ALTERNATIVE MEDICINE AMONG THE URBAN ASSAMESE: A STUDY OF 'MEDICAL SYSTEMS' AS A DIMENSION OF THE SOCIAL AND CULTURAL SYSTEM

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DECLARATION

I hereby declare that the work embodied in this thesis is original and has not been submitted, either in part or in full, to any university or institution for the award of a degree, diploma or certificate.

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Preface

Assam lies at the heart of northeast India. The cynosure of attention of most anthropologists working on the region has been either tribal communities or village life. This study, in that sense, is not a 'conventional' one. It focuses on an urban community, more specifically the middle class and upper middle class Assamese in Guwahati. It is a study of my 'own community', and it seeks to contribute to the field of *urban* medical anthropology.

The focus here is on health as a cultural category. It attempts to view disease not just as a biomedical reality but in terms of illness experiences that are socially constructed and understood within their contextual processes. The leitmotif of the thesis is, therefore, illness behaviour and the resort to treatment alternatives by patients in the event of a confrontation with exigencies posed by ill-health.

It first situates the patient within his social environment and then it proceeds to explore: a) the availability of health care; and b) how they affect the prospective patient's access to resources within the community under study. This entails an exploration of how individual experiences, beliefs, values and lay networks shape perceptions and responses to health and disease, and how they take remedial action and in the process utilize various sources of informal and formal care en route to a search for a cure.

The thesis consists of six chapters and a conclusion. Chapter one explores the emerging perspectives and paradigms in medical anthropology and it attempts to locate the present work against this backdrop. In the process the conceptual framework followed in the thesis and the theoretical models that I draw upon have been delineated.

Chapter Two has three parts and gives a general introduction to the area. The first part begins with a brief description of Assam, its people, religious life, economy and the caste system. The kinship structure and life cycle rituals of the Assamese are briefly described here in an attempt to give an ethnographic backdrop against which I study the cultural orientation of illness experiences later in the thesis. Part two focuses on the city of Guwahati, its development, population pattern, sacred geography and the contemporary medical landscape. The concluding part describes Zoo Narengi Road, which is the neighbourhood under study.

At the outset of the third chapter I present a narrative of my field experiences as a researcher. This is followed by a description of the various research tools that have been employed in the field. A section on fieldwork in one's own community explores the advantages and obstacles that an 'indigenous ethnographer' faces while working in a community to which the researcher belongs.

In the fourth chapter I present local beliefs connected with health and illness of the urban Assamese which is rich in allusions to diet and climate. I furnish a description of Assamese dietetics in use both in everyday discourse as well as on

special occasions like pregnancy. In this chapter, I describe a number of herbal-based domestic remedies that are employed regularly by the people to combat common ailments. There is a section on religion and healing. Ritual healing and the place of the Kamakhya temple within it are located here. This chapter may be seen as being divided into two halves, which can be variously seen as dealing with the domestic and the public or with dietetics and worship.

Chapter Five deals with medical pluralism. A description of the various treatment options that are most popularly used by the urban Assamese is followed by an attempt to illustrate their contrasting perspectives. Institutionalised systems of medicine like Ayurveda and Homeopathy as well as the recently introduced Pranic Healing and Reiki are included here. There is a section on Mantra Therapy, and astrology as a system of healing. The latter assumes significance because of the presence of the Nabagraha temple in the city. The Bathini Fish Treatment has also been described here. Although it is not a part of the medical landscape of the city and is administered only in Hyderabad in Andhra Pradesh, the fact that it has been cited widely by many of my respondents occasions an explication of its basic premises along with the other medical systems.

Entitled 'Therapy, Cure and Prophylactic: the patient's point of view', Chapter Six attempts to understand health-seeking behaviour with a biographical approach. A number of case studies have been presented here to explore how cultural predispositions shape illness behaviour. I have attempted to see how the illness explanation is constructed and the effect of the social environment on it. Patterns of

usage between alternative systems of healing, and the constant interaction with biomedicine, are explored. It is in this chapter that one is truly outside the quotidian space of the everyday, in so far as the event of illness propels the patient onto a journey that often breaks the boundaries of culture, milieu or class. Illness – an event, a crisis and a journey – recasts the cognitive categories of the sufferer during and through his encounter with various systems and often breaks and reconstitutes his frame of his reference.

CHAPTER 1

Theoretical Orientation and Conceptual Model

THEORETICAL ORIENTATION AND CONCEPTUAL MODEL

Illness is a universal phenomenon. It refers to a condition that is experienced by an individual or a group of individuals and for the amelioration of which every culture has a set of prescriptions regarding etiology, diagnosis, preventives measures, and regimens of healing.

Despite the universality of illness, the trajectory that it follows is not uniform across cultures. Individual experiences vary. Moreover, since all knowledge and experience are culturally structured and are products of a particular history, a juxtaposition of various social factors infuses the illness experience with meaning. An understanding of disease and illness in a society, therefore, requires an unraveling of the linkages of manifestations of health and disease and social institutions and cultural values.

On the one hand is the individual, his physiological make-up, susceptibility to disease and his experience of symptoms and, on the other, is his social milieu, which to a large extent, predetermines his interpretation of the condition. Illness, as defined by Auge is, thus, an "elemental event" which is "at one and the same time the most individual and the most social of things" (1995: 24). He argues that its biological manifestations do not simply affect the body of an individual but is, for the most part, the object of social interpretation.

The concept of health has been interpreted at various levels:[1]

1. Health as *having*: where health is perceived as a state of positive fitness

[1] Outhwaite and Bottomore (1994).

or well-being. Implicit in this idea are the concepts of 'equilibrium' and 'balance';

2. Health as *doing*: where health is defined by the ability to function or perform socially prescribed roles assigned to the individual; and

3. Health as *being*: where health is conceived of as a condition where there are no symptoms that denote ill health.

The essential function of medical care in any society is, therefore, to provide remedial services for conditions defined as illness and disease. Most systems of health care provide therapy, cure and prophylaxis in varying degrees. Western biomedicine has established a stronghold in most countries of the world. This system evolved from the empirical medical tradition in the West and consolidated itself as a science in Europe in the nineteenth century. Since then the world has seen dramatic results that have been wrought by biomedical scientists be it in the fields of diagnostic technology in the form of X-rays, ultrasonic scans, or organ transplantation, genetic cloning and mapping of the human genome. Advances in medicine have resulted in improvement in the mortality rates of many parts of the world. However, despite these phenomenal advances in science and technology crucial debates have raged about allopathy and the delivery of biomedical health care. Inequity of medical delivery, arbitrary prescription of antibiotics, social responsibility of a doctor, clinical iatrogenesis and costs of treatment are some of the moot points that have been raised in diatribes against the

biomedical health care system.

Western medical care has been based on suppositions revolving around the doctrine of specific etiology and the universality of the disease taxonomy. Doctors have historically concentrated on the diagnosis and treatment of physiological and anatomical conditions. A change in focus came about in the beginning of the latter half of the twentieth century. The World Health Organization promulgated a definition of health which replaced the strictly biomedical model of health with a more holistic concept.[2] The concept of health became more multidimensional and encompassing and did not refer to just the absence of disease. The definition of the subjective well-being of an individual has gradually changed as psychosocial factors have gradually become recognized as a pertinent dimension in the cause of ill-health.

Anthropological literature is, thus, replete with distinctions between 'healing' and 'curing' and 'illness' and 'disease'. Loudon argues that ". . . some clinical syndromes biologically definable as diseases are not necessarily regarded as disease in all societies; and there are some conditions, culturally defined as illness, which do not fit any category of disease established in external biological terms" (1976:41). An extension of this proposition is formulated by Eisenberg when he writes that "patients suffer 'illness'; physicians diagnose and treat 'disease" (1977:11). It is, therefore, found that the characterisation of illness behavioural and phenomenological indicators into 'health' and 'illness' and 'not

[2] In 1948, the World Health Organization proposed a definition of health as "a state of complete physical, mental and social well-being, not merely the absence of infirmity" (Outhwaite and Bottomore: 1994).

illness' is culturally conditioned and these may be diametrically opposed to the Western biomedical paradigms (Bhasin and Srivastava 1991).

The recognition of the cultural determinants of illness categories finds prominent mention in the works of Kleinman (1978a) Foster and Anderson (1978) and Lock (1980). The incidence of disease too is affected by cultural parameters. Culture shapes important behaviour patterns regarding diet, activity patterns and sexual practices, which in turn may predispose the individual to certain diseases. Besides, people often change the nature of their environment through culture that may, in the long run, affect their health. Thus, one cannot divorce one world from the other.

Perspectives in medical anthropology

As an area of interest, medical anthropology encompasses a divergent range of interests strung together by their common interest in health, disease and illness. Medical anthropology, Good argues, is 'heteroglossic', the socially distributed product of numerous perspectives and opinions. This is necessarily so, he contends, for "disease and human suffering cannot be comprehended from a single perspective" (1994: 62).

The subject has progressed beyond its roots in early ethnographic studies of ritual and religion to a proliferation of research interests. The field now encompasses a wide range of concerns, from the historically predominant cross-cultural study of local health beliefs and practices to the cultural construction of biomedicine. There has been tremendous expansion in the body of literature

relevant to medical anthropology. Tracing a linear development of the field, therefore, is not possible. Besides, such expansion bedevils an attempt to review *all* the debates implicit in the theoretical stances of the writers. A general account of the development of issues concerning health, disease and medical systems has been provided in the following pages in an attempt to try and trace the major paradigmatic changes which have taken place within the field.

Four 'orienting approaches' have been outlined by Good (1994) in his study of the development of medical anthropology:

1. The empiricist tradition where illness is represented as part of folk beliefs;

2. The cognitive tradition in which illness is analysed as a cognitive model;

3. The interpretive or the 'meaning centered' tradition where illness is represented as a culturally constituted reality; and

4. The approach of 'critical' medical anthropology which views illness representations as 'mystification'.

Each of these approaches, Good points out, is distinguished by its specific interpretations of illness. It is the convergence of the rationalist theories of medical beliefs, ecological theories of ethnomedical systems as essentially adaptive, and the analytic primacy of 'choice' in studies of illness behaviour that constitutes what he calls the 'common-sense' or empiricist paradigm in medical anthropology. While cognitive anthropologists are generally inattentive to the

epistemological status of disease, interpretive anthropologists, he writes, place the relation of culture and illness at the centre of analytical interest (ibid.:52).

Although anthropologists like Frazer, Tylor, and their European and American contemporaries had a large body of information on 'primitive medicine', their emphasis was more on religion, sorcery and magic and their descriptions of medical beliefs of non-Western peoples were Eurocentric and pitted against the assumed 'rationality' of the West. Their accounts were, therefore, peppered with colonialist and value-loaded terms like 'primitive', 'magical', and so on.

It was with Rivers, Clements, Ackerknecht and Paul that medical anthropology as an independent sub discipline entered its formative period. Their works typified distinct and important theoretical frames in the field in the early part of the last century.

Rivers (1924) attempted to relate 'native' medicine to other aspects of culture and social organization. He classified the manifestations of 'primitive' medicine as either magical or religious and defined three types of worldviews depending on social beliefs: magical, religious and naturalistic, with emphasis on the first two. His contribution set the stage for medical anthropologists to view medical practices and beliefs as integral parts of culture.

In 1932, Clements formulated a 'culture-trait' approach within which he classified disease causation among 'primitive' people into five categories, namely, sorcery, breach of taboo, intrusion by a disease object, intrusion by a spirit, and

soul loss. Treating these beliefs as isolated cultural elements, he mapped the geographic distribution and the historical diffusion of these traits (cf. Wellin 1977: 50-51). Clements did not relate any function of these folk etiologies to any other institutions of society; instead he brought forth the generalization that every society develops a set of cognitive categories for defining disease.

Though Rivers and Clements had given a base to the study of medicine and culture, it was Ackerknecht's work that first shaped the ground for medical anthropology to emerge as an independent sub field within social-cultural anthropology. He conducted research in libraries and museums and published extensively for three decades beginning in 1942. His emphasis was on the total cultural configuration of the society and the place that the 'medical pattern' occupies within that totality. He highlighted the functional integration among the constituent parts of a medical pattern and between the latter and the overall cultural context. He held that primitive medicine as a system "is primarily magico-religious, utilizing a few rational elements, while [our modern-Western] medicine is predominantly rational and scientific employing a few magic elements" (1946: 467; quoted in Wellin 1977: 52).

Medical anthropology acquired an applied dimension as international welfare agencies led public health and community development programmes after World War II. The first major survey of emerging anthropological interest in the field of health and disease was given by Caudill in 1955 (ibid.). His work expressed the view that for a successful delivery of health care in developing countries the social institutions and cultural beliefs of the people would have to be

studied. Another notable contribution to applied anthropology and public health around the same time was Paul's (1955) formulation of a systemic approach. He emphasised that beliefs of a people in a given community are not independent items but elements of a cultural system, where some elements are central to the system and others are peripheral. According to him, the responses of a given socio-cultural (and medical) system to the introduction of new elements are to be explained by the complex interaction of the nature of the system and the mode of introduction. The socio-cultural (and medical) system may get affected by the introduction of new health related elements and vice versa. Paul's system model, as Wellin points out, permits the medical systems of modern or complex communities to be as appropriate for study as those of the traditional groups. This is in contrast to medical anthropological inquiry which was hitherto restricted to traditional or relatively simple societies in the works of Rivers, Clements, and Ackerknecht.

Another significant theoretical strand developed in the late 1960s when there was a shift in the focus from the social-cultural parameters to biological factors underlying the state of health and disease in a population. This dimension, which included both biological and cultural criteria, was referred to as ecological by Alland (1966). Within this tradition a single disease was adopted as the focus of attention and the effect of biology, culture and environment on its morbidity was observed. The disease specific studies from an ecological perspective signaled a kind of revival of the single trait approach of Clements. Livingstone's (1958) and Wiesenfeld's (1967) work on the sickle-cell trait and malaria, Dunn's

(1968) work on diseases as agents of natural selection affecting population size in hunting-gathering life, and McCracken's (1971) study on lactose intolerance as a biocultural trait, among others, were the main works which ushered in disease-specific studies within an ecological perspective (Wellin 1977). This model served to interpret health and disease as a "... measure of the effectiveness with which human groups, combining biological and cultural resources, adapt to their environments" (Lieban 1973: 1031).

This orientation led various anthropologists to investigate culture-bound syndromes such as *kuru, susto, amok* and *malgri,* among others. These illnesses are recognized only in particular cultures and not across all cultures. These syndromes have received particular attention not only because they are held to reflect issues of relevance within the cultures in which they occur but also because of their exotic nature (Nichter 1989).[3]

Kleinman's work, beginning in the 1970s, on complex medical systems and his detailed ethnographic analyses of illness and healing in Chinese cultures marked the emergence of a distinctive approach in medical anthropology. Ethnomedical systems which hitherto were largely defined in ecological and adaptive terms were seen in a different perspective as he designated the medical system as a 'cultural system'. Kleinman's research in anthropological studies in medicine and psychiatry paved the way for a renewed interest in theoretical developments in the field. He (1978a) proposed the use of what he called

[3] While many are considered to be psychosocial in origin, some, like *susto*, for instance have been found to be linked to organic disease.

'explanatory models' and illness narratives (1988) to elicit patients' understandings of their condition. This served as an entree to teaching clinicians to elicit the 'native's point of view' during their clinical encounters (Good 1994). Around the same time, Nichter (1981) argued that cultural 'idioms of distress' organize illness experience and behaviour quite differently across societies.

Medical anthropological research became more diversified with studies which sought to incorporate the 'patient's point of view' and the individual experience of illness in various cultures. Around the same time the role of therapeutic practices associated with certain healing activities in producing distinctive illness trajectories and efficacy in healing rituals were also investigated. (Csordas 1983; Csordas and Kleinman 1990; Roseman 1988).[4] Within this trend there were attempts to explore the subjective theories of illness and conceptualization of meaning at the individual level. Coping strategies within the context of a serious illness like cancer were analyzed via the perception of self *vis-à-vis* the individual's social environment (Fife 1994). It is argued at this point that the course of chronic diseases is not only determined by biomedical factors but also by way a patient deals with the illness (Schussler 1992). It has thus been demonstrated that a number of psychosocial adjustment processes are necessary when a person confronts a chronic disease and the personal evaluation of threat (illness concepts) has a decisive influence on coping with the illness.

Increasing sophistication of anthropological ideas about sickness and

[4] For more information on this trend,see Good (1994).

disease, therefore, not only led to a tremendous growth of interest in the field of medical anthropology but also witnessed a growing interest in modes of seeking care and illness behaviour. The social idiom of care-seeking was transformed into a tool for rich ethnographic investigations with Romanucci-Ross's (1969) analysis of care-seeking as a 'hierarchy of resort' to European curative practices on the Admiralty Islands. Many researchers subsequently focused on how 'choice points' are organized in a setting which has diverse medical traditions and healers (Kunstadter 1976) and how culture shapes the 'health seeking process' and the ends sought through treatment (Chrisman 1977; Kleinman 1980; Nichter 1980). The context of illness within this tradition is explored in terms of the way 'therapy management' (Janzen 1978b) and referral are organized and via the process of how people enter sick roles and make choices regarding the use or non-use of different kinds of health services (Kroeger 1983).

In an attempt to formulate a conceptual system centered on the 'social and experiential particularities of sickness and healing', Young (1982) like some of his predecessors in the field, distinguishes between 'sickness', 'illness' and 'disease'. He uses the term sickness to refer to all events involving ill health, be these defined in terms of disease or of illness. Disease, he says, refers to pathological states of the organism, whether or not they are culturally or psychologically recognized (the medical definition of ill health). Illness, on the other hand, is used to denote culturally and socially defined or conditioned perceptions and experiences of ill health, including some states which may be defined as disease and others which are not classifiable in terms of medical definitions of

pathological states.

The anthropology of illness, according to Young, focuses on the cognitive dimensions of illness. The anthropology of sickness, on the other hand, focuses on the social relations which 'produce the forms and distribution of sickness in society' (ibid.:268). This approach concentrates not on the experience of illness but on social systems and the social meaning and outcome of sickness. Each society possesses its own set of rules for the translation of signs into symptoms, the definition of illness and the patterns of treatment. Social forces not only affect diagnosis but also the access to different kinds of treatment and therapists by different sectors of the population. At the same time, medical practices are also ideological practices, since as Young notes, "symbols of healing are simultaneously symbols of power" (ibid.:271).

The cognitive tradition in anthropology was ushered in by the ethnosemantics and ethnoscience movement in the 1960s. Cognitive anthropologists working on health and illness focused on developing disease taxonomies and illness categories based on an emic understanding and the structure and rendering of illness narratives in various societies.

Within the cognitive tradition Good developed an analytical device in order to interpret illness as a 'syndrome of meaning and experience' (1977: 27). He proposed the notion of the 'semantic illness network' as the "network of words, situations, symptoms and feelings which are associated with an illness and

give it meaning for the sufferer".[5] Drawing on research on popular illness categories in Iran and from American medical clinics, his work has explored the diverse interpretive practices through which illness realities are constructed, authorized, and contested in personal lives and social institutions[6]. He focuses largely on epistemological issues and addresses the nature of language, subjectivity and social process in cross-cultural studies of illness and human suffering.

A 'critical' approach to medical anthropology has developed in the past decade and a half. Anthropologists in this tradition have emphasised the limitations implicit in the model where emphasis is given more to the ritual and symbolic realm in culture while the political and economic issues which affect health behaviour of populations get obfuscated (Singer 1989). This approach questions the studies that focus on care-seeking alone in the light of whether illness representations are actually misrepresentations which serve the interests of those in power, be they colonial powers, elites within a society, dominant economic arrangements, the medical profession, or empowered men. Health decisions, the proponents of critical medical anthropology insist, are far more constrained by objective social factors and macro-level structures of inequality, than by subjective 'beliefs' or cognitive factors alone. They have, therefore, focused on the distribution of health services and the role of power in health care relationships and transactions.

[5] Blumenhagen (1980) and Kleinman (1978) subsequently described semantic illness networks while explaining the nature of folk illnesses.
[6] Good (1977).

Morsy (1990) has argued strongly that narrow attention to culture and perception ('socioculturalism') has led to the neglect of both local and global power relations which constrain many aspects of the care-seeking process. Such critical medical anthropological studies are an effort to understand health issues in light of "the larger political and economic forces that pattern interpersonal relationships, shape social behaviour, generate social meanings, and condition collective experience" (Singer 1990: 181).

This debate has generated empirical studies which have sought to investigate the relative role of beliefs, about the appropriate methodological locution in understanding the nature of an illness and such structural factors as availability and cost of treatment in determining choice of therapies (Young and Garro 1982; Sargent 1989). This shift in paradigm in critical studies in medical anthropology, as Good (1994) suggests, is in consonance with Young's proposition to develop "a position which gives primacy to the social relations which produce the forms and distribution of sickness in society" (Young 1982: 268).

A distinct theme in the critical medical anthropological discourses has been a set of pointed criticisms of those anthropologists who advocate introducing clinically relevant concepts from the social sciences into medical practice. Taussig warns that "there lurks the danger that the experts will avail themselves of the knowledge only to make the science of human management all the more powerful and coercive" (1980: 12). The call to 'disengage' from the "interests of conventional biomedicine" (Scheper-Hughes 1990: 192) has been proposed time

and again (for example Singer 1989, 1990; Morgan 1990; Visvanathan 1997). Good (1994) contends that this critical medical anthropolological stand emerged both 'in conversation with' and in reaction to the interpretive approach. In his view an interpretive or meaning-centered approach that remains 'conversant with critical theory' is essential if medical anthropology is to comprehend the claims of medical science and biology while still recognizing "the validity of local knowledge in matters of sickness and suffering" (ibid.:63).

Cross-cultural studies of nonbiomedical health care systems

The late 1960s and the 1970s ushered in a growing body of academic work on 'ethnomedicine' along with studies on medical ecology and epidemiology.[7] Adherence to and choice between different medical systems, especially 'folk' medicine, became the focus of research.

While new methodological ventures burgeoned in the West with the introduction of the ethnoscience methodology, Frake used this ethnosemantics model for eliciting and analyzing the 'emic' taxonomy of skin diseases in a study of the Subanun of Mindanao. Taking into account the cognitive processes rather than sociocultural factors, he stated that, ". . . disease is not only suffered and treated but also talked about, disease concepts are verbally labeled and rapidly communicable" (in Landy 1977: 185). Fabrega and his colleagues later elaborated Frake's techniques and used the ethnosemantic techniques in investigating the Zinacanteco ethnomedical system in Mexico (Fabrega and Silver 1973).

[7] For more information on this trend see reviews by Scotch in 1963, Fabrega in 1972, and Colson and Selby in 1974.

Subsequently, Press (1978) argued that 'folk medical systems' are characterised by a high degree of shared knowledge between the public and the practitioners and this serves as an effective social control mechanism.

In the Indian context, many surveys and researches were undertaken by both Indian and foreign sociologists and social anthropologists - most of which were basically exploratory and touched on a variety of aspects of the medical sub-system. The three important categories of persons who evinced keen interest in the medical field were - social anthropologists and sociologists; medical scientists who attempted to use this knowledge in medical practice, research and education; and health administrators who required this knowledge for formulation of policies and the evaluation and implementation of health programmes. These approaches provided an analytical framework for studying and interpreting the variegated medical sub-systems of folk and tribal therapeutic traditions within the larger system of health care.

Most of the research on traditional systems of medicine attempted to study them as systems of values, beliefs, knowledge, tools and techniques, as also organization of roles, activities, and relationships. These systems were mainly viewed with reference to:

a) Their distinctive notions regarding various aspects of food, disease, health, human anatomy and physiology, (Khare 1962) etc.,

b) Their important differences in the institutionalisation of norms and expectations, in medical techniques and in procedures for making

diagnoses and prognoses (Marriott 1955); and

c) Their organisation of persons, roles, groups and categories. (Mandelbaum 1970).

Comparative studies of health care systems within the Great Tradition drew attention with Leslie's (1976) edited book on *Asian Medical Systems*. This lead to more developed research and cross-cultural studies on Great and Little Traditions of medicine and healing in Asia, Latin America, Africa and the Middle East. The hegemony of Western biomedicine was questioned and it was shown to be one system among many others. Many of the traditional systems of healing were shown to be more holistic in approach, taking into account social relations and personal beliefs of the patient in comparison to the impersonal curing in biomedicine which views disease as a biological condition and transcends social and cultural contexts (Fabrega and Silver 1973).

Cultural studies of Asian therapeutic systems, more particularly Japanese, Chinese medicine and Indian systems of healing burgeoned in the post seventies period (Lock 1980; Ohnuki-Tierney 1984; Farquhar 1987; Nichter 1989). Non-Western epistemologies, especially systems of medicine in Asia have been read as intellectually coherent systems which are embedded in distinctive cultural premises and symbols (Leslie and Young 1992).

Medical theory and practice in Ayurveda has been extensively studied from various angles of vision; as a means of curing disease and restoring humoral imbalance in the body and as a system of knowledge within the realm of science

and culture (Trawick 1987, 1992; Obeyesekere 1976; 1977, 1992; Leslie 1992), as embodying health, physical fitness and good health (Alter 1999) and its evolution as a professionalised system of knowledge in a modern state.[8] The study of the structural logic of Ayurveda by Zimmerman (1988) is considered to be one of the seminal works on this medical system.

Studies of various pluralistic medical settings have not only focused on the different medical practices *per se* but also on patterns of usage between systems and the reasons for their survival in competitive situations. It has been suggested that plural systems survive because each system is used for different purposes; the choice may be disease-specific, or may stem from personal affinity for a particular treatment. Sometimes social, linguistic, or ideological characteristics of the physician have also been identified as reasons for resort. Waxler-Morrison (1988) finds no significant differences between the practices of Ayurvedic and allopathic physicians in Sri Lanka, except the suitability of the allopathic medicine they prescribe and the cost of their services. Each system in Sri Lanka, she finds, provides unique services to persons who select treatment in that system. She suggests this as the reason for the survival of both the systems where each system survives because it fulfils specific functions for certain sick people in society. Obeyesekere presents another line of argument for the persistence of Ayurveda in Sri Lanka (1976). Ayurvedic beliefs about cause and cure are shared by the patient and the physician insofar as they are part of a 'shared culture'. He subsequently suggests that the patient thus is able to comprehend the treatment of his illness

[8] Also see Zimmerman (1992): and Nordstorm (1988)

whereas treatment in a Western medical idiom is 'culturally alien and psychologically implausible' to the patient (1977:177-178).

Linking of different medical traditions to supplement and complement each other for advancing primary health care goals has been proposed at various levels. It has been recognized that traditional medical care systems address the psychological well-being of individuals in traditional cultures (Neumann and Lauro 1982). Therefore, the integration of medical systems, more particularly of biomedicine with nonbiomedical systems, has been studied in the light of improving health care services.

Classification of medical systems

Several researchers in the field have attempted to present categorizations of medical systems worldwide in order to pigeon-hole all systems of healing into a particular standardized framework.

Dunn (1976) posits a classification based largely on geographical and cultural influence in his demarcation between local, regional and cosmopolitan medical systems. Each medical system in his scheme evolves to meet a peoples' conception of their health needs. The distinction between Little and Great Traditions may be referred to while cognizing the continuum of different types of medical systems. *Local* systems, according to him, are indigenous and restricted to a particular geographical area. This group includes folk curers who may be part-time, self-taught practitioners. *Regional* systems have standardized practices and extend over a larger geographical area although they too are indigenous, Ayurveda

being offered as an example of this system. Specialists within this system are trained either under tutelage from an expert or in academic settings. *Cosmopolitan* systems are distributed globally. Leslie, Dunn and others use this label to signify the allopathic system of medicine but Press (1980) argues for Homeopathy to be included in this category as well if the defining criterion is just its world-wide distribution and transcultural presence.

Kleinman has suggested that in most developing societies there are three overlapping sectors of health care which he terms as "social arenas within which sickness is experienced and reacted to" (Kleinman 1978: 86). The *popular* sector includes lay, non-professional, non-specialist people who probably offer more advice about health maintenance and improvement as about illness. The *folk* sector, which may be sacred or secular, includes a large range of people. Religious counselors, advisors like astrologers, clairvoyants, palmists as well as lay and alternative healers who may advocate Acupuncture, Homeopathy, Radionics or massage. The third and *professional* sector comprises the organized, legally sanctioned healing professions which includes physicians of various types as well as paramedic professionals like nurses, midwives and physiotherapists. A sick person moving between these sectors encounters divergent medical languages, epistemologies, explanatory models, and activities since the clinical realities in each of these sectors differ.

En route to defining medical systems as 'socio-cultural adaptive strategies', Foster and Anderson (1978) identify two distinct etilogical concepts underlying their classification of medical systems. The *personalistic* system

comprises beliefs that illness has been caused by an active, purposeful intervention of a 'sensate' agent who may be a supernatural being, a non-human being or a human being. The *naturalistic* system, on the other hand, identifies the cause of illness to be impersonal and systemic. Health, in this idiom, is believed to prevail when the 'insensate' elements of the body, the heat, the cold or the humours are in equilibrium. When this equilibrium is disturbed, illness results. This model, as suggested by Kleinman (1978b), implies a cognitive consistency that may not be apparent in all spheres of health care. There could often be, as Kleinman points out, a combination of explanatory models for the same sickness episodes. Besides, it fails to recognize the influence of culturally constituted beliefs on lay attitudes toward health and normal bodily functions. This dichotomy is thus considered to be outdated and insufficient.

CONCEPTUAL MODEL

As the title of the thesis suggests, I seek to explore alternative medicine among the urban Assamese with an emphasis on how these 'medical systems' are a part of the social and cultural system. This includes a focus on the various ways in which the urban Assamese defines, interprets and reacts to symptoms and the subsequent adherence patterns to different modes of treatment during the course of illness. A baseline model I have used in delineating the experience and management of illness is the concept of illness behaviour as outlined by Mechanic (1982). He defines it as ". . . the manner in which persons monitor their bodies, define and

interpret their symptoms, take remedial actions, and utilise the health care system" (ibid.:1).

Illness is not a static category. The trajectory of illness beginning with the onset of symptoms and the subsequent search for remedial measures for the condition takes various lines of development. During this time, the condition may worsen or the patient may find a cure; there may be instances where a complete cure is not found and the patient has to reconcile with a case which is 'controllable' (like diabetes). Besides, there are cases where a state of 'non-life' is sometimes reached - as in the case of coma. The ultimate denouement in life-threatening cases is death.

Illness is approached in various ways. the individual may contend with the problem on his own or advice may be sought from within the household or the extended kin group (the 'lay referral system') or expert counsel may be sought from medical specialists.[9] Thus, I do not study illness just 'as it is' as is read by functionalists, but as a *continuum* or as a *process* where I focus on its diachronic perspective by delineating the past, the present and the future aspects of the condition. For this purpose I use the 'processual' approach. The context of illness within this tradition is explored *vis-à-vis* how people enter sick roles, cope with the situation and make choices regarding the use or avoidance of different kinds of health services

[9] Friedson conceptualized the 'lay referral system' in which he stressed the importance of 'a network of potential consultants' from the nuclear family and other possible lay referents before reaching the 'professional' in 'the process of seeking help' (1960:377). This approach developed in opposition to

Suchman (1965) was the first to analyse the process of illness behaviour as a logical sequence of steps in health seeking behaviour. Drawing on the components of the health seeking process which were outlined by Suchman, Fabrega, and Chrisman, Joshi (1984) has discerned certain pathways in the decision making models which are inherent in the healing process:

Stage I: *Presentation of the symptom and its recognition*: This stage marks the onset of the illness episode. The person recognizes the beginning of a particular discomfort and tries to casually cope with it on an individual level. Certain preventive and remedial measures based on available personal knowledge and resources are used in an attempt to get back to the original state of good health. No significant change occurs in the regular activities of the person and no consultations are sought from any specialist.

Stage II: *Acceptance of the sick role*: This stage commences with the increase in the severity of the symptoms. Unable to cope with the management of the experience on one's own the individual solicits the help of the larger social group. The members of this group take the responsibility of taking decisions and prescribe norms for the behaviour of the patient who is ascribed a special sick role which is socially legitimized.

Stage III: The *Therapy Management Group*: This group comprises

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the synchronic study of medical phenomena which presupposes the monolithic cause and effect equation.

members of the family, friends, neighbours and other related people. They evaluate or examine the severity of the illness, the social and economic costs while negotiating with various possible therapeutic alternatives and formulate strategies for appropriate action. They aid in making the experience of illness a meaningful process.

Stage IV: *Therapeutic action*: Culturally prescribed ways of dealing with the particular illness are routed by the Therapy Management Group (TMG) for building further strategies of action. The patient may either be subjected to self medication which requires no intervention from any external agency, often adhered to in the initial stages of the illness experience, or consultations may be sought and treatment taken from various health care systems which may belong to the folk, lay or professional sectors. At each stage the outcome of the treatment is weighed and further courses of action taken.

Stage V: *Adherence:* This is usually the end point in the health seeking process. In this stage the illness may be completely overcome, that is, the patient has been healed, or it enters a realm where the illness assumes a chronic dimension. The third possibility occurs in the event of the illness progressing to a point where the aggravation of the symptoms without a cure leads to death of the

patient. The wider social group of which the individual is a member plays an important role in handling these eventualities.

It is not imperative that all the stages of the health seeking process are played out in every case. It is possible that the illness episode may be curtailed at a point if healing is achieved by self medication alone. In this case, the TMG does not come into effect at all. Again, there may be cases where the patient assumes responsibility for himself and seeks therapeutic counsel on his own without referring to the members of his social group. He may take individual responsibility for his condition instead of 'surrendering' the management of illness to the 'significant others' (ibid). Thus, although most of these stages are discernible in episodes of illness behaviour in the event of seeking health care, they are not sacrosanct entities which are applicable to *all* cases.

It is not possible to describe cultural phenomena without taking into account the ideas of the participants (Sperber 1985). My interviews revealed that most conditions exist in the plural, that is, there are a number of ailments which are reported in the biography of a single individual. During the rendering of life history accounts of illness episodes I would often encounter references to several ailments and resort to different medical systems on the basis of the perceived seriousness of the illness. For example, a cold and say a fracture are both considered illnesses but there is a distinct hierarchical difference between these conditions. Thus, the principal method of collecting information pertaining to individual illnesses over an extended period of time was through 'medical biographies' of the actors.

For the analysis of my data, I use Geertz's (1973) hermeneutic paradigm. He defines culture as 'webs of significance' which provide people with the ways of thinking that are simultaneously models of and models for reality. The interlocked system of symbols within this meaningful context, he suggests, should be explicated by 'thick-descriptions'. He argues that the way to analyse cultural phenomena is to search for and interpret the subjective meanings by ". . . sorting out the structures of signification . . . and determining their social ground and import" (ibid.: 9).[10] This involves not only the actor's own interpretation of phenomena but also the anthropologist's interpretation of the actor's interpretation. I borrow this model to enable me to formulate a framework to assess how people give meaningful form to health and illness and how illness behaviour is subsequently determined.

Medical system as social and cultural systems

The terms 'medical system' and 'health system' have often been used synonymously. Although in many cases this overlapping of terminology would not jeopardize the concept in any drastic sense, it is nevertheless useful to identify their different meanings for the proper delineation of their concepts.

Health systems may be said to comprise the whole array of components of the broader social system which are related to the health, including the physical, mental and social well-being, of the population (Pedersen and Barufatti 1989). Medical system, on the other hand, generally implies a single system with

[10] Within this tradition reality, as Sarantakos writes, "is socially constructed through interaction and interpreted through the actors and is based on the definition that people attach to it" (1998: 36).

technologies and services specifically designed for the development and practice of medicine and more specifically an organised system with hospitals, professional associations and regulatory agencies that train practitioners and administer services for the prevention, care, cure and rehabilitation of the ill person. Press (1980: 47) defines a medical system as "a patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention, and treatment of sickness." However, for the purpose of the thesis, I would prefer to apply a more inclusive definition as proposed by Leslie (1980) and consider the medical systems as pluralistic structures where there is a competitive and complementary realtionship between medical practices in the management of disease and illness.

I find Pedersen and Barrufati's delineation of the characteristics of a medical system particularly useful in my study. They define each system as conceived of in terms of a more or less organised set of technologies (comprising materia medica, drugs, herbs or procedures such as divination, surgery or acupuncture) and practitioners (doctors, therapists, shamans, bone-setters, herbalists, midwives). These practitioners in turn adhere to their own 'ideological substratum' of concepts, notions and ideas which are a part of the cultural repertoire of a society (Pedersen and Barrufati 1989: 487). This takes into account not only the allopathic system of medicine but also those medical traditions which I have termed as 'alternative' in my thesis

I have used the word 'alternative' for therapies of healing that are based on theoretical formulations which are distinctly different from allopathy. I do not

imply that the users of these 'systems' adhere to any particular alternative way of life although at the level of the systems the approach to sickness and healing are markedly different from the biomedical paradigm. I have, used the term in a generic sense to include those systems *other than biomedicine* which happens to be the dominant medical system in Guwahati. Thus, I have used the term 'non-biomedical' interchangeably with 'alternative' in the chapters that follow.

Medical systems are anchored in institutions and interpersonal interactions within a cultural matrix which predisposes the understanding of these systems. I borrow Geertz's (1973) formulation which he used for analysing religion, and later art (1983), to study the systems of medicine and healing in my field area. The first stage involves an analysis of the systems *per se* in an effort to unravel the meanings embodied in the make-up of the medical system and the next stage attempts to relate these systems to social and cultural processes of the urban Assamese community.

This interpretive approach in medical anthropology is also discerned in Kleinman's (1978a;1980) model of medical systems as cultural systems.[11] A cultural system, as he uses the concept, is a system of symbolic meanings fixed in patterns of interpersonal interaction and social institutions. Since patients, healers and illness and healing are all embedded within social relationships and symbolic meanings they cannot be extracted from context and understood in isolation from one another. Kleinman's formulation of medicine as a cultural system, like

[11] The concept that a medical system is composed of ideas that are drawn from the cultural context is also emphasised by Foster and Anderson (1978).

Geertz's earlier formulations of religion and ideology as cultural systems, rests on phenomenological interpretations and beliefs, judgments, and behaviours that both constitute, and are expressed in, these processes. Disease, within this tradition, is not seen as an entity by itself but as a model which not only explains the culture of medicine but the meanings attributed to it by the people - the cultural shaping of illness realities.

The idea of a medical system as a social system was originally initiated by Parsons (1951). In his analysis of the structure of the patient-physician relationship, he argued that physicians' and patients' roles comprising the clinical relationship were to be viewed within the framework of the overall social system. While illness implied a significant disruption of the normal role performance, the patient's obligation to cooperate with competent medical authority constituted a mechanism for containing this disruption. The norms establishing the physician's authority over medical matters were derived from a larger context of social relations. The response of the social system to the problem of illness conditioned this normative arrangement.

The role of a sick individual, according to Parsons, in society is sanctioned and institutionalized. The sick is not in a normal state as he is unable to enact roles prescribed by the society. It is the duty of the physician to help him achieve normalcy. Thus, the doctor and the patient are assigned roles according to the dictates of social norms, values, beliefs, etc.

The relationship of the individual to the social and cultural milieu, thus,

plays a crucial role in the construction and presentation of the illness experience. While some proponents adhere to the saliency of either the social or the cultural configurations in studying medical systems, others argue that both cultural (ideational, practical) and social (structural, organizational) concerns should occupy places of equal importance within the analysis of a medical system (Press 1980; Foster and Anderson 1978). Thus, an analysis of a medical system must involve a description of the social structure, the social organization and the belief system but must also demonstrate how this relates to the total cultural idiom in which it is embedded (Lock 1980).

Medical systems are therefore conceptualized as a network, a social system as well as a cultural system. Viewed as a network, it implies the search for relations between individuals, groups or institutions and which of these have priority over the others depends on the analytical perspective of the researcher. Treating it as a social system implies functionally related social relations which includes rights and duties, beliefs and values. As a cultural system the focus is on beliefs, values and attitudes which are functionally related with sickness and death.

Within the rubric of this theoretical backdrop my thesis serves to explore illness as a cultural category. On the one hand, at the level of illness behaviour, the focus is on the individual patient and his family; on the other hand it seeks to explore how the alternative medical systems which the actors resort to in the event of ill-health are entrenched within the overall social and cultural system. This

model not only allows a better understanding of the knowledge of the individual patient but also the culture within which the individual is anchored.

CHAPTER 2

An Introduction to the Area

AN INTRODUCTION TO THE AREA

Part I : Assam

Located between 89° 46′ and 96° east longitude and 24° to 28° north latitude, the state of Assam lies in the northeastern corner of India. It shares its borders on the north and east with Bihar and Arunachal Pradesh, on the south with Nagaland and Manipur (with Mizoram on the extreme south), with Meghalaya on the south-west and on the west with West Bengal. Bhutan and Bangladesh are the surrounding foreign countries. It has a total geographical area of 78, 438 square kilometres.

