TRADITIONAL SYSTEMS OF MEDICINE: PRACTICE AND UTILIZATION IN HYDERABAD CITY

A dissertation submitted to the University of Hyderabad in (partialfulfillment of the requirement for the award of the degree of

Doctor of Philosophy in Anthropology

By

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DECLARATION

I, hereby declare that the work embodied in this dissertation titled **"Traditional Systems of Medicine : Practice and Utilization in Hyderabad City",** has been carried out by me, under the supervision of Dr. B.V. Sharma and this has not been submitted for any other degree or diploma in part or in full to this or any other University.

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Place: HYDERABAD

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CERTIFICATE

This is to certify that the dissertation titled **"Traditional Systems of Medicine: Practice and Utilization in Hyderabad City"** submitted by Priya Jose in partial fulfillment of the requirements for the award of the degree of Doctor of Philosophy in Anthropology is a record of the bonafide work carried out by her under my supervision and guidance.

This dissertation has not been submitted previously either in part or in full to any other University or institute of learning for the award of any degree or diploma.

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INTRODUCTION

Health is the most basic and primary need of an individual. It is the supreme foundation of virtue, wealth, enjoyment and salvation for members in many societies (Lele, 1986). If health is the supreme foundation of life, illness is considered to be the greatest impediment to the progress of humanity. Every society develops means to cope with this impediment by evolving a unique health culture.

Different communities develop their health culture in lune with the overall ways of life and in response to the health problems encountered by them. Health culture of any community consists of preventive, promotive, and curative components.

The preventive and promotive component of health culture consist of activities undertaken to promotes ones health and prevent the onset of illness. It may include measures such as maintenance of personal and social hygiene, welfare measures like rejuvenation activities (Park 1977).

The main function of the curative component is to restore the health of the individual when he is affected with an illness. Every society evolves certain institutional mechanisms and contains specific roles to deal with or negotiate illness. However, this process of seeking care is also influenced by the perceptions and evaluation of symptoms by the ill persons or their

families. Thus, broad **gamut** of topics like etiology, illness **behaviour,** sick **role and choice of** therapy are covered under this aspect.

The present study deals with the curative component, in the field of traditional system of medicine, thus the study is guided by the conceptual and theoretical frameworks evolved with the area of medical pluralism and health decision models. The relevant literature in this regard is reviewed following a discussion on Medical pluralism and Traditional medicine with specific reference in the Indian context.

MEDICAL PLURALISM

Medical pluralism is defined as the co-existence of more than one model of prevention, diagnosis and cure, or an active policy of a government to promote the integration of traditional medicine into biomedical practice. (Miller.D.Barbara et al, 2004).

A variety of health care options co-exist in most cultures, even in those in which one medical system enjoys dominance. They range from home care with grandmother remedies and patent medicines to the services of specialists of traditional system of medicine and biomedical super specialists to the expertise of spirit medium, shamans, and exorcists.

The emergence of alternative therapies in the west is somewhat a response to the limitation faced in biomedicine and to escape from negative side effects of the modern therapies. On the other hand in the developing world it is more or less the failure of the health policies based solely on the

biomedical system to fulfil the needs of their population more effectively that led to the perpetuation of varied forms of traditional medical beliefs.

Kleinman. A (1980) provides a classification for healing activities in plural medical systems. According to Kleinman the model can be applied to research in developed and developing societies that contain both high order, literate (or classical) and low order, oral (or folk) indigenous healing tradition. In this model, health care is described as a local cultural system composed of three over lapping parts: the popular, professional and folk sector.

Popular health sector: It is the largest part, within which healing acts depend on a general body of knowledge available to the populace. It is the lay, non-professional, non-specialist care, present in all societies. The majority ol sickness episodes are managed entirely within this sector often at the household level and under the supervision of mother or other women.

