may either be caused due to natural or individual factors.

Similarly, the hill *korwa* of Chattisgarh attribute health to proper functioning of the body that permits hard physical work and intake of heavy food. Also, a good pulse rate denotes a healthy body. They differentiate between *kaccha* (young) and *buddha* (old) body through the vigour of blood where fluidic and red blood signifies youth and thick and black blood signifies loss of youth leading to an unhealthy body (Khatua 2012).

For the *baiga* of Madhya Pradesh, health is an ability to do work without feeling tired and have a good appetite while illness almost invariably stems from decrease in amount of blood in the body due to various natural and individual causes (Khatua 2012).

The *mishings* of Assam also view health in functional terms of ability to carry on day-to-day tasks at ease like ability to plough one bigha of land in two days or ability to cover 2 km on foot at a stretch, etc. with an ideal body which meant being tall and strong with healthy white teeth and the ability to laugh loudly with additional features of long, black hair and the potentiality to give birth to 4–5 children in women (Kar 2013).

The native beliefs on the organization of body organs and their functions is an important aspect of their medical systems (Joshi and Khattri 2008) which leads them to deduce the causes of mal-functioning of certain body organs as well as types of explanations used for such mal-functioning. So, one find these societies using various etiological concepts that are derived from and relate to native understandings of their bodies.

Disease Etiologies and Causality Concepts

Foster and Anderson (1978) discuss non-Western disease etiologies in two realms —the personalistic and the naturalistic which lead to different types of causality concepts for the explanation of illness. The naturalistic medical systems explain

illness in impersonal, systemic terms of natural factors of climate, humoral misbalance, etc. As such health is essentially a state of equilibrium when all insensate elements in the body—hot and cold or various humours are in proportion to an individual in her/his physical and social environment (ibid). Contrary to this, personalistic medical systems describe illness to be caused by an active and purposeful intervention of some sensate agent supernatural in origin like a ghost, evil spirit, angry gods or a human being in command of such forces like witch, sorcerer, etc. (ibid). However, no society exhibits a neat delineation or simply one type of causality etiologies and one comes across causality attributes on a spectral level.

In Indian contexts, most of the communities have causality concepts that effectively attribute illness and disease to both types of etiological categories. So, one finds most of the communities including the tribal groups, essentially distinguishing between personalistic and naturalist causes and categories of illnesses.

Joshi (2013) lists the differentiation of *bimari-dos* among the Jaunsari tribe of Uttarakhand where *Dos* includes all kinds of sufferings and misfortunes including an individual's illness as well as calamities affecting a large group but bimari refers to bodily disturbances in the case of an individual (Joshi 2013). Ailments like cold, fever, headache, body ache, bone fracture, snake-bite, skin infections like scabies etc. are treated as natural ailments (Rizvi 2013) occurring due to imbalance of various humours and ecological-environmental hazards. The essentially personalistic *dos* not only explains etiologies in a sensate manner due to various hierarchies of demi gods, spirits and evil entities but also points towards a more holistic nature of indigenous causality factors extending the conception of health not only to the individual bodily processes but to successful integration of individual body into a wider social world. This is also to be seen in several other indigenous communities that offer personalistic etiologies for a variety of illness concepts that may or may not be labelled diseases according to a bio-medical view.

The *chenchus* (Sharma and Srinivasu 2013) and *yerukala of* Andhra Pradesh ascribe natural causes to diseases like jaundice, stomach pain, dysentery, headache, cough, fevers during rainy season, rheumatism, bone-fractures, etc. while other illnesses like small pox, snake/scorpion bite, body-swelling, psychological illnesses, etc. are understood through personalistic causality factors (Reddy et al. 2013).

The *kannikar tribe* of Kerala distinguishes between two broad categories of illnesses—*rogam* and *upadravam* (Menon 2013) where *rogam* are attributed to natural factors and require medication while *upadravam* illnesses are attached to supernatural beings like evil spirits, angry deities, etc.