The word 'Assam' is an anglicized derivation of the Sanskrit word Asom which gained currency during the British rule in the state. Widely believed to mean 'unparalleled' or 'peerless', the word describes the might or the invincibility of the Ahom rulers. Barua (1991) traces another implication of the word which he writes was used to describe the unparalleled scenic grandeur of the landscape of the region.

Assam may broadly be divided into two distinct physical units: the hill tracts of the northeastern and central regions and the plains of the Brahmaputra Valley and the Barak Valley. The Brahmaputra River cuts right across the state dividing the major part of its territory into north and south banks. Fed by the Himalayas in the north and other hill ranges in the south-east, the river is also

known as Lohitya in Sanskrit and Luit in Assamese.[12]

High humidity and heavy rainfall are the two distinguishing markers of the climate in Assam. The monsoons arrive by June and persist till August. The raised plinth and the typical roof structure of the traditional 'Assam-type' houses are built as an adaptation strategy in such a heavy rainfall belt. The sloping *(dusolia)* roofs allow easy outflow of rain water. These roofs were originally made of thatch and palm leaves and the pillars of the houses were made of bamboo and timber as heavy stones and marble were not available easily.

The state has rich flora amidst lush vegetation, with the *kapauphul* (wild orchid - *Aerides odoratum*), which blooms in April, being the most popular flower.

Brief history of the state

The land finds mention in the epics Ramayana and the Mahabharata where it is referred to as Pragjyotisha (which includes not only the present state of Assam and parts of Bangladesh and North Bengal but also the hill tracts on the border of China (Barpujari 1990:1).[13] The earliest epigraphic reference to the region, however, is to be found in the inscription of the Allahabad Pillar which dates back to the fourth century A.D. Here, the present day Assam, then referred to as Kamarupa, is mentioned as one of the *pratyanta* or frontier states outside Samudra

[12] This literally means 'red river'. Barua (1991) suggests that this is probably because of the colour that the river acquires during the rainy season when it cuts through the red soil of the adjoining embankments. It is believed that Parasuram was absolved of his sins of matricide after he washed his hands in this river.

[13] *Prag* implies earlier or eastern and *jyotisha* means astrology.

Gupta's empire (Barua 1991).[14]

The Chinese pilgrim, Hiuen Tsang, also describes the land in his travelogues when he visited the region in the second quarter of the seventh century during the reign of King Bhaskaravarman.

According to *Assam 2000*, the earliest rulers of Pragjyotisha belonged to the Danava dynasty, the most illustrious of them being King Narakasura whose is believed to be the progeny of Lord Vishnu (in his Varaha incarnation) and Vasumati (Mother Earth).[15]

The Tai Ahoms, a Mongoloid race belonging to the Shan group of Southeast Asia, led by their leader Sukapha, migrated into Assam from Upper Burma via the Patkai ranges in 1228. They conquered the local Kachari and Chutia kings and ruled over the land for over six hundred years till the consolidation of Assam by the British Empire. They were known to be valiant rulers who were able to withstand repeated invasions by the Muslims, led by the Turks, and the Koch kings. Meanwhile, Biswa Singha led a powerful Koch army, defeated the local chiefs and established the Koch kingdom in 1515 A.D. He was succeeded by his son, Naranarayan, the most successful of the Koch rulers who integrated large portions of Assam and present north Bengal and established suzerainty over Cachar, Tripura and Khasi and Jaintia Hills. Thus, the Koches in

[14] It is a popular myth that Kama, the Hindu God of Love, had tried to distract Shiva while he was deep in meditation after the loss of his wife, Parvati. When Shiva opened his eyes, he was so enraged that he burnt Kama to ashes with his third eye. According to mythology, it is in this land that Kama regained his form (*rupa*). Hence the name Kamarupa.

[15] Naraka's descendant Bhagadatta finds mention in the epic Mahabharata as an ally of the Kauravas in the battle of Kurukshetra.

the west and the Ahoms in the east resisted the Muslims led by Turbak, a Pathan general, who attacked the kingdom in the sixteenth century. There were as many as fourteen invasions during the reign of the Ahoms and the Koch kings but the Muslims were unable to establish a stronghold here.

However, towards the beginning of the nineteenth century, there was a spate of successive Burmese invasions which resulted in large-scale damage in the entire region. Assam was, therefore, annexed into the British East India Company from the hands of the Ahom rulers of the time in 1826. The Yandabu Treaty was signed. David Scott was appointed the Senior Commissioner of the state. It became a Chief Commissioner's Province in 1874 and it was in 1921 that the state was designated as a separate Governor's Province.

The recurrent invasions and consolidation of the land by various communities during different periods in the history of Assam have resulted in a synthesis of many culture complexes to form a composite culture in present day Assam. Distinct strains of cultural traits found in south-east Asia are easily discernible in many artifacts like the *xorai* (a raised dish with a dome-like cover, made of brass and bell-metal) which is indispensable in most ceremonial occasions.[16] Many temples and the ruins of early Ahom structures bear the strains of Cambodian (Ankor Vat) art as well as that of the Gupta period (Gogoi: 1991).[17]

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[16] I have used the alphabet 'x' to designate the Assamese pronunciation in the relevant words. This could be defined, to borrow Crystal's (1991: 24) definition, as " a sound made by back of the tongue against the soft palate - or velum."

[17] Very few buildings of ancient Assam remain, the only exceptions being those built by the Ahoms. Barpujari (1990) traces this phenomenon to the frequent occurrence of earthquakes in the region.

People of the area

Successive waves of migration over the ages from other places in India as well as abroad, as has just been mentioned, have led to intermingling among populations and the presence of diverse ethnic strains among the people of Assam. In tracing the ethnic history of Assam, Das (1987) has identified strains of two major races - the Caucasoid and the Mongoloid.

The principal migrants to the area were the Austro-Asiatics, the Dravidians, the Tibeto-Burmans, the Mongoloids and the Aryans (Gogoi 1991).[18] The Austro-Asiatics are believed to have been the first people to arrive. They initially lived in the Brahmaputra Valley but later moved to the hills; the present-day Khasi and Jaintia of the neighbouring state of Meghalaya are believed to be descendants of this stock. The Dravidians were the next to arrive; the Kaibarta and the Bania of Assam are considered to be the descendants of this stock. The different Mongoloid populations entered Assam through various routes at different points in history.[19] The ancestors of the present day Kachari, Dimasa, Bodo, Rabha, Lalung (Tiwa) and most tribes living in the neighbouring hills came earlier. The admixture of the Dravidian and Mongoloid stock resulted in the Hinduised tribal group - the Koch who are also called Rajbanshis in the Western part of Assam. The descendants of the Tibeto-Burmans are the Mishing who live in the northern plains of Upper Assam, and the Karbis, living in the Karbi Hills

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[18] Dravidian and Aryan are linguistic categories.

[19] Most of the present tribal groups of the northeast region are descendants of these Mongoloids whom the Veda referred to as Kiratas.

(*Assam 2000*).

The physical division within the state has given rise to two distinct ethnic and cultural groups, the hill dwellers and the plains dwellers. The present day Mongoloid population comprise tribal (Kachari, Rabha, Lalung, Karbi, Mishing, etc.) as well as other communities not defined as Scheduled Tribes who live in different parts of the state in large numbers, namely the Ahoms, Chutias, Morans, Deuris and the small Buddhist communities like the Tai Phake, Aiton, Turung and Duamia. Some of these groups are included under Other Backward Classes in the Constitution of India. The non-tribal population - the Brahmin, Kayastha, Kalita, Kaibarta, Baishya, Jogi, Kumar, Keot, Hira and the Muslim - as defined by Das (1987) belong to the Caucasoid group.

There have been a series of Aryan migrations to the area over the ages, the moderate climate and fertile land perhaps being the two main attractions for the settlers. In the early part of the nineteenth century, with the establishment of tea gardens (beginning in 1815) labourers were brought in from Orissa, Bihar and Madhya Pradesh. The Nepalis came mainly as farmers, first of livestock and then of land, and the Bengalis were brought by the British to assist them in professions ranging from trading to government service. There was a fresh influx of immigrants from East Bengal and Mymensingh with the emergence of Bangladesh after the Partition of India. Among the migrants that are most populous in Assam today are the Marwari businessmen, Bihari labourers, Bangladeshi immigrants and Pathan moneylenders.

The state has sixteen Scheduled Castes and twenty-three Scheduled Tribes.

Language

Assamese is the anglicized version of the local *Axomiya* which is the *lingua franca* in the state.[20] It is one of the official regional speeches of the country and belongs to "the eastern group within the Magadhan subfamily of the Indo-Aryan languages" (Comrie 1987:490). It is a composite language "into which words of both Indo-Aryan and Indo-Chinese origins have crept in" (Barua1991:45). Moreover, pre-Aryan or non-Aryan influences are also discernible in the grammar, syntax and pronunciation of the words. There are more than ten million people who speak this language in the state *(Assam 2000)*. There are substantial pockets of Bengali speakers as well.

Religion

Religious life in the state has long been, and continues to be, dominated by Hinduism although there are followers of Islam, Christianity, Sikhism, Jainism and Buddhism as well.

According to the Census 1991, 71.04% of the people of Assam are Hindus. It is widely believed that Hindu priests and warriors had migrated to Assam and settled in the Brahmaputra Valley under royal patronage at different periods of history. Gradually, they managed to wield considerable influence in the region, as a result of which the tribal rites and rituals of the original inhabitants were

[20] The identification of the people whose mother tongue is Assamese is defined by the Census Report of 1951 as the 'language first spoken from the cradle'. By *Axomiya,* I refer to the people of the Brahmaputra Valley who profess Hinduism and Islam and who speak the language.

replaced by Hindu customs and traditions. Shiva, Durga and Kali became the dominant deities in addition to sacrifice and idol worship which were already being practiced here.

The advent of Vaishnavism towards the end of the fifteenth century was a milestone in the religious and cultural history of Assam. Barua (1991) writes that it represented a revolt against the 'pretensions of the priestly class' and the 'licentious rites' of the corrupted forms of Shaktaism. Sankardev, a religious reformer, led the Vaishnav renaissance in Assam. The leitmotif of his preaching was the worship of one God (in the form of Vishnu or Krishna) through recitation of His name in devotional hymns (*borgeet)* and prayers.[21] Known as *ekasarana namadharma*, this form of Hinduism, as Neog (1991) rightly observes, interdicts the votaries from the worship of any other deity.

Sankardev also founded the *xatra* (akin to the monastery system of the Buddhists) which remains as the epicentre of religious education and associated activities. The holy seats of the *xatra* system, spread over Assam, are Auniati, Dakhinpat, Kamalabari and Goramura. The most important of them is the Auniati *xatra* in the river island of Majuli which stands at the confluence of the rivers Brahmaputra and Subansiri near Jorhat.

The Goxain or Xatra Dhikar, the spiritual or religious head of a *xatra*, occupies a prominent position in the social and religious hierarchy of the

[21] Gogoi (1991:12) contends that Vaishnavites initially used to worship Vishnu but with Shankardev's reformist movement the emphasis shifted to Krishna and the Vedic rituals gave way to singing and chanting hymns (*nam-pradhan).*

Vaishnav society and is highly revered by all. In some *xatras*, Krishna is worshipped as Vasudev, Balgopal, Banshigopal or a Larugopal idol, while in others the Bhagavad Gita is worshipped as the embodiment of Krishna. Congregational prayer halls *(nāmghar)* constitute the venue where men and women assemble (separately) to read the Gita and sing hymns (*nām*). Devotional dramas are also enacted here and in the villages the *nāmghar* serves as an important site for important public gatherings. The largest congregation is held between August and September (known as the month of *Bhado*, according to the Assamese calendar) to mark the birth anniversary of Lord Krishna.[22]

Muslims constitute 24.08% of the total population, according to the report of Census 1991. Islam was reportedly propagated by the Muslim saint, popularly known as Azan Fakir, who came to Assam in the middle of the seventeenth century (Das 1987:7). Many local people embraced Islam during his lifetime.

Social intercourse between Assamese Hindus and Muslims for the past several hundred years has resulted in alliances being forged through marriage which is commonly cited as the main reason behind the many socio-cultural features and festivals (such as Bihu) that the two groups share in common. Moreover, there was no large-scale migration of Muslims to Assam; they came in small numbers over different periods and gradually became part of the greater Assamese community (ibid.).

The British annexation of Assam in 1826 heralded the entry of Christianity

[22] For Assamese calendar, see Appendix II.

to the state. The Christians, most of whom are tribal, constitute a relatively small community, comprising 4.5% of the total population of the state (Census 1991).

There is a small population of Sikhs who are mainly concentrated in the Nagaon district of the state. They consider Assamese as their mother tongue. Communities with names such as Khamyang Aiton, Tai Phake, Turung and the Duania are Buddhists found in Upper Assam.

The predominant deity among the Hindus today is Shiva who is worshipped by different names (Burra Gosain, Mahadeo, Rudro) by members of different sub-communities within the state. Incarnations of the Mother Goddess are also worshipped in different parts of the state. There are many Shakti *piths* although Shiva temples outnumber any other site of worship in number. Durga Puja is held on a large scale in most places. Saraswati Puja and Biswakarma Puja are also celebrated. Evidence of nature worship is found during the Bihu festival. Traditionally cows are worshipped on Bohag Bihu, basil plants worshipped on Kati Bihu and fire is worshipped on Magh Bihu.

There is a relative absence of strictures on fasting and extreme rules of renunciation in Assam which are imposed on the adherents of the Hindu religion in some other parts of the country (Gogoi 1991). Eating of fish and mutton are not considered taboo, even among the Brahmins.

Economy of the state

Almost 89% of the population in Assam lives in rural areas(Asam 2000). A Majority (75%) of the total population of Assam is directly or indirectly

dependent on agriculture and 69% of the work force is actually engaged in agricultural activities (ibid.). Rice, which is the staple cereal crop, is raised extensively throughout the state.

Handloom and sericulture are the most important cottage industries of the state. Earlier all women were required to know weaving which was considered as a skill in all strata of society, irrespective of caste affiliation. All the clothes worn by the Assamese would be woven at home. In villages, most houses have looms and women weave items like the *gamusa* (towel) and mekhela sador (the Assamese dress).

Sericulture is undertaken for production of the famous local silk yarns - *endi*, *muga* and *pat*. Sualkuchi village, located near Guwahati, is the epicentre of this weaving industry. Production of cane, bamboo and bell-metal also form important industries of the state. The most popular artifacts which are infused with rich cultural connotation are the *japi* (a flattish, round hat) traditionally used in the agricultural fields to protect the skin from the harsh rays of the sun and which is now ornamented with different designs, and the *xorai*.

Assam has a rich assemblage of natural resources. Almost half the tea produced in India is grown in Assam. 600,000 workers are engaged in the tea industry and 3.4 lakh people are dependent on it. Crude oil is supplied by the oil fields in Digboi (the oldest oilfield in India), Naharkatiya and Moran. Coal is found mainly in Ledo and Nazira. Timber and plywood are the other important products of the state.

The Caste System

The caste groups are hierarchically arranged but the differences between them are not very rigid. Social interaction between different castes is amiable. One of the main reasons behind this liberal ethos, as suggested by Das (1987) could be the influence of the Vaishnavite doctrine preached by Sankardev which emphasised equality and fraternity. Another reason could be the fact that prior to the influence of Aryan culture which made its presence felt much later, the socio-cultural background of the non-Aryan settlers was not conducive to the spread of casteism (ibid.).

At a more generic level, the caste Hindus can be divided into Brahmins (*bamun)* and non-Brahmins (*xudir:* Sudra), the latter embracing several castes of different hierarchical positions (ibid.).[23]

The Kayasthas, mainly found in Lower Assam, occupy a distinctive position in Assamese society. They are traditionally believed to have been officers and scribes and are considered to be part of the pan-Indian Kshatriya caste. Like the Brahmins, they are not supposed to plough land.

The Kalitas are the largest caste group in Assam. They were once a powerful caste who equated themselves with the Kshatriyas of ancient Assam (Barooah 1993:114).

The Scheduled Castes in Assam constitute 7.2% of the state's total population (Census1991). The Kaibarta, Namasudra, Patni, Malo, Hira, Dhubi,

[23] It is interesting to note that some respondents from my field area would not include certain castes like the Kayastha within the *xudir* group.

Bania and Mali are some of the Scheduled Castes in the state.

The Ahoms, members of the Tai or Shan group, migrated to the Brahmaputra Valley and consolidated the land in the early part of the thirteenth century. Hindu beliefs and rites were gradually assimilated in lieu of their traditional rituals and practices and ultimately they adopted Hinduism by the sixteenth and seventeenth century (Barooah 1993). Their position in the caste hierarchy is, however, not specified and they constitute a distinctive community by themselves.

Kinship, family and marriage

As in the case in other societies, two categories of kin *(atmiya)* are commonly recognized in Assamese society - agnates or those related through 'blood' *(tejor xamparka)* and affines or those members whose relationship is forged through marriage *(mitir)*. It is believed that closest genetic connections imply highest 'degree of shared blood' (Bhattacharjee and Bhagabati 1996: 377). *Mitir* are considered as affinal kin not only of the individual concerned but also of the entire family of which he is a member. Bhattacharjee and Bhagabati clarify that all affines are not, however, included in the category and identifies the *kutum* as a 'residual category' of affines (ibid.). A man's *mitir* would be *kutum* to his sons and in the next generation these *mitir* are transformed into *kutum*. The term *mitir kutum*, therefore, is used to comprehend all kin.

Descent is traced through the male line and a descent group *(bonxo)*

includes a number of patrilineal families *(poriyāl)*. A man, therefore, reckons and retains his membership through his father's descent group while a woman's membership in her father's descent group remains till such time she gets married, at which point she is considered to become a member of her husband's descent group. The term *poriyāl* is often used to imply a larger group spanning several generations and sometimes even used as a synonym for *bonxo*. The most common usage of the term, however, is restricted to mean the family.

The solidarity and cohesion of the *bonxo* becomes particularly evident at the time of ceremonial occasions like *annapraxsan* (commemorating the first intake of solid food of a newborn baby), marriage *(biyā)*, thread ceremony *(logundioni)* and the death anniversary *(sraddha)* of a kin. The senior members of the *bonxo* are shown respect on occasions like marriage when the newly wedded bride gives them gifts *(mān)* placed on the *xorāi* Assamese stand called *sorai*. Members of the same *bonxo* have to perform pollution rites related to birth and death when the entire *bonxo* is rendered ritually impure. Membership in a *bonxo* is usually reckoned up to seven generations on the father's side and five generations on the mother's side. This pattern could be explained by the fact that it is a patrilineal society. There are, however, instances, albeit rare, where descent is thought to endure for nine generations.

The importance of the members of one's *bonxo* is borne out by the fact that no important ritual occasion (birth, initiation and marriage) is celebrated before conducting an ancestor worship *(naupuruxar sraddha)*. The function of this ritual is to offer *pindo* (made of rice and sesame) and inform the ancestors of nine

preceding generations that a ceremony is being held in the family and to invoke their blessings for the same. During marriage, the groom himself (or a member of his *bonxo)* performs the ceremony while in the case of the woman, the bride's father performs it. The nine members of the preceding generation are the father, father's father, father's father's father, mother, father's mother, father's father's mother, mother's father, mother's father's father and mother's father's father's father.

A third category called *xamparkiya* (which literally means 'related') is discerned in Assamese society. This term is used to connote the relationship between persons when no distinct blood relationship is traceable but who are otherwise considered to be related, however indirect the relationship.

The pattern of residence is usually patrilocal or neolocal with the newly wedded couple setting up their independent household. Hardly any cases of the traditional joint family can be seen nowadays. The father is the head of the household and is usually the focal point of authority in the family. Cantlie observed that ". . . . commensality is seen as the defining criterion of a single family" (1984:34). Division is understood as eating separately. In every household there is one kitchen, symbolised by the presence of one rice pounder *(dhenki)* in the olden days. All sons get equal share of the property and the distribution of property is the prerogative of the father. Daughters, in many families, get an equal share of the property. The obligation to perform the mortuary rites of the father and mother and thereafter to annually perform the prescribed death anniversaries is inherited by the sons.

Monogamy is the prevalent rule among the Assamese. Rules of endogamy (marriage within the same caste group) are generally followed although there are many cases nowadays, especially in cities, where a man and a woman from two different castes get married. The preferred form of marriage is by negotiation between the families of the bride and the groom with compatibility of horoscopes being a major factor in forging alliances in most families. Members of the same clan (*gotra)* are prohibited from marrying each other as they are considered to be descendants of the same ancestor.[24] Hypergamous (*anuloma)* marriage, where a man from a higher caste marries a woman from a lower caste, is preferred while hypogamous (*pratiloma)* marriages traditionally do not elicit much approval.

The practice of demanding dowry is not prevalent in Assam. The family of the bride, however, presents her with certain items like the bridal bed and some furniture, utensils, clothes and jewellery, considered to be essential for the setting up of her new household. The amount of gifts given to a bride remains the prerogative of her natal family and is most often contingent upon their economic condition. The women in a descent group or family are classified into broad categories - *jiori* , the daughters of the family, and the *bowari* (daughters-in-law) to include the women inducted into the family or larger descent group by marriage ties.

A married woman traditionally keeps her head covered in the presence of relatives who are senior to her husband. This custom is not followed as rigidly

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[24] The only exception to this rule being that members of the Kashyap *gotra* are allowed to marry. In fact, if a man is not aware of his *gotra,* the priest assigns him to the Kashyap *gotra.*

nowadays, especially in the urban areas, although I observed, with much interest, that there were many elderly women (often septuagenarians and octogenarians) who still subscribed to this practice.

Widows in Assam follow more or less the same restrictions that are followed in any other part of India although these are more prominent and rigid in the case of Brahmin widows.[25] Pre-pubescent marriages used to be the norm earlier, especially among girls belonging to higher castes. Among the Brahmin and the Kayasthas, especially before Independence, the girls would be married between the ages of nine and fourteen. In post-puberty marriages, in most cases, a purification rite (*prayascitta)* would be performed. This is no longer the case. In fact, the trend among many women in the urban areas is towards later marriages while they opt for higher education and careers of their own.

Life cycle rituals[26]

The birth, initiation, marriage and death rituals in the Hindu communities of Assam are all performed according to Vedic prescriptions. The descriptions offered here pertain largely to Hindu customs and rituals as most of my respondents are Hindu.

In contrast to earlier times, most women in cities nowadays give birth in hospitals and nursing homes. Rituals are subject to slight variation across different

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[25] Brahmin widows are not supposed to eat non-vegetarian food, onion and garlic. Refer to section on food in Chapter Four.

[26] I have given a brief description of the rituals that mark each rite of passage without going into much detail.

caste groups but generally the ceremonies begin on the sixth day after the birth of a baby. On this day, an earthen lamp (*sãki)* is lit and some pen and paper are kept next to the baby. It is believed that fate (*bidhata)* comes on this day to 'write' the future of the newborn baby. Most families get an astrologer to prepare the baby's horoscope on this day. The period of impurity attached to the mother and the baby lasts for ten days.

On the eleventh day, the mother and the child are bathed and in many cases, have to symbolically 'cross' fire and water. Then the baby is ceremoniously 'shown' to the sun (*xurya pranam* or *surya dekhowa)*(see photograph). On this day, the egg of a duck is wiped on the cheeks and heels of the baby (care should be taken to see that the egg does not break). A pestle (*pota-guti)* is used to symbolically 'hit' the four corners around the baby who is placed on a raised stool (*peera)*. It is believed that this ritual tests the sensory faculties of the baby. On the thirtieth day (for a female child) or on the twenty-first day (in the case of a male child), when the period of impurity for the family ends, the family is supposed to perform a rite called *coru pelowa* (throwing away of cooking utensils).[27] Another rite called the *annapraxan* is held when a *puja* is conducted and affinal and agnatic kin members are invited for a ceremonial feast after the baby is six months old if it is a boy and five months old in the case of a girl. Many families in my field area reported cases where they had freed fish in the river on this occasion (in even numbers for a boy and odd numbers in the case of a girl).

[27] *Coru* refers to earthen pots which were traditionally used for cooking.

The ceremony of *xurya dekhowa* (showing the child to the sun) in progress

A family priest conducting a Chandi Path

Many non-Brahmin families hold a ceremony called *tolani biya* to mark the onset of puberty of a girl. It is usually held on the fourth or the seventh day of the menstrual cycle. Some people reported using a banana sapling and on the base of which two pots of pounded rice powder *(pitha-guri)* are kept. The girl is ceremoniously bathed with turmeric and green gram *(mah-halodhi)* and dressed like a bride. Members of the kin group, friends and neighbours are invited for a feast. Some families keep the menstruating girl in exclusion for the first three days when she is allowed to meet only female members of the family. In towns and cities the *tolani biyā* is not always performed. In villages, however, many families celebrate this custom with great fanfare.[28] In some of the Brahmin as well as the non-Brahmin families of my field area, especially in those which had a living elder female relative (the grandmother, in most cases), they had observed a ritual whereby the girl is allowed to eat only fruits and vegetables and no cooked food for the first three days of having attained puberty.[29]

Marriage rituals

Rituals commence a day or two before the actual marriage with a pre-wedding ceremony *(juron)* which is held to mark the occasion when the family of the bridegroom presents the bride with clothes and ornaments. In Brahmin families, the mother of the bridegroom puts vermillion *(xendoor)* on the forehead of the

[28] A ceremony called *shanti biya* was held earlier in Brahmin households. Since the Brahmin girls would be married before they attained puberty, this ritual would be performed at the time when the groom came to take the bride to his house after she attained menarche.

[29] Some of the older women respondents that I interviewed told me that the observance of this ritual is connected to the health of the menstruating girl. They attribute the increase of gynaecological disorders and menstrual cramps in 'young unmarried girls' to the fact that hardly any ritual observances are adhered to nowadays in the cities. This view is, however, not corroborated by all women.

bride during this ceremony. On the day of the wedding both the bride's father and the groom's father perform the *nandimukh puja* after which the guests are fed. At the time of departure of the groom as he leaves for the wedding ceremony at the bride's house, the mother of the groom stands with her arms outstretched across the doorway. After three (notional) attempts he finally passes under her right arm. This ritual is called *duwār dhora*. The father (or a male guardian of the bride) performs the *xampradan* (giving away) ceremony in front of the sacred fire (*hom)* according to Vedic rites. The mother of the groom and the mother of the bride are not allowed to watch the marriage rituals. On the third day after the wedding when the bride goes to the groom's house a ritual called *khoba-khobi* is held.

When a married daughter leaves her parents' house, she walks out very slowly, throwing rice over her head as she does so. She is considered to be the embodiment of Lakshmi, the goddess of wealth, and this is a 'gesture of entreaty' (Cantlie 1984) to the goddess not to leave the house with her. On the eighth day of marriage (*ath-mongola),* the married couple pays the first visit to the bride's house.

Death rituals

The body of the deceased is bathed and dressed in fresh clothes after which it is taken to the cremation ground by the male members of the kin group and close associates of the deceased. The eldest son lights the pyre. In case the person dies without any progeny, there are no strict injunctions on who should carry out this ritual although in such a case, the father lights the pyre for the son, an elder

brother for a younger sibling and a husband for the wife.[30]

After the cremation is over, the persons who return from the cremation ground are traditionally supposed to wash their mouths with a decoction of neem leaves, hands and feet are heated and among the Brahmins the sacred thread (*logun*) is changed. A bath is then taken to 'wash away' the impurity consequent upon cremation.

In the household of the deceased member, all the sons of the deceased are meant to shave their heads. No fire is lit for three days. Friends and members of the extended family bring fruits, milk, curd, and so on for the members of the family. The members of the descent group become ritually impure (*cuwa)* for ten days (in the case of Brahmins) and for thirty days (in the case of non-Brahmins). As long as the period of impurity lasts, members of the family are prohibited from entering any place of worship or from holding marriages. The restrictions fall most heavily on the first descending generation - on sons and brothers' sons. On the fourth day (*saturtha)*, the restrictions on women are lifted. *Pindo* is offered to the dead person for the first ten days.[31]

The period of impurity is believed to end with the first mortuary rite (*sraddha)* which is held on the eleventh day by the Brahmins and on the thirtieth day by the non-Brahmins. Material things are given away in the name of the deceased. Some families even give a cow away to a needy person. On the

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[30] In the case of death of babies and small children the bodies are buried instead of being cremated.

[31] *Pindo* is an offering which contains banana *(kol)*, uncooked rice *(cawl)*, sesame seeds *(til)*, curd *(doi)* and 'raw milk' or *keca gakhir* (which has not been boiled) and ghee.

thirteenth day in the case of Brahmins, and thirty-first day in the case of non-Brahmins, members of the clan, affines and people from the neighbourhood are invited for a feast *(giyatali)*. This ceremony, also called *matsya sporxo*, marks the day after the death that members of the descent group eat fish for the first time. It is believed that the soul of the deceased does not immediately go to heaven. Every month, therefore, a ceremony *(mahekia)* is held and at the end of one year, the soul is considered to have been set free. Sons of the deceased member continue to perform a ceremony on the annual lunar anniversary *(tithi)* of his or her death.

Dress and ornaments

The traditional Assamese dress is called the *mekhela-sador*. It is a three-piece ensemble and traditionally made of silk - of either *pat*, a white or cream coloured silk, or of *muga*, a buff coloured silk made from mulberry worm. Tied to the waist is the long flowing ankle-length *mekhela* and teamed with it are the *riha* (a relatively narrow strip of cloth) and another long piece of fabric (measuring around two and a half meters) called the *sador* to cover the upper half of the body. Women regularly wear the *mekhela* and the *sador* and use the *riha* only on special occasions.[32] Another fabric, popularly used for shawls, is called the *endi*.

Intricate weaving in different shades and designs embellish most of these dresses. Tribal motifs on the dresses are geommetric and tend to be linear in pattern while traditional Assamese motifs are more curved and floral.

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[32] Some elderly women, however, still wear the entire outfit, with its three parts, even when they are at home.

Traditional Assamese ornaments are made of twenty-four carat gold and are often encrusted with stones. Among the lockets are the *dhol biri, gejera, bana* and the *dugdugi* which are found in various shapes and sizes. Traditional earrings are of various types as well, the most popular among them being the *keru* and the *thuria.* On the wrist are worn the *gam kharu* and the *muthi kharu* and on the fingers, rings called *senpota* and the *jethi neguria* are worn. The most popular jewellery is the green and gold *lokaparo* and the red and gold *golpota.* Use of anklets and nose-rings are rare among Assamese women and if they are used, are instances of diffusion from other parts of the country.

The Bihu festival

Folk culture in Assam, as in other parts of India, is inextricably connected to agriculture. The most important festival of the state, the Bihu, therefore, exhibits distinctive agricultural overtones. It is held three times in a year, in the cusp period between two months, each commemorating the onset of a new season and coinciding with the agricultural cycle in the state.

The Bohag Bihu is the most important. It marks the beginning of the Assamese New Year and the advent of the cultivating season. It is held in the middle of April.[33] Traditionally seven days, beginning with the day before Bohag Bihu mark separate occasions for celebration and ritual.[34] On the day of Manuh Bihu (held on the first day of the month of *Bohag)* one is meant to bathe with

[33] This time of the year is celebrated in many other states of India. Baisakhi is celebrated in Punjab and Haryana, Naba Barsha in Bengal and Vishu in Kerala to commemorate the beginning of the New Year.

[34] They are known as Goru Bihu, Manuh Bihu, Hat Bihu,Senehi Bihu, Maiki Bihu, Rongali Bihu and Sera Bihu.

turmeric and black gram, wipe oneself with a newly woven *gamusa* and wear new clothes. The younger members of the family are supposed to touch the feet of the older members and seek their blessings. Celebration in the form of singing and dancing and holding of special dances called *husori* symbolise this Bihu. It is, therefore, also called Rongali Bihu.[35] It has now become a major urban festival accompanied by competitive performances of folk songs, group dances, playing of drums and so on.

Kati Bihu is held in the middle of September. It is the most insignificant of the three Bihus and the main theme revolves around the welcome and propitiation of Lakshmi, the goddess of prosperity. The kitchen is ritually cleaned. A basil *(tuloxi)* sapling is planted on a raised bed of earth in the courtyard *(sotal)* of each household and an earthen lamp *(sāki)* is lit under it for the entire month (the month of *Kati* according to the Assamese calendar). This light is called *akāx bonti.*[36] At dusk blessed food *(praxād)* is offered to the plant and then distributed among members of the family. A total of seven lamps are, in fact, to be lit within the compound of each house on the day of this Bihu. The designated places include the area under the basil plant, by either side of the main door, in the kitchen, in the compound (rice fields, in the case of villages), next to the alter *(than)* of God and at the main entrance of the house. In the villages the last two lamps are lit outside the granary and the cowshed.

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[35] *Rongali* means merriment.

[36] In the villages this light is kept on roof tops and placed atop bamboo poles. It is a functional ritual to ward off insects which appear before the harvest matures in the field.

Uruka, the day prior to Magh Bihu, marks the beginning of celebration on this particular Bihu. Held in the middle of January, it symbolises the end of the harvest season and involves large-scale feasting, hence its name Bhogali Bihu (it takes its name from *bhog* which means food). On this day dried husk of newly harvested paddy is used to construct a temporary thatch hut *(bhela ghor)* in which a communal feast with non-vegetarian food is held. Early next morning, before sunrise, this structure is burnt. On the day of Magh Bihu, most people, especially in the urban areas, erect a *meji* (a large conical structure constructed with tall sticks of raw bamboo and thatch) for a traditional bonfire.[37] Members of the family first bathe at the break of dawn and then pray to the god of fire *(agni)* by chanting mantras with offerings of local sweets *(pitha)*, betel leaf and areca nut *(tamul-paan)*, newly harvested rice *(natun sawl)*, and sesame *(til)*. [38] Sweet potato and arum are roasted in the ashes and eaten with great relish. An elaborate spread of local delicacies like *bora sawl* (steamed rice specially prepared in sections of bamboo), *pithas* of different kinds and *jalpan* (pounded rice in various forms) with curd or milk and jaggery *(gur)* are eaten on this day. No non-vegetarian food, however, is eaten.[39]

Writers are divided in their opinions regarding the origin of the Bihu festival. Some say it was derived from the Ahom word *boihu* (which means cow

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[37] This ritual is rigorously followed in every household even in the urban areas.

[38] This period marks the onset of the dry season and the worship of fire at this time carries great symbolic value.

[39] This particular Bihu coincides with many other festivals in the rest of the country, namely Pongal in Tamil Nadu and Makar Sankranti in Uttar Pradesh and Bihar.

worship) but most modern thinkers trace it to the Aryan word *bishuv* which connotes the period around the equinoxes.

PART II : THE SETTING

Urban Guwahati

Kamrup district, with an area of 4345 square kilometres and spread over both banks of the Brahmaputra River, has the largest population, comprising 2000071 persons among all the districts of Assam (Census 1991). The district has a population density of 457 persons per square kilometre and the highest literacy rate (64.8%) in the state (*Assam 2000)*. Hindus, (comprising 74.3% of the total population), form the largest religious group followed by Muslims who constitute 23.4% of the total population (Census 1991). Christians, Sikhs, Buddhists and Jains are the other communities in the district. Scheduled Tribes and Scheduled Castes form 10.72% and 7.5% of the total population of the district respectively. The report of Census 1991 recorded 1345000 persons in the rural areas of the district and 655000 in the urban areas.

Guwahati, the headquarter of this district and the capital of the state, is the largest urban centre in northeast India. Located at an altitude of 55 meters above sea level on the south bank of the river Brahmaputra, the city lies between 26° 10′45″ north latitude and 91° 45′ east longitude. It is situated on plain alluvial land and is surrounded by many small hills. In 1951 the city had an area of 7.7 square kilometres which increased to 14.24 square kilometres in 1961 (Barooah 1993). There has been tremendous expansion since then. The Census of India, 1991,

recorded an area of 216.7 square kilometres.

The city is connected to the north bank of the Brahmaputra by the Saraighat Bridge. It has three main administrative subdivisions, Guwahati, Rangia and Chandrapur.[40] It is connected by air, rail and road to other parts of the country. Rail link to the region was facilitated after the establishment of the Assam Bengal Railway in 1890 and direct air travel between Guwahati and Calcutta from the Borjhar airport commenced in 1947. It remains the gateway to the other states in the northeast as bus services ply regular traffic to all the neighbouring regions.

Brief history and development of the city

The city was originally known as Pragjyotishpur (city of eastern astrology). The name was derived from the Nabagraha temple in the city which was a widely acclaimed seat of astronomical research and astrology in the eastern region.[41] The present name of the city, Guwahati (village of areca nuts), is a recent modification of the anglicised word Gauhati.

Along with Goalpara, this city had developed into an urban centre well before the consolidation of Assam by the British Empire in 1826 (Bose 1989). In fact it was part of the Ahom kingdom during which time it served as the provincial capital of western Assam.

The British shifted the capital of the province to Shillong (in the present

[40] Guwahati is the only urban centre in Assam which has a Municipal Corporation. In 1971 Pandu and Kamakhya were merged with the Guwahati Municipal Corporation (Census 1991).

[41] The temple is even today recognized as an official centre for astrological learning.

state of Meghalaya) after the annexation of the state under British rule and it was only in 1973-74 that Guwahati (Dispur) was designated as the capital of Assam.

Formal education got an impetus soon after the British took over. Collegiate High School, the oldest high school in Guwahati, was set up in 1834 and the first college in Assam, Cotton College, was established in 1901 under the auspices of Sir Henry Cotton, the then Chief Commisioner of Assam. Soon after, the Department of Education was formed by the British Government in 1905. The year after the Independence, in 1948, saw the establishment of the first university of the region - Gauhati University at Jalukbari. In the same year the Assam High Court, which was till then under the jurisdiction of the Calcutta High Court, was set up as an independent establishment in the city.

The public sector oil refinery was commissioned by the Government of India in 1960. Subsequently, industrial units like the Assam Carbon Products Limited (in 1963) and the Assam Industrial Corporation (in 1969) were established. It has now evolved into an epicentre of industrial development with the setting up of a large number of private companies and public sector enterprises. The city has thus become a commercial hub of trade, commerce and industry in the region.

Population pattern

Rapid migration to the city from neighbouring rural areas and other parts of the state has seen a phenomenal increase in the population of the city. It graduated from a Class III town in 1951 to a Class I town in 1961. No census operation was

carried out in the year 1981 but it was designated as a B-2 city on an estimated population figure of 4.5 lakhs (*The Assam Tribune*, 29 June 1989 in Barooah 1993).

The report of Census 1991 subsequently identified Guwahati as a Class I town with the urban Guwahati area alone recording a population figure comprising 584,342 persons. Out of this population 56.1% are males and 43.9% are females. The sex-ratio shows that there are 783 females per 1000 males. The literacy rate is 81.1% with male literacy (85.7%) indicating higher figures than female literacy (75.2%).

Table no. 1

Population pattern of Guwahati : 1901 - 1991

Year	Persons	Males	Females	Sex ratio
1901	11,661	7,772	3,889	500
1911	12,481	8,138	4,343	534
1921	16,480	10,786	5,684	528
1931	21,797	14,506	7,291	503
1941	29,598	18,883	10,715	567
1951	48,615	27,990	15,625	558
1961	100,707	67,289	33,429	497
1971	123,783	75,583	48,200	638
1991	584,342	327,725	256,617	783

Compiled: Barooah 1993: 58; Census of India 1991, Series 4, Part IX-A.

Table no. 2

Religion-wise distribution of persons in Guwahati

Religion	**Total no. of persons**	**Percentage of total pop.**
Hindu	503,696	86.2%
Muslim	65,165	11.2%
Christian	4,377	0.8%
Jain	4,221	0.7%
Buddhist	846	0.1%
Sikh	3,159	0.5%
Other religions	299	0.1%
Religion not specified	2,579	0.4%

Source : Census of India, 1991, Series 4, Part B (ii), p. 50.

Nearly 86.2% of the city's population is Hindu with Muslims (11.2%) forming the next largest majority (Census 1991).

The city is known as *pancha-tirtha* (site of five pilgrimages). This is because of the presence of the Kamakhya temple complex, the Umananda temple, the Nabagraha temple, the Ugratara temple and the Vasisthashram. Kamakhya, situated atop the Nilachal Hill is the most popular of all the sites of worship in the region. It attracts thousands of devotees every week from all parts of the country. It is, however, widely believed that pilgrims ought to first visit Umananda, a Shiva

temple on a rocky island on the Brahmaputra River within sight of the Nilachal Hill, before visiting Kamakhya. Other important sites of pilgrimage are the Ugratara temple located in the heart of the city on the banks of the Jurpukhuri pond and Vasisthashram, the ancient hermitage of sage Vasistha. Set in idyllic environs around seven miles from the city, the Vasista temple bears the alleged footprints of the sage and is situated next to the confluence site of three rivulets (Sandhya, Lalita and Kanta). The Nabagraha temple, where nine monoliths representing nine planets are worshipped, is located on top of the Citrasala Hill on the eastern part of Guwahati. Attached to it is a school for astrological learning.