Professional heath sector: The second sector is the professional sector, comprising the organized healing professions. In most societies, this is simply modern scientific medicine. But in certain societies e.g. Chinese, Indian and Muslim, communities there are also professionalized indigenous medical systems. The traditional Chinese medicine, Ayurvedic medicine and the Unani medicine or Galenic Arabic medicine that have professionalized along lines similar to those of the modern medical profession. Some of the defining characteristics of this sector are (1) standardized and formal training based on an organized body of knowledge (2) credential or licenses required to practice (3) structured relationships among those in the

profession (e.g. mutual referrals, specialization) and (4) Organization **that** enforces standard of practice, share knowledge and protect the profession.

Folk health sector :In an intermediate position between the popular and professional sectors, is a folk sector, in which healing is performed by "non professional, non-bureaucratic, specialist". Folk healers typically undergo a non-formal education, often by apprenticeship, to learn their curing art. Healing roles in the folk sector lack the defining features of a healing profession.

According to Maureen. D.L. (1984), studies in pluralistic settings reveal two basic patterns of resort to healers which include (a) Multiple therapeutic use and (b) Illness specific use.

Multiple therapeutic use imply that clients use more than one therapeutic system during a single illness episode, either simultaneously or in succession. This pattern has been reported by various authors Janzen (1978) in lower Zaire, Nichter (1978) in Karnataka India, Gonzalez (1966) in Guatemala.

The second pattern i.e. illness specific implies that clients classify disorders as amenable to different types of therapy and seek care accordingly. This behaviour has been reported as early as in (1965) by Gould his study in North Indian villages.

BENEFICIAL ASPECTS OF MEDICAL PLURALISM

Pluralistic health settings helps the afflicted and healers in different ways. The presence of alternative health care systems offers the afflicted and their kin multiple lines of treatment. It also helps to generate illness scenarios around which personal narratives may be developed and instantiated in contexts in which they are contested (Nichter et al 1996).

For the practitioner the multiple systems provide avenues of referral and alternative means to explain the ill health of patients following treatment efforts. Leslie (1983) while highlighting the benefits of medical pluralism for health care planning insists that pluralism in medicine should be recognised and advocated not only in the third world but also in the industrial west.

TRADITIONAL SYSTEM OF MEDICINE

As observed by Oyeneye O.Y. (1985) there is no community that has not developed its own traditional systems of health care.

According to World Health Organisation (2004) the term "traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercise, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well being". Traditional medicine is also referred as indigenous medicine (Banerji, 1981) alternative

medicine (Hasan.M, 2000) Fredrick Dunn. L. (1979) refers traditional system of medicine as regional medical system in the book Asian medical systems edited by Leslie.C (1976). The National centre for complementary and Alternative medicine (USA 2002) terms it as Complementary and Alternative medicine. According to WHO (2003) complementary and alternative medicine are used interchangeably with traditional medicine only in some countries. They are referred to as health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system.

During the last two decades, because of issues on population, ageing, changes in patterns of common diseases and for other reasons, the use of traditional medicine has in creased world wide (WHO 2002).

In China, traditional medicine accounts for around 40% of all health care delivered. In Chile 71 % of the population, and in Colombia 40% of the population have used such medicine. In India, 65% of the population in rural areas use Ayurveda to help meet their primary health care needs. In Malaysia, it is estimated that about US $ 500 million in spent annually on traditional medicine, compared to about US $ 300 million on conventional medical practice (WHO 2001). In a report by the Secretariat of WHO in the 56th world health assembly (2003) it was reported that traditional medicines are popular in developed countries. The percentage of the population that has used traditional medicine at least once is 48% in Australia, 31% in Belgium, 70% in Canada, 49% in France and 42% in USA.

Traditional medicine often plays an important role in the development of nationalistic pride, since it may symbolise the antiquity of the country concerned, and the high levels to which culture had evolved in ancient time (Foster G. 1978). Practices of traditional medicine may vary with country and region as they are influenced by factors such as culture, history, personal attitude and philosophy. The traditional Chinese medicine is guided by the 'dual forces of Yin and Yang, whose continuous interaction lies behind all natural phenomena, including the constitution and functioning of the human body' (Croizier 1968). The proper balance within the body of Yin and Yang is essential for good health.