Similarly, the *irular* people of Tamil Nadu consult medicine men or herbalists *rangamsamiar* for both body ailments requiring only medication and ailments due to sorcery or *kodangi* depending upon the causality logic involved (Saheb 2013).

Also the *mishings* of Assam ascribe certain ailments to natural causes while still invoking the personalistic etiologies for most of the others. So, ailments at personal and community level like epidemics, accidents, sudden onset of fevers, diaorrhoea or diseases like leprosy, paralysis, tuberculosis, etc. are understood to be caused by supernatural personalistic forces while other illnesses like upset stomach,

cold-cough, body aches, skin-diseases, etc. are thought to be causes by natural forces under rules of purity and pollution and humoral imbalances (Kar 2013).

The *rathwa* tribe of Gujarat attribute majority of illnesses to supernatural entities or sorcery including small pox, leprosy, severe body aches and other illnesses due to evil eye, high fever as also general misfortune and societal misintegration. Minor ailments like headaches, minor fevers, oils, skin ailments, toothache, constipation, etc. are attributed to imbalance of bodily humours and resorted to medication (Das 2004).

The *gaddis* of Himachal Pradesh (Kaushal 2004; Kaushal and Joshi 2007) attribute the causes of various ailments to factors like punishment from deities or affliction by supernatural entities like *autars*, *kailung*, *gunga* or by magic and witchcraft while many day-to-day ailments like body-aches, minor fevers or bruises, skin infections, etc. are treated through the use of locally available herbs.

Among the *moyons* of Manipur (Moyon 2004), though most of the people resort to allopathy for their illnesses, those ailments that cannot be diagnosed by doctors are taken to visionaries who tackle illnesses caused due to spirit intrusion and other supernatural entities. In addition, various locally available herbs are also used to cure illnesses like cold and cough, joint pains, dysentery, indigestion, jaundice, etc.

The *monpas* of Arunachal Pradesh (Ibata 2004) conform to a highly spiritual *bon* religion in which the mountain spirit *pfu* influences all aspects of health and illnesses in combination with the malefic forces *don* and *grib*; diseases are cured by a *monpa*, the traditional healer, and the spiritualist *bonpo.* However, bonpos distinguish between illnesses occurring due to natural causes and those due to spiritual ones and no rites are performed for natural ailments like fractured bones, aches due to strenuous work, some ailments of blood, diseases like cholera. For these ailments a *bonpa* sends patients to doctors trained in western medicine. For spiritual illnesses like psychological and social maladjustments, chronic and lingering illnesses, etc., a number of rites are performed.

The common thread that binds the disease etiologies and causality attributes in all these and similar indigenous groups are a native understanding of severity of deviation from health in the personalistic illnesses. These illnesses are different from diseases or bodily troubles in being assimilated at a wider level of social and communal well-being in addition to lingering or chronic versions of naturally attributed illnesses. These are to be satiated at the level of social body in terms of Lock and Schepher-Hughes (1990) as well as individual body. This brings in the major role played by religious specialists or diviners or medicine men who perform various rituals and thus, aim at rooting out the causes of hiatus through a sleuth of supernatural entities. These medicine men often perform the role of herbalists also, while in some more hierarchal organized tribes; different roles may be given to different specialists (Joshi 1981a, c, 2013). The herbalists take care of most of the illnesses attributed to natural causes. It is also interesting to note that in most of the indigenous societies, the illnesses belonging to the realm of personalistic causality factors can often also cause other ailments pertaining to the natural causality factors but not vice versa (Joshi 1981b, 1988, 1991, 2004, 2013), hinting at the priority given to social sustenance and group well-being over individual well-being.