In addition to Bihu, Saraswati Puja and Biswakarma Puja, Durga Puja is celebrated with great fervour in the city. Scholars (Gogoi 1991; Kakati 1989) are of the opinion that this festival probably gained popularity in the state by diffusion from Cooch Behar and other north Bengal districts which constituted the ancient kingdom of Kamarupa.

Medical culture of urban Guwahati

State government departments undertaking issues related to health in the city are the Directorate of Health Services, the Office of the Chief Public Health Engineer and the Directorate of Health Education. There are fourteen hospitals in the city out of which Guwahati Medical College is the oldest. In addition to the biomedical hospitals, there is one Government Ayurvedic College cum hospital in Jalukbari, an Umachal Yogic Hospital in Kamakhya, and the Shaheed Yadu Nath Homeopathic Chikitsa Mahavidyalaya in Panjabari that runs a large clinic cum

dispensary; and several private clinics offering non-allopathic treatment.

There are thirteen allopathic dispensaries and two Ayurvedic dispensaries set up by the Government of Assam in urban Guwahati. It is to be noted here that out of one hundred and sixty-nine Medical and Health Officers under the Joint Directorate of Health Services, Kamrup, there are twenty-one Ayurvedic and six Homeopathic specialists.

The city has seen a tremendous increase in the number of nursing homes in the last decade and a half. In addition to the older establishments, the last five years, in particular, have seen many non-resident Indians of Assamese origin investing in the setting up of these centres which are equipped with the latest diagnostic machinery. The nursing homes in Greater Guwahati alone number thirty-five (Joint Directorate of Health Services, Kamrup).

Among the health options that are available for the people of the city are:

1. Allopathic hospitals

2. Homeopathic clinics and dispensaries

3. Ayurvedic dispensaries

4. Bone-setters

5. Mantra Therapists

6. Pranic Healing and Reiki workshops and training sessions have hugely popularised this form of healing. There are a number of practitioners who are well acclaimed in the city.

7. The Alternative Medical Centre at Rajgarh offering an assortment of non-allopathic therapies like Acupressure and meditation.

8. Tibetan medicine

9. There are some people who avail of tribal medicine, especially from Khasi and Karbi medical practitioners.

The most common ailments (according to data compiled by the researcher from two major hospitals in the city: The Guwahati Medical College Hospital and Mohendra Mohan Choudhury Hospital) in the city are amoebiosis, peptic ulcer and upper respiratory disorders. No recent epidemics have been reported in the city for the past five years. I obtained official figures pertaining to the number of government health centres from the Office of the Joint Director of Health Services, Kamrup (which I have furnished below). No such figures specific to the city of Guwahati were, however, available.

Table no. 3

Health services offered by the state at the district level

Block Primary Health Centres	41
Mini Primary Health Centres	30
Community Health Centres	9
State dispensaries	44 (13 in Guwahati)
Subsidiary Health Centres	2
Medical sub-centre	45
Ayurvedic dispensaries	3 (2 in urban Guwahati)

Source : Joint Directorate of Health Services, Kamrup.

Zoo Narengi Road

The neighbourhood is located in the eastern part of the city. It is spread along two sides of one broad tarmac road that leads from Zoo Road towards Narengi, the oil refinery settlement in the outskirts of the city (see map). Hence, its name Zoo Narengi Road. The juncture at which the Zoo Narengi Road breaks off from Zoo Road is called Tiniali which has evolved into a moderately sized commercial hub of shops and several grocery stores. A few kilometres from Tiniali, situated on a hillock is the Geetamandir, a temple dedicated to lord Krishna.

The main Zoo Narengi Road is flanked on either side by wards 41 and 49, designated by the Guwahati Municipal Corporation.[42] The total population of the area is 18, 954, with ward no. 41 having 9554 persons and ward no. 49 consisting of 9400 persons (Census 1991). The literacy rate of the area is around 80% with males having a higher literacy rate than females (Census1991).

There are a large number of bureaucrats, businessmen, company executives, well-placed government officials, etc. living in the area. I did not attempt to use any pre-formulated brackets of economic class as officially defined by economists. Instead, I chose to give free rein to the respondents themselves. In the first questionnaire that I distributed in the area after my pilot survey, I asked my respondents which class *they* thought they belonged to. A majority (59.8%)

[42] The entire city is divided into these wards by the Guwahati Municipal Corporation and population figures are collected accordingly.

said that they belong to the upper middle class and 40.2% felt that they belong to the middle class.

A majority of the population of the area are Hindu. The portion of the area that I studied has a large concentration of Brahmins; this caste group comprises one hundred and twelve persons out of my total sample of one hundred and seventy nine people.

The neighbourhood is flanked on both sides by hillocks which are dotted with houses and the area displays a more planned lay-out than most other neighbourhoods in the city. It is well connected to other parts of the city by public transport. Buses to and from Narengi ply regularly via this area. Hatigarh Chariali serves as a centre point which has a small shopping area with a vegetable market, ration shops, pharmacies and shops selling items of daily necessity. An opthalmologic clinic called the Eye Care Foundation clinic is located in this area. The building of apartment complexes in the area has transformed the original local landscape of the area which had mainly Assam-type houses and single-storeyed reinforced concrete buildings.

The neighbourhood has three chemist shops, one Ayurvedic clinic and one Homeopathic dispensary. There are no hospitals or nursing homes in the area, the nearest nursing homes being five or six kilometres away.The recent mushrooming of flats in the area has attracted a number of small schools and shops in the locality. Several radial roads lead off the Zoo Narengi Road to interior extensions

of the neighbourhood. Narikolbari (which literally means cooconut grove in Assamese), one of the main sections of the neighbourhood, was the epicentre of my study.

The urban water supply to the area that commenced around four years ago has minimised many of the problems that were hitherto faced by the people of the area with respect to poor supply as well as high iron content in the water. Some households have their own supplementary arrangements like deep tube wells and wells. All the roads of the area are tarmac and the neighbourhood appears cleaner than most neighbourhoods in the city. The broad main road ensures a smooth flow of traffic.

Most of the houses are independent single-storeyed bungalows - slight modifications of the traditional Assam type house, or double-storeyed houses with a few multi-storeyed structures. Drainage in the area is one of the few factors that poses a problem for its residents. In the event of a heavy downpour, parts of the area, including a portion of the main road, get flooded and it is sometimes several hours before the water is drained out completely. The toilets in all the households that I have studied have the flush system. The toilets are all attached to the bathrooms; in many houses there is a toilet outside the house for the domestic help living in the house.

The households under study have a minimum of two, often three, bedrooms, a room designated as the drawing room, a separate dining area, a kitchen and a moderately-sized to large verandah. Although I did not enter the bedrooms of most houses out of a sense of propriety, I found that the other parts

of the house would be clean and well maintained.[43] Most of my interviews were conducted in the drawing and dining room areas. Most of the drawing rooms are well-decorated with a number of objet d'arts. Each house, except the flats in the apartments, have an outer compound.

A majority of the houses (81.1%) I visited are nuclear families (including supplementary nuclear families) and the remaining 18.9% are extended families with an average of two to three children per family.[44] The average age at marriage is 26-28 years for males and 23-25 years for females. I pigeon-holed my respondents into educational brackets of under-graduates, graduates, post-graduates, and those with higher or special degrees (medicine, engineering, etc.) which comprise 9.9%, 34.3%, 31.1% and 24.7% respectively.

Table no. 4
Distribution of respondents according to age group

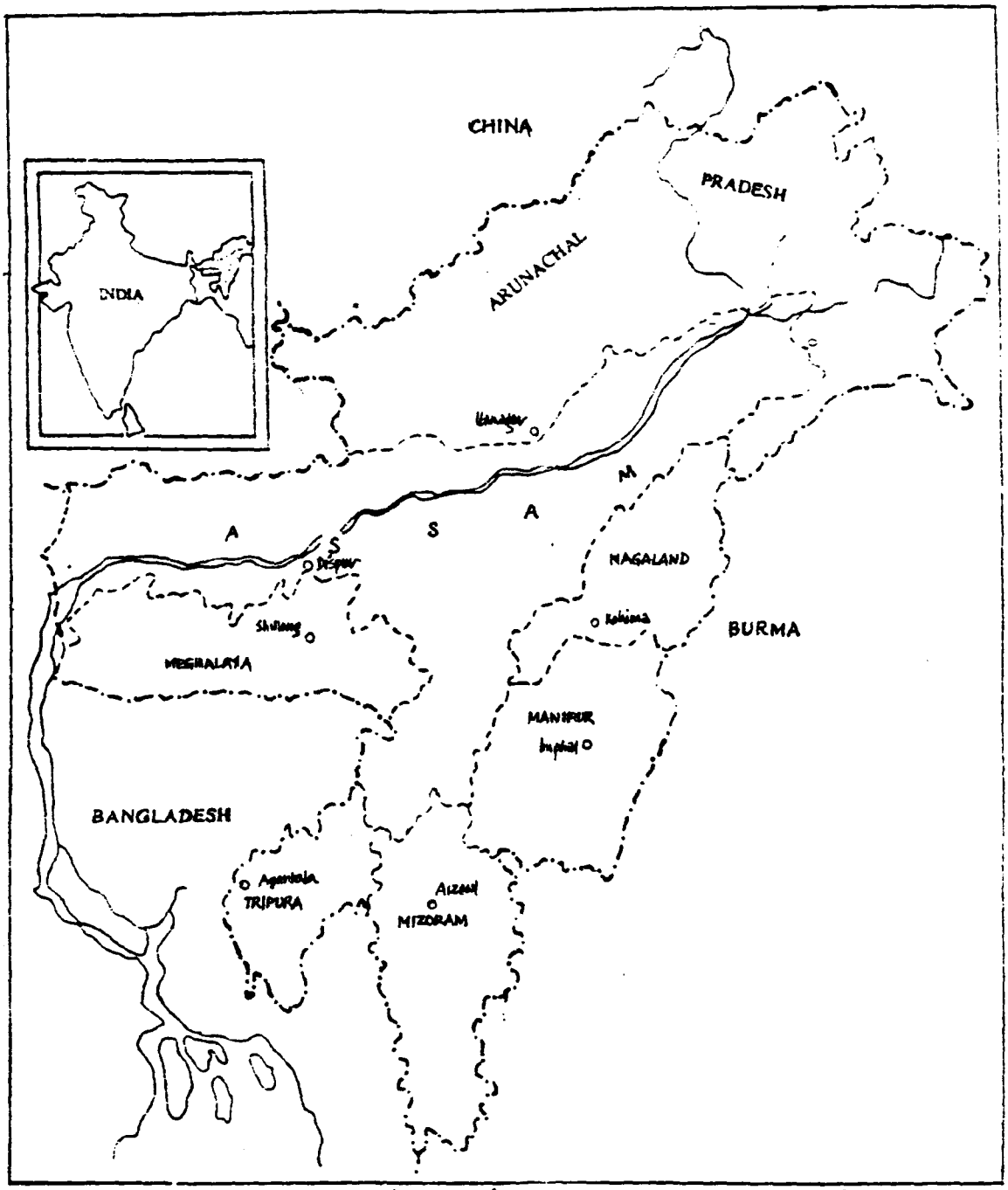
Age group (in years)	No. of Persons	Percentage of total sample	No. of Males	No. of Females
11 – 20	6	3.4 %	3	3
21 – 30	14	7.8%	6	8
31 – 40	21	11.7%	8	13
41 – 50	36	20.1%	12	24
51 – 60	40	22.4%	21	19
61 – 70	33	18.4%	13	20
71 – 80	19	10.6%	11	8
81 – 90	8	4.5%	3	5
91 – 100	2	1.1%	1	1
Total	**179**	**100.0**	**78**	**101**

This chapter serves as an introduction to the area under study. It provides the ethnographic background for the rest of the chapters to follow.

[43] The barrier between the 'public' and the 'private' very often collapses with participant observation but I would be careful not to appear transgressive. I must mention at this point that most of my respondents seemed to accept me easily and I became quite close to a number of families living in the area.

[44] These figures pertain to the time period when I did my fieldwork.

MAPS



FIG·1: Assam in the context of northeast India

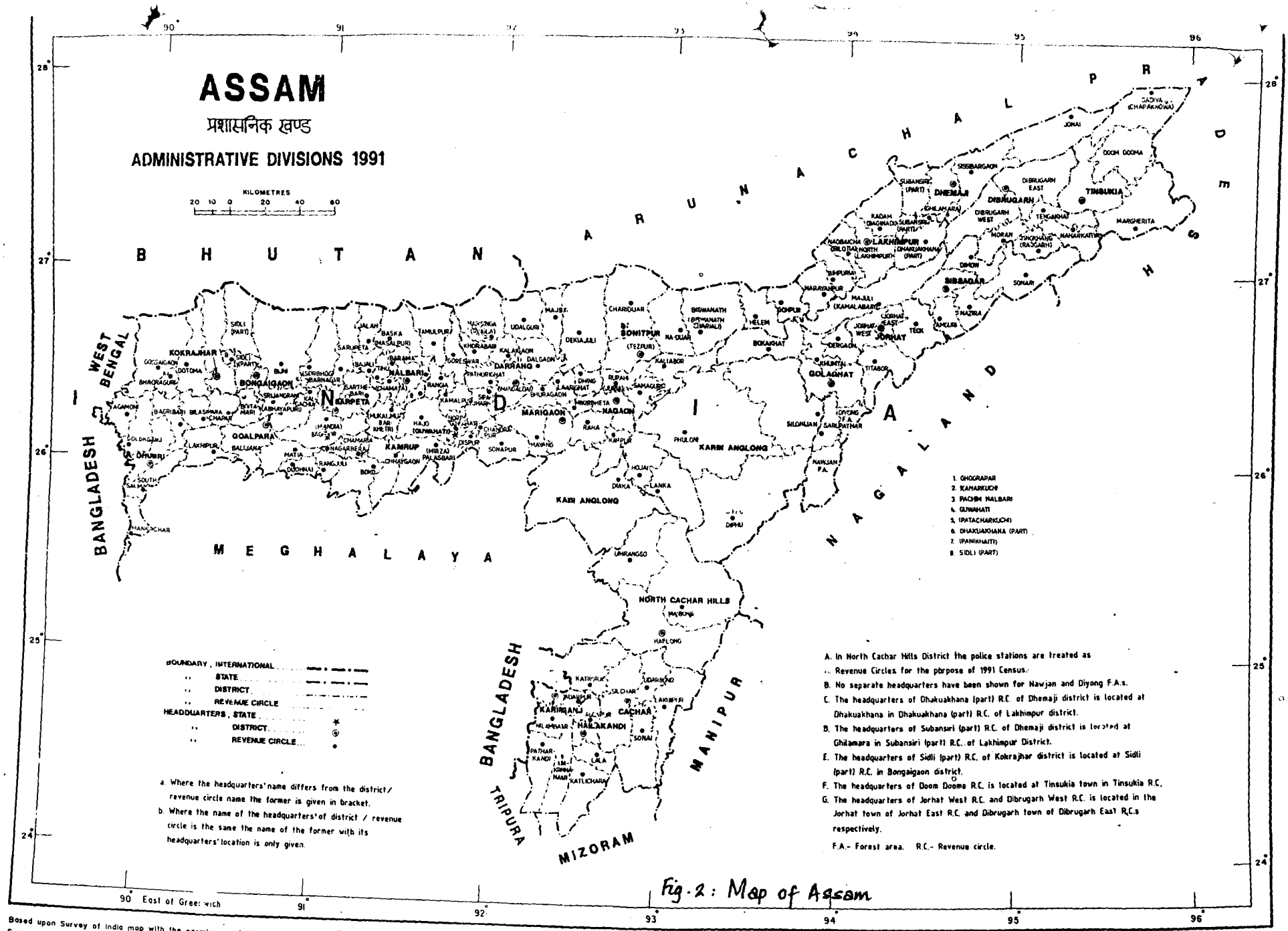
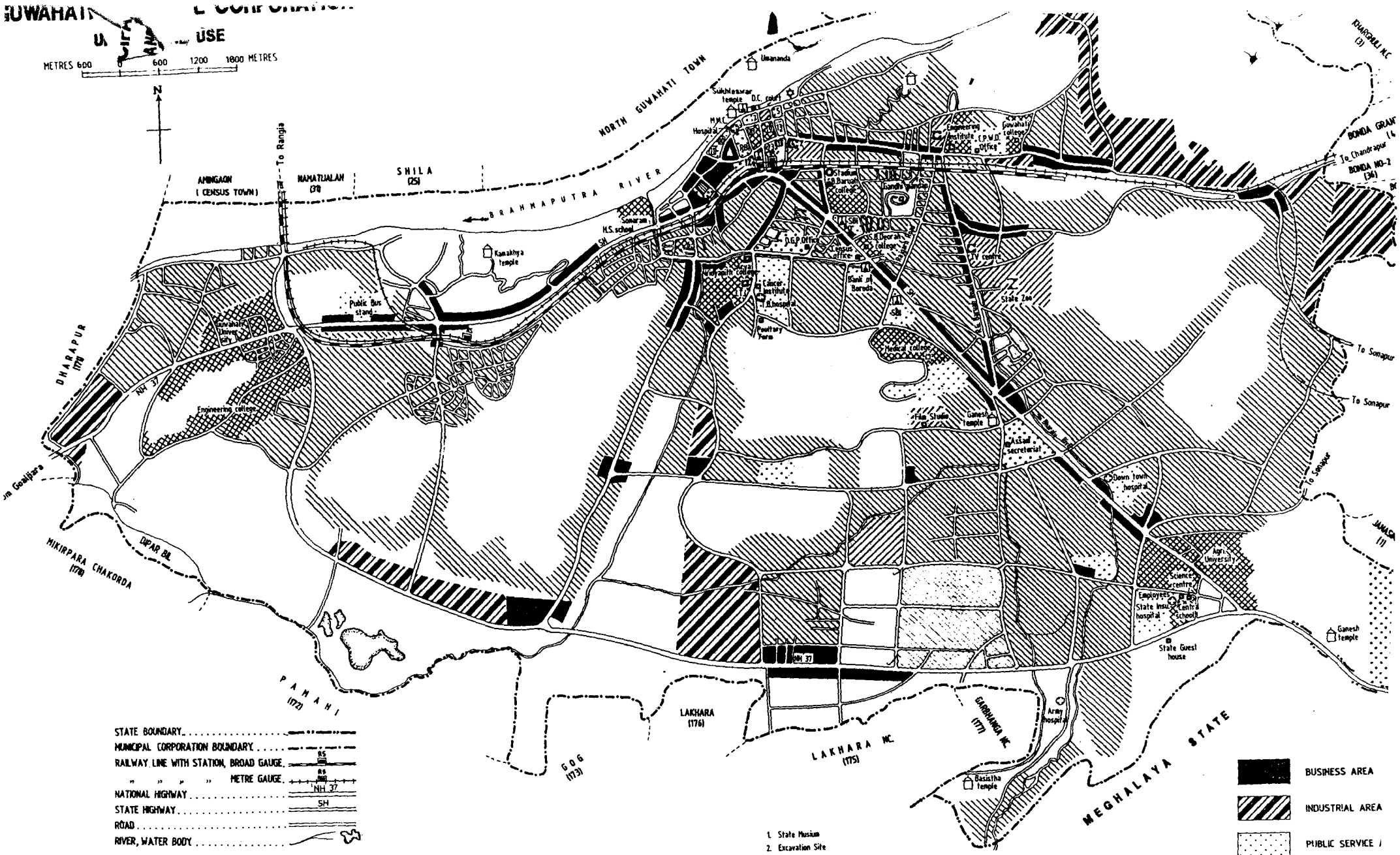


Fig. 2: Map of Assam

Based upon Survey of India map with the permission of the Surveyor General of India.

The boundary of Meghalaya shown on this map is as interpreted from the North-Eastern Areas (Reorganisation) Act, 1971, but has yet to be verified

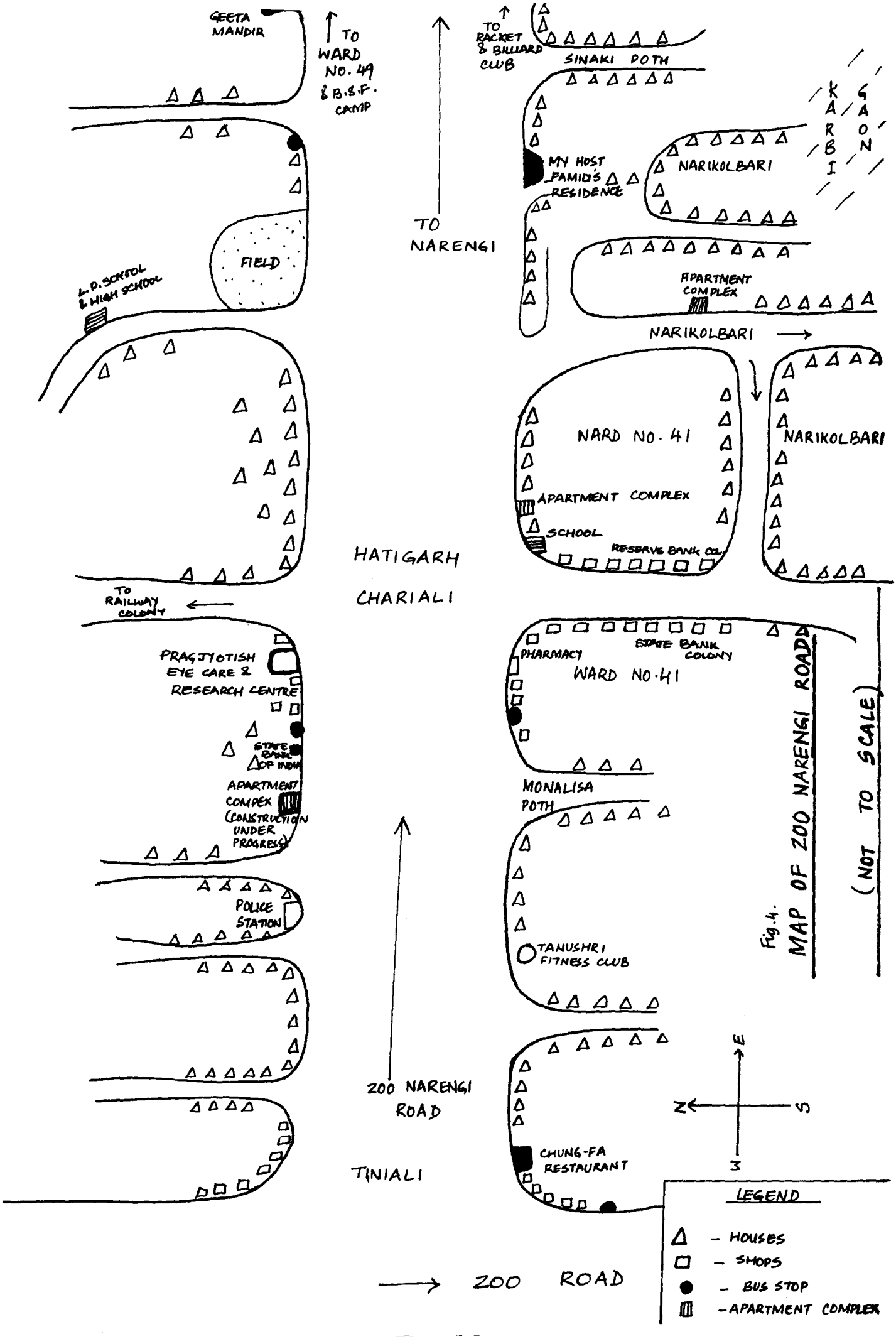
The Indo-Bangladesh boundary shown on this map is the one existing prior to the conclusion of the agreement on May 16, 1974 between India and Bangladesh.



(1) Villages adjoining the urban boundary are shown by location code number and name.

(2) Village boundary alignment and some of the details of land use are approximate.

Fig.3. Map of urban Guwahati


GEETA MANDIR
TO WARD NO. 49 & B.S.F. CAMP
TO RACKET & BILLIARD CLUB
SINAKI POTH
KAARBI GAON
MY HOST FAMILY'S RESIDENCE
NARIKOLBARI
TO NARENGI
FIELD
L.P. SCHOOL & HIGH SCHOOL
APARTMENT COMPLEX
NARIKOLBARI
NARD NO. 41
APARTMENT COMPLEX
SCHOOL
RESERVE BANK COL
NARIKOLBARI
HATIGARH
CHARIALI
TO RAILWAY COLONY
PRAGJYOTISH EYE CARE & RESEARCH CENTRE
STATE BANK OF INDIA
APARTMENT COMPEX (CONSTRUCTION UNDER PROGRESS)
PHARMACY
STATE BANK COLONY
WARD NO. 41
MONALISA POTH
POLICE STATION
TANUSHRI FITNESS CLUB
MAP OF ZOO NARENGI ROAD
(NOT TO SCALE)
Fig. 4.
ZOO NARENGI ROAD
TINIALI
CHUNG-FA RESTAURANT
E
W
S
N
LEGEND
- HOUSES
- SHOPS
- BUS STOP
- APARTMENT COMPLEX
ZOO ROAD

CHAPTER 3

Reflections in Retrospect:

Fieldwork in One's Own Community

REFLECTIONS IN RETROSPECT

Fieldwork in one's 'own' community

The central concept underpinning anthropological research involves empirically observing human cultures. Intensive fieldwork conducted with the help of a battery of appropriate research tools allows the anthropologist to uncover and decipher the nature and meaning of culture and social life.

The traditional anthropological approach of ethnography spearheaded by Boas, Evans-Pritchard and Malinowski has undergone considerable refinement and change in the last few decades. Geertz's *Interpretation of Cultures* (1973) and *Local Knowledge* (1983) heralded the interpretive approach with its emphasis on deep meanings derived from 'thick descriptions' of particular events, rituals and customs. Subsequently, Marcus and Fischer's *Anthropology as Cultural Critique* (1986) and Clifford and Marcus' *Writing Culture* (1986) saw another upheaval in reshaping research protocols. The emphasis was now more on reflexive research and writing. New models of qualitative research have thus been attempted at various stages and epistemological theorizing has seen considerable change from classical ethnographies to the postmodern sensibility. But the driving force of ethnographic research remains more or less the same; the leitmotif of this endeavour is to basically understand human life by exploring social reality within its contextual processes. Ethnography, therefore, continues to be the 'emblem' of cultural anthropology as "a distinctive form of knowledge production" (Marcus

1998: 231). And fieldwork still retains its pivotal role in being the *modus operandi* of generating this knowledge.

Situating the Problem

Most reflections on fieldwork in anthropology have been redolent of anecdotal accounts of 'exotic' customs and traditions of 'other cultures'. Even in medical anthropology there has been an over-arching emphasis on studying ethnomedical profiles of tribal and rural communities while urban studies have more often been subsumed under the rubric of medical sociology. As I began to draw up viable research topics for my doctorate I decided that I would take a detour from the traditional preoccupation of documenting life ways other than one's own and would study my *own* community - the Assamese.

During my initial research on Assam I was struck by Cantlie's observation (1984: ix) that "the many tribes in the hill tracts of Assam early engaged the attention of anthropologists but no significant studies have been made of the people living in the Assam valley who call themselves Assamese." This is true. There are a large number of studies on health and illness that have been carried out in rural Assam and tribal communities, even on tea garden labourers, but I found that there was hardly any medical anthropological research that was conducted in an urban setting. I, therefore, decided to work on urban Assam.

Illness categories are constructed largely by cultural experience and are deeply enmeshed within the belief systems and cosmology of a people. With this as the accepted baseline premise, my focus was to examine the cultural

interpretations assigned to health problems by the community, the change in the perception of these problems over time and the means adopted by the people in order to adequately meet the vicissitudes of health. In the context of the pluralistic medical setting of Guwahati I focussed on how people incorporate conceptual frameworks from different medical traditions into their own perception of health and medicine with an emphasis on alternative or non-allopathic traditions of healing. These 'medical systems' were thus analyzed as a part of the social and cultural systems of the community. The attitude towards biomedicine was also studied within the purview of medical pluralism.

Selecting the area

I conducted a preliminary field study in Assam in May 1997 to ascertain the place that would appropriately serve as the epicentre of my work. I visited the towns of Dibrugarh and Tezpur but I finally chose the city of Guwahati. It is not only the largest urban centre in Assam but is also a burgeoning site for multiple healing systems. One would expect that with the city's rapid modernization and the presence of many biomedical centres, which not only offer state-of-the-art technology but also enjoy institutional dominance over traditional medicine, people would use only allopathic treatment. This is not so. Despite dominant resort to biomedical consultations and treatment, the everyday health and medicine-related behaviour of the urban Assamese are not *always* in conformity with the bioscientific conceptualization of modern Western medicine. There are several establishments in the city which offer a wide range of therapeutic alternatives and even run courses on non-biomedical healing. My daily interaction

with people from the city would often reveal references to alternative medicine and traditional healers for ailments - both for minor ailments as well as for conditions which are labeled as 'serious'.

I set about to choose an area that would have a large congregation of people from a higher income bracket. I wanted to explore patterns of usage between systems within the backdrop of a group which would have access to expensive allopathic treatment and yet deliberately choose other systems. Lack of exposure or economic considerations alone would not be disqualifications for such a group in choosing medical alternatives from the large therapeutic repertoire that the city has to offer.

I finally chose a neighbourhood called Zoo Narengi Road as the locus of my research. The area is centrally located and has good communication facilities. There are a large number of residents here who are senior government officials, businessmen, doctors and executives of corporate houses. Besides, the layout of the neighbourhood seemed more systematic than most other areas in the city. I knew some residents of the neighbourhood, either through kinship ties or as friends of the family. During informal conversations with them they assured me that they would extend their cooperation and would introduce me to many people in the area. All these factors, I presumed, would lend themselves favourably to my fieldwork in the area.

My first spell of fieldwork began on June 6, 1997. During the initial week I stayed with my parents who live in another part of the city around eight kilometres

away from Zoo Narengi Road. My father accompanied me on the first day to Narikolbari to meet a gentleman, Jiten Sarma, with whom he had already had a conversation regarding my proposed plan of work. This gentleman plays tennis with my father and he had been very enthusiastic about the fact that I had chosen that area for my work. He had assured my father that he would introduce me to many of his neighbours. Mr. Sarma accompanied me to three households on the first day. All the families were very welcoming and I was offered tea and snacks wherever I went.

Having been socialised into a curriculum which teaches the tenets of anthropological fieldwork largely with reference to rural settings, I was initially unsure of how to proceed. However, I had an advantage in that I could 'step out' through the families that I was acquainted with. I chose to begin my fieldwork by visiting these families so that I would gain confidence with the easy interaction. I was received with enthusiasm and warmth wherever I went. In urban areas residents are generally suspicious of letting strangers in. I did not, however, encounter this difficulty as I would be referred to one household by another person or persons living in the same neighbourhood; they would either call them on the telephone or apprise them otherwise of my intended visit. Very often I would meet ladies from one household visiting a family where I would be conducting interviews. These meetings allowed me the opportunity to meet them in an informal setting. They would enthusiastically invite me to their houses. They seemed keen to 'participate' in 'some kind of research work'. So rather than beginning in a systematic predetermined fashion, my fieldwork began by simply

selecting the households in a random manner, primarily on the basis of referrals from other respondents.

I began conducting my household survey from the second week onwards. This not only allowed me to introduce myself and my intended plan of work to the families that I had recently met but also infused my initial interactions with a certain sense of direction. Most people were familiar with surveys. Marketing companies and summer trainees in corporate houses often send their employees for surveys, they said. I explained that this was not the sole motive of my research and that this was a means whereby I could arrive at a general perception of the demographic pattern, occupational structure, educational level and economic stratum. I explained that I would require extensive and in-depth interactions with them for the next two or three years. This allowed me to assess the response of the individuals and I began to ear-mark certain households which I thought would be more cooperative than others.

During the first few days, the interactions with the people that I had been newly introduced to were rather formal. In sharp contrast to village life where anthropologists have been known to partake of household activities of the people they visit regularly, urban culture does not always welcome such assumed familiarity. In the initial months, most of my interviews were conducted in the drawing rooms. I was very careful so that my repeated visits would not be misconstrued as transgression into their busy lives. Since most of the men would go out for work during the day and the women would be busy with their household chores in the morning, I would conduct my house visits mostly in the

afternoons and evenings. It was only during my later visits when the relationship became more informal and I was invited for meals to their houses that long, informal conversations would be held. Most of my data was elicited in this manner. These interactions gradually evolved into informal relationships that I forged in the course of my sustained interaction with them.

Intensive observation, long considered crucial to comprehend what Malinowski (1922) describes as 'the imponderabilia of actual life' entails daily proximity to the field as a participant observer. I was, therefore, on the lookout for a place to stay in the neighbourhood. Three weeks after I had begun my fieldwork, I met a family of distant relatives at a marriage who invited me to their house. They lived in Zoo Narengi Road, further down from the area where I had begun my study. I visited them the next day. Naren Chakravarti, a retired Principal Chief Conservator of Forests, who is the head of the household, is an amiable, helpful and well-liked person in the neighbourhood. He is a member of several civic organizations in the city and was able to later introduce me to several people in the neighbourhood. When I told him of my intention of living in the area, he offered me residence at their house. Their annexe on the second floor of the house was vacant at the time. The one-bedroom set-up with its own bathroom and balcony suited me perfectly. It also had an independent entrance if one chose to use it. I moved in there a month later.

This arrangement seemed conducive to my work. Not only did I have my private space, yet it was accessible to visitors that I had from my field area. I ate my meals with the family and would often help Mrs. Chakravarti in the kitchen

and around the house. They are a family of four members - the husband and wife with their two young children, Navaroop and Nandini. Both of them became good friends of mine during the course of my fieldwork and would not only keep me company in the evenings after work but would also occasionally accompany me on my numerous house visits. More importantly, Navaroop later became one of my pivotal case studies. He suffers from acute asthma and has undertaken the Fish Treatment at Hyderabad along with a number of other treatments for the same condition. I was able to document his medical biography with much detail as I saw it unfolding before my very eyes during the course of my residence with them. Besides, living with this family allowed me to see how people's values and beliefs are acted out and reinforced in everyday social activity. All these advantages outweighed any possible disqualifications of living with relatives during fieldwork. This proved to be a good decision and I profited from my stay with them.

The only constraint I felt, and that too during the initial months of living with them, was that they would invite me down each time a member of the kin group would visit the household. I often found it irritating, sometimes even stifling. But I later learned to override this conundrum by treating each encounter as part of my 'fieldwork'. In fact, on reading my field notes much later, I realized how much information I had gathered in the course of these seemingly 'uneventful' interactions.

I would often go and live with my parents in another part of the city. Besides the urge to spend time with them, these visits turned out to be fruitful

from the point of view of fieldwork. They were a constant source of information and help. I would carry my tapes containing long hours of conversation and would transcribe the data at home. I sometimes had difficulty understanding the more chaste Assamese terminology used by the older generation and I would take the help of my mother and grandmother, both of whom were, in any case, actively involved in translating the local vernacular texts that I had to use as reference material. Moreover, conversations with the members of my immediate family and other relatives, notwithstanding the fact that they were not from my field area, proved to be very insightful as they helped me to cross-check the information that I had gathered in the field. They were an important link of information.

Techniques employed in the field

I conducted my fieldwork over twelve months in six spells of fieldwork beginning in May 1997 and my last trip to the field was in June 2000. During this period, I deployed several field techniques to facilitate the collection of empirical data.

"No single method can grasp the subtle variations in ongoing human experience" (Denzin and Lincoln 1998: 24). Any particular research endeavour cannot be fruitfully carried out unless a range of field techniques are juxtaposed and used in accordance to the requirements of the situation. I formulated a tentative research design before I began my fieldwork. I deliberately avoided framing any hypothesis on the assumption that hypotheses, if any, could emerge in the course of fieldwork.

I had already gotten acquainted with a large number of households during

my initial survey. I chose my key respondents on the basis of the interactions that I had had with them during the first three or four months of my work.[45] Primary informants for children were mothers. Fathers were also participants along with their wives in these matters.

One of the core forms of research, observation, which serves as 'the bedrock source of human knowledge' was applied in its more general form in the initial stages and got more focused as I forayed deeper into fieldwork.[46] This allowed me not only to render descriptions of the area and of the lifeways of people but proved indispensable for providing first-hand accounts of the healing rituals *in situ.*

Most of my data was gleaned through interviews. These interviews would mostly begin as informal conversations and it was only much later into my fieldwork that I used semi-structured interview guides to execute my questioning in a more systematic way. I collected most information about life cycle rituals, customs and traditions via casual conversations with people and I used the interview guides to collect specific information on illness experiences, symptom recognition and usage of treatments.

The study was carried out at two levels. At one level were the observations carried out of the 'clinical population' (found at a particular healer's location) engaged in practitioner-patient interactions during the therapeutic encounters. At

[45] However, in course of time, the other families also became quite cooperative and volunteered information.

[46] I have borrowed this phrase from Adler and Adler (1998: 79).

the other level, the patient's point of view, considered to be central to the monitoring and evaluation of medical care in any situation, was elicited. So after every therapeutic encounter both the healer *and* the patient were extensively interviewed.

Since my focal interest was on pathways of seeking therapy, a processual approach was employed. I followed the extended case study method. Medical biographies and illness narratives of the patients, collected over a long period of time, formed the core databank for my study. Out of a total sample size of one hundred and seventy-nine individuals, I have collected fifty-eight medical biographies. Here, peoples' verbal descriptions of their illnesses were coalesced with their narratives on resort to various forms of medical treatment. I would begin their biographies with the onset of the disorder and continued to record the progression of events as they unfolded. This not only facilitated the interpretation of the actor's interpretation of the condition but also to document their usage of different systems of treatment. The descriptions of most illness encounters were collected in the form of verbatim texts to preserve the original meaning of the information. I have taken the help of quotations from the subjects to lend greater credence to my analyses. Each time I went back to the field, I would follow-up these case studies to evaluate the progress in the health of the patients and to mark attitudinal changes, if any.[47] This allowed me to schematize changing illness explanations over a period of time. In the same manner, the patients who were

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[47] My regular and repeated visits to the field stood me in good stead as I was able to update the illness biographies of my respondents over an extended period of time.

administered the Fish Medicine in Hyderabad (for the mandatory three consecutive years) were interviewed afresh each time they came back from their trip to the city.

I did not restrict my interviews to respondents from Zoo Narengi Road alone. I visited several clinics in the city where I interviewed patients who were from other parts of the city. This allowed me to document and follow these cases even after they left the clinics. I used referrals to identify many patients of specific disorders which were either given by fellow patients or by some of the healers. This way I was able to collect case studies pertaining to a wide range of ailments.

During my interactions with the healers, I conducted extensive interviews of Ayurvedic specialists, a Mantra Healer, Homeopaths, Reiki and Pranic Healing specialists, and a Lu-Tong bone-setter. I interviewed several astrologers as well.[48] In addition to these non-allopathic practitioners, eight medical doctors (three general practitioners, one dentist , one pediatrician, two gynaecologists, and one cardiologist) were also interviewed.

The Alternative Healing Centre at Rajgarh proved to be a fecund site for collecting biographies of patients. Located approximately within a three kilometre range from Zoo Narengi Road it is possibly the only centre of its kind in the city where a variety of nonallopathic treatments are offered under one roof.[49] I visited this clinic twice every week and would sometimes frequent it more often. I would

[48] In the act of diagnosing ill-health and then prescribing remedial measures for the same, I have categorized them as 'healers in this study.

[49] I have given a brief description of this clinic in Chapter V.

spend the entire day in the clinic interviewing patients as well as the healers. I also attended Pranic Healing sessions at Don Bosco School and Reiki workshops at Maniram Dewan Road to witness the proceedings. In December 1999, I took a course on the first level of Reiki in an attempt to partake of the rituals along with many of the respondents from my field area.

I visited the two temples of Kamakhya and Nabagraha in Guwahati several times for in-depth observation of health related rituals that are performed at these sites. I interviewed four priests (*pandas*) and attended the Ambubasi Mela at Kamakhya for three days in June 2000, where more than forty-thousand devotees of the temple had congregated to pay obeisance to Goddess Kamakhya.[50] It was a fascinating experience. Although I found no evidence of any health-related rituals performed in the premises during the period, I interviewed a number of tantriks who had assembled here from different parts of the country and widows who were largely from Bengal.