In the Ayurvedic medicine in India good health exist when the "three dosha' or humours are in equilibrium in the human body, ill health manifests it self when one or more of the 'dosha' are not functioning properly (Leslie 1959). In Unani system of medicine that traces its origin from Greece, the human body contain blood, phlegm, yellow bile and black bile. Health is primarily that state in which these constituent substances are in the correct proportion to each other. The Unani medicine is found in many Muslim countries and other South Western Asian countries. Humoural pathology underlies much folk medicine in Malaysia, Java and Philippines (Foster 1978). Traditional Kampo medicine in Japan is an adaptation of Chinese medicine but herbal medicine also prevails in Japan. Traditional medicine in Thailand and Vietnam derives from Chinese and Indian traditions.

REGULATIONS FOR TRADITIONAL MEDICINE

In countries with ancient documented medical systems there is frequently an urge to elevate the traditional system of medicine to 'separate but equal' status with contemporary western medicine basing the argument, both on the antiquity of medical knowledge in the country concerned and the putative effectiveness of traditional treatments.

According to Nigenda. G (2001) there are three major tendencies for the existence of national medicine in a country. It includes (a) Integration (b) Co-existence (c) Tolerance. Integration is referred to the process where traditional medicine is integrated into the health system. This situation in found in China where traditional medicine in China is integrated with the modern medicine (Kleinman 1980). This is also found in Korea and Vietnam where traditional doctors are recognised and can be employed in public-health institution. They share clinical decision making with doctors trained under the scientific biomedical model.

In other countries traditional medicine has only achieved the level of co-existence with official medicine, based on a well-established legal framework, which has permitted a certain level of integration in the official health system. Some of examples of this are India, Pakistan, Burma and Bangladesh. Finally there are countries where the practise of traditional medicine is only tolerated. There is no legislative framework for regulating the practice of doctors who use traditional medicine. Countries in this situation include Mali, Malaysia and Latin American countries.

Murray last article on the 'Professionalisation of indigenous healers' in Medical anthropology (1996) ed by Sargent F.C. et al talks about three broad types of regulatory systems that help to determine politically the nature of a state medical culture and with it the organisational possibilities for indigenous practitioners. Murray highlights three types of systems which include exclusive systems which is prevalent in Soviet Union, France and America, tolerant systems which include the British model and German model. The Integrated system is prevalent in India and China.

TRADITIONAL MEDICINE IN INDIA

In India different medical systems have existed for centuries throughout the country. India has a plural health setting where, more than two systems of traditional medicine co-exist with the modern system of medicine. In the history of medical system in India, traditional medicine has not been static but has continually evolved and progressed even in urban setting (Ramesh, et al 1981).

HISTORY OF TRADITIONAL MEDICINE IN INDIA

The history of the traditional medical systems in India has passed through phases of stagnation and growth. This has been revealed in studies by Banerji (1981), Jefferey (1982).

It has been noted that during the colonial rule policies that were created affected the growth of traditional medicine. In 1835 Macauley's

Minute on Educational policy, argued that European culture should provide the curriculum of schools and colleges. In medical education it meant that the Calcutta 'Native medical Institution" founded in 1822, would no longer teach aspects of Ayurveda or of Unani (Jeffery R. 1982). This shifted the state patronage from the traditional systems of medicine to western system of medicine during the British period.

It was not until in the early 20^{lh} century that traditional medicine became more and more important among Indian Nationalists. In 1920, the Indian National Congress passed a resolution to the effect that "having regard to the widely prevalent and generally accepted utility of the Ayurvedic and Unani systems of medicine in India, earnest efforts should be made by the people of India to popularize schools, colleges and hospitals for instruction and treatment in accordance with these indigenous system" (Udupa 1975). Subsequently schools of Indian medicine were opened in Madras, Bombay, Delhi and Bengal.