Traditional Healers in Ethno Medicine

The centrality of traditional healers is a characteristic of indigenous medicine. Whether these native medical systems are naturalistic or personalistic or combine both, traditional healers that include herbalists, faith-healers, diviners/shamans, etc. are found in all scenarios. These traditional healers are informally trained in their healing practices by virtue of culturally accepted idioms of illnesses and their healing and may get their training from previous healers like herbalists through apprenticeship or over a time with experience or through special abilities that are inborn and refined through elder practitioners like shamanism, etc. The informality of occupation results in their close association with the people as these healers interact with patients in a culturally meaningful therapeutic discourse. Kleinman (1978) calls this form of healing as the folk sector which is largely resorted to by the indigenous communities but is also found in communities with a more established professional sector of health consisting of certified doctors. The cultural orientation in explaining, understanding and reciprocating idioms of distress of the sufferers by these healers lends cultural credibility to their practices.

The role of shaman is central in medical systems of various communities in India. So, one finds regular mention of sacred healers who act as a mediator between patients and mystical powers like *siamphu* among *paite* tribe, *kamyou* among *jangkhul* nagas, *thempu* among *rongmeis*, *ithim* among *thadou* kukis, etc. (Hemlata and Kumari 2004).

These shamans or witch-doctors perform various functions in a community which range from warding off epidemics by following preventive measures of sacrificial offerings to protecting the community and individuals from attacks of evil spirits, ensuring crop production by bringing rains, treating various diseases like small-pox, cholera, etc. In Uttarakhand, among *tharus*, the shaman *bharra* performs functions like tracing out diseases by spelling out the name of responsible spirits, warding off epidemics and protecting villages from evil spirits by invoking goddess *bhawani* and *sayana* of *bhoksa* tribe is consulted for treatment of diseases like chicken pox and cholera (Singh 2004).

Often, different types of traditional healers may be found in one community who perform different functions. For example, Joshi (1981a, 2013) describes the hierarchy of traditional healers consulted for various illnesses by the Jaunsari people of Uttarakhand, where the priest cum astrologer, the *baman*, and the diviner cum shaman, the *mali*, deal exclusively with personalistic attributed *dos* whereas herbalist and pulse specialist *jariyara* and the female specialist deal with naturalistic illnesses called bimari.

Similarly, the *anals* of Manipur (Hemlata and Kumari 2004) differentiate between two types of *athim* (physician)—the *larni* (those who are possessed by spirits) and *patakang* (those who heal without being possessed).

Among the *suskal* of Gujarat (Das 2004), the shaman is known as *bhua* who is consulted for various chronic and other ailments thought to be due to supernatural

causes while other types of healers are snake-bite specialists, local herbalist or *vedji* in addition to practitioners of allopathic medicines.

The hill *korwa* of central India depend traditionally upon the services of *ojha* as diviner and shaman, village priest *baiga*, spiritist cum medicine man *panda*, while herbal medicine is taken from herbal specialist called *dewar* (Khatua 2013). Similarly, the Birhors of Chattisgarh also rely on ojhas for ailments related to supernatural causes. The tribal doctor among the *kamars* of Chattisgarh is called *gunia* who performs all types of healing from herbalism to shamanistic. *Gunia* is usually consulted along with the free medical treatment available to them through government health centres (Sinha and Banerjee 2013).

The religious specialist *plathi* among the *kannikars* of Kerala (Menon 2013) are consulted to treat maladies due to *upadravam* or supernatural causes. This is usually done simultaneously to other types of naturalistic treatments and bio-medicine.

The psychosocial aspects of the shamans or other faith healers have been widely discussed in anthropology (Devereux 1961; Lewis 1971; Taussig 1987; Eliade 1961). In the context of shamans in Indian communities, a few studies highlight these psychosocial aspects. Joshi (2010) discusses the processes leading to successful initiation of a shaman among the *jaunsaris* of Uttarakhand. Here a shaman is seen not only as a person who provides family therapy and counselling to psychosocially troubled people but also as a psychosocially rehabilitated person himself who by virtue of effective and culturally valued rehabilitation, has been able to gain better healing for himself which he then perpetuates to others. He, through his therapy, not only mitigates the various illnesses but also acts as an agent of social justice and functioning according to the cultural norms.