I made use of an elaborate questionnaire which I mailed to my respondents only towards the end of my fieldwork. By this time I had most of the qualitative information pertaining to my work and I was able to formulate an extensive set of questions on the basis of what I had learnt from my experiences in the field. I managed to schematize the answers and quantify some of the data after I received most of the questionnaires.

During the course of collecting illness biographies of people over a period

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[50] The temple remains closed to public on the three days when the Earth is held to be ritually impure.

of three years, I have come into close proximity with a number of my respondents. In the process I have forged personal ties with many of them. I have often been privy to the most private confessions of several respondents of chronic illnesses who have unburdened their anxieties and disquietude while narrating their case studies. There have been instances where my advice has been sought regarding options for action. Given the nature of my research, some people would assume that I would have information on the *efficacies* of medical treatments the unravelling of which, in any case, was not the motive of my work. I would often have to remind them that my research did not dwell on the 'scientific efficacy' of any system of medicine. Besides, and more importantly, I have undergone a certain rite of passage myself as I have almost 'travelled' with my respondents from one treatment option to another.

This 'intrusion' into their lives has been treated very seriously by some people. I have been 'inducted' as a member of the family in many households. In one case, in particular, the patient began to feel a sense of attachment to the extent that she decided to 'make' me her sister. She would insist that I stay with them each time I go back to the field. I would never refuse. I was, in fact, with her when she tried to commit suicide in a fit of acute helplessness of being unable to cope with her illness. During the days when she was recuperating from this event, she would often coax me to spend more time with her because it made her 'feel relaxed'. This was probably because I would always patiently listen to her speak. This also constituted fieldwork for me. In the process I have been able to record

her case with much precision and detail. However, in occasions like these, my emotional involvement with some of the respondents made it immensely difficult for me to later document the case as part of my 'study'. Although I have the 'informed consent' and permissions from all my respondents to present their cases in my study, I am not without a sense of unease at making a study out of their predicaments.[51] As Chase (1996) rightly points out, all research based on in-depth interviews raises ethical issues and narrative research, in particular, demands that the researcher pays special attention to the vulnerability of the participant (and the interpretive authority of the analyst).

The fiction of one's 'own' community

I have attempted an 'auto-ethnography' (Hayano 1979; cited in Adler and Adler 1998: 85) where not only have I studied my own community but have also assumed an active role as a patient at various stages of my fieldwork.. This stance not only helped me to interact with participants on a more informal level but also provided a vantage point from where I was able to experience medical interactions as a member of the community.

It is not easy to define what is actually one's 'own' community. There could be various interpretations of the term 'other'. At the level of the nation, it could mean an Indian studying a Western society; at the level of religion, it could mean a Hindu studying a Christian community; at the level of linguistic affinity, it could mean a person from one linguistic group studying someone from another

[51] I have borrowed the phrase 'informed consent' from Plummer (1983).

group, and so on. If one were to use standard diacritical markers to define a community, it is perhaps a simple task to situate oneself as belonging to one or the other community. I, for instance, had begun my fieldwork by merely identifying myself as an urban-based Assamese woman. But as I delved deeper into fieldwork, I realized that this definition was not comprehensive enough and there were many more strands of identification that had to be utilized to offer a more accurate summation.

No culture is homogenous. Each society is fragmented by caste, class, gender, neighbourhood, educational level, marital status, migrations and possible ethnic affiliations. These factors, and more, have to be taken in cognizance if one is to accurately ferret out the bracket that one actually belongs to. My field area, for instance, has a mixed population comprising Muslims, Ahoms and caste Hindus including Vaishnavites, Brahmins as well as non-Brahmins. As I made an attempt to ensign all their respective rites and rituals under the superscription 'Assamese', I found that Assamese culture would not lend itself to easy description unless the cultural components of all these groups were systematically represented.

Srinivas and Madan have dwelled extensively on this topic of fieldwork in one's own community. Srinivas (1966) suggested that the study of foreign societies is a prerequisite for the study of one' s own society. Madan considers this an "overstated position" and proposes the view that "the starting point of one's studies may well be one's own society"(Madan 1975:150). The issue of which ought to deserve precedence over the other in order of chronology should

perhaps not be called into debate. In the process of fieldwork, the trajectory of developments that mark each journey is unique, whether it is among a 'foreign' society or a society that one is a part of. The problems encountered are specific to the two different field situations. It is then perhaps best to enter the field as one would enter an unknown community because preconceived formulations tend to weigh down later experience as I found out in the course of fieldwork. Moreover, the role of serendipity cannot be ignored in any field situation.

The role of 'indigenous ethnographers' (Fahim, ed. 1982; Ohnuki-Tierney 1984; Berg 1989) - persons who are already members of the group they study - has been reviewed by a number of scholars. Ohnuki-Tierney, in her study of the illness and culture in contemporary Japan, emphasises that the "reservoir of knowledge" that anthropologists have about their own cultures "defies qualitative assessment" and that it has "profound theoretical and epistemological implications" (Ohnuki-Tierney 1984:13-14). Their accounts are "empowered and restricted in unique ways" (Clifford 1986: 9).

The entitlements are no doubt rich. There are no language problems and subsequent translations to wrestle with. Gaining entry into the field is smooth. I did not, at any point in my fieldwork, have to agonize over impression management and how to present myself to the people in trying to 'break into' the community. My Assamese identity invoked a very favourable response from the people. The motive of my visit was well taken. Rapport was established instantly and no hindrance was encountered in communicating with the people. News of my proposed field study had traveled to most people during my first few weeks

there. Rarely did anyone shy away from the appurtenances that I carried as a researcher like the camera or from speaking in the obvious presence of a Dictaphone. 'Getting inside' was thus no problem at all. In fact, I would often encounter respondents who felt *happy* that I had chosen to 'come back' to study my own community for my research despite the fact that I was studying outside the state. They would often go out of their way to give me access to information and vernacular records which an 'outsider' perhaps would not have had privy to with such ease.

The familiar and the unfamiliar

There are, however, a number of disqualifications that a 'native' fieldworker has to contend with. Very often, especially in the initial stages of fieldwork, I would find that the information that I was gathering would not seem significant enough to constitute 'data'! Most of the forthcoming ethnographic information seemed so mundane and familiar to me that it seemed to render them almost inconsequential from the point of view of research. Madan dwells on the same problem when he says that an anthropologist studying his own culture "is placed in a particularly difficult position; he is an insider who takes up the posture of an outsider, by virtue of his training as an anthropologist . . . and looks at his own culture hoping to be surprised. If he is, only then may he achieve new understandings" (Madan 1975:149).

The problem, I later realized, lay not in the data that I had procured but in my own angle of vision. I had to 'look harder' to register the presence of cultural

nuances that would simply pass me by because they were a part of the social landscape that I was too familiar with! My encounters in the field had so far been with cultures other than my own and there was a tacit search for the exotic which was an impediment till I learnt to override it. The anthropologist as self and the subject as the other were obviously not clearly definable categories in this situation. To unveil the symbolic structures that underscore the cultural patterns that seemed so familiar to me I had to constantly school myself to learn the process of 'making strange' or enact the act of 'defamiliarization' (Marcus 1998: 21). I had to 'neutralize' my frame of mind - make it *tabula rasa* - and then approach the familiar to make them *become* unfamiliar. Although a complete dissociation, even for an interim period, from one's own society is never possible, a certain amount of distance is necessary to be able to navigate through the data and structure the narrative into an anthropological piece of work.

Being a participant observer in one's own community is not an easy proposition. I could never 'get away' from the field even while I was relaxing at home with my family. During the course of idle conversation, my grandmother, for instance, would suddenly come up with the most interesting piece of information which would serve as a platform for further queries with other respondents. I had to thus bear the 'weight of perpetual inquiry' at all times (Narayan 1998: 179).

It was often a paradoxical situation. The fact that I was a member of the community meant that I was naturally familiar with a number of the customs and traditions of the Assamese. However, I would frequently encounter situations

where I was *not* familiar with what ought to have been so. Having been brought up in the relative seclusion of a tea estate and long years spent studying outside the state meant that I was a stranger to many crucial details of religion and ritual followed in several Brahmin households. Many of the intricacies woven into the healing rituals performed at the temples of Kamakhya and Nabagraha were, for instance, completely new to me. In this sense, I was as much an 'outsider' as an outsider might have been.

Insider and outsider

The mosaic of social life in any community has a bewildering number of complexities and no observer can be ubiquitous. "One knows about a society from particular locations within it" (Srinivas 1966: 154). It is impossible to possess information on *all* the facets of a culture. During a number of interviews, respondents, especially the older generation, would tend to gloss over some of the details in their rendition of social phenomena and merely allude to them on the assumption that, as a member of the same community, I was familiar with them. They were not without derision when they realized that I did not know what they *expected* me to know. My naiveté regarding what they considered to be 'common' beliefs often surprised them. My being an insider seemed to, therefore, impose a heavy obligation on me to understand cultural phenomena more accurately than an ethnographer from outside the community. Narayan highlights the "personal and intellectual dilemmas" involved by a similar assumption that a 'native' anthropologist is inherently equipped to present an "unproblematic and authentic insider's perspective . . ." (Narayan 1998:164). But if donning the mantle of a

professional inevitably requires creating some distance, Messerschmidt (1981) questions the extent to which *anyone* is an authentic insider.

I had already completed more than two months' fieldwork in the temple of Kamakhya when a friend from South India visited the temple. He was studying religious shrines in India. I introduced him to my informants and to some of the religious specialists in the temple. What surprised me most was that he would often come back from the temple with narratives that I was yet unfamiliar with. The priests (*pandas*) would take him on extensive tours around the temple complex, to sites that I had not been shown earlier. Kamakhya is one of the most famous seats of tantrism in the country and tantric philosophy abounds in the narrative discourses of the priests. My efforts at probing into the significance of certain phenomena would often be stymied by statements like "you are a young unmarried girl, how can you expect us to tell you everything . . .?" Despite my concerted and long drawn-out attempts at breaking through this barrier it was obvious that my gender was a disqualification. Being an 'insider' and treading a cultural world that is familiar, therefore, does not obviate the problems of communication in the field that arise due to gender and other considerations.

Age was another factor that seemed to stand in the way. I would very often be told that I looked "too young to conduct doctoral research." I had to constantly work at instituting an atmosphere where my respondents would take me seriously. Attempts to subtly convince my respondents of the seriousness of my intent, notwithstanding *their* perception of my age, would often be frustrating. Although most of my visits to my field area were received with warmth and even

enthusiasm, I would often be greeted by "Oh, look how you have grown . . . it feels so good to see you doing your Ph.D . . . I still remember you when you . . . " and so on. My preexisting identity defined by kinship affiliations subsumed my presence as a researcher and I had to constantly redirect conversations from remembered anecdotes from my childhood. It was often difficult breaking out of the mould of being my parents' daughter.

Respondents' answers were often misleading. Since my research interest also touched upon belief and practice of rituals believed to be efficacious in healing, it would require questioning about topics like belief in tantric practices, for instance. Queries like these did not always elicit a reliable response. Members of the upwardly mobile middle class, I feel, are too much on guard to maintain a front that does not allow them to make statements that might hint at their being, what they would perceive as, untoward. Telling an insider about such beliefs, they probably felt, would amount to their being labeled as 'superstitious' or irrational while the same would probably have been shared proudly with an outsider.

I had managed to collect ample medical biographies of certain illnesses like asthma, cardiovascular diseases, arthritis, spinal anomalies, and stomach disorders but narratives on gynaecological disorders pertaining to unmarried girls and sexual problems were not easy to come by. As far as women's problems were concerned, I documented a satisfying number of narratives by married women. Unmarried girls would be loath to share their experiences; many of them would initially deny having any such problem despite the fact that the information that I had procured from the records at the Alternative Healing Centre at Rajgarh said

otherwise. I took care not to record their narratives on tape and instead took down notes. Here, it was not so much encroachment of privacy but the fear of the information being passed on to other members of the community, especially in the case of unmarried girls. The status ascribed to me as an insider (as a potential betrayer of confidential information?) seemed at variance with the role that I wished to portray as a serious researcher who was merely following a scientific procedure to create a database for analyses rather than an insider who might 'spill the beans' to others.

My susceptibility to sudden changes in temperature and subsequent acute bouts of sinus occasioned my entry as a patient to most of the practitioners that I was studying as I have mentioned earlier. My experiences as a perpetual patient did not stem from a calculated simulation of an assumed role to elicit more data as a researcher but my own pragmatic search for a cure. From this vantage point I, no doubt, possessed many 'strategic advantages' (Berg 1989) which enabled me to get the 'inside scoop' as a researcher studying the same phenomena. I have been on Ayurvedic medicines for the past one year. I have undertaken Homeopathic treatment, have been 'given' Pranic Healing, Reiki and even Mantra Treatment. In the process, I have developed a firm belief in some of the systems, been impressed by the (perhaps unexpected) outcomes of others and of course, have been quite doubtful of the efficacy of a few systems. However, I had to constantly guard against letting my personal proclivities flavour the generalizaions that I was making in my study. I had to constantly keep reminding myself of the pitfalls attendant on imputing my own worldview while analyzing the data that I had

gathered from my respondents. Instead, I learnt to infuse a new texture to my own medical biography on the basis of systematic anthropological introspection. In the process, I was able to discover that one's own categories of cognition need not necessarily reflect *the* only categories that are common to all the people of the community; rather one of the *several* alternatives that one has chosen.

Despite the epistemological predicament involved in studying ostensibly familiar cultural patterns and the implications involved in imputing one's own categories while tracing the symbolic content of the various episodes of culture, the study of one's community offers a rich and unique arena for research. The leitmotif of the exercise is not just about the act of discovery alone but about achieving the greatest possible *depth* of understanding.

Data collected in the field thus undergoes various stages of reflection and transformation from the beginning of fieldwork to the end. It is interaction and experience that enable the anthropologist to negotiate these stages. The 'participant' observer's experience, therefore, remains crucial and cannot be dispensed with, whether it is in one's own culture or among other people. What distinguishes one from the other is neither so much the techniques used nor the ease or difficulty of carrying out the research. In both field instances, the anthropologist simulates a double role: that of a participant in and as an interpreter of a way of life. However, in studying others the anthropologist tries to see and feel *for the first time* what it is to be part of a particular culture; in systematically examining and then analyzing one's own culture, on the other hand, the anthropologist learns to see, feel, and know *afresh* those institutions, processes,

and world views to which he belongs (Cole 1982).

Although studying one's own community lacks the same "dramatic quality" as the study of an unfamiliar culture, "its contribution to the understanding of society is no less significant" (Beteille and Madan 1975:4). The romance of the unfamiliar may be absent and the emphasis may be on what Okely (1996) terms 'prosaically familiar' while documenting lifeways which are not shrouded in mystique. However, if the avowed aim of the anthropologists is truly the study of humankind, then so-called 'native anthropology' (or 'anthropology at home') would provide the most holistic view to the study of cultures.

CHAPTER 4

Local Beliefs

LOCAL BELIEFS

All societies have explanations about the world around them. Categories of cognition are framed within a particular matrix and the narrative trope that an individual adopts to explain most phenomena is culturally shaped. Belief remains central to the analysis of culture.

A study of illness behaviour necessitates, above all, an emphasis on individual perceptions of sickness and disease. It is seen that the Assamese have a significant concern for preventive care and daily health care. This chapter provides a description of some of the local beliefs that are associated with health and illness. Most of the respondents (73.1%) I interviewed to elicit this information were above fifteen years of age. This choice was intentional because older people were found to be more familiar with everyday measures reflecting local beliefs.[52] I must mention at this point that the more knowledgeable informants tended to be older married women with children. This was probably because they had adequate experience with trying to cope with not only debility or suffering of themselves or of members of the family, but giving birth, rearing and nurturing children are tied to health and diet.

Definitions of health and illness

Most people define health *(sāsthya)* in terms of 'quality of life'. Although the

[52] Although I found that people less than twenty years were familiar with local terms, specific information about health beliefs was more forthcoming from respondents above this age.

respondents were not able to offer an exact denomination to describe it in terms of objective, operational things, the general concept they outlined was in terms of 'mental and physical well-being'. Impairment of this condition is explained in terms of inability to perform functions of daily routine. Cognition of what constitutes a 'health disorder' rests on various factors. A large majority said that they 'realize' they have an ailment *(hemār)* when the situation impinges on the usual schedule of work. A term refered to as *gā beyā* usually connotes a general condition which could perhaps be equated with the concept of illness sans an accurate definition of a disease. The *initial* symptoms of most minor ailments are first met by home remedies of various types according to 72.1% of the people. The rest claimed first recourse to allopathy in the event of any symptoms that are equated with illness. In the case of heart attacks, sudden detachment of the retina, sudden stoppage of urine, severe kidney pain, etc., people are seen to jump the intervening stages and take immediate recourse to allopathy. When the illness is not considered to be serious enough, for example, in cases of cold and cough, 'regular' stomach ailments, etc.,they usually try a variety of home remedies.[53]

The definition of the word 'initial' is offered variously with words like 'nagging', 'irritating', etc. A feeling of discomfort is the main implication. Here they make a distinction between an 'initial symptom' and a symptom that 'sets in' which requires medical intervention. A large majority (73.8%) said that they take allopathic medicines the moment a symptom 'sets in', that is, they feel that it

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[53] Stomach ailments of various types were commonly cited in people's narratives. It seems to be a recurrent problem in the area.

begins to definitely interfere with their lives.[54] The rest of the people said that they consult specialists of alternative medicine. Specialized medical counsel, either from an allopath or from an alternative healer as the case may be, is usually sought between three days to five days of the onset of the problem.

Medical facilities in the city are felt to be adequate by 86.1% of the respondents although many feel that the distribution of doctors is not. The remaining 13.9% feel that there should be diagnostic clinics and medical centres in every neighbourhood and a large hospital complex in the city where doctors from reputed medical institutions in other parts of the country could be brought in as visiting consultants.[55] Most families (61.3%) have a family doctor to whom they first refer in the event of any ailment and those who do not, consult a physician of their choice in the event of illness. This physician may or may not be a specialist. Many respondents (39.4%) said that they consult a specialist directly, the choice of the specialist being contingent upon their perception of the disorder. For instance, for a disorder of the ear, an E.N.T. specialist would be consulted or a dermatologist for skin problems.

Decision making is influenced by various factors. Questionnaires indicated highest preference for doctors who are 'well-known' and have favourable social

[54] By 'setting in' here means something serious - that 'interferes with life'. This phrase is also used to convey a condition when people find that no relief is forthcoming and signals medical intervention.

[55] There were many respondents who, during the course of interviews, said that they had gone for surgeries or even 'second opinions' in the case of serious ailments to places like Calcutta, Delhi and Bombay. This, they felt, would not have been necessary had medical facilities in the city been more adequate.

characteristics *(byebohaar)*.[56] Medical qualifications are also deemed significant. Technical equipment (especially in the case of dentists) is cited as an important factor in influencing decisions. Decisions are often taken after consultations with members of the family, extended kin group and sometimes even neighbours. This is especially so when a choice has to be made between several doctors. If there is a medical doctor within the family, he is invariably consulted for an opinion on the condition and for advice on which specialist to consult.

Members of the family play a significant role in the care of the sick. Women (be it the mother, wife, sister, daughter or daughter-in-law) of the patient are considered to be more important than men. In cases of chronic ailments and mental ailments, in particular, the therapy management group (TMG) is much larger and comprise persons beyond the immediate family. In most of the case studies of chronic illnesses that I have collected, members of the extended family and in many instances, neighbours, play an active role in the management of the 'crisis'. There are regular visits to the household of the patient and ideas are exchanged on possible strategies for action. In many households with a serious cardiac patient or a severely diabetic person the dietary pattern is regulated not only for the patient concerned but is largely followed by the rest of the family as well. Children up to the age of twenty to twenty-two years, are accompanied by their parents, more often by the mother, for medical consultations. This is more prominent in the case of females who may be accompanied to the doctor's clinic

[56] The emphasis on social characteristics was specially indicated by many of the respondents as they sought to highlight this point in words despite marking the variable in the questionnaire.

till they are much older. Decisions regarding treatment of their children are taken jointly by both the parents although I noticed that most decisions to take recourse to non-biomedical treatment are taken by women. An interesting point to note here is that decisions regarding extended allopathic treatment are communicated to a male member, even if the patient under scrutiny happens to be a woman.

The principal referent among a majority of people is allopathy where definitions of what constitutes 'medical' is almost always rooted in biomedical language. However, 57.9% said that they had used non-allopathic medicine in the past one year and 68.7% said that they had used any one of these systems at one point in their lives. This does not mean that they stopped using biomedicine altogether. An interesting finding is that many people who had emphatically stated that they did *not* believe in alternative medicine had used them at some point in their lives. This was mainly in a time of exigency when other treatments had failed to deliver a cure for their illness and they had 'tried out' one or the other form of alternative medicine.

Domestic remedies are mostly herbal-based. However, for conditions which are not considered serious (like headaches, cold and cough, minor stomach ailments, etc.), a large number of people resort to taking allopathic pills as well which form a part of their household medical kit. These pills are mostly analgesics, anti-inflammatory, antacid tablets, etc. A number of respondents said that they take an Ayurvedic preparation called Nagarjun for stomach disorders like indigestion and diarrhoea.

Homeopathy and Ayurveda are rated as the two most trusted nonbiomedical systems in the city. It is difficult to conclusively estimate which is more popular than the other because usage is found to be related to the type of illness.[57] For stomach ailments more people are seen to resort to Ayurveda while for respiratory ailments and for ailments in children Homeopathy seems to be the more popular option.[58] Similarly, for sexual disorders men are seen to consult Ayurvedic practitioners over Homeopaths. On the whole, however, Ayurveda seems to be the most cited system.

Alternative medicine is mostly used after allopathic treatment has failed to cure a condition; sometimes it is used to complement allopathic treatment which has already been undertaken or is currently being used. The former is more prominent in the case of post-surgical convalescence and the latter for illnesses with a long history of continuing allopathic treatment as in the case of cancer, diabetes, asthma, mental illnesses and gynaecological disorders.

Almost all the respondents, with the exception of eight persons said that they believe faith *(bissāx)* is important in healing. Astrology is used frequently. It is interesting to note that most people do not classify it as a 'medical option' and deny having consulted an astrologer for 'healing' but during the course of their narratives, visits to the astrologer on health grounds figure prominently. I have, therefore, delineated this practice along with other systems of alternative medicine

[57] When people suffering from chronic ailments consult these specialists they are mentally prepared for a lengthier treatment.

[58] Some of the respondents told me that Homeopathic pills are easier to administer than Ayurvedic medicines; although this cannot be used as the demarcating feature between patterns of usage, this point calls for further study.

in Chapter Five.

It is to be noted that Acupuncture and Unani are absent in this scenario. There are no trained Acupuncturists in the city although two of my respondents, one suffering from spondylitis and the other from arthritis, have taken this treatment during visits to Hong Kong and Japan. Not many people had knowledge of the Unani system of medicine; certain products of Hamdard Dawakhana like Safi and Ruhafza, however, are used, albeit without the conscious knowledge that these are based on Unani. This may well be due to the fact that the Unani system has not received state or public patronage, especially since 1948, which was the year that the Ayurvedic College was set up.

Hygiene, climate and illness etiology

Daily hygienic practices among the Assamese are based on the most fundamental concepts of cleanliness and dirt. Houses are swept, mopped and dusted every morning, usually by a domestic help. All the families that I interviewed have at least one domestic helper. There is a distinct spatial classification between the outside *(bāhir)* and the inside *(bhitor)*. Traditional Assam-type houses have an inner courtyard *(ṣotāl)*, which is not considered to be dirty as the outside is and thus serves as a site for household activities. Styles of architecture, however, have changed much in the city giving rise to 'modern' houses which seldom have these traditional courtyards thus breaking down this inside-outside classification. Shoes are associated with the outside and hands are meant to be washed each time shoes

are touched. Connected to this is the Assamese belief in 'germs' *(bijānu)* which are believed to pervade the atmosphere. These germs are considered to be etiological factors for disease and are believed to exist in the air and as well as in water. All the families that I interviewed said that they use filtered drinking water. One often hears older people tutoring children not to touch anything that is considered dirty *(leterā)*. Bihu festivals are ceremonial occasions which signify the elimination of pollution of the previous year with cleaning of kitchens and 'heating' of old utensils on fire.[59]

Climatic conditions are considered to be possible factors in inducing ill-health. The transitional period between seasons are believed to be unsuitable for a person's health. The months of *Phāgun, Sot* and *Ahār* are considered to be particularly harmful as far as illnesses are concerned.[60] During the month of *Phagun* the strong and dry winds that blow in the region are considered to have deleterious effects on health, especially with regard to the air-borne diseases like chicken pox and measles (which are known as *māju āi* and *xoru āi* respectively). During this time people use *dhunā* (fumigation) in the evenings in their houses to not only purify the air but also to ward off mosquitoes. The summer months coinciding with the onset of the monsoon *(xixā)* in the month of *Ahar* are believed to be harmful as far as water-borne diseases are concerned, the most predominant among them being stomach ailments (including worms) of various

[59] This could be compared to Ohnuki-Tierney's statement that New Year's Day rites among the Japanese guarantee ritual purity for the following year (1984:23).

[60] See Appendix I for a description of the Assamese calender.

kinds.[61] The high humidity and the heat are quoted as the main reason why people wear light clothes and there is a predominance of white and pastel shades in traditional clothes. The high humidity is also regarded as the main cause behind the high incidence of respiratory ailments in the region.

I find distinct parallels at this point with Ohnuki-Tierney's (1984) study of Japanese illness etiology where she finds that climatic conditions are considered to be the *factors* that induce humoral imbalance, which then becomes the etiological factor for the occurrence of illness. In the Assamese world view, like the Japanese belief, climatic conditions are held to trigger internal imbalances in the body which then lead to sickness. So one often hears statements like '*thanda lagibo. . .* ' (will catch a chill) and '*petot gorom xumāle . . .* ' ('heat' has entered the stomach), etc. as explanations for conditions that are believed to be caused by climatic factors.

There are concepts regarding purity and pollution which are more prominently attached to rites of passage, as has been described in the Chapter Two.[62] In everyday life the concept of pollution is more explicitly framed *via-a-vis* food and also menstruating women, both of which are believed to hold implications for health. For instance, many of my female respondents told me that the three day abstinence from cooking, ritual and household activities imposed on

[61] Several families told me that they regularly use *dhunā* every evening in their houses. This is also used when religious ceremonies (pujas) are conducted.

[62] The concepts of purity and pollution are most evident during life cycle rituals, as has been mentioned in Chapter Two , and food prescriptions. However, as Cantlie (1984) has noted, there is also the aspect of committing certain sins, believed to produce a psycho-social condition in the body, which are considered to be polluting. In this case, recourse is made to the sacred and the person has to undergo penance *(prayascitta).*

a menstruating woman was actually designed so that she would get enough rest during these days. "Nowadays, with many young girls not observing these rituals has heralded a host of gynaecological problems for them," said a seventy-four year old respondent.

The passage of night is believed to render things stale *(bāhi)*, therefore, impure. It could refer to rice cooked the previous day and kept overnight *(poita* or *bāhi bhāt)*, or one's mouth that has not been washed in the morning *(bāhi mukh)*, and even the courtyard that has not been swept in the morning *(bāhi sotāl)*. Although no explicit connections between this concept and disease could be offered, the fact that anything which is *bāhi* is considered unfit for ritual conveys, however tangentially, implications for health. This is possibly connected to the belief that everything putrefies or ferments with time[63].

Food and health

There is a rich repertoire of dietary rules *vis-a-vis* conditions of health among the Assamese. Many items of food which are eaten on a regular basis are believed to contain medicinal value and food prescriptions are often tailored according to the perceived qualities of 'hot' or 'cold' that the item may be believed to inherently possess. These attributions do not refer to the actual temperature changes produced by cooking but to the constitutional properties believed to be contained in the substances. If a person is understood to have a condition that is classified as

[63] For an elucidation of the central role that both weather and putrescence play in the causation of disease see Naraindas (1996).

'hot', intake of foods of the opposite quality, that is 'cold', would be prescribed. Hot *(gorom)* foods are considered to be heavy or difficult to digest.

Food is generally classified according to whether it is uncooked *(kesā)* or cooked*(pokā)*.[64] Whole raw *(kesā)* food is not usually regarded as polluting. Addition of salt and oil are, however, considered to alter the configuration of the item. Cooking with oil renders the food impure (*suwā*). It is traditionally believed that eating foods that are considered *suwa* can trigger ill-health. This word connotes food that has been left over by other people as well as as stale food that has been left overnight, as has been described in the previous section. Cooked food items are also considered as 'wet' food.

Food is categorized according to the effects they induce in the body.[65] *Sattvik* foods include milk and milk products, rice, pulses like Bengal gram and green gram, fruits and most vegetables; *rajosik* items include meat, fish, eggs, onion, garlic, spices, honey, buffalo milk and certain pulses like *rohor* and *mati dal* and finally, alcohol, pork, chilly, stale food and beef are labeled as *tamasik* items. *Sattvik* food, considered to have 'cooling' properties, is most conducive to good health while *rajosik* items are considered to be 'hot' and passion-arousing; *tamasik* food which increases laziness, are believed to induce laziness.

Traditional Assamese food is very light and cooked with minimum oil and spices. This means that they are easily digested. Much of the food that is eaten

[64] *Kecā* also means 'raw' and *pokā* means ripe.

[65] Although not everybody refers to this classification with these labels, there is common reference to the foods contained within it as 'heavy' and 'light'.

regularly has prescriptive value for conditions which are believed to be caused by the high humidity in the region. Thus, food is regarded not only as health promoting but also as having medicinal value. Respiratory and stomach disorders are the most commonly cited illnesses. There is, therefore, constant reference to food prescriptions considered to be effective in curing them.

Steamed or boiled rice *(bhāt)* is the staple food. *Khār* is an alkaline preparation made of vegetables and cooked with soda. It is usually eaten before the meal begins, either by mixing it with hot rice and mustard oil or on its own. It is considered to be very beneficial for stomach disorders, especially in cases of acidity, and for infections of the throat. The peel of a kind of banana, *bheemkol (Musa sapientum),* is first cut and dried in the sun. It is then roasted, the ashes of which are collected, moistened with water and strained through straw. The water which is distilled in this manner is collected drop by drop and is called *khāroni.* This is then used to cook the vegetables.[66] *Tengā* is a light curry, slightly soured with tomatoes and lemon (even tamarind juice) and popularly cooked with an edible fern called *dhekiā* and other 'light' vegetables, mainly different kinds of gourd. This is considered to be particularly 'soothing' during the hot, humid months in the summer. *Pitikā* is mashed boiled potato eaten with mustard oil and salt and often made with boiled vegetables. Non-vegetarian food, especially fish, is popular. Bitter gourd or *titā kerelā (Momordica charantia)* is eaten, either boiled or fried, with rice in the month of *Ahār* to combat stomach ailments.

[66] This was traditionally used to cook vegetables and prepare the *khar* but this is rapidly getting substituted by soda bicarbonate which is more readily available in the market. According to popular belief, the *kharoni* prepared on a moonlit night is considered to be of the purest quality.

Soft rice *(komal sāwl)*, cooked rice flour *(pithāguri)*, flat rice *(sirā)*, and parched rice *(ākhoi)* are generically known as *jalpan*. These are also classified according to *kesā* and *pokā*. They are generally eaten with curd or milk and jaggery *(gur)*. *Ākhoi* is generally considered to be the only 'pure' *jalpan* which can be eaten on ritual occasions. *Komal sāwl*, according to some, is also considered *kesa*, hence pure, because it is paddy is boiled with the husk and not rice.[67]

There are also seasonal proscriptions on food. Eating a 'heavy' diet (which is difficult to digest) during full moon *(purnimā)* and the *bel* fruit (*Aegle marmelos)* during the period of Panchamtithi is considered to be particularly harmful for health. *Tengā* and the various kinds of *pitikā* are prescribed during the hot summer months.

During Ambubasi, when the earth is considered to be menstruating, no cooked food is eaten by widows. Besides, they are not supposed to eat anything that grows under the ground because it is believed that the earth becomes ritually impure during this period.

Prescriptions during pregnancy

Pregnancy is particularly punctuated with dietary prescriptions and proscriptions. Milk and other dairy products, fruits, liver, dry fruits, etc are recommended for a

[67] The husk is believed to provide a proetective shield in much the same way as the skin of raw vegetables.

pregnant woman because they are considered to be nutritious and strength-inducing food items. Pineapple and papaya, believed to be 'acid-causing' items, are prohibited, as they are believed to have an adverse effect on the womb.[68] Very sour food is avoided.

On the fifth month of pregnancy, the expectant mother is ceremoniously administered a concoction called *panchamrit* (which literally means 'five nectars'). It is a combination of five raw ingredients, namely, uncooked milk *(ewa gakhir),* curd, ghee, honey and sugar out of which a semi-solid consistency is made. Usually five married women (who have children) feed this to the pregnant woman who is supposed to fast all day and is allowed to eat only this preparation. In the evening, fish (usually *rohu* fish) is baked in banana leaves over a charcoal fire and she is supposed to eat this with other items of regular diet. This ritual has significance for the health and wellbeing of the mother and the baby. It is tied to the belief that the baby in the womb learns to eat from the fifth month onwards. This preparation, therefore, is given to the mother so that the baby may eat it from her.

On the seventh month of pregnancy, there are seven types of food which are fed to the pregnant woman. The items that are generally prescribed include fish, meat, eggs, vegetables, and *bhāt-pithā* (pounded rice powder mixed with

[68] The thin membranous layer inside the papaya is considered to be particularly harmful for a pregnant woman.

boiled water)[69] Food prescriptions and proscriptions are followed till after childbirth. Till the third day after the birth of the baby, the new mother is not supposed to eat meals that are considered to be heavy *(godhur)*, that is, difficult to digest. Light soups and boiled tapioca *(sàgu)* are usually given to the new mother. In the olden days, the woman would be disallowed from drinking water during this period but with almost all women giving birth in hospitals and nursing homes, this practice has been dispensed with as doctors nowadays prescribe water after childbirth.

On the third day after giving birth, the mother is given fish, locally known as *magur maas* (Indian Magur - *Clarias batrachus*), which is cooked with a paste made of sesame *(til)*, ground with black pepper and plenty of garlic. Some people substitute the fish with pigeon meat. The latter is believed to increase the blood supply and help dry up the 'internal system' of the woman after delivery. Often the fish is cooked in plantain leaves and a fern called *kosu xak.* This preparation is known as *til jaal.*[70] It is on this day that she is allowed to eat rice for the first time. For the first three weeks, diet restrictions persist. During this time period, she is prohibited from eating any 'heavy' food like meat, fried food and food that is

[69] Apart from the food preparations around this time a ritual is carried out by some families, either in the form of a puja for the welfare of the baby and the mother or in some cases chanting of a set of mantras called *punxo bon* which are considered to be very beneficial for the unborn baby. The pregnant mother is made to sit on a raised stool *(pirā)* made of a wood, locally known as *dimoru.* All this, as envisioned by the people, are considered to enhance the growth of, and to ward off illness from, the baby.

[70] 'A woman who gives birth to a baby is particularly susceptible to infections', I was told. My respondents believe that this preparation was first started at a time when there were no antibiotics but it performs the same functions as modern antibiotics do. It is interesting to note that despite all my respondents having given birth to their children in hospitals they have all followed this custom in addition to taking the usual gamut of allopathic drugs prescribed by their doctors.

cooked with too much oil or spices.

***Nojor-loga* (evil eye)**

There are several instances where certain recurrent ailments are thought to be caused by evil eye *(nojor loga* or *mukh loga)* of certain persons.[71] This explanation of illness causation, I found, is not usually subscribed to in cases where the illness is of a serious nature; it is offered in cases where the ailment is nagging, extends for a few days and to which no apparent cause can be assigned; or in cases of a abrupt loss of appetite and sudden 'loss of colour' (when the individual begins to look very pale). Although there is no specific 'type' of person who is attributed with the power to effect this kind of condition, some of my respondents, after much vacillation, said that there *are* some people who are by nature envious of other peoples' success and happiness and choose to 'cast their eye' on them in an attempt to negate those qualities. This may be done voluntarily or involuntarily. Women, more than men, seem to be attributed with the power to cast the evil eye. The general opinion, however, is that too much flattery or eulogy of a particular trait of a person, male or female, especially when the person concerned is beautiful or successful, sometimes makes one susceptible to afflictions. Jealousy seems to be the primary motive.[72]

[71] I found it interesting that the people of Zoo Narengi Road, despite being educated and 'modern' still have the traditional theories of disease causation, one of them being the belief in the effects of evil eye.

[72] Evans-Pritchard (1934) found that in the case of the Azande witchcraft provides a 'natural philosophy' to explain misfortune. In the same way, 'evil eye' is an explanatory construct. It reinforces the belief that the child who is most vulnerable to evil eye is handsome or beautiful. This belief highlights how individual characteristics which are considered impressive are accentuated by concepts like evil eye.

There is an enduring belief that babies and children are more susceptible to the effects of evil eye than others. However, I did come across cases where even pregnant women were advised to 'be careful'. I observed that many babies, small children and some pregnant women wore amulets and talismans as protective measures.[73] These are given to them, on request, by specialists, either from priests or Mantra Healers in whom the family has faith. Babies are also given a small black spot on the forehead to ward off possible evil eye.

One of my case studies is of a thirty-two year old mother who attributes the sudden bout of diarrhea that her one year old baby suffers from to the effect of evil eye. She tells me that her daughter is a very healthy baby and is not usually susceptible to many external infections. However, every time she takes her out to a social gathering where this particular old lady, a neighbour, makes a remark about her health, she falls ill from the very next day. The old lady has two sons who are married but are childless. Another case is of a two year old baby girl whose father and mother both believe that her sudden loss of weight over the past two months cannot be attributed to any reason other than *nojor loga*. "Her pediatrician has prescribed a number of vitamins but she still has not regained her health. She looks so pale now," her mother told me. Her mother-in-law performed the divination ritual *(mukh bhonga)* one Saturday morning and they confirmed that she had been afflicted when there was absolutely no smell coming from the

[73] My respondents did not rule out the possibility of evil eye being cast on inanimate objects like houses, cars, etc. but general discourse on the topic implied its effect on human beings, particularly children. There are, however, several instances from my field area where people have taken their new cars to temples, not only for blessings from the deity but also for 'protection'; in this context, protection could imply both a bulwark against the effects of evil eye as well as general protection from possible mishap (accidents) while driving.

mustard seeds in the fire.

Usually the ceremony that is conducted to diagnose and then mitigate the effects of evil eye is called *mukh bhonga.* Black mustard seeds and dried red chillies are the main ingredients. The procedure involves first holding these ingredients on the right palm and 'sweeping' a fistful of these ingredients three times in an anti-clockwise direction, accompanied by the chanting of a special mantra, and then throwing it into a dish or trough containing live charcoal.[74] The belief is that if the burning chilly emits a strong smell, the person has not been affected by any evil eye but if no smell emanates from the fire on throwing the mixture, then it is interpreted to be the effect of evil eye. This ritual is usually done on Saturdays.

Although there are sporadic instances where older women in the family have performed this ritual for adult members of the family, I found that it is usually carried out for babies and children who are considered to be more susceptible to the effects of *nojor loga.* Sabita Debi, a seventy-one year old respondent told me that she performs this ritual twice every month for her three year old grandaughter.

Domestic remedies

Traditional folk prescriptions are seen to persist at various levels, especially in the realm of domestic remedies for any condition. These, as I mentioned earlier, are

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[74] This ritual is generally performed by an elderly woman in the household. I did not find any instance of a specialist or a priest whose services were solicited for the purpose.

based on locally available herbs or fruits (see Appendix).

Besides the general prescriptions I collected a number of remedies which are prepared according to certain specifications.[75] Most of these remedies, generally prepared by a member of the family or a domestic help who has been instructed to do so, pertain to ailments which are most common among the people.[76]

Pigeon meat cooked with pepper is considered to be beneficial for persons who have a **cold**. If a baby refuses to drink milk, dried *amlokkhi (Emblica officinalis)* and *xilikha (T. chebula, T. citrina)* are ground, mixed with a little bit of honey and rubbed on the baby's tongue. For cases of **krimi**, five seeds of *guti nemu* (lemon- *Citrus limon*) are ground and drunk with water on an empty stomach. Juice of *amlokhi* is extracted and mixed with sugar and eaten to stop **vomiting**. One teaspoon of the juice of *dubori bon (Cynodon dactylon)* and a little lemon juice is mixed with water and is given for the same purpose; sometimes *xilikha* is ground and eaten with honey.

There is a particularly extensive repetoire of domestic remedies for **stomach aches**. The most common ones are:

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[75] These remedies are deemed to be very effective. Many households have a vegetable garden in the backyard and some of these vegetables are grown there. Others buy the ingredients from the market. Most of these ingredients are easily available.