It was in 1946, in the health minister's conference, the resolution was passed to promote and develop the traditional system of medicine along with modern medicine (Ministry of Health GOI 1948). The government of India in 1969 constituted the central council of research in Indian medicines and homeopathy with four sub councils.

1) Ayurveda and Siddha
2) Unani Medicine
3) Homeopathy
4) Yoga and naturopathy.

In the new National health policy 2002, the traditional systems of medicine Ayurveda. Unani, Siddha, Naturopathy and Yoga, Homeopathy have been included in the wide framework of health services. The policy aims at reviving the ailing health system and increasing the primary health sector outlay to ensure a more equitable access to health services across the social and geographical expanse of the country.

PRACTICE OF TRADITIONAL SYSTEM OF MEDICINE **IN INDIA**

Ayurveda, Siddha, Unani and Yoga medicine is referred to Indian system of medicine or traditional system of medicine. Charles Leslie (1979) classifies Ayurveda and Unani as "great tradition" medicine, a term derived from Robert Redfields work on the comparative study of civilisations (Redfield 1956). Homeopathy and Naturopathy are grouped under the modern imported system that appeals to humoural concepts of healthcare.

Ayurveda is practised all over the country (Jaggi 1981). Siddha is practised in the southern states of Tamilnadu and neighbouring states. The Unani system is used predominantly in areas of Muslim culture (Izhar 1990). Homeopathy is popular throughout India and most prominent in the North and Northeast. According to Izhar (1990) Naturopathy is an urban middle class practise of limited scope. If the study would be conducted on all the traditional systems of medicine the scope of the study would be large and the quality affected so the study was restricted to Ayurveda and Unani in Hyderabad.

Besides these great traditions of medicine there has been a number of lesser traditions known as little traditions of medicine, which flourished under their shadow. There is a large number of shamans and folk healer in modern India, and it is certain that such practices have been common since earliest time (Kakar, 1984). These Folk traditions trace their origin from great traditions of medicine. Today in addition to the established medical system, there are Traditional bonesetters. Faith healers, Massage therapists. Herbalists and traditional midwives.

LITERATURE REVIEW

Patterns of practice and utilisation of health services have always been an important area of research in both developed and developing countries. The literature reviewed will be broadly classified under two subheadings studies related to the practice of traditional medicine and utilisation of traditional medicine. The researcher has tried to segregate the studies based on the main focus of the study i.e. if the study focused on the patients it was classified under studies on utilisation of traditional medicine and if the study focused on the practitioners it was classified under studies relating to practice of traditional medicine.

During the review it was found that utilisation studies outnumbered the studies relating to the practice of traditional medicine. But it is also important to note that utilisation and practice of a health service are two related concepts, which means that when utilisation of a health services has occurred, it also means that the particular health service was also practised in the particular setting.

STUDIES ON UTILISATION OF TRADITIONAL MEDICINE

While trying to understand utilisation patterns it is important to know the frameworks that have been developed in the area of health seeking and illness behaviour.

Different models showed how people enter the role and make choices regarding the use or non-use of different kinds of health services based on varied conception of health, as well as conceptions of cause, cure, treatment and diagnoses of different diseases (Suchman (1965), Fabrega (1972) Chrisman (1977), and Igun (1979). These models are known as pathway models (Kroeger A. 1983). Suchman's model separates the illness experience into five stages. The stages include:

(l)Symptom experience (2) Assumption of the sick role (3) Medical care contact (4) Dependent patient role and recovery and rehabilitation.