Faith-healing is prevalent not only in indigenous tribal groups but also in various rural and urban communities belonging to organized religions. Faith-healing in *dargahs* and temples like Balaji in Rajasthan also contribute to traditional ways of healing of the psychologically affected (Joshi and Vashist forthcoming).

Ecology, Health and Ethno Medicine

Medical anthropology has always been ecological in its orientation which deals with the inter-relationships between humans and their environment, combining the biological and sociocultural dimensions that determine health and illnesses. Though nature provides its own determining limits to the availability of resources and orientation of certain diseases more than other, the sociocultural dimensions of health govern many different factors ranging from social cognizance of 'food' from amongst the available sources of nutrition, various aspects of environment-specific diseases and cultural institutions to deal with them as also the cultural factors that trigger disease and the environment in which the patient gets after-care or treatment (Bhalla 2013; Gadekar et al. 2013). Also, the cultural norms of marriage and mating also play a central role in perpetuation of certain genetic disorders through the effect of inbreeding (Ramachandraiah 2013).

Owing to the pathological and sociopsychological dimensions of illnesses, ecology occupies a central place in determining the health of people occupying a certain niche. Various dimensions become significant of which nutrition is preliminary. Nutrition, as a bio-cultural feature, is determined by availability in the natural environment, however, what becomes available to humans is culturally determined and defined as the edible part of all sources of nutrition, known as 'food' (Foster and Anderson 1978).

Various communities in India classify food according to the prevalent ayurvedic tridosha theory where food is believed to be of *vayu*, *pitta* and *kapha* nature which is further categorized as hot and cold. This classification of food determines the edibility of food according to various beliefs of body-functioning and processes as also environmental concerns like for illnesses caused due to hot elements like sunstroke, it is believed that eating cold nature foods like curd would provide relief.

The *bettakuruba* of Karnataka (Vijayendra 2013) classify food into hot or *churuka*, cold or *thampu* and gaseous or v*aya* substances in accordance to the *pitta*, *kapha* and *vaya* elements in these. Thus, during summer season cold foods like jackfruit, guava, banana, millets as *ragi*, meat of pig and sheep are preferred while during winter and rainy season hot foods like fried vegetables and cereals are preferred. The native beliefs lead them to totally discard egg, chicken, raw papaya consumption by pregnant women. Also, gaseous foods are to be avoided during pregnancy while foods like bottle-gourd and papaya are known as milk-enhancers and encouraged during lactation.

The *savara* women of Andhra Pradesh (Narahari 2013) deny the new-born the first milk or colostrum by squeezing it out and alternatively feed the new-born sugar water or honey or castor oil to clean the digestive tract. The same is also true of other tribes like *gadaba* and *porja*.

Pasuvula Banda of Visakhapatnam (Subramanyam 2004) have a taboo against consumption of their own totemic plants and animals. Extensive dietary restrictions are placed on pregnant and lactating mothers that may or may not be in sync with that of nutritional requirements as per the bio-medical standards. Prohibitions like consuming liquor are beneficial while on the contrary those like prohibition of fish, meat, eggs and vegetables like pumpkins, cause a substantial protein deficit in pregnant and lactating women.

Due to ecological factors, certain diseases caused due to vitamin A and B deficiency are also prevalent, so are those pertaining to skin and urino-genital tract due to constant contact with microbes in their immediate environment. Similarly, infant and child mortality as well as maternal health are important concerns in many of the indigenous groups in the country. Among the *moyons* (Moyon 2004), main diseases among the children are air and water borne like chicken pox, whooping cough, fever, cold diarrhoea, dysentery, jaundice, cholera, typhoid, etc.

Nutritional anaemia has been a consistent factor for low health among most women in indigenous communities (Paliwal 2004). Coupled with factors like malarial environment, genetic abnormalities like thalassemia, G6PD deficiency and sickle cell disease, this constitutes major disease burden among the indigenous population. For example, *Birhors* and hill *Korwas* (Sinha and Banerjee 2013) report

a high incidence of nutritional anaemia, more in women due to heavy workload, low dietary intake and burden of multiple pregnancies as well as diseases like cataract, thalassemia, etc. while sickle cell trait is absent unlike most of the tribal groups in India.