[76] This kind of knowledge is usually found to be the repository of the older members of the family. They are orally transmitted to the next generation. There are certain books which are now available in the market, the most well-known being Khanikar's (1995) work on herbal medicines. However, the 'grandmothers' remedies' are considered by the people to be most effective.

i. Juice of the leaves of *noroxingho* mixed with water is drunk.

ii. Three grams each of *podina*, asafoetida, jeera and pepper are ground and mixed with salt and eaten.

iii. About ten grams of garlic extract is mixed and eaten with a little salt.

iv. *Saunfguti (Foeniculum vulgare)* and black salt are mixed with warm milk and drunk.

For **cough** usually *khar* is made with the ends of *athiya kol (M. paradis ica)* and dried *kosu (Colocasia esculanta)*.

For **allergies** of the skin, the juice extract of *tuloxi* (*Abies wabbiana)* leaves is mixed with juice of raw turmeric and eaten. Moreover, juice of ginger is mixed with old *gur* and eaten. Four to five leaves of *bhedai lota (Paederia foetida)* are ground and anointed on the site of the allergy. Raw turmeric juice is eaten for about ten to fifteen days as a remedial measure. Eucalyptus leaves (usually four to five of them) are rubbed on the region. *Dubori bon* and raw turmeric are also ground together for anointing as well as for eating.

For patients of **diabetes**, more particularly to stem frequent urination and excessive thirst, few grams of green gram and turmeric *(mah halodhi)* are ground and mixed with half a teaspoon of honey and water as medicine. The juice of ten to twelve berries of *amlokhi* is mixed with honey and eaten for fifteen to twenty days. Juice of *mani muni* is to be eaten early in the morning for a few days. *Amlokhi, xilikha* and *bhomora* are mixed with honey and eaten as well. *Tita kerela*

(Momordica charantia) juice is also recommended for an entire week. Carrot and spinach juice are often drunk by diabetic patients.

For **gastric ulcers**, the extract of garlic is taken with a little bit of water for about a fortnight. For **palpitations** which 'indicate a weak heart', according to a large number of people, about two hundred grams of ground bark of the *Arjun* tree is mixed with ten grams of ghee and two hundred grams of milk. For **stomach ailments**, considered to be caused by wind, *xilikha* seems to be the most popular recommendation. Either some are roasted and eaten with food or it is chewed raw after meals. Broken ginger is often mixed with salt and washed down with warm water half an hour before meals. Some warm milk is drunk with little turmeric juice and salt as well. A preventive prescription is *amlokkhi, xilikha* and seeds of *bhomora,* ground and mixed with water. One *pipli (Piper longum)* is sometimes mixed with warm milk. Little bits of *pipli* and *xilikha* are often mixed with a small quantity of water which is then warmed and eaten in cases of severe **diarrhoea**. Raw *bel (Aegle marmelos)* is mixed with jaggery and eaten by some for the same pupose. *Bhedai lota* leaves cooked with light vegetables, often *kas kol,* is one of the most popular home remedies for all stomach ailments .

Blessed food *(praxād)* that is offered at pujas, although eaten in small quantities, have tremendous nutritive value. All the ingredients of the *noibidyo* (nine items included in the *praxād)* are raw *(kesā).* It consists of two varieties of pulses - Bengal gram *(but)* and green gram *(mogu)* - washed and soaked in water, ginger, a fine variety of rice called *joha sāwl,* banana, other seasonal fruits, coconut, areca nut placed inside funnel-shaped betel leaves, and salt (which is

added only before the *praxād* is eaten, not when the *noibidyo* is offered to God).[77] All the items are considered to be 'cooling' except ginger, which is offered as a digestive.

Religion and healing

Although I have incorporated a section on astrology and healing in the next chapter, the intention here is to discuss people's attitudes towards the role of religion and healing.

The principal deities in most people's houses are Shiva, Krishna, Ganesh, Durga and Mahamaya. Other deities include Saraswati, Lakshmi, etc. 63.1% of the respondents said that they believe in *groho puja* (propitiation of the planets) and 71.8% said that they had performed some kind of religious ritual for health at some point in their lives. This indicates the large percentage of people who actually delineate a connection betwen health and religious ritual. Among the shrines that are more often visited by the people are Kamakhya, Nabagraha temple, Dol Gobindo (Krishna temple), Ugratara and Shani Mandir.[78] There are several people who mentioned having visited a Muslim shrine at Ulubari in the city.

Gems prescribed by astrologers are worn by 39.1% of my respondents, out

[77] In Upper Assam, it is cut and placed inside the betel leaf *(thuria-tamul)* as described and in Lower Assam the areca nut is usually offered without being cut *(gota-tamul)*.

[78] Dol Gobindo is in North Guwahati across the river Brahmaputra and Mahamaya is in Bogoribari in the Dhubri district. The latter entails travelling to the area for puja. Many of my respondents said that they sometimes send money by post to the head priest of the temple who performs the puja for them and sends back the flowers which have been offered to the goddess *(nirmali)* smeared with vermillion from the goddess' idol (see photograph).

of which 20.3% wear it for health reasons. Amulets, talismans and *rudrakhyo* (*E. ganitrus)* are the most popular ritual artifacts. Amulets and talismans are worn by 20.4% of the people (amulets being used more often) and *rudrakhyo* are worn by 11.1%; the remaining 29.4% do not wear any of these items.[79] Amulets, talismans and the *rudrakhyo* bead are consecrated *(xudhon kora)* objects. It is believed that they carry a power only if they have been potentized by specialists who chant mantras on them. I was told that the *rudrakhyo* bead is categorized according to the faces *(mukh)* that it possesses and are related to the planets.

Table no. 5

The association of *rudrakhyo* with respective planets

Rudrakhyo	**Associated planet**
One face *(ekmukhi)*	Sun
Two faces *(dumukhi)*	Moon
Three faces *(trimukhi)*	Mars
Four faces *(soturthomukhi)*	Mercury
Five faces *(ponchomukhi)*	Jupiter
Six faces *(jostomukhi)*	Venus
Seven faces *(xoptomukhi)*	Saturn
Eight faces *(ostommukhi)*	*Rahu*
Nine faces *(nobomukhi)*	*Ketu*[80]

Usually these beads are worn around the neck or upper arm. Some priests are of the opinion that they ought to be strung on a red thread but many of my

[79] This group said that they did not believe in the efficacy of these objects.

[80] Rest of the *rudrakhyos* fall outside the influence of the planets.

respondents wear them on chains and some on black thread.[81] They claimed ignorance of this stricture on wearing the beads on red thread. There are several persons who wear these beads on their own sans a ritual prescription from any astrologer or priest because they believe them to posses healing powers by themselves.[82] This could be compared to the self-administration of drugs that people often resort to as explained earlier in the chapter.

There are divergent opinions regarding the efficacy of each of these beads.[83] They are not restricted to health issues alone and there are several people who wear them for general welfare. I have documented all these opinions and tried to formulate some basic generalizations. It is believed that the *ekmukhi rudrakhyo* is the most powerful of all but none of my respondents were seen to wear it. The *dumukhi rudrakhyo*, it is believed is particularly beneficial for pregnant women and the *trimukhi* ensures a good education and for averting obstacles in life. The *soturthomukhi* and the *ponchomukhi* are generally worn to avert misfortune and illness. One of my respondents who is childless wears the *soturthomukhi* around her neck because a relative told her that it is known to be effective for begetting children. The *josttomukhi, xoptomukhi* and the *ostomukhi* are believed to ensure prosperity and success. The *nobomukhi* is worn generally by women; no accurate explanation of its perceived qualities, however, was

[81] I found that people from all ages would wear these *rudrakhyos* so I was not able to bracket users into any particular age group. However, it must be mentioned that I did not encounter any children who wore it.

[82] The source of this knowledge is either through specialists (like the priests) or through the lay referral network.

[83] This could perhaps be attributed to the fact that these beads are not very easily available.

forthcoming.

Out of the religious rituals that are conducted for health conditions, there are some which are performed for general well-being in which health is usually subsumed; and others which are specifically performed for a particular condition. The former may occasion a Krishna *naam*, a *xatyanarayan* puja, a Chandi *pāth* or a Ganesh puja performed at home or they may be performed at specific temples; for the latter a majority of the rituals which are specifically performed according to prescriptions laid down by a specialist are performed at the Nabagraha temple or at the Kamakhya temple. I have, therefore, given a brief description of the Kamakhya temple below because it forms a very important part of the sacred geography of the region. Moreover, I was able to document cases where specific rituals for health were actually performed in the temple complex.[84]

Health rituals at the Kamakhya temple

The original temple, built by king Naraka was destroyed during Muslim invasions in the early sixteenth century.[85] The present temple was rebuilt in 1665 A.D. by king Naranarayan. It is located at a height of 525 feet above ground level on the Nilachal Hill amidst a large complex. The present motorable road to the temple was built in 1958, prior to which pilgrims had to climb up the hill on foot.

The origin of the temple is shrouded in mythology. It is believed that King Daksa, at the behest of Brahma, had prayed to the primordial energy *(adya shakti)*

[84] I have described the role of the Nabagraha temple in the next chapter under the heading of medical astrology.
[85] The exact date when the temple was fist built is not known.

for three thousand years so that the mother goddess be born to him. The goddess acquiesced on the condition that she would give up her life the moment she felt neglected or slighted. She was thus born as Daksayani at the king's house and Shiva subsequently married her. One day Parvati (or Sati as she is often known) heard that her father was performing a grand sacrifice for the benefit of the world. She rushed there to find that he had invited everyone except Shiva because of his Kapalika status. She was so enraged at this slight that she immediately gave up her life. Shiva was deeply wounded at the sudden death of Parvati and carried her body in grief.'all over the three worlds' (Goswami 1998). In a conclave held by the gods it was decided that Vishnu would cut Parvati's body into fifty-one pieces with his discus *(sudarsan cakra)* so that Shiva would stop grieving and resume his duties. It is believed that the temple was built at the site where the pudenda of the goddess had fallen.

There is no complete image of the goddess in the temple. Worshipped instead is a symbolic representation of what is believed to be the genital organ of the goddess *(yonipith)* which is enshrined in the Manobhav cave deep inside the temple. This is reached by climbing steps leading down to it. The length of the *pith* is *ekabahu dvadasa anguli,* that is, 'one arm and twelve fingers' (Kalika Purana in Goswami 1998: 5).[86] More than half the conical stone is covered with cloth, flowers and garlands. It is surrounded by water from a natural fissure and next to it is a Shiva linga. The water is believed to acquire a reddish tinge during

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[86] The Kalika Purana and the Yogini Tantra are two ancient texts which were composed in Assam around the eight century.

the days of Ambubasi, considered to be the period of menstruation of the goddess. To the eastern side of the *pith* are the icons symbolizing Matongi (Saraswati) and Kamala (Laksmi) Mahavidyas.

Red is the leitmotif of everything connected to the temple. The priests *(pandas)* are robed in deep red (see photograph) and so are the votive offerings like the flowers offered to the goddess and the cloths offered during Ambubasi.

According to the *pandas* the worship of the goddess is followed according to the ritual prescriptions laid down in the Tantras. It is performed by the *kram* method where worship centres around Shakti as opposed to the *trik* method where the chief deity is Shiva. The former is believed to be associated with the fulfillment of all human desires while the latter seeks spiritual fulfillment. The *pandas* told me that apart from the large number who visit the temple to pay general obeisance to the goddess, a majority of devotees congregate to seek realization of certain desires and many childless couples visit the temple in hope of blessings which would enable them to beget progeny. There are people who come with specific health problems for which the astrologers prescribe rituals to be carried out in specific temples of the complex. The salutation mantra itself symbolizes a prayer for fulfillment of desires.

Permission from the goddess is first sought by the mantra:

Amade kamarupasthe subhage surasevite

karomi darsanam devyah sarvakamarthasiddhtte

(Debasarma 1991:66)

The salutation mantra is to be chanted next:

Kamakhya varade devi nilaparvata vasini

tvam devi jagatam mataryonimudre namostute

(ibid.:67)

Touching the image in the cave, the *sparsa mantra* is recited:

Manobhava guhamadhye raktapasani rupini

Tasya sparsamatrena punarjanama na vidyate

(ibid.:67)

Along with the worship of Kamakhya, ten other Dasamahavidyas are also worshipped in different temples which lie within the same complex in the Nilachal Hill.[87] They are Kali, Tara, Sodasi, Matongi, Kamala, Bhubaneswari, Bhairavi, Chinnamasta, Bogola and Dhumavati. These Mahavidyas are worshipped with their consorts (Bhairavs) which are Mahakala, Aksaubha, Panchavakttra, Tryamvaka, Daksinamurtti, Kavandha, Ekavaktra, Matonga and Srivisnu, respectively. It is to be noted here that Dhumavati has no Bhairav as she is believed to be a widow.

The temple is kept shut during Ambubasi in the first fortnight of June from the seventh to the eleventh day of Asadha which is regarded as the period of menstruation of the goddess. On the fourth day when the temple reopens red cloths which have been consecrated in the *pith* are distributed to the devotees.

[87] Most people believe the Mahavidyas to be different incarnations of the same goddess and another version is that these are the ten images that the goddess displayed in anger when Siva tried to dissuade her from going to her father's *yajna*.

Congregation of tantriks at the Ambubasi Mela at Kamakhya.

Gathering of devotees at the Kamakhya Temple during Ambubasi

This is called the *ongo bostro,* held to symbolize the dress of the goddess. I visited the temple during the Ambubasi festival in June 2000. Thousands of devotees converge from all parts of the country for the purpose, most of whom camp within the temple premises for the three days and leave only after the first puja is carried out when the temple reopens. Majority of the devotees are tantriks and widows. Many tantriks told me that the site acquires so much power *(shakti)* during these days that any tantrik who meditates within its premises is able to 'replenish his powers' by virtue of being present there at the time. It is believed that widows who otherwise have to follow a strict regimen during this period do not have to follow any ritual injunctions during their stay there in the temple premises. All Shaktas refrain from performing any puja, even in their homes, during this period. Although I did not find any evidence of any healing rituals that are performed during this period within the temple premises, it is widely believed that visiting the site during this period augurs well for the general welfare of an individual.

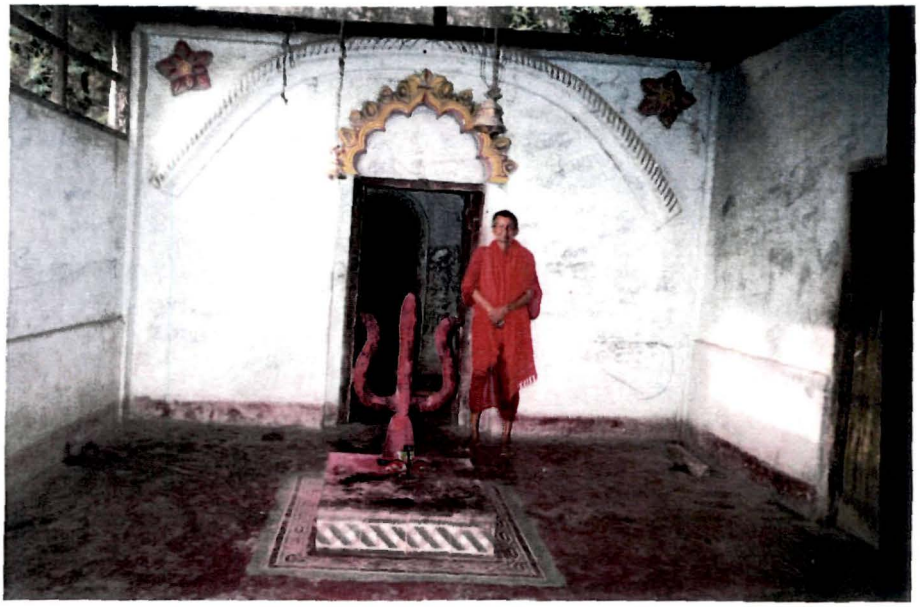
Thus, a visit to the temple may be a 'regular visit', mainly for blessings and general welfare (all-encompassing) or for a specific health problem. For the latter, rituals are either conducted at the *pith* for them by the *pandas* as requested by the individuals themselves, or specific pujas are recommended by astrologers on the basis of the reading of the astrological chart.

Kumari Puja at Kamakhya

This is the worship of virgins in the temple. In this case, virgins are regarded as the living embodiments of the goddess. This concept is believed to be of Tantric origin. It is either recommended by a specialist for a specific reason or performed at one's own initiative. I witnessed a Kumari Puja which was being performed by a childless couple. The husband is a thirty-eight year old Assam Civil Service officer. His wife is thirty-five years old. She works as a school teacher in Chandmari, Guwahati. They have been married for the past eleven years and they said that they were performing this ritual in the hope that they would be able to bear children. It is a simple ceremony. Three young girls, between ages three and six, were brought from the neighbouring houses by their *panda.* They were given a red saree each by the couple which the girls draped around themselves. Then they were made to sit together in one row on a cloth that was spread on the ground just outside the temple. The couple knelt down together on the ground in front of them and chanted mantras as directed by the *panda:*

Sarvavidya svarupa hi kumari natra samssayal
eka hi pujita vala sarvani hi pujitani bhavet
Mantraksatamayini devim matrnam rupadharinim
navadurgatmikam saksat kanyamavahayamyham

They are served *luci*, a vegetable preparation, rice pudding *(payox)* and two types of sweetmeats on banana leaves. A *gamusa* is given to each of the girls before they leave.



A priest *(panda)* at Kamakhya

The site at Kamakhya where goats are sacrificed *(boli)*

It is interesting to note that there is no caste bar in choosing virgins for worship. I was told that in many cases low caste virgins are preferred. In most cases they are fed, given a set of clothes each to wear and in other cases they are prayed to by chanting mantras in this manner. The *panda* told me that this ritual is performed in a more elaborate manner on the day of Asthami during Durga Puja and within the period of *xuklopokhyo* (waning of the moon).

Sacrifice *(boli)* of goats and buffalo are a common practice at Kamakhya. The days during Durga Puja are considered to be particularly suitable for buffalo sacrifice. On Saptami, one buffalo is sacrificed, on Asthami two (one at midnight and the other in the morning) and on Nabami, another one is sacrificed. Goats are sacrificed every day, early in the morning at a site appointed for the purpose (see photograph). On other days, vegetables are 'sacrificed' by many people. Sugarcane, ash gourd and cucumber are usually the chosen vegetables. *Rohu* fish and the Indian Magur *(magur maas)* are also sacrificed. People who do not believe in sacrifice often set the animal free *(usorga korā)*.

I met a couple during their consultation with an astrologer who had prescribed a puja at the Chinnamasta temple at Kamakhya. The man is forty-seven years old and the wife is forty-three. She has been suffering from a gynaecological problem for the past two years for which the doctors have recommended a hysterectomy. She tells me that she has very heavy bleeding which continues for ten to twelve days after her periods. She feels very scared that she might have to undergo surgery that she wants to avoid 'at all costs'. She tells me that she has begun extensive Ayurvedic treatment and also goes for regular meditation to an

institute near her house. Her mother advised her to consult their family astrologer. He read her horoscope and told her that the planet *Rahu* was very badly vitiated. The puja at the Chinnamasta temple was then recommended by him for the purpose.[88]

I accompanied the man and his wife to the temple in March 1999. It was 9.30 in the morning. The procedure was simple. He had given one thousand rupees to a *panda* one day before the appointed day. The priest had procured all the items by the time we arrived the next day. He took us to the temple at the entrance of the Kamakhya complex (see photograph).[89] The temple is also known as Gupta Durga. The temple is built over a cave-like structure and one has to climb downwards to a dark sanctum sanctorum which is barely lit by some earthen lamps *(sāki)*. I was thus unable to see much of what the *panda* was doing. It is a very small area and I had to ultimately come out of the temple to allow space for the man to remain there with the priest.

I sat outside with his wife and spoke with her. She told me that she is very tense about her condition. She feels particularly upset because she suffers from mood swings very often and she feels very emotional all the time. She has one son who is away in college in Baroda and the only person she can turn to is her husband. She tells me that he understands her problem and is caring but he

[88] For a description on temple healing see Skultans (1987) and Kakar (1982).

[89] The couple I had accompanied denied my request to include them in the photograph outside the temple. They told me that since this was a ritual occasion for them they did not want to participate in 'any event other than the puja'. They, however, seemed quite forthcoming during my interviews with them on the topic.

remains at office for most part of the day and she feels burdened by her illness especially when she is alone at home after she gets back from work. She feels guilty to sound cantankerous when her husband comes home but she often cannot help it as she is always 'under tension'. She tells me that she fervently hopes that this puja would 'do something'. They are firm believers of goddess Kamakhya and she visits this temple once every month and feels infused with a sense of 'peace and confidence' after each visit. "She is after all Shakti," she tells me. She told me that should I ever feel worried about anything all I have to do is shut my eyes, think of the *yonipith* and chant the main salutation mantra. I would immediately feel an overwhelming sense of peace and strength, she assured me.[90]

A *hom* is performed at the temple. The priest tells me that the items that one procures depends on the financial ability of the individual. "Whatever is given to the goddess makes her happy as long as the ritual is performed with devotion," he tells me. There are, however, ritual injunctions that are to be followed as per the instructions of the astrologer. The simplest set of items that are collected for the puja is called the *poncho uposār*, which includes incense sticks *(dhup)*, earthen lamps *(saki, deep)*, *noibidyo*, vermillion *(xendur)* and flowers with garlands. For this couple, however, he had performed the ritual through the *bixex uposar*. This includes a red saree, red bangles, colour *(alta)* for the goddess' feet, a little bit of gold, a red ribbon (for the goddess' hair), a comb, vermillion, anklets *(junuka)*, a mat *(aaxon)*, incense sticks and earthen lamps, sweetmeats, wood of the mango tree (for the *yagya)*, leaves of the *bel* tree *(bel paat)*, *purna patro* and a *xorai* with

[90] This brings to the fore the possible interaction between psychic relief and physical amelioration.

the nine items of *pāxād* required for the ritual *(noibidyo)*. A dhoti and a cloth *(sador)* were bought for the priest. The wife is called into the temple at one point to offer flowers to the goddess with the chanting of mantras by the priest. She comes out again. The entire procedure takes about one hour and a half at the end of which the couple is given the *xorai* with *praxād* to eat and carry back for their relatives. Flowers and garlands are also given to them along with the extra box of vermillion that the wife had offered to the deity. They pay the *panda* rupees two hundred and one and we leave the premises to take a tour of the entire temple complex. The wife remains quiet for most part of the day. She says that she feels relaxed now that the ritual is over. She tells me that Kamakhya has the power 'to do anything'. She is convinced that she would get better now.

An astrologer, explained that the Mahavidyas at the Kamakhya temple are the presiding deities *(adhistatri devis)* of each of the planets of the celestial system. "They are like the bosses of the planets," he said. Thus, each planet has to be placated with propitiation of the associated deity. This astrologer is a Shakti worshipper.

The *panda* tells me that Chinnamasta is a very fiery goddess who is believed to be in an incarnation where she drinks blood that springs out of her own throat. She is also known as *pracanda candika.* Her consort is Kalarudra. The astrologer told me that she is the presiding deity of the planet Rahu.

The Chinnamasta shrine at Kamakhya

The sanctum sanctorum at the Mahamaya Temple at Bogoribari in Dhubri district

Table no. 6

Planets associated with the respective 'goddesses' in Kamakhya

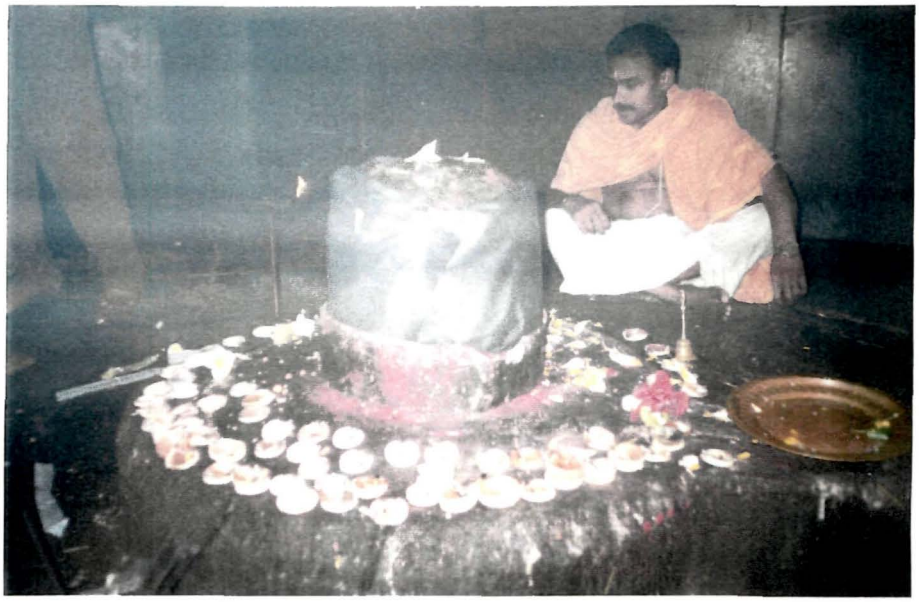
S. No.	Planet	Local name of planet	Associated goddess
1.	Sun	Robi	Matongi
2.	Moon	Sondro	Komola
3.	Mars	Mongol	Bogola
4.	Mercury	Budh	Tripurasundari
5.	Jupiter	Brihaspati	Tara Devi
6.	Venus	Xukro	Bhubaneswari
7.	Saturn	Xoni	Dakhinakali
8.	Rahu	Rahu	Chinnamasta
9.	Ketu	Ketu	Dhumaboti

The belief system and cosmology of the urban Assamese, as we have seen in this chapter, is a juxtaposition of several factors. Urban residence and Western education have socialized the people into an ostensibly 'modern' landscape where health care is largely dominated by technology and the allopathic system of medicine. Thus, everyday references to conditions of the body emerge with biomedical definitions and are constructed by interactions with doctors. However, despite this paradigm of reference, the urban Assamese have not cast off their traditional beliefs and practices. There are frequent allusions to climate, local herbs, Ayurvedic doctors *(kobirāj)* and the sacred geography of the region (predominantly the temples of Kamakhya and Nabagraha).

'Assamese culture', therefore, needs to be examined in the context of whether the people in question reside in a village or in a cosmopolitan setting

before generalizations are offered. Although there would be similarities between them, the fact of urban residence allows my field a distinct set of medical choices. The residents of Zoo Narengi Road, through their class and education, seem to be privy to medical systems that are 'global' in their reach – well-established ones like allopathy and the current ones like Reiki or Pranic Healing. But the fact remains that the local beliefs, rather than being jettisoned, continue to form an integral part of the medical landscape and at times seem to shape the very choice and trajectory of individual medical biographies.

A view of the Nabagraha Temple from the entrance



Votive offerings (lighted lamps) around the *xoni* (Saturn) lingam marked by the grayish black cloth wrapped around it

CHAPTER 5

Medical Pluralism:

Contested Meanings and Competing Systems

MEDICAL PLURALISM:

Contested meanings and competing systems

Pluralism implies multiplicity. In the realm of health care pluralism is evident at several levels. Firstly, there could be a plurality of explanations for a particular condition of health.[91] Then at the level of decision making, there could be plural ways of taking remedial action. One could decide to take rest, self-medicate or solicit advice from a kin member or a friend or seek specialised medical counsel. Treatment options are also in the plural; there could be a choice ranging from folk traditions to institutionalized systems which are available to an individual at any given point in time. And lastly, there could be a co-existence of several practitioners within a particular system who offer specialised knowledge as part of the larger system of division of labour within that system (as is the case with allopathy).

Cognitive categories of different traditions of medicine vary. The modes of treatment follow divergent routes and often the structural logic followed by one healing tradition is challenged by another.[92] However, all forms of medicine are, by definition, remedial as healing presumes the existence of disease, illness and pain (Alter 1999).

In the medical culture of urban Guwahati, there are a large number of

[91] A cold, for instance, could be interpreted as a condition caused by a virus or due to a change in the climate or a depletion of the energy level of the body.
[92] This point has been discussed in more detail later in the chapter.

healing traditions which persist despite the dominant system of allopathy which is not only patronised by the state but also figures as the first referent in the 'hierarchy of resort' of medical systems.[93]

In this chapter I have chosen to present only those systems, which my respondents have delineated as the most preferred treatment options. Although many of them could be referred to as 'systems', there are others, like the Fish Medicine, which is an oral tradition used in administering an illness-specific cure and Mantra Therapy for which I was able to interview only three healers. None of them are full-time practitioners nor have they learnt their skills via a professional network. My motive, however, is to present these alternative epistemologies as part of a larger rubric of health care which patients resort to and I shall not dwell on the arguments regarding their terminological appropriateness.[94] Most of these systems rest on complex bodies of knowledge which require detailed explication but since the purpose of the thesis is to highlight the systems *vis-à-vis* the patients, the descriptions below are aimed at merely apprising the reader of the basic theoretical premises that the specialists follow in administering treatment.

Homeopathic treatment

The clinic is a modest two-room set in Chandmari, the inner room separated from the waiting room by a white curtain. It is a weekday and there are about nine

[93] The state also provides support to Ayurveda and Homeopathy as has been indicated in Chapter Two.
[94] For a theoretical discussion on the concept of medical systems, see Chapter I.

patients waiting for their turn at 6.30 p.m. It is a private clinic.

The doctor is a fifty-six year old man who has been in this profession for the past thirty-three years. He says that Homeopathy is 'a very, very safe' treatment option and could be used for all ailments. He has achieved maximum success with conditions like influenza, swift healing of a broken ankle, headache, easing labour at childbirth, indigestion and diabetes. The medicines, he said, are more swift to act upon the individual and the problem is easier to control if he is able to treat the patient at the onset of the disease.

The patient, a fifty-two year old woman, walks in and seats herself on a wooden chair opposite the practitioner who faces her across a table. She tells him that she has some kind of an 'allergy'. This results in her skin breaking into red rashes the moment she touches anything that is made of metal. She feels that the problem is aggravating with age. It initially started with a slight allergy to metals other than gold when she was seventeen years old. Then gradually she began to experience itching sensations with all metals that would come into contact with her skin. She has been on allopathic medicines, mainly antihistamines, for the past eight years. She began the treatment when the symptoms began to aggravate and the rashes would continue for days and her skin would swell up. After the rash subsided skin would flake off from the areas that would be most affected. The same symptoms recurred frequently, she said. The allopathic medication is effective in arresting this condition within a few hours but the symptoms present themselves again after a few weeks even if she touches items as small as safety pins. She feels very demoralised each time she has to carry a host of medicines

before she leaves the house even for a short visit. She tells him that she is 'tired of being on tablets' that would cause side effects in the long run and has come to him for a permanent cure for her problem.[95]

The practitioner listens to her narrative without interrupting her. He examines the skin on the back of her palms and on her neck where remnants of the last allergic reaction are still visible and asks her to describe in detail the way the allergic reaction sets in and whether it starts at any particular part of the body and about how it spreads. He takes down her medical history pertaining to the problem on a foolscap register. He then asks her whether she has taken Homeopathic treatment before to which she replies in the negative. He proceeds to ask her about her diet pattern and whether she is allergic to any food items.

He seems to ponder for a while after which he writes out a prescription for her with instructions about the dosage of the medicines. He tells her that if the symptoms appear to initially aggravate slightly she must not worry and must continue with the medicines but if they intensify beyond a certain point, she should consult him immediately.[96] He tells her that the condition would be completely cured in 'about a month's time'. She takes the prescription and pays his fees. He instructs her to take the prescription to the dispensary attached to the clinic and reminds her to bring the prescription when she comes back to him after

[95] The Homeopath later tells me that most patients consult him only after they have taken extensive allopathic treatment. This implies that the condition is referred to him only at an advanced stage which means that it would take longer than usual to effect a cure.

[96] In Homeopathic treatment the initial phase with mildly enhanced symptoms is followed by the amelioration of all symptoms and a return to good health (Vithoulkas 1983).

two weeks. The man behind the counter at the dispensary proceeds to prepare sachets of a fine white powder as well as thin vials of white sugar globules in some kind of a solution and hands them to her.

All patient-practitioner interactions in the clinic follow a more or less uniform procedure. Since the therapeutic modality involves a 'holistic approach', the practitioner explains that the disturbances of the patient are treated on physical, emotional and mental levels at once. A patient history is, therefore, always taken and the patient's physical (and sometimes even psychological) symptoms are observed and then the initial prescription is made. The physician told me that the aim is to try and fathom the correct remedy that would produce the patient's symptomatology. If the prescribed medicines do not have the desired effect, a second analysis is done and another prescription is given. This continues till the accurate medication for the underlying ailment is found. The time taken for subsequent analyses is generally much shorter than the first.

One of the most respected and widespread forms of alternative therapies in Guwahati, this system was founded by a German physician, Samuel Hahnemann, in the 1790s. It is based on the principle of *similia similibus curentis* (like cures like), that is, substances that produce specific symptoms in healthy individuals can also cure the same symptoms in someone who is sick although the symptoms may have arisen from another cause like bacteria, viruses, and so on. The symptom complex is not read to indicate the disease *per se.* It is believed to be the reaction of the defence mechanism mobilized by the body to counteract the influence caused by a specific stress such as bacteria or virus or a non-specific stress like

climatic changes, environmental pollution, mental and emotional disturbances, and so on (Vithoulkas 1983) In fact, the symptoms are held to be the means through which the body tries to regain its homeostasis. Thus, the physician concentrates on strengthening these reactive powers rather than suppressing them. The body is conceived as having a vital force which tends to be self-healing and whatever causes the derangement of this vital force is believed to hold the cure. Thus, administering of substances which will produce symptoms similar to which the patient experiences is held to stimulate the body's capacity to cure itself.[97]

The substances offered as medicines are administered in an extremely diluted form. Most practitioners prescribe at dilution ratios ranging from one (one part substance to nine parts dilution medium) to two hundred (two hundred repetitions of diluting one part substance with ninety-nine parts dilution medium). Very often it could even be as little as one part per million.[98] The active ingredient is made of assorted herbs, animal products and minerals. Remedies cover alleged benefits for every conceivable disease symptom. The Homeopath told me that the solutions, however diluted they may be, always continues to hold a 'trace memory' of the original healing substance.

Homeopaths emphasise that the system is based on the idea that each person's constitution, with the individual's whole range of mental, physical and

[97] This could be compared to the more modern system of immunotherapy used to treat allergies in which patients receive repeated injections of allergy causing substances in order to become desensitised to it.

[98] Dr. Arun Mahanta, a medical doctor, insisted that the majority of doses offered by Homeopaths are so diluted and 'infinitesimal' that he considers it to be impossible to detect the original substance in laboratory tests. This renders these medicines, according to him, devoid of any meaningful amount of medicine. He attributes Homeopathy to the placebo effect.

emotional pathology, needs to be treated along with the specific ailment under focus. Thus, the Homeopathic remedy for a specific problem is different for each person. Classically, only one Homeopathic medicine is used at a time.

Many of my respondents told me that they regularly make use of the commonly recommended Homeopathic medicines as home remedies. These medicines are available over the counter for self-treatment of minor conditions like cold, cough, fever, diarrhoea, and so on. They seek professional advice for prolonged illnesses so that the specialist could then prescribe constitutional treatment for the ailment.

Pranic Healing and Reiki

These two systems have gained ascendancy in Guwahati only in the past half a decade or so. Of the two systems, Reiki seems to be gaining ascendancy.

Pranic Healing views the human body as being composed of vital energy or Prana which is considered to be the 'life force' which keeps the body alive and healthy. It rests on the axiom that the physical body is composed of two parts - the visible physical body and the invisible 'energy' body, also referred to as the bioplasmic body. The physical body is the one that we are able to see and the bioplasmic body is that invisible luminous body which interpenetrates the visible body and extends beyond it by four or five inches (Sui 1983). This is also referred to as the 'etheric double' and it is through this that Prana is absorbed and distributed throughout the body. The three major sources of Prana are the sun, the

air and the earth. A person is susceptible to sickness when there is an 'energy leak' either in his inner aura or the outer aura. Meridians or bioplasmic channels are akin to the blood vessels of the physical body as defined by the biomedical paradigm. These serve as channels through which Prana and bioplasmic matter flow and are distributed throughout the body.

Reiki, a Japanese word, means 'universal life force energy'. This energy is not only used for healing (under the Usui System of Natural Healing) but can also be used to 'cleanse' one's life. Here, *ki* holds the same connotation as the word *chi* or *qi*, the Chinese word for energy which underlies everything.[99] Both Pranic Healing and Reiki postulate that the energy field or aura is concentrated around seven major Chakras in the body. These Chakras, which have been extensively discussed in the Vedic scriptures, are situated where the glands are as defined by medical science. In addition to the seven major Chakras there are also twenty other minor Chakras.

Prayers and invocations form a part of the healing process. The Master, through prayers, opens one's Crown Chakra (situated on the top of the head) to the Reiki. Once this energy enters the body, one becomes a Reiki channel for life, whether the technique is practiced or not. It becomes a 'dormant' technique, which is activated automatically when the individual begins practicing it regularly. Hands are used to heal.

The system is used to extend beyond ailment specific healing. Paramita

[99] In Greek, it is called *pneuma* and in Hebrew - *ruah*, the breath of life.

Choudhury, one of its adherents, said that Reiki allows one not just to achieve a state of well-being but to derive maximum benefits from the food that one eats, the air that one breathes and the water that one drinks. The training sessions focus on ways to mitigate anger, anxiety and stress and encourages meditation for a peaceful and energetic existence.

One of the best benefits of Pranic Healing, according to one of the practitioners, is that it is also a preventive healing system. The healer is able to detect the disease before it manifests itself in the body and eradicate it. Sometimes, he said, the aura's colour indicates an ailment as early as three months before its physical manifestation.

Degrees in both Reiki and Pranic Healing are easy to acquire and require no special skills. Training sessions and workshops impart courses on energy healing and are held almost every three or four months in the city. In addition to extensive workshops held at the Don Bosco School and the Alternative Healing Centre at Rajgarh, there are many individuals who organize these sessions by inviting a Grandmaster or a Master to come and teach the courses. In Pranic Healing, the teaching is imparted in three stages. In the first course, basic healing is taught over two full day sessions where one is taught to feel the energy, receive it and transfer it for healing minor ailments. In the second level, advanced Pranic Healing, one is taught to enhance one's healing powers, again in two full day sessions. In the third and final level, psychotherapy is taught for healing mental and emotional disorders and for spiritual growth. These courses are taught one level at a time and many months pass before the next course is imparted. Learners

are required to heal a minimum number of patients before they can enrol in the subsequent course.

Reiki has a similar four-level programme where a Master has to 'initiate' or 'attune' a student. In the first level, attunements are given which enable the healer to transfer Reiki to himself and others, to become a channel for life. The second level intensifies the effect of the healing wherein one is imparted the ability to heal without laying of hands, to heal emotional and mental problems as well as distance healing. Reiki III is a one-day workshop and is divided into two levels - an advanced Reiki training followed by Mastership. One receives the Master status and the final two initiations depending on the learner's ability to heal and 'spiritual growth'. There is also a Reiki IV which is a teacher's training programme.

The Alternative Medicine Healing Centre at Rajgarh is an institution where Reiki healing, along with Acupressure and Sujok Therapy are administered. Binoy Talukdar, a Reiki Master, conducts regular workshops once every quarter in the city. He is the main healer in the clinic along with two other Reiki healers whom he has trained himself. His sixty-eight year old father is an Acupressurist in the clinic.[100]

I visited this centre regularly to observe patient-practitioner interactions over an extended period of time. The clinic consists of one large room that is separated into sections by a white curtain. The outer room has a table with books

[100] Acupressure involves pressing with the ball of one's finger, or with a more pointed object, the designated pressure points on the palms and soles of the feet.

on Reiki, Acupressure and meditation. There are chairs arranged along the walls of the room for the patients to sit. The inner section has a bed draped with a white sheet on which a Reiki healer administers treatment to patients (see photograph). Each time I visit the clinic there are at least six or seven people waiting at any one time.[101] At least twenty to thirty people visit the clinic everyday seeking help for a variety of ailments. The atmosphere appears very relaxed and the patients generally speak to each other while they await their turn. This atmosphere is obviously generated by the father who is a very congenial man. I noticed that he keeps talking to all the patients while he performs Acupressure on one patient at a time. In fact, many of the patients told me that they enjoy coming to this clinic because it allows them to feel very relaxed and not constrained and tense, as they would inevitably feel in the medical doctor's clinic.[102]

Daisy Mahanta is a thirty-seven year old cancer patient. She told me that she was diagnosed with a malignant tumour on her right breast four years ago. This had come as a tremendous shock to her and her family. Nobody had thought that breast cancer would affect a person at such a young age. She had to ultimately undergo a mammectomy and subsequent chemotherapy. She responded well to the chemotherapy physically but the entire process had mentally scarred her. It had

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[101] I was told that most of their patients suffer from spondylitis, arthritis, asthma, menstrual disorders, sinus, migraine, insomnia, slipped disc, leucorrhoea, kidney problems and gout. These descriptions are as offered by the practitioners themselves. It is to be noted that most of the conditions cited above are those that allopathy has not had much success with in terms of a complete cure.