In the first stage the whole medical care process begins with the individuals perception that 'some thing is wrong'. This perception may include awareness of physical change, an evaluation of to change as to its degree of severity and some kind of emotional response attached to the evaluation. The responses may range from denial or a "flight into health" to acceptance in which the individual decides he or she is sick and assumes the sick role and enter into the second stage. Once the symptoms persist the individual decides to adopt the sick role and seek to obtain "provisional

validation" for that claim. The illness becomes a social phenomenon because the sick person seeks agreement from significant others that he or she is sick and should be excused from regular duties. Many individuals seek professional help at once, others continue self-treatment and try various remedies suggested by others concerned for the individual health. The provisional validation of the sick role by the family leads into the third stage the medical care contact stage. In the third stage the sick person leaves the lay care system and enters the professional care system. Here the individual is seeking authoritative validation for the claim to the sick role as well as treatment. It is in this stage Suchman brings out a phenomenon called 'shopping'. The patient goes to different physicians until the diagnoses wanted is achieved. The sick person and the doctor may agree that the former is ill, thus providing legitimisation for the sick role and enters into the next stage. The next stage is the dependent patient role where the sick person becomes a patient. Different behaviours characterise this stage, which include adherence to treatment, increasing resistance to the treatment regimen by the patient and go 'shopping' or logically the patients and physicians work together and commence a recovery of the normal physical state and subsequent resumption of normal roles. The last stage is the recovery and rehabilitation stage. The recovery time may be different for different ailments. Patients who cannot effectively leave the sick role may take on the chronic sick role. At the other extreme is the achievement of a cure and the patient once again joins the ranks of the well.

Extending the scope of Suchman's stage of illness behaviour and at the same time providing greater precision for predicting behaviour, Fabrega suggested nine stages. Further the focus is on decision-making, which takes

into account judgements by **the** individual as **to the** degree of 'danger' implied by symptoms, weighing costs against anticipated benefits, and choice of behaviour based on previous experiences with illness.

Like Suchman's model, this one starts with identification and labelling of a problem as illness (stage I) and an evaluation of the presumed danger or degree of disability (stage II). The action to be taken include selecting from a range of available treatment options, assessing the potential outcomes based on previous experience, and making a judgement of expected benefits against potential costs (social as well as economic). These stages represents stage 111 to VII. The patient then selects a treatment plan (stage **VIII)** and evaluates the outcome. This information becomes part of memory system for subsequent experience (stage IX).

Chrisman's (1977) model is a step further in the illness behaviour studies. He identified components of health seeking, which include 'symptom definition', 'Illness - related shift in role behaviour', May consultation and referral' 'treatment action and adherence'. The significance of this framework is the integration of cultural and social factors into the framework.

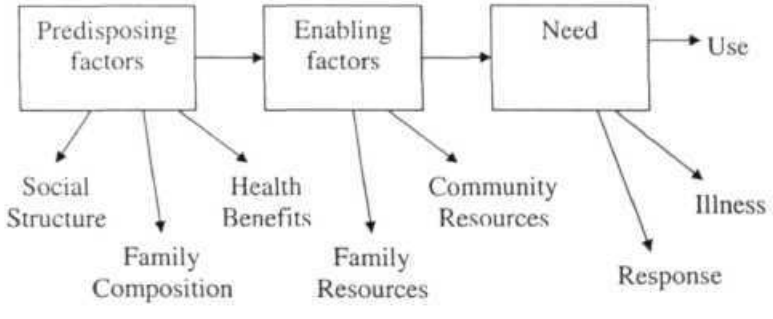
Igun (1979) demarcated ten stages from 'symptom experience' to 'recovery and rehabilitation'. This models the logically possible stages through which health seeking as a process might go. Iguns model not only gives a descriptive account of the sequence of events and actions associated with health seeking, but also explains why patients may move from one source of care to another.

Once the decision to seek medical care has been made **the** 'determinant models' come into action. These models focus on a set of 'explanatory variables' or determinants, which are associated with the choice of different forms of health services.

Anderson's R. (1968) 'behavioural model of health service use' explained how and why individuals and families use health services. This was a three-stage model consisting of predisposing, enabling and need component. Use is dependent on: (1) the predisposition of the family to use services (2) their ability to secure services (3) their need for such services.