Ethno-Medicine in Interaction with ISM and Biomedicine: Current Issues

Owing to the immense ethnic diversity of India, there is a great variation in the nature of health seeking among people across country. In the face of illnesses, different communities seek different types of medicine based on their cultural beliefs and availability of health resources. Though every community possesses its own intrinsic knowledge of various ailments and resources needed to cure these, often pragmatism in healthcare leads them to simultaneously seek other options available. The Indian medical system comprises several locally based and valued ethno-medical systems under an over-arching pan-Indian systems of Indian medicines like ayurveda, unani, siddha, etc., which is further diversified by a hegemonic western or bio-medicine. With the proliferation of Western medicine worldwide, there have been sustained efforts on part of the government to allocate modern health resources and personnel to indigenous areas.

Medically pluralistic societies deal with numerous aspects that are of interest to the medical anthropologist like, decisions influencing selection of available medical systems, role expectations of patients, clientele, patient–healer interaction and patient satisfaction, notions of efficacy, treatment and types of cure, placebo effect, interaction of various medical systems, strengths and weaknesses of indigenous systems vis-à-vis medicine. In context of national medical systems, questions of mainstreaming the ISM, interaction of ISM and ethno-medicine as well as successful incorporation of western medicine, its extent and reach, issues in outreach and acceptance are also of significance. Also, the essential premise that a medical system needs to always be analysed in terms of cultural background and the total social system, makes the issue of interaction between various medical systems a complex one.

Owing to the resource limitation in healthcare sector in highly populated and diverse countries like India, there is a strong need for integration of ethno-medicine and ISM to the mainstream model of healthcare that focuses heavily on western medicine. Of late, attempts have been made to incorporate AYUSH in national policies for health delivery but ethno-medicine still lags far behind due to various reasons. The foremost among such reasons is a lack of documentation of the native systems of medicine, others being lack of ‘scientific’ evidence, loss of bio-diversity leading to reduction in ethno-medical base of pharmacopeia, informal nature of healing that is difficult to incorporate in a formal nationalized system, hierarchical and distrustful role of professional healers for traditional ones, insufficient cultural sensitivity, etc. (Banerjee et al. 2013; Reddy 2013; Kakar 2013).

Conclusion

Ethno-medicine is a rich field of enquiry in the discipline of medical anthropology. Cross-cultural in nature, it aims at not only documenting the indigenous beliefs about the concepts of health, illness, disease and healthcare but also an applied interest in studying and implementing the trajectories of efficacy, utility, cultural validity and interaction of ethno-medicine with professional medicine for the betterment of healthcare in a multi-cultural world. In India, as also other developing nations, where professional healthcare is heavily affected by limitations in health resources and personnel, an effective health planning needs to incorporate locally available resources for wider health coverage.

As such, medical anthropology with its emic and culturally situated perspectives is of great significance in bridging the gap between healthcare demand and availability with its grass-root oriented and practical interventions through the studies of indigenous medical systems. Various dimensions pertaining to the ethno-medicine in India have been covered in this chapter which deal with issues ranging from conception of health and illness, etiological dimensions, healing beliefs and traditional healers as well as interaction of ethno-medicine with other systems of medicine like the Indian systems, viz., ayurveda, unani, etc., and the Western medicine system or allopathy. Various empirical studies have consistently described the ethno-medical richness of beliefs, cultural settings, ecology in governing the formation and sustenance of native medical beliefs. These medical beliefs may or may not be syncretic to Western notions but nonetheless form the very basis of the social system of indigenous communities. For effective healthcare in India, the anthropological perspectives on these aspects have immense significance for a culturally acceptable, efficacious and pragmatic healthcare that is accessible to all.

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