[102] I asked several people why they felt more tense in a doctor's clinic. Some said that the doctor approaches the patient formally while the alternative healers are more informal with them and they take more cognizance of the patient as a person rather than concentrating on just the disease under examination. It is possible that medical doctors are more constrained by the time factor as they have

been a long process during which she had really suffered. She was not able to fathom why *she* was 'chosen' to suffer so much while all the members of her peer group were healthy and had children.[103]

She had lost a lot of hair during the treatment. She had also become very thin. She lost the will to recover when the doctors told her that she could not conceive a child anymore. That had really shattered her. She gradually stopped meeting people and would confine herself to her house. She felt that nobody was able to understand her angst and sorrow, not even her husband. On the insistence of a neighbour who is also her good friend, one evening she accompanied her to the Alternative Medicine Healing Centre where she was undergoing treatment for spondylitis. This was in 1998. She said that the atmosphere in the centre made her feel calm and she began visiting the clinic regularly with her friend. It helped to know that there were other people who were also ill, she told me. One of the healers told her that he would perform Reiki on her. She was skeptical at first but after two sessions she felt that there was 'something' to it. She began going for regular sessions to the clinic. After seven months, she insists that she no longer feels depressed about her condition. She took treatment there for one and a half months and enrolled in a course soon after. She has now taken two courses in Reiki and feels that she is en route to the third level. She tells me that she has become 'more positive' and is 'at peace' with herself now. She no longer feels

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more patients to deal with and thus cannot spend as much time with each patient. A few patients said that the use of high-tech machinery in doctors' clinics also sometimes unnerves them.

[103] Most of the patients suffering from chronic conditions echo this feeling of 'why me?' One of the implications of Geertz's (1973) essay on religion as a cultural system is that when people are happy they never ask this question and it is only when they suffer that this point becomes pertinent.

traumatised by her illness. More importantly, she visits the clinic twice a week to help as a voluntary healer.

I interviewed the healers at the clinic several times. I was told that the selection of treatment is contingent upon the disorder of the individual. Very often, in acute cases of arthritis and rheumatism, they use all three kinds of treatment, one session at a time. The healers assure almost immediate relief for headaches, gripes in the stomach, toothaches and muscle pains but major ailments like those affecting the liver, kidney, eye and heart problems require several sessions, sometimes even months, of healing, they said.

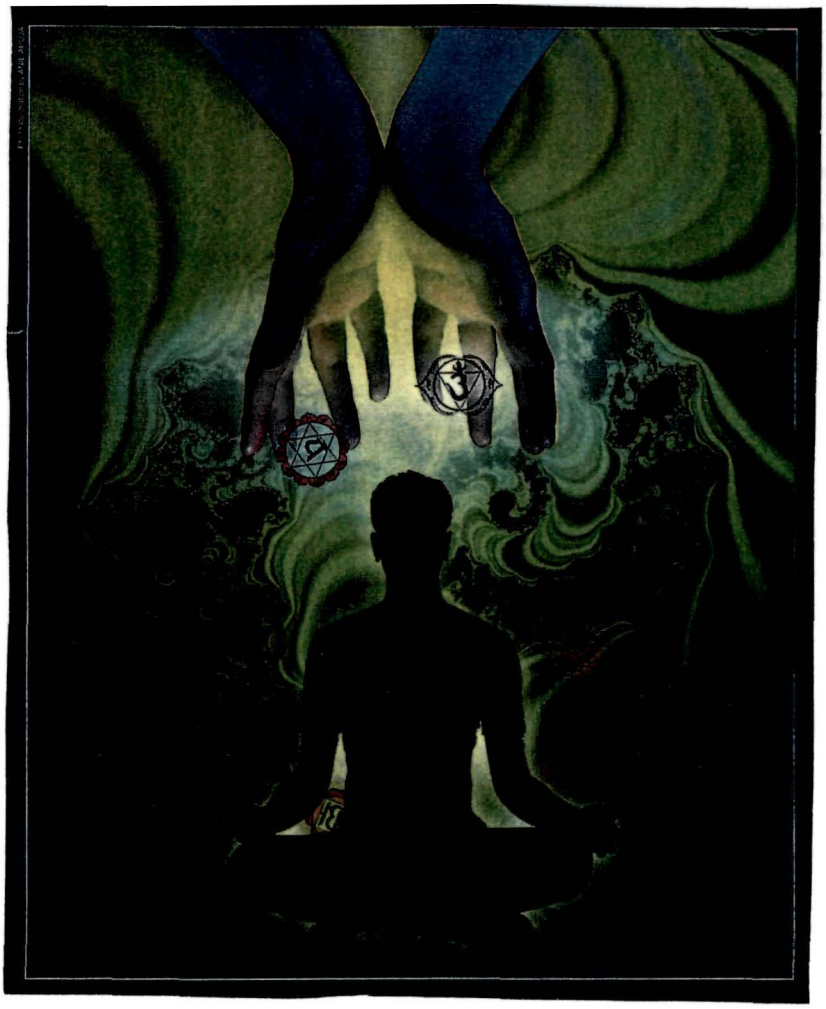
I present an observational account of one healing ritual. The patient is a forty-two year old man with acute pain in his knee joints. The patient lies in a supine position on the bed with his legs and arms outstretched in a relaxed manner. The healer closes his eyes and concentrates. He later tells me that he does this to hone his kills in order to sensitise his eyes and fingers to scan and feel the patient's aura respectively. This is necessary so that he can identify where the 'energy leak' is. This is the point at which the diagnosis is done.

After approximately five minutes, he opens his eyes and proceeds to 'cleanse' the diseased portion by sweeping motions of his hands over the patient's body and toward a small plastic trough, which contains some saline water. This procedure of cleansing is crucial, I am later told, in order to facilitate the absorption of energy by the affected part. Fresh energy cannot flow into the

affected part when the bioplasmic channels remain blocked. The healer then closes his eyes again. He cups his palms slightly and places one facing, but not touching, the other.[104] He then places his palms four or five inches above the knee region of the patient. This is the stage of 'energizing' the affected Chakra with sufficient vital energy. He keeps his palms there for about four minutes. Once he is satisfied that the healing has been accomplished, he opens his eyes and asks the patient not to sit up immediately. He asks the patient how he is feeling. The patient looks very relaxed, nods in affirmation and sits up. The healer throws the water in the plastic bowl into a basin placed nearby.

Pranic Healing follows almost the same procedure except that the healer places his hands on the affected part instead of putting it above the body as in Reiki. A Pranic Healer told me that for more severe cases, apart from the specific part that is affected the entire bioplasmic area has to be cleansed. Very often, after the initial cleansing, if the patient's immune system has dropped drastically in coping with a prolonged ailment the patient needs to be partially energized in order to increase the receptivity of the patient. The whole process is repeated several times until the whole bioplasmic body is normalized. It is only after this that the actual process of treatment begins. There are no injunctions regarding the gender of the healer; anyone who is interested to learn how to heal can undertake training to become a specialist.

[104] Two very important Chakras at the centre of each palm serve a cardinal function in being the sites through which absorption of the energy takes place and is projected to the patient.



A depiction of the close relationship between meditation and Reiki

Reiki healing in progress

Ayurvedic treatment

Ayurveda is one of the oldest text-based systems of healing over three thousand years old. The tenets of Ayurveda have been systematized in the Atharvaveda. The original texts are believed to be of divine origin (Trawick 1992). The word, of Sanskrit origin, means the 'science of life'. It is based on a humoral and constitutional conception of the body, which details the physical, mental, emotional and spiritual components necessary for holistic health.

According to Ayurvedic theory, each individual's constitution is determined by the balance of three basic biological elements in the physiological system, which in turn is derived from the five basic elements in the world. These elements are ether, wind, water, earth and fire and are known as *Panchamabhutas*. All the physical and physiological processes in the human body and the pathogenesis of various diseases are explained with the help of the three *doshas* - wind *(vata)*, bile *(pitta)* and phlegm *(kapha)*.[105] *Vata* is responsible for all motion in the body, *pitta* is connected to energy and *kapha* is the binding factor such as facilitating the holding together of the joints, etc. Seven *dhatus*, which constitute the supporting units of the body, are the body fluids *(rasa)*, blood *(rakta)*, muscular tissue or flesh *(mamsa)*, adipose tissue or fat *(meda)*, bone *(asthi)*, nerve tissue and bone marrow *(majja)*, and generative tissue including sperm and ovum *(shukra)* The specific capability that each of these possesses helps it to digest

[105] Obeyesekere defines *dosha* as 'troubles' in the body (1992: 175). Alter considers calls it a 'morbific domain' which signifies a 'corrupting agent' or 'cause of disease' (1999: S48). He suggests that although the body is regarded as naturally predisposed toward disease, it is 'potentially perfectible' (ibid.).

specific food and to manufacture its associated higher tissue (Kurup 1983). During such metabolic activity, each tissue forms its specific waste products *(malas)* in the body - stool, urine, sweat, nail, hair, etc. Health depends on the balanced state of all the *doshas*, *dhatus*, and *malas*.

Each person's constitution is governed by these *doshas* in varying degrees but an individual is controlled by one or possibly two dominant *doshas* so that one is designated as *vata-pitta* or *kapha-pitta*, and so on. One's *dosha* is believed to not only determine the constitution and the illness to which the individual is susceptible but it also determines one's temperament, the colour of hair, the tendency to put on weight, type of food to eat, and so on. In other words, one's *dosha* affects every aspect of one's life. A healthy person is defined as one in whom there is equilibrium of the humours and the body tissues with normal digestive and excretory functions. Since imbalance of these humours is considered to cause disease, restoration of the homeostasis is the prime motive in a treatment schedule. The aim is not just to eliminate the disease but also to improve vitality and strengthen the immune system to resist a future relapse of the same problem.

Diagnosis is usually based on a reading of the pulse and on the basis of the symptomatology offered by a patient.[106] An elaborate patient history is taken to facilitate diagnosis. Subsequent treatment involves prescribed medication (either prepared by the physicians themselves or in the form of patented drugs), a suitable diet and a recommended daily regimen that is considered to restore the balance in

[106] Obeyesekere writes that '. . . there is virtually no physical examination' in Ayurveda (1992: 163). Kurup (1983), on the other hand, suggests that in addition to the reading of the pulse *(nadi pariksha)*, examination of the eye and tongue, sometimes faeces and urine are also conducted.

the body.[107] A lot of emphasis is placed on food that a patient is allowed to eat. The physician told me that flouting the stipulated diet regime renders the treatment futile. As Zimmerman points out, "the idea of a remedy and that of nourishment are [thus] both parallel and complementary; pharmacy and cuisine are two aspects of medical activities regarded as a single set" (1987: 203).

The Ayurvedic clinic, which I studied, is well known in the city.[108] The main room is entered via a dispensary, which contains a large collection of patented medicines. There is a small spartan room in which chairs are placed for patients to sit. And one by one, on a first-come-first-serve basis, the patients are called to the inner room in which the physician is seated. There is a sliding wooden door separating the inner from the outer room. The practitioner is a sixty seven year old man, a retired Principal of the Ayurvedic College in the city. He started this private practice in 1993 after he retired from the college. He tells me that he gets an average of sixteen to twenty patients a day. What struck me as particularly interesting was the presence of a stethoscope and a blood pressure machine on the table of the practitioner.

The patient is a sixty-two year old woman who walks in very slowly and appears to be in great pain. She seats herself opposite the practitioner and tells him that she has been having 'problems connected to arthritis' for the past seven

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[107] Emesis, purgation, enemas and massage are also sometimes recommended, as Kurup (1983) points out. These are, however, very seldom recommended by the specialists in my field area.

[108] There are two clinic-cum-dispensaries sponsored by the state in the urban Guwahati area. This, however, is a private clinic.

years. She had taken Ayurvedic treatment from another healer for four months and it had not worked. In fact the pain and swelling in her joints was aggravating and she said that she is barley able to walk without excruciating pain.

The practitioner listens to her and asks her whether she is carrying her medical reports. She hands them to him which he reads in detail. He reads the various reports from a number of allopathic doctors.[109] He asks her whether she is presently on any allopathic medication. She tells him that she has to regularly take painkillers. He looks very disapproving and instructs her to avoid taking them. She insists that she has to take them occasionally, as she is unable to bear the pain. In fact she had even fainted once after the other physician had told her to stop painkillers totally. He then reluctantly agrees to allow her to use them, albeit as restrictively as possible. His unequivocal statement was that these medicines aggravate the system irreplaceably. He proceeds to check her left pulse for about a minute, then feels the pulse on her right hand as well. He then asks her to tell him in detail when the problem had started and to describe the progression of the ailment. He asks her about her daily itinerary and the food that she generally eats and whether she gets mood swings, whether she is a tense person, and so on. She chronicles the events as per his instructions. She tells him that she is very worried about her condition. Apart from the pain that she has to constantly endure, she feels burdened by the possible implications of her condition. The latest allopathic

[109] This combination of diagnostic methods is interesting. Although most Ayurvedic practitioners reject the allopathic system, many of them do not hesitate to look at the pathological reports. Whether they do this to draw certain inferences for treatment or they do it to offer an explanatory model that the patient is socialised into, namely the biomedical model, as some of the practitioners insist, is not clear. This question requires extensive research.

tests indicated that osteoporosis was setting in rapidly and her greatest fear was that she might get bed-ridden.

He tells her that he will try and remedy the situation but cautions her all the same saying that she should not expect a 'miracle' to happen immediately and that the treatment would take some time to take effect, as it was a very deep-rooted problem. Since it had taken so many years to set in, he explained, it would take at least a few months to root out the cause of the disease completely.

After this he writes out a prescription for her and asks her to come back to him after one month. He tells her that she has to observe a strict diet regimen with a complete restriction on non-vegetarian food, spicy and oily food, stale and sour food and vegetables that are not seasonal. He prohibits all *godhur* (heavy) foods like heavy pulses, dry fruits, non-vegetarian food, tea and coffee and so on. These items, he explains, would be difficult to digest and would further aggravate the imbalance in the body.

The medicines are obtained for three weeks from the dispensary attached to the clinic.

Mantra Healing

Mantra specialists in Assam are traditionally referred to as *bez*. *Jaar-phuk* or *jora-phuka* connotes curing through chanting mantras by waving a hand or a blade of grass in front of the person. I was given accounts of curing rituals where the specialist takes the help of a broom-like object to 'sweep away' the evil. There

was, however, a certain sense of ambivalence about this category of specialists among my respondents because they are believed to cause harm as well as heal with their use of esoteric mantras. Most accounts revolved around someone who 'does mantras' *(mantra kore).*

The respondents were not able to categorically define who a *bez* is, and often equating them with other local healers like the *oja* and herbalists. These categories are more clearly defined in the rural areas but most people from my field area told me that although they are aware of these categories, they do not visit them for treatment. A significant observation was that while many respondents denied having taken treatment from a *bez,* they evinced a general belief (albeit hesitatingly) in the use of mantras for healing purposes. I encountered several households where domestic help from villages would 'give mantras' *(jaari-diya)* for common ailments like headaches and backaches. The method would involve softly chanting some mantras and then blowing on the affected area. My respondents told me that this method is popularly considered effective for certain conditions that involve pain. There are specialists in the rural areas that are considered to be experts in this field.

There were several people from my field area who spoke about a particular healer and the efficacy of his treatment. He was a highly placed government official when I interviewed him in June 1997. I present below an observational account of a healing ritual conducted by this healer.[110]

[110] His status could be a probable reason why people did not hesitate to admit that they had consulted him, despite their emphatic denials of having treatment from a *bez.*

The 'clinic' is his official residence in Guwahati. The practitioner administers his therapy free of cost on Saturday and Sunday mornings in his office. The appointments are made in advance through a private secretary. There are about eight people waiting to be treated in a large well-furnished room adjoining the room where the healer sits.

He sits on a sofa facing the main door of the room through which the patients are called in one by one. A peon escorts a middle-aged man (who is in crutches) along with his companion (whom he introduces as his wife) and then leaves the room. The healer is in conversation with me. The patient enters, folds his hands and greets the healer. The healer smiles in return and beckons him to sit on a chair placed close to where he sits. The patient has a very pronounced limp.

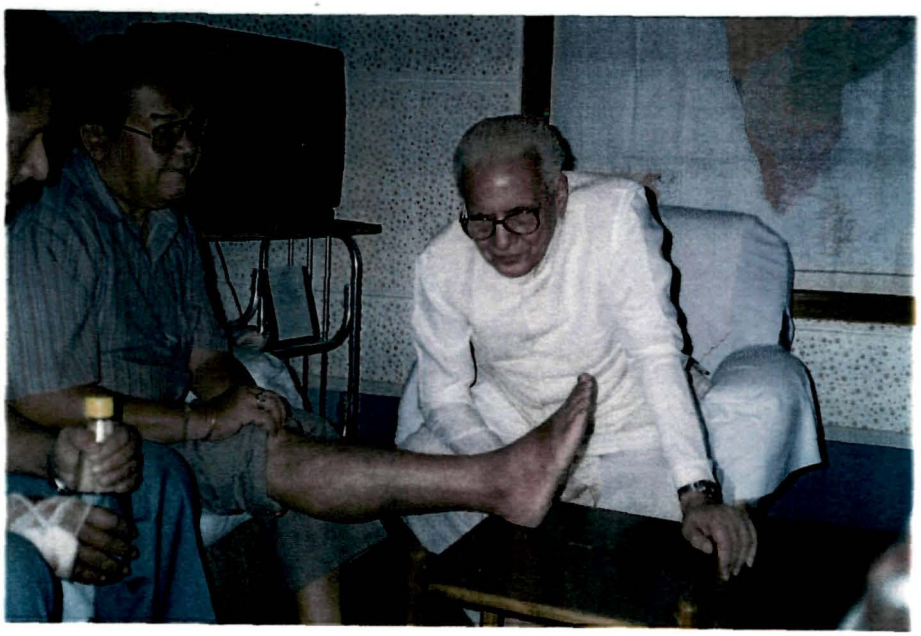
On being asked to describe the symptoms of his ailment, the patient tells him that he has damaged nerves on the right arch of his foot caused by a road accident three years ago. He had consulted several medical doctors who had put him onto extensive treatment but says that ultimately he has to take recourse to painkillers on an everyday basis. He was very frustrated with the large number of pills that he has to take which, he said, merely dull the pain temporarily till it recurs the next day. He has to attend office in crutches and can no longer drive a vehicle. He says that he has reached the end of his tether and that he has come to the healer looking for a long-term relief from the pain and discomfort. The doctors, he says, have recommended surgery but he is not sure that the problem would be eliminated after surgery as doctors are divided on the issue.

The healer listens intently and asks him to stretch his foot on the stool placed in front of him. The patient rolls up his right trouser-leg and reveals a severely swollen right foot (see photograph). The healer feels the area gingerly with the fingers of his right hand, appears to think for about a minute, reclines back on his seat and closes his eyes. There is absolute silence in the room, as he appears to meditate with both his hands outstretched on the arms of the sofa on which he sits.

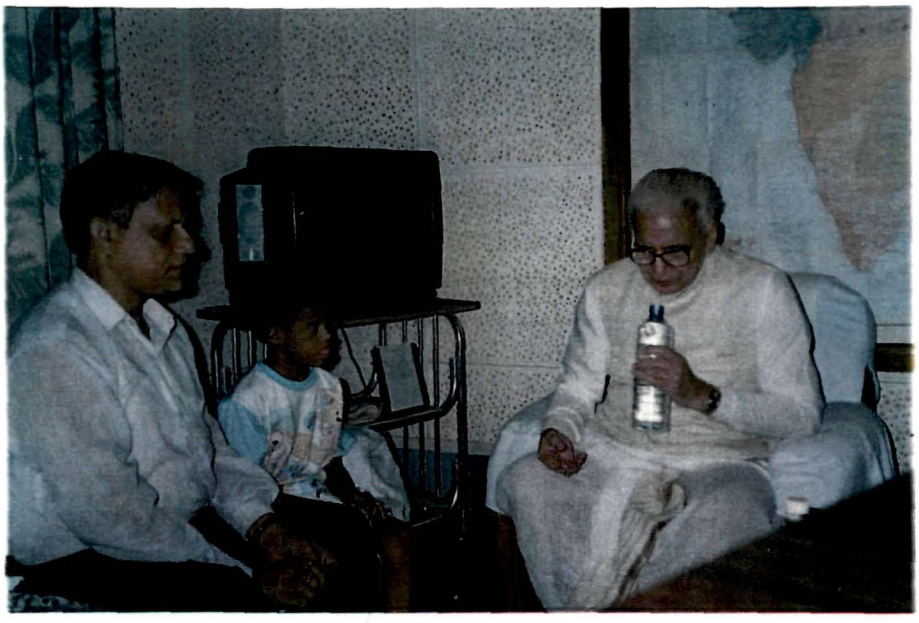
About four to five minutes later, he begins to move his lips in a barely audible whisper and appears to be 'counting' with the fingers of his right hand. Nobody else in the room is able to hear what he is chanting. He later told me that he counts the mantras that he begins to chant to himself.

After about six minutes, he opens his eyes, bends forward and blows, in short spurts, on the swollen area of the foot. He continues this for about a couple of minutes (I keep timing the procedure so that I can render a more accurate description). He then looks up and asks the patient whether he feels any change regarding the intensity of the pain. The patient looks unsure. The healer tells him to get up and to start walking on the carpet. The patient does as he is told but still looks unsure. But the moment he sits down and attempts to rotate his ankle he winces in pain.

The healer asks him to sit down again with his foot outstretched as before and begins a replay of the entire ritual once again. When he is through with blowing on the damaged foot for the second time, and the patient gets up for an



Mantra Healing in progress



The healer potentizing the water by 'blowing' on it, which follows the chanting of mantras

experimental walk, the patient smiles and says that the pain is 'much reduced'. "How much?" the healer asks with a look of satisfaction on his face. "About sixty percent," is the answer.

The healer asks for the bottle of oil that his wife has brought with her (they obviously know about the procedure of the treatment in advance).[111] The healer sits down again and, with his right fingers counting, blows after chanting mantras into the bottle eight times in succession, closes the cap shut and gives it to the patient with instructions that it is to be anointed three times a day for one month on the site of the pain. He tells them to come back to him immediately if the symptoms aggravate. The patient stands up and touches the feet of the healer with a grateful smile on his face. The couple leaves after the healer blesses him. The healer then folds his hands and chants a prayer.

The healer told me that he 'identifies' a particular ailment with a symptomatic description offered by the patient. Being a practicing Homeopath helps him to arrive at an accurate diagnosis, he asserts. He then calls into focus an assemblage of mantras that he feels are going to be effective as a remedy for the affliction. On being asked about the repetition of the ritual and whether the configuration of the mantras were the same both times, he told me that if the first set of mantras do not work, he restructures the combination of mantras, keeping the 'essential' mantras same as the first time but adding or deleting some others which may be considered as peripheral.

[111] I observed that in many occasions he charms bottled water instead of oil. The patients are instructed to replace the exact amount of water in the bottle after drinking it.

A mantra, according to him, is a sequence of sound units with a specific pronunciation and intonation. This, when used in the prescribed combination, creates a power 'to do many things' but in this case, he uses them to heal. Each mantra is designed for a particular task and it is believed that it achieves the desired end only when it is used in a particular manner. He said that he uses mantras only as a device for healing and while conducting religious rituals and not ever for other purposes.

Most of his clients, he said, either have gynaecological disorders or have various manifestations of severe pain.

The Bathini Fish Treatment

This treatment, administered in Hyderabad, Andhra Pradesh, is very popular among asthmatic patients in Assam.[112] The description about this treatment has been compiled through interviews with patients who have taken this medicine.[113] A personal communication with Harinath Gowd, one of the healers, through mail helped clarify certain details of the history of the treatment.[114]

Part of an inherited oral tradition, the knowledge of this medicine remains the repository of one particular family, the Bathini Gowds, in Hyderabad. This family lives in Shankar Gowd Lane in a locality called Doodhbowli in the city.

[112] Eastern Railways, in fact, commissions special bogeys in trains to facilitate people to reach there on time for the treatment each year.

[113] The popularity of this 'medicine' could be attributed to the large number of people who suffer from asthma in the region. This condition can at best be controlled by allopathic medicines and I met several patients who have tried out several types of nonallopthic treatment for amelioration of the same.

[114] I have, therefore retained the names of the healers to authenticate the description.

The three brothers (Vishwanath, Harinath and Umamaheshwar), assisted by the women of the family and the elder sons of the five brothers (including of the two other brothers, Shiv Ram and Somalingam, who have now died), annually administer the medicine to patients of asthma. Many helpers, which include the patients who have been cured of the disease after taking the medicine, and trained volunteers from various voluntary organizations, assist the family in co-coordinating lakhs of patients who congregate in Hyderabad for the purpose.[115]

There is only one particular day that is earmarked for distributing this medicine. The appointed day is known as Mrigasira Karti (which signifies the onset of the monsoon according to the Hindu calendar) and it falls between the seventh or the eighth of June each year.

The medicine is a mixture of herbs, which is finely blended, and ground into a paste few hours before administering it. It is then dried in the shade and shaped into six pills to be given to each patient. These are to be taken after the initial dosage on three successive occasions following the Karti days as prescribed by the healer.[116]

The eldest living brother of the family presides over the ritual, which begins with the worship of Shiva, the household deity, whose idol is placed on a small sanctum sanctorum at the entrance of the house. Around twelve to fourteen

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[115] I was told that many patients from west Asia, Germany, Singapore, Hong Kong and Japan come for this treatment.

[116] The medicine is not administered anywhere except Doodhbowli in Hyderabad.

hundred kilogrammes of medicine are apparently prepared each year with water drawn from the family well located in the courtyard of the house. The members of the family insist that no other water carries the same efficacy.

This paste is then kept in the mouth of a live Murrel fish (of the *Korrematta* species), which is two to three inches long. The fish is slippery so that it causes no obstruction while swallowing it. It is then thrust down the patient's mouth by the healer, to be swallowed whole without the help of any water. For orthodox vegetarian people who do not wish to touch or swallow the fish, they are given an alternative means of having the paste wrapped in ginger pulp mixed with some jaggery. However, Harinath Gowd insists that inserting the fish is considered to be the most effective treatment, as the live fish is believed to 'clean' the respiratory system with its fins and tail as it courses through the system. It is believed that this itself initiates the process of cure.

Raktim Saikia, a thirty-seven year old patient narrated his experiences to me.

> I went to Hyderabad for this treatment six years ago on the recommendation of many other friends and colleagues who were suffering from asthma. They insisted that the treatment had brought much relief to their condition. I was initially not moved by their claims and was particularly anxious about swallowing a live fish. My apprehensions took a back seat when my wife insisted that I try out the medicine. We agreed that if it worked then we would also take our six-year-old son, who is also

severely asthmatic, there for the treatment. I myself had been suffering from the disease for the past fifteen years and the allure of a cure was so overwhelming that I finally decided to go for it. I arrived Hyderabad the day prior to the treatment. I bought the fish myself early in the morning and carried it in a container of water while I stood in a serpentine queue of people who had come from all over the country. When my turn came I offered the fish to the healer who immediately inserted a paste into the mouth of the fish, asked me to open my mouth with my tongue stuck out as far as possible. The moment I opened my mouth he thrust the fish towards the base of my tongue and jolted my chin from below so that my mouth shut immediately. Before I realized anything I had swallowed the fish and it was another person's turn after me. The entire process took only a few seconds.

Each patient is subsequently given some extra mixture out of which six equal tablets are made as per instructions given by the healer. These tablets are then kept in the shade for about four hours so that they dry completely before being transferred to a dry plastic container for storage. These tablets are taken twice a day for three days once every fifteenth day commencing from the day of the first dosage. These days coincide with three more Karti days, namely, Arudra Karti, Punnarvasu Karti and Pushyam Karti which fall on the twenty-second of June, sixth of July and the twentieth of July respectively. Each pill is supposed to be taken on an empty stomach in the morning with luke-warm water and another tablet after dinner (before bed-time).

A strict diet regimen is prescribed for this period, that is, for the forty-five days following the first dose of the medicine. A leaflet containing a list of food items that are allowed is given to each patient with the reminder that transgression of these dietary regulations would render the treatment ineffective.

The recommended diet includes only certain items like old rice, wheat products, white sugar, mutton, snake gourd, arum, dried pieces of old mango, ginger, garlic, turmeric (old), spinach, *chamakura bhaji*, black gram dal, *amboti bhaji*, dry chillies, salt, ghee, sweet lime, figs, tea (prepared only with cow's milk), bread, buttermilk and biscuits.[117]

The patients are instructed to arrive in the city the day before the treatment so that they are explained the procedure and the diet. The treatment is given free of cost. This is apparently connected to the myth regarding the origin of the system.

Veerana Gowd, the great great grandfather of the present (and fourth) living generation was a toddy vendor. He is believed to have inherited the 'formula' for this cure from the descendants of Charaka sometime around the year 1860. He was known to be a very generous man who would distribute free toddy and white bread to labourers and it is believed that his philanthropic ways won him this secret. A sage would reportedly visit him often and just before he left the city, he imparted this 'secret formula' to him. He was given strict injunctions to confine the 'formula' only to the members of the family and to impart it only to

[117] Instructions are given that a hot iron rod be immersed into the buttermilk (prepared with cow's milk) before it is drunk.

those who were in dire need of it. The family believes that the healing power of the medicine would be lost forever if it is either questioned or sold for a fee for commercial gains. They are not aware of the chemical properties of the herbs they use. They regard it as a spiritual legacy and they have been distributing the medicine and treating asthmatic patients for nearly one hundred and forty years since then.

Another version of the story that was narrated by some of the respondents is that the secret formula was imparted to Veerana Gowd by a Wali (Arabic for God's friend) who had wandered into the city 'from the north'. Nobody could give me his name. He could very well have been a Muslim, this conjecture being particularly possible since Hyderabad is a Muslim dominated city.

The medicine is supposed to be taken for three consecutive years on every Mrigasira Karti day. Many patients told me that they had taken this treatment for more than three years if they felt that they had been unable to adhere to the diet restrictions that are considered cardinal to the system.

In a written communication with Harinath Gowd, I was told that the live fish survives the journey in the patient's body for about fifteen to twenty minutes during which it swims through the region in the body and clears the phlegm and congestion that causes the acute wheezing in the lungs. He believes that the treatment has a 95% accuracy rate if all the restrictions are adhered to as prescribed by the healers. The most important thing, he reiterates, is that this

medicine can only be administered within the premises of their ancestral house which, he feels, has some 'special powers' that imparts potency to the medicine.

Other healers

A small percentage of people quoted Khasi medicine and a Karbi cure for jaundice as medical options. I was unable to interview Khasi healers as they are all stationed in Meghalaya.[118] I was told, however, by my respondents that most of these medicines are herbal-based and they seek treatment from specialists for conditions which are associated with pain. An oil that they prescribe is considered to be particularly effective for pain of the joints.[119]

The Karbi cure for jaundice involves the use of a garland *(mala)* which is made of 'a particular natural substance'.[120] It is 'given' by a specialist who instructs the patient to wear the garland around the neck for as long as the symptoms of jaundice last. I was told that initially the garland is very small and just about slips over the head and binds itseld snugly around the neck and as the illness progresses, the garland 'keeps getting longer and longer'. It often reaches down to the navel, I was told. This 'medicine' is believed to stall complications associated with the disease. "Liver problems are not aggravated if you wear this *mala* through the period of jaundice," a respondent said. He had used this

[118] It is to be noted that all the respondents who informed me that they use Khasi medicines all have been residents of Shillong in Meghalaya at some point in their lives.

[119] The proximity of the neighbourhood to a Karbi village behind Narikolbari could be a possible reason behind resort to this treatment.

[120] The descriptions provided here are not enriched by personal interviews with a healer; instead the information is gleaned from patients' renditions.

treatment eight years ago when he had got a severe attack of jaundice. He was thirty-eight years old at that time. He had been recommended this treatment by a clerk in his office and he had gone to the neighbouring village of Birkusi for treatment by a Karbi healer in the village. The garland, he says, is prepared by the healer and then potentized by chanting special mantras.

Another healer that I encountered is a bonesetter from Baskandi in Cachar. He practices bone, muscular and nerve therapy and calls himself a naturopath (see photograph). The system that he practices has its origins in the Unani system of medicine, he tells me. The knowledge has been handed down orally to him by his father and it has been part of the oral tradition of his family for the past one hundred and fifty years. His son had polio when he was born. He had treated him for nine years. Now he is almost cured and he is able to attend school regularly. The essential components of his therapy involve prescribing exercise and dry heat (*xek*). This heat is given either with dry sand or with infrared lamps. It has been six years since he moved to Guwahati in search of a more lucrative clientele. He specialises in setting fractured bones in any part of the body, except the bones of the skull.

He first feels the broken or damaged area and then feels the pulse of the patient. He says that he does this in order to check the 'stability of the heart beat'. He then ties the area with a herb called *haar jura* (*Cissus quadrangularis*) and then applies some herbal medicine on it.[121] After the anointed medication begins

[121] He did not divulge the names of the other herbs to me. He believes that if he declares the 'secret' of the entire formula the potency of the mixture will vanish.

to dry he re-bandages the area over and over again depending on the severity of the fracture.

He says he has tactile knowledge and that just by feeling the area, he can tell how and what kind of fracture it is and the kind of treatment that it requires. If the patient comes within one hour of the fracture, he claims a 90% success rate. He said that his craft, however, does not extend to curing conditions in which bones have been splintered completely as a result of something heavy running over it. His wife assists him in collecting raw materials for the medicines. Faith, he tells me, plays a vitally important role in cure.

Medical astrology[122]

The astrologer's house is a traditional Assam-type structure located against the Nabagraha hillside facing the Brahmaputra river. A long flight of steps leads to the compound with a main house and a one-room annexe that serves as the site for consultation with clients.

At 7 a.m. on a Saturday morning, there are twelve persons waiting outside the room, who are sitting on chairs on a narrow verandah or standing around reading the day's newspaper. I sit inside with the second client as he begins his consultation with the astrologer. The first person had denied permission to me to sit in during the interaction. This man too looked hesitant when I tell him of my intention to tape the session and asks me whether I could take hand-written notes instead. I agree.

[122] I borrow this term from Kurup (1983:59).

The client is a forty-three year old man and is a chartered accountant. He walks in and hands over his astrological chart to the astrologer with folded hands. We sit in silence as the specialist proceeds to open a large exercise book and on a fresh page commences with his calculations. He explains that this data would remain there for reference and future consultations would take less time if the client quotes the number of the page. He takes about twenty minutes to finish his calculations at the end of which he asks the client whether he would like to ask any specific questions. The man tells him that he and his wife have been unable to bear a child for the past seven years of marriage. They have had extensive medical check-ups which did not reveal any biological reasons for not being able to conceive. "I want to know what is actually wrong," he asks. He tells him that he is also having a lot of tension at his workplace.

The astrologer looks back at the calculations that he has just done and proceeds to tell him about his personality, his physical and mental characteristics, his strengths and weaknesses and then explains the configurations of the planets at that point in time. The Sun *(robi)* in his second house indicates that he has a 'diseased' face.[123] It is also the lord of the sixth house which implies that he has a number of enemies who might be able to get the better of him often. The second and the ninth houses are very important in any natal chart, he explains to me. The lord of these, in this case, happens to be Mars *(mongol)*. It is powerfully placed in the fourth house but in the sign of that which is inimical to him, thereby curtailing

[123] Although powerful, because he is exalted in that sign, the Sun is a malefic planet and in the second house seems to produce these effects.

and weakening its power. To enhance its power he recommends the use of a gem *(protikaar dharon)* - a red coral stone of nine to twelve carats *(roti)* set on silver to be worn as a ring on the ring finger of the right hand. He identifies Venus *(xukro)*, which is far too powerful and seems to be the owner of a bad house - third and the eight, albeit placed in its own sign. This is not a favourable indication, he explains. This indicates a slump in all aspects of his life for twenty years up to the age of fifty-two years. Ten years have already passed and another ten remain for this phase to continue. After the age of fifty-two years he would have a very successful career and would prosper in every aspect of his life. Mercury *(mongol)* stands as the lord of the fourth and the seventh houses but its debilitated condition, he says, implies a poor concentration, although he is sharp and quick-witted. Owner of the first house and also occupying the ninth house is Jupiter *(brihaspati)*, which indicates that he would be learned and respectful. His other favourable planets are Moon *(sondro)* and *Ketu*. Venus, a benefic planet, is the owner of two problematic houses - the third and the eight. His occupation of the third house in particular, make him powerful. A gem, in this case, would precariously enhance the already powerful planet; instead he recommends a puja to placate it. He asked him to perform a special puja at the Bhubaneswari temple at Kamakhya, besides which he also advises him to perform a Kumari Puja at the Kamakhya temple.

He writes all this down in Assamese in a writing pad (which has his name and address embossed on it) and hands it to the client.

I present a brief account of the structure of the astrological world to bring out its relationship to suffering as described to me by the astrologer.

Astrology is based on the assumption that there is a very close connection between celestial bodies and all human beings.[124] Combinations of twelve zodiacs, twenty-seven stars and nine planets are believed to hold an all-pervasive influence on an individual's existence. The position of the planet at the time of birth and its subsequent placement at different periods of life exert varying degrees of influence on an individual. The planetary position is discerned, among many other things, to calculate an individuals' susceptibility to illness, the severity of illness and the duration of the illness.

Different parts of the body cohere to form one whole, the astrologer said. "Similarly, the different planets are akin to different organs in performing their independent functions towards the effective working of the whole. Thus, it is important that they perform their division of labour well, otherwise the balance is disturbed." First, the horoscope is read, the 'errant' planets identified and then prescriptions given either toward appeasement of the planet or to enhance its powers. Each planet has a presiding deity attached to it.[125] So when the fault in the configuration *(groho dox)* is identified, there are two ways of prescribing remedial measures *(groho xanti).* The process is either carried out at the Nabagraha temple or at the Kamakhya temple. The astrologer recommends Kamakhya because he

[124] For more information on astrological counselling, see Pugh (1983).

[125] This claim is repudiated by astrologers who are not Shakti worshippers; instead they feel that rituals in the Nabagraha temple are most effective in propitiating planets.

feels that the elaborate list of items needed for these rituals are not readily available elsewhere. In the absence of the actual items and the enormous cost of procuring some of the items, the almanac *(ponjeeka)* prescribes substitutes, for instance, Rs 1.25 in lieu of a cow, which he feels is a highly unrepresentative substitute. This, according to him, is not always advisable in the case of acute illness. The problem is eliminated when one goes to Kamakhya where the priests themselves procure most of the items and even know the mantras extensively. So he prescribes pujas at the Kamakhya for most of the cases. He mentions that the *bhujoni daan* (a symbolic meal with the recommended monetary offering) is particularly 'effective'.

There are three principal ways of appeasing the planets:

1. Mantra
2. *Jantra,* and
3. *Ouxodhi.*

Mantras, he said, emit vibrations, "like the rays emitted by a television which allows one to see the pictures on the screen notwithstanding the fact that the person is not present there." The *jantra*, he describes, as the ritual artifacts, the talismans and the amulets that he potentizes and prescribes for the wearer. The best *ouxodhi* , he says, is the gem *(rotno)*. "It is like ray treatment," he told me. It is believed that the rays from the sun penetrate the gem and enter the body, thereby empowering the gem to give the body extra energy thereby rejuvenating it. The effect of a gem, therefore, is two-fold: first it works on the affected planet and then, its own scientific presence benefits the body. For every gem, the carat,

transparency, colour and quality are of paramount importance. If the gem is genuine and has the required qualities, the astrologer assures that the initial effect can be felt within seconds of wearing it. The wearer is able to feel a significant difference in his condition within the next seven days. "It is like a bullet proof jacket," he says. Sometimes, the associated metal of the planet and roots of plants are also given to a person to wear them against his skin.

Diagnosis is, therefore, done with the help of the planets and the treatment is given by recommending the *ouxodhi* (medicine). He says that the astrologers, in this sense, are 'doctors' and the priests at the temple are the 'pharmacists' who perform the task of offering or dispensing with the medicines. The astrologer says that out of fifteen to twenty people who visit him everyday at least seven or eight persons consult him for health problems.

Health, according to these specialists, can be affected at two principal levels. The internal problems are most often caused by celestial constellations and the external problems may be caused by the atmosphere. Diet restrictions, therefore, are considered very important during certain periods of the year.