Each component of the model includes sub-components. The model can be diagrammatically represented as

FIGURE 1.1: BEHAVIOR MODEL OF HEALTH SERVICE USE



The first set of factors is the predisposing (demographical and social structural) characteristics such as the consumer's age, sex, colour and education. These factors precede the onset of any specific illness episode and reflect the greater propensity of some individuals to engage in utilization and as a result, patient practitioner relationships (Wolinsky D. Fetal 1982).

The health beliefs of diseases, physicians and medical care constitute a third sub component of predisposing conditions. Like the demographical and social structural characteristics, health beliefs are not considered to be a direct reason for using services but do result in difference in inclination towards use of health service.

For example, families who strongly believe in the efficiency of treatment of their doctors might seek a physician sooner and use more services than families with less faith in the results of treatment.

The second sets of factors are enabling characteristics. Even though families may be predisposed to use health services, some means must be available for them to do so. According to Anderson's model enabling factors are measured by family resources and health service resources of the community in which the family lives.

Family resources: The family's ability to obtain services for its members is assessed largely by the extent of their economic resource and source of medical care. Measures include family income, family savings, health insurance, and regular source of care.

Community resources: The characteristic of **the** community in which **the** family lives also enable the use of services. One such characteristic is the availability of health services.

Assuming the presence of predisposing and enabling conditions, the family must perceive illness or its possibility among its members for use of health services to take place. Need can be measured in a variety of ways, self perceived health status (e.g. excellent, good, fair, poor) frequency of pains, number of symptom, restricted activity days and disability days are some of the most common methods. Need in defined not only in terms of perception of illness. Some families may not respond to illness or disability, by seeking medical care. Response is examined by two variables seeing doctor for symptoms and regular physical examination.

Patient satisfaction is important since the ultimate validation of the quality of care is its effectiveness in achieving or producing health and satisfaction (Fiedler J.L. 1981). In Anderson's generic access model, consumer satisfaction with previous physician encounter influences the subsequent use of health services, those who have been satisfied in the past use more services in the future than those who have not been satisfied, regardless of their need (Wolinsky, 1982).

There are a variety of survey instruments for assessing patient satisfaction. The major satisfaction dimension constructed by Ware and his associates (1978) include, art of care (humanness or the amount of 'caring' shown toward patients), technical quality of care, accessibility / convenience, finances, physical environment, availability / provider -

population ratios, continuity **of care, continuity of care, efficacy/ outcomes** of care.

Different authors like Ludwig et al (1969), Unshuld (1975). and Shuval. R (1981) have proposed "recognition and significance attached to symptoms" "degree of difficulty in seeking care" "faith in medical systems" "economic factors" "communication gaps" as some of the factors determining the utilisation of service. Different approaches have been advocated to study the different factors influencing the utilisation of health service. One approach suggested that the predisposing and enabling characteristics might be subsumed under the general heading of social network variable. The argument is that the kinship, friendship, organisation and referral network are too closely enmeshed is the socio-economic matrix to permit useful desegregation.

The International Collaborative Study on health care (1976) modified the model suggested by Anderson. The explanatory variables governing the use of care are classified as (i) predisposing factors which include demographic characteristic, household and family composition, education, attitudes, responsibility for health related decision (ii) enabling factor include accessibility of regular source of care, health insurance, income security (iii) health services system factors refers to **the** structure of the health care system and its link to a country's social and political macro system.