Most astrologers said that they are often able to prescribe 'better' treatment given by the medical doctors. Their virtuosity lies, according to them, in being to able to predict an ailment even before it actually occurs. They are able to very often foretell an impending illness at a certain period in the person's life thereby providing an opportunity to help minimise its adverse effects and sometimes to ward it off altogether. "Many allopathic doctors have taken prescriptions of gems

from me and wear them, if not on the fingers around their necks," one astrologer said. "If I cannot stop the rain, at least I can provide the umbrella," another well-known specialist asserted.

Table no. 7

Classification of disease and associated planet

S. No.	Planet	Local name of planet	Associated disorder
1.	Sun	*Robi*	Heart disease
2.	Moon	*Sondro*	Depends upon its configuration with other planets
3.	Mars	*Mongol*	Accident (bloodshed)
4.	Mercury	*Budh*	Epilepsy/childlessness
5.	Jupiter	*Brihaspati*	Liver
6.	Venus	*Xukro*	Impotency
7.	Saturn	*Xoni*	Nerve ailments/paralysis
8.	*Rahu*	*Rahu*	Several possible disorders
9.	*Ketu*	*Ketu*	Several possible disorders

Mars, Saturn and *Rahu* generally indicate problems in health. The Sun controls the soul, the Moon the mind and Mercury the nervous system, I was told. The Moon and Mercury indicate respiratory disorders and Mars and the Moon gynaecological ailments. An extension of explanation is formulated by Kurup (1983) where he writes that the afflictions by the Moon, Mercury, Mars or Saturn generally indicate mental disorders. Influence of the Sun, Jupiter, Mars centered on Mercury or the Moon induces schizophrenia while conjunction of the Moon and the Sun cause melancholia.

Reading the condition

Several studies have documented differences in procedure based on diagnosis and prescription between biomedicine and nonbiomedical systems (Bharadwaj 1980; Waxler-Morrison 1988; McKee 1988). Empirical data from my field area agrees with and at the same time suggests that some of these propositions are not valid in every case.

The essential difference between the various systems lie in terms of their respective etiological constructions. The biomedical reading of disease rests on the doctrine of specific etiology and is either localised or explained in terms of an intrusion of a virus. In contrast, in Ayurveda, a disturbance in the equilibrium of the three humours is quoted as the main reason behind any disorder. This is related to internal disturbances *vis-à-vis* diet or to the seasons. Astrological prescriptions, on the other hand, are made on the basis of the cosmic harmony between planets. Homeopathic theory conceives the body as an autoregulating device where specific as well as non-specific stresses exert a morbific influence on the body (Vithoulkas 1983).[126] In Reiki the depletion of the 'vital force' (or energy) of the body is regarded as the governing factor behind susceptibility to disease. All these systems differ from biomedicine at a very basic level; the holistic approach of nonbiomedical healing provides an integrated model which sees all parts of the system - body, mind, spirit, environment, and society as interrelated to promote internal and external balance while the allopathic belief in

[126] See discussion on Homeopathy earlier in the chapter.

pathogenic causality places more emphasis on the physical aspect of the body, with the exception of mental ailments. Health in allopathy is defined more in terms of functional rather than in experiential terms where disease is read as a malfunction and medicine aims at curing that disease (Mckee 1988).[127] Social determinants of the condition are generally not considered relevant in allopathic diagnoses.[128]

Therapeutic strategies

Each person's humoral constitution (Ayurveda), reaction to symptoms (Homeopathy), configuration of the aura (Reiki and Pranic Healing) and celestial configuration (astrology) necessitates a focus on the idiosyncratic symptoms, which require individualised attention. This is in contrast to the allopathic emphasis on the disease *per se* which prescribes standardized treatment to all the bearers of the disease.

A particular stereotypical distinction needs to be questioned at this point. It is commonly stated that biomedicine treats the symptom as the disease *per se* while alternative medicines read the symptom as the pathway to discerning the underlying cause of the disease. While this could hold true in many cases, there are exceptions to the rule. Fevers, for instance, are often attributed by a medical

[127] Many of the nonbiomedical practitioners said that the medicines employed in allopathy have a toxic effect on the body. Two Ayurvedic practitioners categorically pointed out that in most cases where sweating, diuresis and vomiting are construed to be the effect of drugs are, in actual fact, the attempts by the body to purge itself of the substances.

[128] This polarity is fast being bridged. I witnessed an increasing number of allopaths laying importance on social variables like keeping calm with yoga and meditation, a diet and exercise regimen, especially in the case of patients with hypertension and cardiac disorders.

doctor to an underlying infection. Here, the symptom is considered to be the manifestation of an underlying cause in much the same way as in nonbiomedical healing.

The difference is thus more marked in the *procedure* that is employed in curing disease. Allopathic medicines seek to cure disease by eliminating the symptoms while in Homeopathy the symptoms are stimulated rather than suppressed. Homeopaths use the description of symptoms only as an indication for the selection of an appropriate remedy. Restoration of overall vitality is the main concern in Ayurveda and Reiki. By establishing an inextricable link with lifestyle, physical, psychological and spiritual influences the patient, therefore, is willy-nilly made to take a proactive responsibility of restoration of health by monitoring one's lifestyle, diet and emotional stability.

Doctor-patient relationship

There are studies (Cant and Sharma 1999; Sharma 1992) where the doctor-patient relationship in a medical setting is quoted as problematic while interactions with non-biomedical healers are regarded as cathartic and relaxing. While some of my respondents have echoed a similar opinion, there are several cases in my field area where patients have found interactions with non-allopathic specialists dissatisfying. A fifty-three year old man who had been recommended surgery for prostate enlargement had visited an Ayurvedic physician in the city. He felt that the practitioner was 'far too brisk' and did not give him enough time to explain all his symptoms in detail. He felt a sense of discomfiture at the fact that there were

other patients who were sitting in the same room while he was consulting the specialist. Not only did the encounter lack privacy but the physician was too 'commercial', he felt.

Similarly, I have documented case studies where consultations with Homeopaths have not lasted more than ten minutes while clinical sittings with medical doctors have run into twenty-five minutes. This finding belies the prototypical distinction between allopathic and nonallopathic consultations on the basis of 'quality time'. As a consequence of an increasing number of patients in some nonallopathic clinics allotment of time to each patient seems to have changed from the traditional norm.

Integration between systems

A close relationship between diet and climate seems to be the leitmotif in most non-biomedical healing. In both Ayurveda and the Fish Medicine the physicians explain that non-adherence to the stipulated diet restrictions would render the treatment ineffective. Climate and season also play a key role. The Fish Medicine is administered only at a specific time of the year. In the same vein, Ayurvedic diagnosis rests on the belief that people with a specific constitution are susceptible to particular disorders during certain seasons. Homepathic treatment also takes cognizance of the effect of climate, and environmental pollution; in Reiki and Pranic Healing the sun, air and water are considered to be the main sources of vital energy.

At a formal level, there may be opposition, even acrimony, between

systems; but in practice I have found that different systems of medicines have been profittably combined with the explicit intervention of the specialist where the specialist himself advises the patients to combine two or more systems. This could be analysed within the backdrop of a possible classification of systems into harmonic and disharmonic.[129] Within this scheme it is possible that there could be systems which could be combined more easily with each other than with other systems. The Mantra Healer employs his knowledge of Homeopathy as a diagnostic tool and as a preamble to Mantra Healing. Similarly, many of the astrologers' discourses are structured in terms of Ayurvedic theory where they talk in terms of balance between the humours and of diet restrictions during certain times of the year. The practitioners of the Fish Treatment too endorse Ayurvedic treatment as a second resort. Sisir Duara, a pediatrician, regularly prescribes Homeopathic medicines to his patients. However, I could not find any cases of an Ayurvedic specialist prescribing Homeopathic medicines nor a medical doctor who was a practicing Mantra Healer. This suggests that some systems with somewhat similar theoretical bases could be combined more easily than others which do not permit such integration.

Specialization within systems

In allopathy it is found that the patient with a complicated case very often moves from one doctor to another for diagnosis and treatment. The movement is usually from a general physician to a specialist and, if need be, even to a super-specialist. Several super-specialists sometimes come together to examine a patient and to

[129] Bhandari, J.S. (Personal Communication, April 2001).

give advice on the course of treatment. I find that the alternative systems, on the other hand, lack such specialisation and there is no clear hierarchy. It is the name and fame of the healer that is more important than his qualifications. As the systems lack objective pathological examinations, the symptoms of the patient can be presented to any healer who understands them and much of the diagnosis depends upon the healer and his mode of healing. Therefore, if in the allopathic system, it is the objectivity of the reports that is considered important, in alternative medicine it is the charisma of the specialist. I am not arguing that allopathic doctors lack charisma, they certainly do - especially surgeons - but their charisma is subordinated to the system of objective knowledge. For instance, an angiographic report can be interpreted by any cardiologist who is schooled in this knowledge. It is knowledge that has a primary place; whereas in the alternative systems it is the specialists' command over knowledge as well as his ability to interpret it that is more important.

Notwithstanding the differences and commonalities between the systems themselves or between alternative medicine and biomedicine, what is more important is the way they are perceived by the people. Trawick has suggested that in a pluralistic medical scenario, sometimes the 'very lack of congruence' among the traditions or the lack of a uniform meaning accounts for their 'culturally satisfying quality' and at times for the healing of the patient (1992: 134). Thus, even if medical pluralism precipitates a scenario of contested meanings and competing systems, as long as people make profitable use of the systems, they cohere to form a viable landscape of multiple health resources.

CHAPTER 6

Therapy, Cure and Prophylactic:

The Patient's Point of View

THERAPY, CURE AND PROPHYLACTIC:

The patient's point of view

To understand perceptions of health and illness, it is important to take cognizance of the actual spectrum of practices as they unfold within the quotidian existence of peoples' lives. The patient's recognition of his condition, the way he imputes meaning to it and his decision to seek medical care are largely conditioned by culture and becomes central to the evaluation of health seeking behaviour.

Cultural practices inevitably shape worldviews and those practices that the individual chooses become priorities. The medical biography of a patient, therefore, reflects his world of meaning and his illness behaviour is an embodiment of an ideological framework, which is largely framed by the cultural milieu in which he lives. The need to study illness and health in its cultural context, therefore, has been consistently stressed in medical anthropological literature (Landy 1977; Kleinman 1980; Lock 1980; Helman 1984; Nichter 1980).

Cultural knowledge is neither completely unified nor without contradictions. I, therefore, concur with Radley's (1993) emphasis on the importance of the biographical understanding of health and disease from the point of view of the patient. I have made extensive use of case studies, and illness narratives (Kleinman 1980; Good 1994), in this chapter, to give a first hand account of the patient's situation, the way he experiences and bears his illness, his

attempts to seek amelioration for the condition and above all, to illustrate the dynamism of culture.

Out of my total sample of one hundred and seventy-nine persons, I collected fifty-eight medical biographies. Although all these narratives were used to glean information for my thesis, it may be noted that I have chosen to present only those cases which I thought would render a more explicit understanding of the phenomena under study, that is, to understand the health seeking behaviour and patterns of usage between systems of healing.

I have made use of pseudonyms for the patients as well as the healers in order to maintain their privacy.

CASE STUDY NO.1[130]

Name: Manjushree Sarma Sex: Female Age: 28 years

Manjushree got her periods when she was eleven years old and has had painful cycles for as long as she can remember. In the initial years she would take care to rest during the first day of her cycle so that she could cope with the pain. Female relatives in the family would tell her that this was a normal phenomenon for some girls and that the pain would diminish as she grew older and would completely disappear once she got married. However, when the intensity of the pain increased and she could no longer afford to miss classes and practicals in

[130] I collected this case study in the beginning of my fieldwork. I spoke not only to the patient herself but also to her mother at length about her resort to various medical systems at different points in her biography.

college she began to take a painkiller called Baralgan on the recommendation of a local doctor who also told her that it was normal for some adolescent girls to experience pain during menstruation. Her grandmother would every now and then grind a local herb called *doron xak* into a paste which, when taken with warm water on an empty stomach, was considered to be very effective in curing menstrual cramps.[131] This herbal concoction, taken over four successive cycles had cured her cousin completely. Manjushree took this preparation for a period of nine months but it had no effect on her. She told me that she had to continue with this domestic remedy for such a long time chiefly because of kin pressure and the assurance that it would work sooner or later.

Her mother strongly believed that Homeopathy would cure her problem.[132] She was taken to a well-known Homeopath in the city who gave her a course to follow for one month. At the end of this period there was no change in her condition. The physician gave her another month's dosage to follow. On recommendations from her mother's sister and her father's two sisters, she was taken to six Homeopathic practitioners over the course of three to four years. The menstrual cramps continued.

A friend of hers who had very painful periods told her that she had gained much relief from Acupressure. She taught her to do it on herself by pressing the specified pressure points on her palms. She tried it out for three consecutive cycles

[131] The botanical name of the herb has been provided in the Appendix I.

[132] This is among many other cases that I encountered in the field where persons have demonstrated their strong belief in Homeopathy.

but it did not work.

By January 1996, Manjushree had become quite sick. Not only did her pain get progressively worse with each cycle but also the painkillers that she had been taking were no longer effective. She would suffer from a persistent backache and abdominal heaviness and would be enveloped with an overwhelming sense of fatigue for most days of the month. She initially withheld this information from her mother because she feared that she might be taken to a gynaecologist. She, however, was alarmed when she fainted in college one day and on another day had a blackout accompanied with cold sweat while she was in the library.

She recounted this to her mother who insisted that she be taken to a gynaecologist. Manjushree was reluctant to go because she felt shy of undergoing a clinical examination but as her condition worsened, she agreed to visit a lady gynaecologist. She performed an ultrasound test and since Manjushree was studying in Delhi at the time, she referred her to a gynaecologist at the All India Institute of Medical Sciences in New Delhi whom she visited in June 1996.[133] Another ultrasound scan of her lower abdomen was performed which showed two large masses on each of the ovaries. A blood test called CA-125, considered to be an effective tumour marker for already diagnosed ovarian carcinomas, showed an abnormally high count of 75.0 (the reference range of which is usually below 34.3 U/ml in 95% of healthy females). The doctor suspected a tumour and recommended immediate surgery.

[133] This gynaecologist was Assamese and a classmate of the first doctor. It is interesting to see how 'cultural connections' are given importance in choosing specialists.

Pujas were carried out in her name at the Mahamaya temple in Assam in which her family has great faith.[134] Her mother's brother visited another temple called the Holeshwor, a Siva temple situated about four hours away from Guwahati and conducted a puja for her and sent her a talisman that she was instructed to wear on her right upper arm. 'I felt that the talisman carried a lot of power and that I would get well soon', she told me.

The surgery was performed at the AIIMS in September, 1996. Despite the doctors' initial apprehensions that they might have to remove the ovaries if the growths were cancerous, Manjushree was lucky. They found that she had a condition which they defined as endometriosis (it had reached an advanced state) and bilateral ovarian cysts. Her post-surgical reports, which I browsed through, indicated that the endometrium had been repaired and that the cysts had been surgically removed. They were able to save her ovaries.

Her parents consulted an astrologer when she went back to Guwahati to recuperate after the operation. His verdict was that once the planet *Rahu*, which was vitiated, was propitiated at the Nabagraha temple 'everything would be fine'. He recommended another puja at the Chinnamasta temple in the Kamakhya temple complex. Both these rituals were performed as prescribed.[135]

Manjushree recovered quickly. I met her in July 1997. "It was a novelty for me to feel so well. It was only at that time did I realize *how* ill I had been for the

[134] Although these were not specific rituals addressing her medical problem *per se*, they were carried out for her general welfare, her health being an important component of this general welfare.

[135] Details of a ritual at the Chinnamasta temple at Kamakhya have been provided in Chapter Four.

past three or four years. Although I had learnt to cope with my protracted illness I had really suffered a lot", she told me.

In December 1997, one year three months after the surgery, Manjushree began to experience excruciating pain again on her lower abdomen. She reported this to her doctor. An ultrasonography in February 1998 confirmed that a cyst had formed again in her left ovary. The same gynaecologist at AIIMS was consulted who said that she would monitor her condition regularly and if the cyst grew further she would have to ultimately conduct a laproscopy where she might have to remove the affected ovary. This really upset Manjushree and the members of her family. Nobody had expected her condition to relapse after the successful surgery.

Seeing how upset she was, a friend of hers, who was taking Ayurvedic treatment herself, suggested that Manjushree try an Ayurvedic healer but Manjushree was unmoved. She felt that she had tried a number of non-allopathic medicines before the surgery which had effected no cure at all so far and given her condition, there was no way any other system could be efficacious when, she said, 'such an advanced science like allopathy' had not been able to cure it.

Subsequent tests conducted in the hospital over the next few months confirmed that the cyst was growing steadily. By the beginning of 1999, a cyst appeared in the right ovary as well. By then Manjushree had once again become quite ill. There was a persistent backache and a dull pain around the abdomen all

through the month and she would be perpetually tired. Onset of periods meant excruciating pain for which she was recommended a very strong painkiller called Voveran SR-100. "Every night I would go to bed with my whole body aching and would wake up with another day of pain. This was very distressing. I did not know what to do. I was very depressed", she told me during the course of the interview.

She visited another doctor at the Apollo Hospital in New Delhi for a second opinion who told her that she needed urgent hormonal treatment. These hormones, the doctor said, would arrest her condition but could possibly induce some side-effects in the form of hair-growth, hot flashes and even mood swings.

The same friend who had recommended that she try out Ayurveda continued trying to convince her and at this point Manjushree decided to give it 'one last try since there was no other way out'. She was taken to the Ayurvedic physician by her friend. She found him 'very kind and reassuring'. He told her that since she was suffering from a problem that had a long history, it would take some time to effect a cure and that she would have to be patient. He prescribed a set of medicines and asked her to go back to him after one month. Her parents approved of Ayurvedic treatment and endorsed her decision to consult him although her brothers felt that allopathy being 'scientifically superior' was a more viable option.

There was no change in her symptoms for the first three months. But with the beginning of the fourth month of treatment, Manjushree noticed that the

frequency of her cramps had begun to lessen and her persistent backache had become less troublesome.

An ultrasound scan in August 2000 (four months after she had begun treatment with the Ayurvedic physician), showed that the cyst in the right ovary had completely disappeared and the cyst on the left ovary had also shrunk although three additional tiny cysts had grown alongside it. This was very heartening news for her and she felt that, despite her initial misgivings, she would continue with this treatment.

At the time of compiling this case study, Manjushree has completed ten months of this Ayurvedic treatment and plans to continue for the next six months or so. The physician has assured her that in another five or six months, she would be cured. 'For the moment I am happy because there has been a significant improvement in my condition and I am hoping for the best', she tells me. She says that she is no longer susceptible to colds and fevers which she would contract every two or three weeks before she began treatment and the backache that used to perpetually pain her is now gone. However, she is still dependent on painkillers as there is a considerable amount of pain and discomfort during many days of the month even now. None of the Ayurvedic medicines that she had been prescribed act as painkillers, she said. Meanwhile, she goes for ultrasound tests to her doctor every three months to confirm that the cysts are not growing. She seems hopeful that the problems will get ironed out with time as the Ayurvedic practitioner had promised and that she would not require surgery at least in the immediate future.

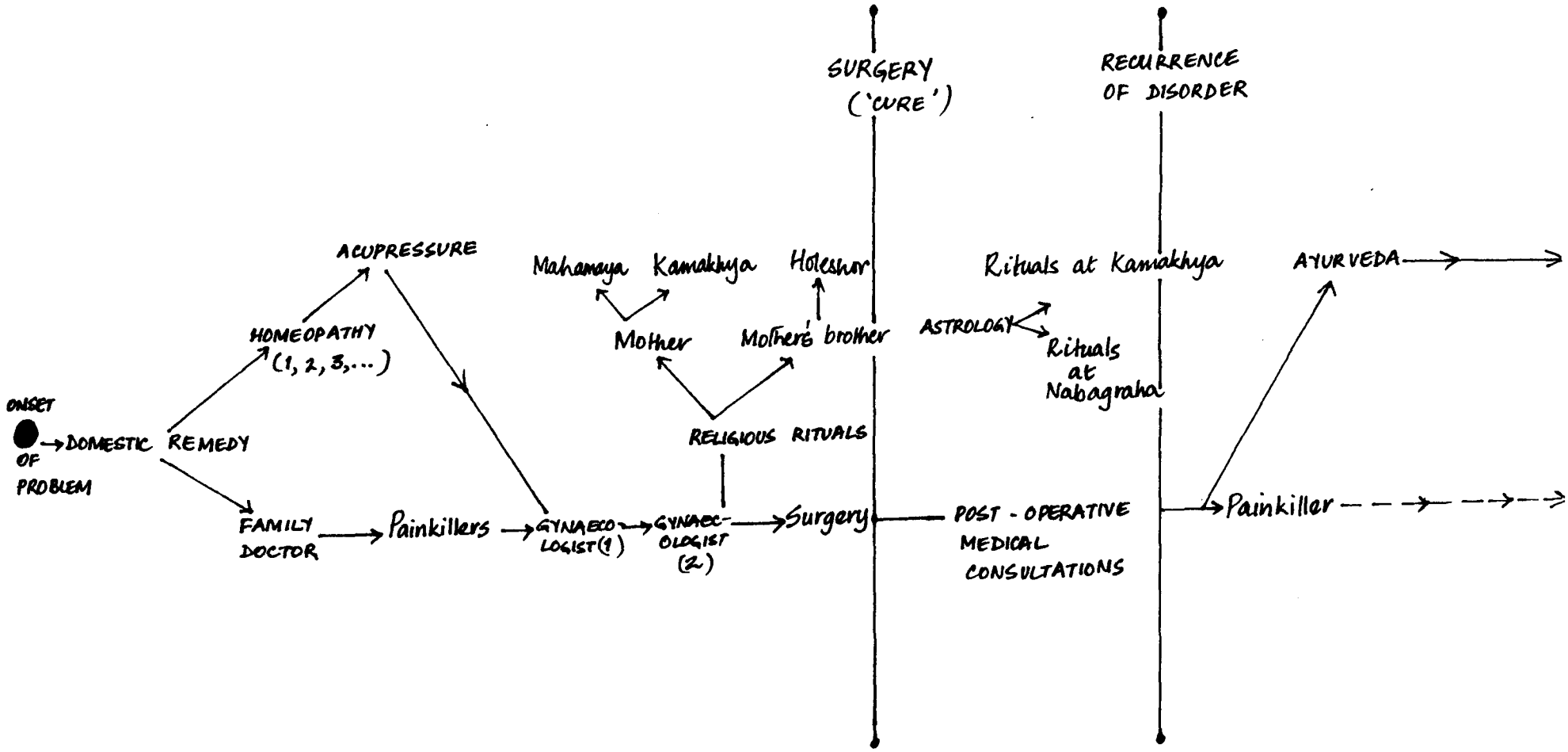

FIG. 1: CASE STUDY NO. 1 : PATTERNS OF RESORT

CONCURRENT USE OF 'MEDICAL SYSTEMS'

CASE STUDY NO.2

Name: Rajib Bora Sex: male Age: 19 years

Rajib tells me that he has 'always' had a 'problem' with his breathing. He said that he would wake up with a severe bout of sneezing every morning. Very often this would continue throughout the day and by the afternoon he would feel very asphyxiated. His nose would be blocked all the time. His parents had initially thought that it was a severe nasal congestion that he was susceptible to and they kept resorting to home remedies and each time the situation worsened they would consult the family doctor. Frequent attacks of cold and cough persisted throughout his childhood and it was only when he was finally referred to a specialist by the family doctor that he was diagnosed with chronic bronchial asthma. He was seven years old at that time.

His parents had been very upset at the diagnosis. He was taken to the famous Aparna Homeo Pharmacy in the city where the Homeopath gave him a course to follow for three weeks. Rajib visited this Homeopath for one whole year with the doses being varied after each consultation but he does not recall any significant changes in his condition. In fact, his condition began to worsen with age. Very often he would have to stay back from school and was unable to participate in any of his favourite athletic events in the school sports days. He would get severe 'attacks' of asthma almost every alternate night. He would be awakened with an acute feeling of suffocation, which would be followed by severe bouts of coughing. He would throw up a lot of phlegm and would often

vomit with the severity of the attack. This symptom would often last for as long as one hour and sometimes even more. As a result, he would not be able to sleep properly and would wake up feeling 'completely exhausted' the following day. He would run a cold perennially and this would be punctuated by extended bouts of sneezing almost every day of the week. "I would feel petrified of going to bed at night in anticipation of what would happen once I fell asleep", he told me.

His mother's sister's husband was under treatment from a Tibetan doctor in Delhi for his gout and he felt that the frequency of his gout attacks had lessened after the treatment. So he advised Rajib's parents to consult the same specialist. They had read about the efficacy of Tibetan medicines in newspapers and magazines and some members of the kin group insisted that it was a good option. Rajib's parents decided to give it a try. Rajib was nine years old at that time.

The diagnosis by this practitioner was chiefly done on the basis of a pulse examination and the symptomatology offered by the patient. He prescribed medicines for two months after which he asked Rajib to come back for a fresh dosage of medicines. Rajib recalls that there was absolutely no change in his condition after the first round of treatment. He was taken by his father for one more consultation after two months as instructed. There seemed to be no change in his condition even after five months so they took the decision not to go back to Delhi for further treatment. Meanwhile, during their second trip to Delhi, Rajib's father made an appointment with an E.N.T. specialist he knew at a leading hospital in New Delhi who conducted a pulmonary test and told Rajib's father that

his son's condition was aggravating.[136] He was given a medicine called Asmovar in addition to being told to use a bronchodilator and a nebulizer. Moreover, he was advised to swim regularly so that this exercise would be beneficial for his lungs.

Rajib went back to Guwahati and enrolled for swimming lessons at the Gauhati Stadium pool. He continued swimming every morning before school for four months but had to discontinue this pattern once winter set in as he would catch a cold if he went swimming in the morning or in the evening after school. In December 1993 Rajib, then twelve years old, was hospitalised for three days following a severe asthmatic attack. On the first day he had to be given oxygen to facilitate his breathing.

The family was alarmed at the fact that Rajib had to be admitted in hospital and realized that the same situation could very well recur in the future. At this point, some of their neighbours recommended another form of therapy. Many of them claimed relief from an assortment of ailments after undertaking Mantra Treatment from a healer in the city. Rajib's's parents considered this option immediately as both of them have implicit faith in mantras. They said that mantras have been practiced in Assam for the past several hundred years and if a person is proficient in its practice, then he can wield a lot of power. Over the next four months Rajib went for as many as eight sessions with the healer. All through this consultation he was still dependent on his allopathic medicines. His mother tells me that the intensity of his attacks had abated for a while after taking treatment.

[136] The choice of the doctor, as in Manjushree's case, was made on the basis of his Assamese connection.

She insists that the treatment at least served a 'protective function' from further aggravation of the condition. Rajib, however, remains undecided about the outcome of the treatment but he feels that he used to definitely feel rejuvenated after each session with him even if he had had an attack the previous night, which used to leave him absolutely drained the next day.

Meanwhile, Paresh Nobis, his father's friend had come back from his third trip to Hyderabad after taking the Fish Treatment for asthma. He had been accompanied by two other colleagues who also claimed that they had found some relief after the treatment. They insisted that Rajib should go for the same the following year.[137] None of the members of his family initially paid heed to this piece of advice. The thought of swallowing a live fish stuffed with a herbal mixture as treatment seemed preposterous at the time. However, in the next six months they found that many of their acquaintances, friends and relatives had either taken the medicine themselves or knew other people who had gone for the treatment.[138] The popularity of the system seemed further borne out by the fact that the Eastern Railways commissioned a special bogey in the North-East Express train to facilitate people to go to Hyderabad in June for the treatment each year.

In June 1994, Rajib and his parents went to Hyderabad for the treatment. He was administered the 'medicine' in June by one of the specialists. He had to

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[137] The description of this treatment has been provided in the Chapter Five.

[138] "It was as if God had sent all these people to us. How else can one explain the fact that we met and heard of *so many* people at that time, who taken this treatment?", Rajib's mother said.

adhere to a strict diet regimen for forty-five days after the medicine was administered during which he was forbidden to eat anything apart from the items mentioned in the diet chart given by them. The first six months after he took the medicines turned out to be very difficult for Rajib. He would cough up a lot of phlegm and the frequency of his asthma attacks increased. They called the specialists in Hyderabad to find out whether they should discontinue with the medicines but he forbade them to do so and asked Rajib to continue with this diet as prescribed by them. Gradually, towards the end of six months the aggravated symptoms began to subside. He went back for the two more mandatory doses in June the following year and the year after that on the appointed date.

Rajib's has been an arduous battle against a breathing problem which he has had to cope with for the past nineteen years. He is still not cured of his problem but he tells me that his condition is much better now than what it was eight or nine years ago. His mother tells me that this is due to the various treatment regimes that he has been put to and the parents are unable to pinpoint conclusively which particular system of medicine is responsible for his improved condition. The mother believes that it is the combination of the many non-allopathic treatments that he has been put through. But Rajib feels that the Fish Medicine has brought him more relief than the other systems. Although he still gets bouts of asthma once every three or four months he feels that there has been significant improvement on two counts - the frequency and the intensity of his attacks. He carries his inhaler with him all the time and each time he senses an 'attack' coming he uses it immediately. He plays tennis every alternate day and

says that he feels energetic on most days although there are 'bad days' when he has difficulty breathing and by the end of the day he feels quite exhausted. I noticed that his voice sounds as if he is wheezing and very often his breathing appears laboured but he does not seem to be particularly constrained by it.

Coping with asthma has become a way of life for him, he tells me nonchalantly. He follows many preventive measures so as not to instigate situations that might trigger an asthmatic attack. He does not drink cold water. He wears an undershirt all the time. He bathes only with tepid or hot water, and so on. He prefers to sleep in an air-conditioned room during the humid summer months because he feels that the dry air inside the room allows him to breathe easier. He does yogic asanas every morning for one hour which he had learnt from a private instructor.

Rajib used to be very conscious that he was 'different' from members of his peer group till about five years ago. "This ailment used to be such a constraining factor all through my childhood but I no longer feel crippled by its presence. There is nothing I can do about it since it has been foisted upon me at birth. I cannot wish it away at will and there is no point in lamenting about why I should suffer so much. Learning to cope with what you have is the most important thing", he says.

CASE STUDY NO.3

Name: Samhita Das Sex: Female Age: 33 years

Samhita was studying for a Masters degree in Gauhati University when she

feels that her 'illness' started.[139] This was in November 1992. She was twenty-four years old at that time. It had initially started with a general feeling of despondency and ennui at whatever she was doing. She would go back to her house after attending her classes at the university each evening and sit in her room with no inclination to converse with any members of the family. She would mechanically eat her meals and make an attempt to join in the conversation at the table but this, she said, required a very forced effort. Her older sister, who she was particularly attached to, noticed the change in her and would keep asking her whether she was bothered or worried about anything in particular to which Samhita would reply in the negative. She said that it all began with absolutely 'no inclination to talk to people'. She evinced a growing sense of indifference in her studies which resulted in her dropping three papers in her final examination. On her parents' insistence she would go to the university each morning but they were informed by her teacher that she would simply sit aside and not write her examination. Her parents felt very troubled at the turn of events and assuming that her problems emanated from academic pressure, even arranged for a private tutor for their daughter. She refused to attend tuition and said that she would retake her papers the following year.

Meanwhile Samhita began to feel a growing sense of alienation from her bevy of friends and she began to extricate herself completely from her social circle preferring instead to spend time alone in her house by herself. The members

[139] Although at that time she felt that she was just 'feeling low', the assumption was not in reference to a clinical condition. She merely thought that she was feeling melancholy or dispirited. It was only after her first diagnosis by a medical doctor much later that she told me that she was 'suffering from a sickness called depression'.

of her family thought that this was a temporary phenomenon and that she would soon revert to her gregarious state. Her mother was selected as the Chief Executive Officer in a large multinational company. This seemed to be the bone of contention for her daughter, Mrs. Das told me. She accused her mother one day saying that she was not spending enough time with her children 'like other mothers do' and kept throwing 'tantrums' about it for almost a fortnight.

She became more and more preoccupied and reticent as one and a half years went by. When her sister and her mother would come back from work, she would often be in a foul temper. She told her sister that she no longer wanted to live in Guwahati as she was 'sick of meeting the same people over and over again' and that she would 'rather die than be in this situation day in and day out'. The persistent question she would ask her sister is 'why can't I *feel* anything?'

A family friend told her parents that he had had his daughter successfully treated for a condition called anorexia nervosa at the National Institute of Mental Health and Neurological Sciences (NIMHANS) at Bangalore. This was further corroborated by their family doctor who felt that Samhita needed to be examined by a trained psychiatrist. When they conveyed this to Samhita she threw a huge tantrum and she accused them of treating her like a 'mental case' and said that she would not agree to having a medical examination. The father and the mother tried to convince her but she became more adamant. Samhita's mother took her horoscope to a well-known astrologer in the city. He read her astrological chart and said that he found a constellation which signaled a state of inauspiciousness

for her. He prescribed a set of rituals to be performed and advised her to wear a gem (sapphire) set in silver on her right forefinger. The family being Vaishnavites was reluctant to perform any rites at the Nabagraha temple. But within the fortnight they changed their mind and had the puja performed at the temple when they realized that Samhita's condition was only getting worse. By this time she had developed a severe temper where she would tear the curtains in her room and break her favourite decorative items in fits of rage.

Finally, in September 1993, they coerced her to accept traveling to Bangalore for treatment.[140] Both of them felt that anonymity in a new place where they had no relatives and friends would take care of an anxiety about the stigma attached to mental illnesses. They stayed on in the city while she was treated at the institute for three months. They took her for tours around the city and to places close to Bangalore for recreation. They came back to Guwahati in January 1994 with medicines for the next four months after which they were asked to bring her back to meet the doctor again.

Samhita could not adjust when she came back to Guwahati. Word had spread in the family and among their friends that she had 'taken ill' and although nobody (by her own admission) asked her 'objectionable questions', she felt that she was under scrutiny all the time. She expressed her desire to go away to Delhi where they owned a flat. Her sister had to now resign from her job because she could no longer avail of any more leave and she accompanied her sister to Delhi.

[140] She was accompanied by her mother and her sister. Her sister is in the government service. Both the mother and the sister took leave from their respective jobs so that they could accompany Samhita to Bangalore.

Samhita was, in the meantime, on several drugs, which made her sleepy all the time and she seemed to slip into some kind of stupor. Her sister noticed that she no longer got into fits of rage anymore. However, she seldom smiled or showed any enthusiasm for anything. They stayed in Delhi for three weeks and then went for a visit to Shimla and Nainital which she 'seemed' to enjoy, her sister told me. On March 18, 1994, five days after their trip to Himachal Pradesh, Samhita locked herself in her bedroom and tried to commit suicide by consuming a very toxic insect repellant. By the time they managed to break open the door she was already unconscious. She was immediately taken to a hospital where the poison was flushed out but she remained unconscious for two days and in delirium for two and a half days after that. After eleven days, she was taken back to Guwahati where she was kept under strict surveillance at all times of the day. She would be escorted everywhere and would never be left alone. She later told me that she wanted to die as she 'no longer felt anything' and that it was better to die 'than be a burden on everybody'.

Samhita now regressed into a further state of depression. She seldom spoke and desperate efforts by the members of the family to enliven her mood failed to elicit any positive response from her. A senior staff member of her mother's office told her about a woman he referred to as 'Ai' in the city. She is held to be some sort of a diviner who has the ability to foretell events and conditions specific to the individual who poses the question, he told her. The mother mulled over this piece of information for about a week and finally decided to visit this woman. It

was a very brief encounter in which she recalls being seated with a large number of people in an enclosed area in front of a house and each individual walking up to a woman who appeared to be in her forties. Ai, as she was addressed, would answer one question posed by the individual without looking at the person concerned. Samhita's mother asked her whether her daughter would recover from her illness. The woman replied that she would although it would take close to five or six years for her to do so. "I felt such a huge sense of relief that I came back crying to my car", she told me.

In May 1994, their neighbour and friend recounted, with much exuberance, a discourse on Reiki by a Reiki Master, who was visiting the city from Calcutta. She would very often come and speak to Samhita about it and suggested that Samhita should learn Reiki. Two months later she organized a workshop on Reiki in the city to which she invited Samhita. Despite her initial reluctance Samhita agreed to go and she attended the four-day workshop with her sister. This kindled interest in this form of therapy and Samhita began to gradually get quite involved in learning about the system. She met the healer during his following visit to Guwahati and this, she tells me later, 'changed her life'. She felt 'drawn to him and his philosophy' and she began to correspond with him regularly. In the next nine months, she took two courses on Reiki. She got very involved in learning and reading about it. She even began, albeit tentatively, meeting people from her family whom she would volunteer to 'heal' in case of headaches, nausea and stomach cramps. And over the next one year there was a sea change in her in that she began to speak more and she began to interact more with relatives. Although

she kept insisting that she did not have the ability to heal others when she herself was suffering from an illness, that conviction seemed to wear out with time as she began to feel better herself. She attributes this change to Reiki.

Whenever she 'feels a dark cloud approaching', she told me, she performs Reiki on herself and that it makes her feel much better. She subsequently took a course on meditation at the Vivekananda Kendra in the city at the insistence of the healer. She told me that she joined the course only when her sister decided to join it with her. She could not meditate at all initially as her mind was very disturbed and was unable to concentrate but after three months or so she was able to meditate for about five minutes. This entire regimen seemed to infuse her with a new lease of life. She began to introspect on her condition and in November 1997 she told her sister that she 'realized' she was 'ill' and that she was no different from other people who were also plagued by other types of ailments. She told her mother and father that she would like to see another doctor so that she could get better.

In February 1998, she came to Delhi to meet a well-known psychiatrist at the Apollo Hospital to seek a second opinion on her condition. He told her to discontinue with the medicines prescribed at NIMHANS and put her on a fresh regimen of medicines. She has been on medicines prescribed by him since then and comes back to meet the doctor every quarter. Her sister told me that she still slips into a state of listlessness every now and then but she no longer resists going to the doctor. More importantly, she has begun attending public functions in the community once again and often meets up with her old friends.

She told me that she had 'something to look forward to' now. After many, many years she has at least 'begun to feel', she told me. Notwithstanding the clinical interpretations offered by the doctors, what seems important at this point is that she herself feels that she is getting better.

Ethnographic decision making

The case studies that I have presented here have been deliberately chosen. Long treatment tenures mark each of these case studies and one sees several alternative systems of healing coming together, and interacting, in each of the medical biographies. I chose the first case study because it is of a specific female illness; the second because it is a condition, that is asthma, which is not sex bound and I have, therefore, chosen a case study of a male; and the last is that of mental sickness which presents a unique trajectory that is quite different from other conditions of health.[141]

In all these cases the role of the Therapy Management Group (TMG) is vividly demonstrated. In the first case, most female members of Manjushree's family, first her grandmother and then her mother, her father's sisters and mother's sister are involved in the decision-making process involved in seeking 'appropriate' medical care. Members of the extended kin group are also consulted at various points as the illness progresses depending upon the interpersonal relations between the members. For individuals till the age of around twenty years

[141] The cases I present here are highly abridged versions of the original biographies which are very prominently punctuated by the individual's own interpretation of the systems at every point of resort. I have presented the general pattern of usage of systems here and utilize the remaining portions of the narratives for analysing the data.

all decisions about health care are seen to be taken by the parents and senior members of the family. In many cases the same reference group is resorted to till an older age, especially in the case of female patients. Similarly, for aged parents, major decisions about health care are taken by their children, even if they do not reside in the same house as the parents. All children till the age of around twenty years, and unmarried girls till they are about twenty-five years, are escorted to doctors and medical centres by a member of the family, usually one of the parents and sometimes even both.

It is seen that in biomedical encounters major decisions about treatment like surgery and extensive medication are communicated to the closest male member even if the patient happens to be an adult female, as I have mentioned earlier. Thus, kin members are seen to play a vital role in almost all the medical biographies that I have collected. In most of the case studies I, therefore, interviewed not just the individual patient but also the closest member of the family who was seen to be playing the most effective role in managing the illness of the patient.

In both Rajib and Samhita's cases I interviewed their mothers along with them (in Rajib's case his father as well for a description of his childhood experiences) and in Samhita's case I interviewed both the mother and the sister. In the latter case it must be recalled that both the mother, and especially her sister, play a constant role all through her illness episode. The sister, in fact, enacts the role of a 'decoy' several times in order to lead her sister to particular situations

which the members of the family consider to be beneficial for the patient. Not only do the sister and other members the extended family 'offer' themselves for Reiki treatment by her, the sister even enrols in a yoga course so that she is able to convince her sister to participate in the same programme. Samhita tells me that she lives in a constant fear of what she would do if her sister decides to get married. Her older sister is aware of this fact. She told me that she has decided to shelve her plans of getting married till such time Samhita is able to cope on her own. Thus, life cycle rituals get affected not only in the case of the patient but also of the most effective members of the TMG, in this case, her sister. I found that in a large number of chronic ailments the TMG is much larger and more active than in cases where the illness has a short biography.

The trajectory of mental illnesses differ significantly from other illnesses in that the former most often entails first recourse to non-allopathic treatment, where astrology and religious ritual play a prominent role. The visit to a medical doctor takes place much later in the biography as compared to cases of other illnesses.

Construction of the illness explanation

Out of the fifty-eight case studies that I have collected, 93.5% of the people began with a biomedical definition of their condition. They described the onset of disease with allopathic terminological categories like asthma, arthritis, cataract, fibroids, etc. There were several people whose versions of what they perceived as the cause of their problem would oscillate between one theory and another and there were others who recruited fresh theories into their explanations as the illness

progressed.

For the purpose of analysis, I would like to forward a set of heuristic categories based on their theories of causality of disease:

1. *Uniformly held causation:* The largest group comprises those persons (56.1%) who adhered to the *same* theory of causation of the particular disease, with which they initially defined their problem. These explanations, rooted in the allopathic paradigm, would be applied to other illnesses as well. This point of view, however, did not come in the way of them seeking 'alternative' cures.

2. *Causal pluralism:* The second group consists of those persons (31.3%) who coalesced *several* theories at the same time to arrive at an explanation for their condition. Most of them uphold the biomedical theory of disease but at the same time cite 'folk' hypotheses revolving around food and other theories underlying 'alternative' systems, like the Ayurvedic theory of imbalance. Also, there were a large number of cases who cited different theories for different illnesses. Here, there is no uniformly held causation explaining all disorders.

3. *Serial causation:* The third group includes persons (12.6%) who conclusively *changed* to another model of causation than what they began with. Most of the members of this group were (or became) skeptical of biomedicine.

At the beginning of the illness, I found that most of the patients are more

emphatic about the selection of one particular mode of treatment which they have chosen but as the illness progresses and the experience of symptoms enters new realms, the course of treatment too takes varied directions. In the process, the understanding and subsequent explanation of the condition are modified with the passage of time.

In the hierarchy of resort, since allopathy occupies the first place, the visit to the doctor socialises the patient into the world of allopathic constructs. A large majority of the explanations, therefore, are grounded in biomedical theory. With increasing visits to the doctor, it is seen that the patient's vocabulary regarding his illness increases and becomes more elaborate. Thus, the patient renders his biography in terms of pik flow tests, tractions, MRI scans, and so on. These concepts help the patients in understanding their illnesses and it is through these terms that the meaning of illness is sought.

Thirty-nine case studies pertain to chronic conditions and these form the crux of my analysis in this chapter. Life circumstances of people with chronic ailments is rendered different as they are forced to cope with long sickness careers and I found that adjustment becomes as much of an issue as finding a cure for the condition.[142] People evolve various coping strategies, especially if the condition does not worsen, but do not stop looking for a cure. I found that 68.8% had consulted an additional biomedical doctor to solicit what they termed as a 'second

[142] I followed these case studies for three years from the beginning of my fieldwork to my last trip to the field in July 2000.

opinion' to confirm the diagnosis offered by the first specialist.[143] Most of these cases pertain to what the patients termed as 'serious' illnesses where a longer biography was imminent. Out of this group, a large number (66.4%) had, during the course of their biography, consulted at least *one* alternative medical practitioner. It may be noted at this point that there were many people who consulted the second allopathic doctor even *after* they sought non-biomedical treatment and I could not discern a specific chronological order to indicate health-seeking resort beyond the first reference to allopathy.

The illness explanation, therefore, is multi-faceted and its explanation is best read as a process. It usually begins with:

i. The realization that the symptoms one is experiencing is not 'normal';

ii. This is comprehended in the light of a larger body of knowledge about health and sickness which predisposes an understanding (however tentative that may be) of 'what is wrong' with the body;

iii. The individual's perception of the etiology of the condition determines the *initial* resort to a certain type of medical practitioner although this perception does not necessarily guide subsequent recourse to treatment.

iv. As the biography evolves, the narrative is often restructured as it is exposed to the social world surrounding the patient. The course of the biography is largely determined by interaction with members of the family, with people

[143] This is done mainly on the advice of a member or members of the kin group.

having the same problem and with persons who render advise – what Friedson (190; 1961) terms the 'lay referral system'. This mosaic of ideas is constantly punctuated by the diagnoses and prognoses offered by the various medical specialists that the patient consults. Media is found to play a key role. Newspaper reports on health and articles in health magazines are often quoted as sites of information which apprise the individual of new trends in research and possible cures for certain conditions.

Lastly, there is a constant dialogue with oneself as the patient tries to grapple with new circumstances that are posed as the illness progresses. In the light of his assessment of symptoms, responses to treatment, and side-effects (if any), his explanation takes on different trajectories.

Thus, it is seen that the illness explanation is a dynamic, interactive process which fluctuates through time and is constantly reworked by the patient as he attempts to accommodate these explanations as he proceeds through the activities of everyday life (Hunt et al. 1989).

Users of alternative medicine

Patients who use alternative medicine represent a wide assortment of people and I was unable to identify a particular category or a single type of person as the prototypical user. Cant and Sharma (1999) caution against using general statements about users of alternative medicine because there are as many differences among users as there are among users and non-users. Variations in values, attitudes and beliefs make comparisons of users and non-users

inconclusive. Therapy specific analysis is, therefore, considered to be the more viable option for overriding this conundrum.

Treating users of alternative medicine as one category, therefore, is not possible. In this context I find Sharma's (1992) classification into three types of users quite useful. The 'earnest seekers' are those patients who cast about for a suitable cure for one particular condition and do not intend to carry on with these medicines once a cure is achieved. 'Stable users' are those persons who have had a favourable experience of a particular therapy and with a practitioner which in turn induces them to consult this practitioner regularly. 'Eclectic users' refer to the group who 'shop around' for what they feel is the best form of treatment (be it biomedicine or alternative medicine) among a variety of practitioners for a variety of conditions. Their aim is to get the best out of all the available treatment options. Furnham and Smith (1988) posit a similar three-fold categorization into principalists who believe in alternative medicine; those who are disappointed or frustrated with biomedicine; and opportunists who shop around for the best alternative available.

The most predominant group among the users of alternative medicine in my field area consists of persons who could be labeled as 'eclectic users' - those who use several therapeutic measures at the same time. They think that the combination of several systems will produce better results than singular use of one system. Deepika Khaund, a thirty-six year old woman who was diagnosed with fibroids in her uterus told me that her gynaecologist had prescribed a hysterectomy within one year. Convinced that such a drastic step would usher in

further complications such as increase in blood pressure and osteoporosis in the long run, she has instead opted for non-allopathic treatment. She now takes Homeopathic medicines (Calcarea and Lachesis), an Ayurvedic syrup (Lodhrasawa), wears an amulet on her right upper arm given by her family priest as well as a coral stone set in silver as a ring on her right middle finger as prescribed by an astrologer. Meanwhile, she often takes allopathic medicines that have been recommended by her gynaecologist when she feels that her bleeding becomes excessive. In another case, a man who suffers from epilepsy wears a talisman (brought from a *pir dargah* in Ajmer) in addition to a *rudrakhyo* (given to him by a local astrologer), both strung onto a thread around his neck. He continues to use allopathic medicines on a regular basis. These eclectic users seem to be interested in the best possible combination.

Each of these ritual artifacts is prescribed by traditions which represent conflicting cognitive bases. In the case cited above, the patient wears on his person representations of different religious orders. However, at the level of the patient, these theoretical barriers are often overlooked and transcended in a pragmatic search for a cure.[144]

I found that women, more than men, were inclined towards these systems. They seemed more drawn towards the concept of holistic healing that is espoused

[144] What is more important is the anticipation of a remedy. The attempt is not so much to look for systems consciously, rather patients 'try out' whatever comes in the way ('shopping around'). This is amply illustrated in Samhita's interaction with Reiki.

by most of these alternative systems.[145] Out of the three Reiki and Pranic Healing workshops that I observed, 86.3% of the participants were women.[146] I interviewed both men and women about this point and I confirmed that women evinced more interest in alternative healing than men. A possible hypothesis could be that most of these individuals are non-working women. They are less constrained by professional work and in many cases interaction with another person who has taken up such an interest and narrates success stories about it is found to have a decisive effect. Such stories, especially from one's peers may have a domino effect and spread rapidly across a class of women for whom being a Reiki healer may become a symbol of class or status.

It is interesting to note that persons in the age group 55-65 years emphatically encouraged use of Ayurvedic and Homeopathic treatment while persons in the age group of 65-75 years preferred Ayurveda.[147] They were unsure about the role of Reiki and Pranic healing which some considered to be 'new-fangled' ideas that would peter out with time. Several people, however, drew parallels between Mantra Healing and Reiki. Use of local herbal pharmacopoeia for 'regular' problems was unequivocally supported by all groups although more

[145] This could perhaps be attributed to the fact that 71.2% of my female respondents in the age group of 35-40 years are non-working women. They hold the household responsibility for arranging the diet itinerary for the members of the family and pay more attention to the nutritional benefits of the food they serve as meals on a daily basis. This concurs with Sharma's (1992) suggestion that gender roles help to understand the household dimension of alternative medicine.

[146] Cant and Sharma (1999) attribute the higher number of women alternative medicine users to the likelihood that women experience more chronic illnesses than men. Although most of my case studies are of women patients, I do not possess enough medical data to conclusively endorse this statement in this study.

[147] This could be attributed to the fact that Ayurveda as a system of healing has been practiced in the region for a long time and there are many success stories of these physicians *(kobiraj)*. The setting up of the Ayurvedic College at Jalukbari in 1948 popularised the system further.

vociferously advocated by persons above the age of 65 years.

Patterns of usage

Chronic conditions, more than life threatening ones, as I mentioned earlier, are predominant among the cases presented to the practitioners of alternative medicine. In most cases, these conditions are referred to biomedical doctors who recommend treatment and it is only after being screened by allopathic specialists, depending upon the success achieved by them, that an 'alternative' is sought.[148] This point is persistently highlighted during interviews with nonbiomedical healers.

> Most of these patients have long histories of deep-seated problems and they have been suffering for a long time. A large majority of them refer to us only when they have reached a dead end with allopathic treatment. The irony of the situation is that they still expect us to produce miracle cures in a fortnight despite the fact these patients have spent considerable time either going from one doctor to the other or using one set of medicines or the other . . . .

(Personal communication with Tarun Bhattacharjee, an Ayurvedic practitioner)

The disorders that are most commonly presented to these practitioners are

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[148] For conditions like diabetes, cancer, and cardiovascular diseases allopathic medicine invariably continues along with alternative treatment.

asthma, menstrual disorders, rheumatism and arthritis, different kinds of allergies, stomach disorders and stress related disorders like depression and anxiety.[149] Most of these are disorders where allopathy has not been able to demonstrate success.

Dissatisfaction with allopathy, however, can seldom be described as total as most of the patients use these systems together with allopathic treatment. In fact, 76.2% of my respondents continue consulting their medical doctors although they are taking treatment form non-allopathic systems at the same time. Moreover, they regularly make use of medical 'crutches' like inhalers, anti-histamines, pain killers and muscle relaxants despite the fact that many of them are on a prescribed Ayurvedic, Tibetan or Homeopathic regimen.[150]

Conversion to another system in the process of 'trying it out' often follows later in the biography of the patient. 12.6% of the case studies had shifted allegiance to a system other than what they had begun with at the beginning of their sickness career. Success in curing an intractable problem or an ideological bias towards the tenets of a particular alternative system could be cited as the possible reasons behind this shift in belief.[151]

There are many patients who continue using the system despite the fact

[149] 'Depression' and 'anxiety' were the terms used to define conditions by the nonallopathic practitioners and I could not ascertain whether they correspond to equivalent diagnoses in biomedical terms.

[150] MacGregor and Peay (1996) report that while users of alternative medicine do not necessarily indicate dissatisfaction with practitioners of biomedicine, they reveal lower levels of confidence in biomedicine in general.

[151] It would be interesting to follow these biographies further to see whether this group remains loyal to the system or will try out another form of therapy the next time it fails to effect a cure for a different problem in the same individual.

that at the end of a long run, the treatment has not resulted in a 'cure'. A sixty-four year old patient who was diagnosed with colon cancer four years ago decided to take Tibetan medicines after he underwent chemotherapy. The Tibetan doctor told him that this disease had led to a very debilitating condition where his body's immune system had collapsed. The patient told me that after being on these medicines for three months, he now feels rejuvenated and much more energetic. Similarly, in Samhita's case Reiki allows her to 'feel' again. Thus, although this does not amount to a 'cure' of his problem, the patient uses the theoretical frame offered by the practitioner and feels that in this sense the medicines have 'worked'. This brings into focus the metamedical framework that Worsley (1982) discusses where the term healing goes beyond the physical ailment.

Just as one is unable to demarcate one type of user, it is difficult to establish one single motive behind resort to these healing practices. Different people enumerate different reasons for selecting these systems. There are people who use some of these therapies to instill a 'general feeling of well-being' while there are others who seek therapy for a specific ailment.

There are people, like Samhita (case study no.3), who use one particular alternative system (Reiki) as the only treatment option while there are others who juxtapose several systems to complement each other (case study no. 2). Pranab Bora, a fifty-one year old male uses Ayurvedic medicines for post-surgical convalescence following his gall bladder operation. He used to undertake regular healing sessions from a Mantra healer, as a 'top up' for hypertension for which he has been on allopathic medication for the past nine years. He feels that Mantras

have tremendous potency for healing.

Some respondents mentioned feeling 'helpless' during a medical encounter or in hospital environs. A forty-eight year old woman said that she feels like a 'passive supplicant' each time she visits her doctor and contrasts his 'medical jargon' (that she is often unable to comprehend) with the discourse given by her Ayurvedic practitioner about the role of diet and lifestyle in curbing a chronic stomach disorder defined as irritable bowel syndrome. She regularly does yoga every morning, meditates once a day and follows a diet regime as stipulated by the practitioner. She says that she now feels infused with a sense of personal responsibility in monitoring her condition.

Side-effects caused by allopathic drugs pose a great cause for concern for people who are dependent on them. Kalyan Das, a sixty-two year old male, suffering from gout has been on a preventive medicine called Zyloric daily for the past seven years. Each time he gets an attack of gout he has to take another medicine called Colchesine, widely acclaimed by doctors as the best medication for his condition. Although this medicine arrests the condition immediately and lessens the excruciating pain associated with gout, he gets acute diarrhoea the moment he takes these pills. This was the main reason why he shifted to Homeopathy. Similarly, a thirty-eight year old woman was given a set of very expensive injections called Leuprolide Acetate for severe endometriosis. Despite being told that this drug was much better than other LHRH analogues which are routinely prescribed to women with this condition, it caused temporary bone wastage in her body. She complained of constant body ache for the next six

months after being administered these injections and she fractured her ankle within this period. When the disease recurred two years later, she opted for Tibetan medicine.

It is, therefore, seen that reasons behind recourse to alternative medicine vary. It could either be a conviction in the theoretical foundations of a particular system or could snowball from a dissatisfaction with biomedicine. There are people who said that they wanted to avoid surgery recommended by the medical doctor which they considered to be too invasive. Some systems are used to complement allopathic treatment, as we have seen earlier, or they are used as the single most important option especially in the case of children. Inherent inadequacies in the allopathic system, more predominantly iatrogenic effects, are seen to be the motivating factor behind the search for alternative cures.

Patterns of usage, therefore, are not uniform for every patient. Individual biographies vary even as their respective conditions differ. Reasons behind resort could be on the basis of one or several of the points enumerated above.

Interaction with biomedicine

A large majority (70.3%) of the user group told me that they had not told their medical doctors that they were using nonbiomedical treatment. This was borne out of fear of rebuttal from the doctors. This corroborated my finding that most of the doctors I interviewed did not endorse the use of these alternative systems. Dr. Anup Phukan, a gynaecologist, told me that he questions the very premise on which these systems are based. He did not believe that in an arena like

gynaecology and obstetrics where there are such specialised categories of disorders like myloma, fibroids, polycystic ovarian disease, etc., another system which simply classifies them as 'menstrual disorders' can claim legitimacy. When I questioned Dr. Dipika Deka about the disappearance of Manjushree's (case study no.1) right cyst, she overruled a possible effect of Ayurvedic medicines by insisting that it was due to a natural remission caused during certain menstrual cycles.

At the other end of the scale, there are medical doctors in my field area who have gone for the Fish Treatment at Hyderabad and have attended Pranic Healing workshops. One doctor told me that for ailments that allopathy is unable to cure but can only 'manage' (diabetes, hypertension, and so on) he sees no harm in trying out other systems of healing although he cautioned against quacks who appropriate medical knowledge without having any proper training for the same. These kind of fraudulent practices often cause harm to the patient, he said. He recounted a case study of a woman who developed gall stones and low blood pressure while she was undergoing treatment for severe spondylitis from an Ayurvedic physician. There are few doctors who themselves use Homeopathic medicines for self-treatment. This group, because of its small number of adherents, cannot be taken as a representative sample to indicate compliance with alternative medicine. There are a larger group who are aware of the benefits of some of these systems but who feel hesitant to recommend these systems to their

patients.[152]

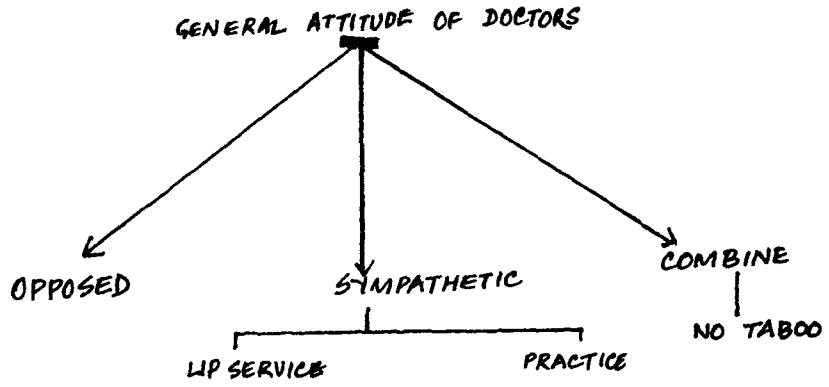

Fig. 2 is an attempt to represent the attitude of doctors toward assimilation of alternative medicine with their treatment. At one end of the pole are those practitioners who are completely opposed to the idea of alternative medicine as a treatment alternative and at the other end are those who combine alternative medicine with allopathic treatment, either for personal use or as prescription to patients. The sympathetic groups are the ones who provide lip-service in endorsing these medicines but will not actively recommend any particular system.

In contrast to the much smaller number of persons who informed their doctors about ongoing nonbiomedical treatment, 83% of the patients I interviewed told me that they had apprised their nonbiomedical practitioners that they had taken allopathic treatment in the past for the condition. While several persons within this group told the practitioners that they did not want to stop biomedical treatment while they took treatment from them, 46.7% said that they did not disclose the fact that they still consult their doctors for fear of the practitioner

[152] There are cases where doctors recommend prescriptions containing medicines like Liv-52 and Livomyn which are actually Ayurvedic preparations. I met a woman who was suggested a tonic called

taking umbrage at this disclosure.

Referrals from other people are the main pathway which leads to the first consultation. Local networks are, thus, found to be very important in influencing people to 'try out' a system. It is interesting to note that while my questionnaires indicate that professional qualifications of the medical practitioner is considered to be an important factor, such is not wholly the case with an alternative medical practitioner. The latter group is consulted *despite* their qualifications and the more cogent factor is recommendations from other users. Stories of success are seen to carry much weight. Social characteristics of the healer are, however, considered important, and recollections of encounters with these practitioners are often punctuated with references to them being described as 'kind', 'compassionate', 'understanding', and so on.

The indigenous nosological categories used by the alternative practitioner do not coincide with those used within the biomedical paradigm as they are based on divergent theoretical formulations. A sixty-nine year old man is diagnosed with Alzeimer's Disease by the medical doctor after several diagnostic tests in the clinic. He is told by a Khasi medicine man that an 'adversary' has performed sorcery *(thlen)* on him. Similarly an Ayurvedic practitioner tells a woman who is undergoing extensive fertility treatment for blocked fallopian tubes that she has a *vayu-pitta* constitution the derangement of which has caused this condition. Once the 'balance' in the body is regained, she would be able to conceive a child. A

Safi (a Unani medicine) by her medical doctor. Yoga is routinely prescribed by many cardiac specialists.

mantra healer, meanwhile, 'blows' mantras on six sets of areca nut and betel leaf and tells her to eat one set each day after lunch and tells her to come back to him every fortnight. He tells her that she has a problem with her blood circulation and that this procedure would allow her blood to flow in an unhindered fashion.

In contrast to this, there are many practitioners of alternative medicine who often offer diagnoses which are couched in allopathic language in response to queries by the patient. These practitioners told me that this is done so that the patient is able to 'accommodate' this diagnosis without being disconcerted at having to reconcile to categories which may go against their established beliefs. A patient who renders a description of his ailment during his first consultation with an Ayurvedic practitioner on the basis that he has a 'very, very complex problem' told me later that he could not accept the diagnosis offered by the practitioner who said that his problem was caused by *apana vayu*.[153] The patient thought that it was too 'simplistic' an explanation for a condition which 'even allopathy could not cure'.[154]

Implications for cultural changes

Furnham and Forey (1994) suggest that users of Homeopathy have more self-awareness than non-users and are more concerned about ensuring a holistic approach to health care. They are also more knowledgeable about their bodies than patients who only use allopathy because long association with alternative medicine makes users more cognizant of leading a 'healthy lifestyle'. I would

[153] *Apana vayu* is wind that is located in the large intestine *(apana)*. It attends to functions such as elimination of semen, menstrual fluid, faeces, urine and foetus (*Astanga Hrdayam:* 1996:167).
[154] Since *apana vayu* translates itself as 'wind', I also got the feeling that the patient was embarassed by the explanation.

repudiate this statement in the light of some of the case studies pertaining to chronic ailments. While it is true that alternative medicine puts greater emphasis on diet and lifestyle, this cannot be equated with having more 'knowledge' about the body. There are patients of allopathy, especially those with cancer and cardiovascular disorders, who are often found to possess elaborate knowledge about their condition, albeit this knowledge is grounded in biomedical theory.

What is perhaps of greater relevance in this context is that alternative healing allows patients to link their illness to wider social and cultural contexts. Most of the systems propound theories of balance. The focus is on the individual as an entity within a particular environment and subsequently on a 'pattern of events' which makes the patient susceptible to the condition, rather than concentrating only on the disease *per se*. The spotlight is on adjustment rather than on an immediate cure for the present medical problem (Lock 1980). Thus, sustained adherence to these beliefs, no doubt, brings about a transformation of attitudes towards the body, health and personal responsibility towards illness although users may not necessarily adhere to 'alternative' ways of life at the collective level (Sharma 1992). As an extension of this argument, I found that 57.9% of my user respondents categorically claimed that they felt an 'overall improvement' in their health condition and believe that they are en route to a cure despite the fact that they still suffer from many of the symptoms caused by the disorder.

Changes are, thus, more pronounced at the individual level of cognition.

Rajib's biography (case study no.2), succinctly illustrates this point. What he initially believed to be 'preposterous' (the Fish Medicine) ultimately turned out to be a treatment alternative and the experience was accepted by the patient further into his illness career as a viable option. Patients are seen to become more open-minded as the illness biography evolves.

Similarly, family members' endorsement of a particular system may well predispose another towards it and if further dabbling in the system yields a satisfactory outcome then it may lead to a cultural trend within the family which may ultimately lead to a larger shift in health care matters over time.

While it is true that cultural predispositions largely govern beliefs about the body, health and sickness, health care decisions are not *always* constrained by cultural prescriptions. Thus, medical systems which profess theories considered to be 'foreign' to the established cultural framework of the region, may also gain ascendancy. Tibetan medicine, Reiki, Homeopathy and the Fish Medicine technically are 'foreign' to Assamese culture but, as we have seen here, they are considered as valid options by a large number of people in Assam. Most patients of chronic conditions are besieged by feelings of 'why me?' and they look for a glimmer of hope at every level of their illness to anaesthetize their suffering (however temporary that may be). In a hopeless situation, patients turn to *any* source of hope despite the fact that a section of allopaths and some people may ostensibly label these practices as 'unscientific' and 'illogical'.

CONCLUDING OBSERVATIONS

CONCLUDING OBSERVATIONS

Illness and disease are inevitable manifestations of human existence and all cultures develop solutions to inhibit its potentially negative consequences. Despite the universality of illness, the meanings that are ascribed to it, however, are not uniform across cultures. The patient's point of view, his recognition of symptoms, interpretation of the onset of disease, and response toward seeking treatment are deeply enmeshed with his belief system and cosmology. This ideological framework is largely framed by the cultural milieu in which he lives. The cultural structuring of knowledge and experience makes it imperative, therefore, to study the conditions within which beliefs emerge and are sustained.

The narrative trope that the urban Assamese adopts to explain health and illness is replete with references to seasons, dietetics and the intrusion of germs. The months of *Phagun, Sot* and *Ahar* are considered to be particularly deleterious for health and specific diet prescriptions and proscriptions are recommended for this period. Besides, there is a rich herbal pharmacopoeia that constitutes domestic remedies. Against this explanatory landscape which is punctuated with allusions to traditional beliefs, allopathy emerges as the dominant medical referent. Not only are definitions of diseases couched in biomedical constructs where people routinely offer explanations of their conditions by using terminological categories like asthma, gout, amoebiosis, or peptic ulcer, this medical system is almost always resorted to at some point of the illness biography; in most cases it occupies

the first place in the 'hierarchy of resort'. However, this saleincy of the biomedical viewpoint does not preclude people from 'shopping around' and seeking counsel from various 'alternative' systems, which have gained ascendancy in the city because of popular usage. It is interesting to note that although 93.5% define conditions using biomedical constructions, 68.7% of my respondents said that they had used nonallopathic medicine at some point in their lives.

From this pattern one learns about the plurality of options within the mosaic of the medical culture of urban Guwahati. Ayurveda and Homeopathy are the most popular systems of medicine, both of which are also encouraged by the state. In this scenario 'spiritual healing' or 'spiritual therapy' has not been marginalised. Although there are no trance sessions and no voodoo in this context to the best of my knowledge, their functional equivalents, the Mantra Healers, Reiki specialists and astrologers are often consulted. A large number of medical biographies reflect quotidian allusions to astrological counseling for problems related to health. Many individuals are seen to wear ritual artifacts; gems are used by 20.3% of the people (for health reasons alone) and amulets, talismans and *rudrakhyos*, which comprise the healing repertoire of these specialists, are worn by 31.5% of the people. Different kinds of rituals are often performed at the recommendation of these specialists. In this context the temples of Nabagraha and Kamakhya dominate the sacred geography of the region.

There is a small percentage of people who consult tribal healers as well, most popular among them being the Karbi cure for jaundice, Khasi herbal

medicine and Lu-tong therapy for bone-setting. The Bathini Fish Treatment for asthma, which is administered in June each year in Hyderabad, has been used by 10.8 % of my respondents.

Each of these 'systems' entails a different notion of illness causation, with varying degrees of emphasis on therapy, cure and prophylaxis. To begin with, there is a wide variation in terms of etiological explanations. While the biomedical reading of a disease rests on the doctrine of specific etiology, which is based on pathogenic causality, Ayurveda reads the condition as a disturbance in the humoral balance in the body. Astrological prescriptions, on the other hand, render diagnoses on the basis of the cosmic harmony between planets; in Reiki and Pranic Healing, the depletion of the 'vital force' or the energy body is regarded as the governing factor behind susceptibility to disease.

The Homeopathic physician reads the symptoms of the patient as the means by which the body attempts to regain homeostasis, and subsequent treatment is aimed at strengthening the reactive powers. The allopathic doctor perceives the symptom as being part of the disease and prescribes remedial measures that suppress these symptoms en route to a cure. In this connection certain broad generalizations need to be questioned. Researchers like Waxler-Morrison (1988) and McKee (1988) posit a basic difference between allopathy and other non-allopathic systems on the ground that the symptoms in the former are held to be synonymous with the disease *per se*, while in the latter they indicate the *underlying* cause of the disease. While this may be true at a more generic level, this difference cannot be regarded as sacrosanct because there are instances

in allopathy too, for example in the case of fevers, where the symptom is *not* read as the disease but is regarded as the manifestation of an underlying infection in the body, in much the same way that a non-biomedical interpretation would. The difference seems to be that in the case of allopathy the notion of cause is 'ideally' specific: it is either a pathogen or a morbid phenomenon that has a local and specific site. In the case of the alternative systems, however, the underlying cause is often general and systemic rather than specific. In fact, it is often the case that where modern biomedicine is unable to 'locate' a specific cause, say in the case of a fever with an unknown etiology, the term to describe it would be idiopathic. This merely means that the search for a specific cause is still on[155].

Moreover, the other distinction seems to be that in allopathy there is a clear-cut distinction between psychological disorders and somatic disorders while in most alternative systems these are addressed together. And beyond this psychosocial realm some of the alternative systems then seem to address what Worsley (1982) terms the 'metamedical' realm where healing goes beyond the physical.

Notwithstanding the competing, and often conflicting, theories of etiology and treatment that is inherent in each system, it is seen that people draw upon a variety of resources in an attempt to cope with vicissitudes posed by illness and disease. While doing so they accommodate conceptual frameworks from different healing traditions within their own perceptions of health and medicine although these medical systems may subscribe to theories that may be in disagreement with

[155] I thank Harish Naraindas for discussing this difference with me.

their etiological beliefs. Often cognitive categories of patients are recast during encounters with these medical systems.

The prototypical presumption that a particular etiological belief predetermines the treatment sought needs to be questioned. While this tenet holds ground in the initial stages of the illness, as medical biographies advance, recourse to a particular treatment could very well be at variance with the individual's etiological explanation for that condition . This is well illustrated in my study. Although 56.1% case studies demonstrate that the patients hold the *same* theory of causation of disease with which they began (predominantly rooted in the allopathic paradigm), this did not come in their way of seeking alternative cures of various kinds.

I was unable to pinpoint one specific 'type' of user of alternative medicine. There are as many differences among users as there are among users and non-users. Variation in beliefs and attitudes imperil comparison between users and non-users. However, women, constitute the more predominant group using non-allopathic medicine. Chronic ailments, rather than life-threatening ones comprise the maximum number of cases presented to nonbiomedical healers. Dissatisfaction with previous treatment seems to be the motivating factor for resort although there are some people who use a particular non-biomedical treatment because of actual conviction in its theoretical premises. This conversion to believing in the system in many cases often occurs with the progress of the treatment.

Consultations with allopathic doctors continue along with alternative

treatment in 76.2% of the cases. The 'eclectic users', therefore, form the predominant group; they coalesce several systems for treatment and their explanations for using all these systems often stem from a shared resonance of all these treatments. In a desperate bid for cure, not only do they transcend 'cultural barriers' but are also willing to 'try out' anything that promises hope. As Jennings (1995) has suggested, any form of treatment or therapy can be seen as a rite of passage where the concepts of Van Gennep of separation, transition and reincoporation can be identified. The 'passage' to health can be seen as a progression through a series of changes from which it is intended that the sick person may re-emerge as a well person. The liminal time is the time of treatment when hoped-for transitions and transformations take place.

The founders of medical anthropology, Rivers and others, believed that biomedicine was the urban system of medicine while medical pluralism was a persisting reality mainly among the rural and tribal people. This heralded a subsequent generalized presumption that biomedicine achieves maximum success with the 'educated' people who are socialised in the postulates of Western science and medicine. People with higher income and Western education would only subscribe to the 'scientific' analysis of disease and illness and would be skeptical of superstition and ritual curing. Empirical data from my field area suggests otherwise. While it is true that the allopathic system of medicine is widely subscribed to, it is by no means the *only* system of health care used by the people. Despite the fact that biomedicine is easy to obtain - there are a large number of clinics and pharmacies in the city - and they have enough money to pay for the

services, there is constant reference to alternative medicine and ritual curing in the illness narratives of the people.

As Auge (1995) points out, it is the very paradox of illness that makes is at one and the same time the most individual and the most social of things. What begins as a subjective realization in the individual that the symptoms one is experiencing is not 'normal' is comprehended in the light of a larger body of health and sickness that predisposes an understanding (however tentative that may be) of 'what is wrong' with the body. This understanding is largely conditioned by interaction with members of the family. Although disease may be regarded as a biological reality by most people, their construction of the experiential reality of the illness experience serves as a grid for interpreting the social relations of the individual.

In daily life, the management of illness in an Assamese household relies on a network of relationships that mediates the course of the illness biography of the individual. Initial strategies of action are often formulated in consultation with members of the nuclear family. Women are considered to be more important in the care of the sick.

There is usually a core group (the therapy management group) around the patient which assesses the configuration of symptoms, effects of treatment and side-effects (if any) and plays a central role in the medical decision making process. Construction of the illness experience is often filtered through interactions with the social environment, which may extend beyond the nuclear

family. This may include members of the extended kin group, friends and neighbours - the 'lay referral system'. There are often several smaller dyadic groups within this group. Thus, the 'extra-medical social environment' plays a key role in the evolution of the medical biography of the individual. There are, however, situations where the individual may cope with the illness on his own without referring to any other person. This is particularly so in the case of illnesses that have a short biography for which he may take rest on his own, self medicate or seek specialised medical counsel. In chronic illnesses and mental ailments, on the other hand, the TMG is seen to be much larger.

My study, therefore, falls more in line with the total cultural configuration formulations of Kleinman (1978;1980) and Lock (1980) which treat medical phenomena as embedded in the overall cultural context rather than Clements' (1932) single trait approach which regards belief as an isolated cultural element.

Notwithstanding the standard definition of anthropology as the study of human society in time and space, not many studies have been conducted by anthropologists in urban settings. A study of an urban community is very different from one conducted in a rural setting. The former occasions a shift from the traditional anthropological holistic approach because urban residence entails an idiosyncratic situation where there is no bounded unit. In this sense the people from my area would resemble other cosmopolitan populations living in urban settings where respondents are educated, have exposure to a wide array of health resources and the impact of globalisation on them is prominent. It becomes difficult then to demarcate what would constitute an 'Assamese system of

medicine' in this study. While the rich herbal pharmacopoeia, which is widely used as domestic remedies, and a cultural predisposition to Mantra Healing and ritualistic offerings in the temples of Nabagraha and Kamakhya could be identified as 'indigenous', widespread use of biomedicine and other alternative systems of medicine bedevils such a generalisation. A study of health and illness in contemporary urban Assam necessitates the inclusion of all the systems of healing that people resort to, whether they are part of the 'original' medical repertoire of the community or they are exogenous influences.

In the light of this one may then advance the following theses about culture and society, particularly as it pertains to health and illness and, I suspect, beyond it as a generalization:

1. *Cultures are not inhibitory.* Modes of healing which may ostensibly be 'foreign' (Homeopathy, Reiki, Tibetan medicine) are accommodated as a form of pragmatics within the overall collage that constitutes the medical culture of urban Guwahati. Thus, cultures are open systems.

2. *Societies are permeable entities.* Foreign innovations, which are introduced to the system, do not cause upheavals in the overall system.

3. *Culture is not unitary, but is heterogeneous and made of many strands.* While this may be clear when one looks at it *vis-à-vis* religion, it seems to be true (especially with reference to healing) even with the upper class Brahmin community which ought to have been unitary. The reason emanates from the crisis that is posed by health.

Several systems of healing, whether they are institutionalised 'systems' or are part of an oral tradition, get 'attached' to the main system, the continuity of which is maintained over a period of time (like the Fish Treatment which involves travelling to a distant land) to comprise a 'mosaic' of systems. Some systems, like Homeopathy, have established a strong foothold within the medical landscape, while age-old traditions like Mantra Healing *(jara-phuka)* seem to have waned although it is still very popular in the villages .

Although Obeyesekere (1977) attributes the persistence of Ayurveda to the notion of a 'shared culture' where the patient is able to comprehend the physician's explanation of treatment, this proposition cannot be held as sacrosanct in all cases; and certainly not in urban areas. A patient with a life-threatening condition is found to use a treatment regimen that may be 'culturally alien' to him.

Ideology, no doubt, provides the basic script (Laderman 1983). The actors, however, are not *always* constrained to conform to a set a normative pattern. Illness is not merely a deviation from a cultural model of health but a marked life event often accompanied by a fresh constellation of norms or a new approach to one's life (Canguilheim 1978). Exigencies of illness and disease impel action that may or may not be commensurate with the cognitive consistency of the shared Assamese culture.

While it is an established fact that cultural predispositions determine resort to, and patterns of usage between, systems of healing, this does not mean that 'static mental templates' necessarily set patterns for action at every stage of life.

Illness behaviour is multifaceted and fluctuates through time in a way that allows the illness situation to be meaningfully incorporated into ongoing life circumstances.

APPENDIX

APPENDIX - I

LIST OF HERBS/FRUITS RECOMMENDED AS DOMESTIC REMEDIES FOR SPECIFIC AILMENTS

Ailment	Local name of herb/fruit	Botanical name
Jaundice	*kordoi*	*Averrhoa carambola*
	paleng xak	*Spinacia oleracea*
Loss of apetite	*podina*	*Mentha piperita*
	bel	*Aegle marmelos*
Anemia	*noroxingho*	*Clausena excavata,* *Murraya koenigii*
	podina	*Mentha piperita*
	sojina	*Moringa oleifera*
	jhilmil xak	*Chenopodium album*
High blood pressure	*brahmi*	*Bacopa monnieri*
Stomach ache	*podina*	*Mentha piperita*
General strength	*brahmi*	*Bacopa monnieri*
	podina	*Mentha piperita*
	bhedailota	*Paederia foetida*
	bel (with milk)	*Aegle marmelos*
Gastric	*podina*	*Mentha piperita*
Menstrual irregularity	*doron bon*	*Leucas aspera* *L. lavandulaefolia*
	noroxingho	*Clausena excavata,*
	mati kaduri	*Alternanthera sessiles*
	moola	*Raphanus sativus*
Cough	*doron bon*	*Leucas aspera* *L. lavandulaefolia*
	bel	*Aegle marmelos*
Tonsil	*layjabori*	*Drymaria cordata*
Krimi	*doron bon*	*Leucas aspera*
		L. lavandulaefolia
	mohanim	*Azadirachta indica*

Ailment	Local name of herb/fruit	Botanical name
Nausea	*podina*	*Mentha piperita*
Diarrhoea	*bhedailota*	*Paederia foetida*
	doron bon	*Leucas aspera* *L. lavandulaefolia*
	manimuni	
	bel	*Aegle marmelos*
	mati kaduri	*Alternanthera sessiles*
	modhuri aam	*Psidium guyava*
	dalim	*Punica granatum*
Asthma	*noroxingho*	*Clausena excavata,* *Murraya koenigii*
Joint pains	*bhedailota*	*Paederia foetida*
(arthritis, rheumatism)	*olkosu*	*Amorphophallus*
		Campanulatus
Paralysis	*bhedailota* *Manimuni*	*Paederia foetida*
Memory enhancer	*Brahmi*	*Bacopa monnieri*
Longevity	*manimuni*	
Liver	*sirota*	*Swertia chirata*
Cracked heels	*noroxingho*	*Clausena excavata,* *Murraya koenigii*
Heart disease	*podina*	*Mentha piperita*
Malaria	*noroxingho*	*Clausena excavata,* *Murraya koenigii*
	mohanim	*Azadirachta indica*
	sirota	*Swertia chirata*
Blood purifier	*mohanim*	*Azadirachta indica*
	sirota	*Swertia chirata*
Cold	*noroxingho*	*Clausena excavata,* *Murraya koenigii*
Nightblindness	*sojina*	*Moringa oleifera*
Urine infections	*paleng xak*	*Spinacia oleracea*

Fever	*sirota*	*Swertia chirata*
Insomnia	*Manimuni*	
Stye	*noroxingho*	*Clausena excavata, Murraya koenigii*
Increasing breast milk of pregnant women	*kolmou xak*	*Ipomoea aquatica*
Stomach ailments	*Manimuni athiya kol*	*M. paradis ica*

APPENDIX – II

ASSAMESE CALENDER

1.	Mid-April to mid-May	*Bohāg*
2.	Mid-May to mid-June	*Jeth*
3.	Mid-June to mid-July	*Ahār*
4.	Mid-July to mid-August	*Xāun*
5.	Mid-August to mid-September	*Bhado*
6.	Mid-September to mid-October	*Ahin*
7.	Mid-October to mid-November	*Kāti*
8.	Mid-November to mid-December	*Aghun*
9.	Mid-December to mid-January	*Puh*
10.	Mid-January to mid-February	*Māgh*
11.	Mid-February to mid-March	*Phagun*
12.	Mid-March to mid-April	*Sot*

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