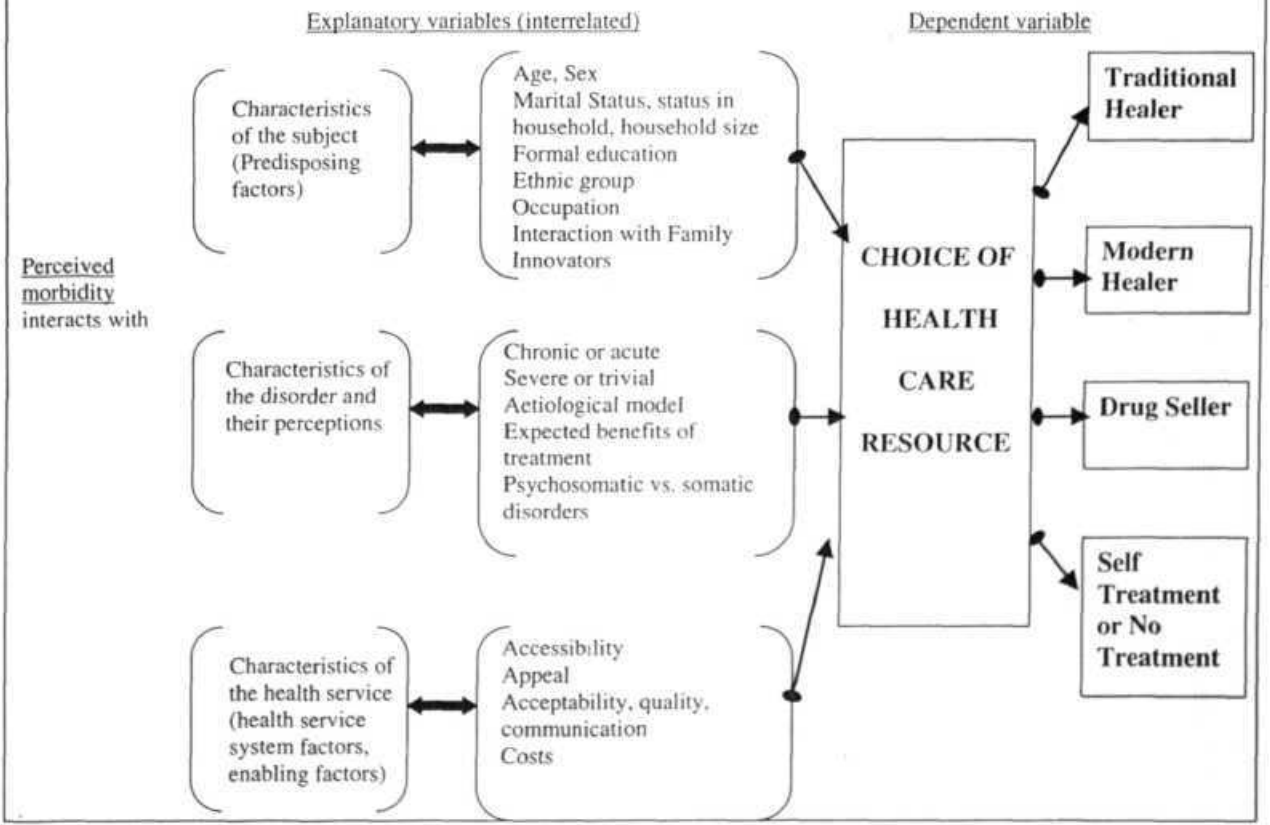
To summarise it can be understood that the interaction of sets of characteristics, those of the family or individual and those of the health care delivery system play an important role in the utilisation of health services.

Anderson's model is still extensively being used in utilisation studies (Fosu 1994, Kang J. T. et al 1994, Fernandez Mayorlas et al 2000, Pillai K.R et al 2003). According to Fosu (1994), this model has been successfully applied to explain the use of other prominent health care services in developing countries such as traditional healers and folk health care.

Benyoussef and Wessen (1974) were among the first to point out that medical care utilization in developing countries is different from that in developed countries. This view was supported by Kroeger (1983) who reported that additional factors are operating such as the continuing process of cultural change, which brings about a change of illness concepts and health behaviour. There also exists a wide range of health services, both in quality and quantity as well as in socio-economic conditions.

Kroeger.A (1983) included the characteristic of the disorders and their perception and reported that aetiological concepts and world views should also be considered in order to delineate the factors intervening in the choice of health care. The variable elucidated by Kroeger is presented in the form a simple integrated framework.

FIGURE 1.2: THE CHOICE OF HEALER IN RELATION TO VARIOUS POSSIBLE EXPLANATORY VARIABLE – KROEGER, A 1983



Based on these frameworks reviewed it can be understood that it is more or less the same factors that influence the use and non-use of health services.

But it was Kroeger's model, which emphasised on the aetiological concepts and this aspect is an important aspect of medical anthropology in general and illness behaviour studies in particular.

Based on Kroeger's A. (1983) framework, different studies reviewed will be presented under three broad areas: (1) Characteristics of the subject (Predisposing factors), (2) Characteristics of the disorders and their perception, (3) Characteristic of the services (enabling factors).

CHARACTERISTICS OF THE SUBJECT

Age

Mac Lean C.M.U (1965) in a health opinion survey in Ibadan Nigeria reported that the elderly most frequently consulted the traditional practitioner. Similar finding were reported by Baker et al (1967) in Taiwan, Franken berg et al (1976) in Lusaka. The same was supported by Klienman (1980) in Taiwan Nakar. S. et al (2001) reported that a significant percentage of elderly Yemenite immigrants in Israel used traditional Yemenite medicine. Increasing age with the use of complementary and alternative medicine was reported by Oldendick et al (2000) in a survey in Carolina U.S. Korean elderly in America reported the use of traditional Korean medicine and this was dependent on health insurance status of the elderly, this was found in a study by Kim. M. et al (2002).

The use of traditional medicine was also **reported among middle** aged groups by Kersnik J. (2000) in Solvenia, Ranzine A. et al (2001).

These studies though reported the use of traditional medicine among deferent age groups, never, accounted the reasons why traditional medicine was used by these groups and not preferred by other age groups.

Sex

Female morbidity rates are greater than the males around the world. Therefore one would anticipate females to be predisposed i.e. more susceptible and therefore greater utilisation of medical care Studies have documented users of traditional medicine to be women.

Stella (1999) report that women use traditional medicine for menopausal symptoms. Gotay (1999) also reported that cancer patients who reported the use of traditional medicine were mostly women in Hawaii. They approached traditional medicine after approaching modern medicine and it was done to improve the quality of life. A similar finding was reported by Henderson et al (2004).

The study by Cappuccio et al (2001) in London on the use of alternative medicine reported that women of African origin mostly used the system of medicine. In a study by Gray et al (2002) it was found that Traditional medicine users were mostly female, younger and better educated. Melchart et at (2003) study in Germany on **the** utilisation of traditional Chinese medicine showed that almost **three fourth** of the **users** are women. This was done to evaluate the quality of a medical provider.

In an article by Christine **A.Court et al,** in Women **Health ed. by** Waller.D (2003) it was reported that women's usage of **complementary** medicine is generally found to excel that of men.

The disease specific studies using traditional medicine by women reported the reasons why traditional medicine was used but other studies never reported why women preferred using traditional medicine.

Education

It is reported formal education negatively influences the utilisation of traditional medicine. This has been revealed by different studies conducted in Taiwan, Korea and Thailand by Kleinman (1980), Rhi B. J (1973) and Hindeling P (1973) respectively (Kroeger.A1983).

Fromm et al (1970) reported that the educated did not utilise traditional methods of healing in Mexico. Similar findings were reported by Benyoussef et al (1974) in Tunisia. Ramesh et al (1981) study in Madras city of India on traditional Indian medicine revealed that half of the clients had no formal schooling and nearly 20% had only primary schooling.

But there has been a gradual shift in the past decade regarding the level of education and use of traditional medicine. Studies by Shuval (1997) in Israel, Kitai et al (1998) in Israel, Astin (1998) in America, Bernstein et al (1996) in Israel, Sirois M. F et al (2002) and Kakai (2003) in Hawaii reported that education had **a** positive relationship with use of traditional medicine. The more educated use traditional medicine more frequently than uneducated.

Ethnic group and Religion

In a study by Kang et al (1994) it was found religion was one of the factor related to the choice of Chinese traditional medicine, it was found that folk religion believed and favoured traditional Chinese medicine. There has been a dearth of studies relating to religion as a factor for choosing traditional medicine, the reason maybe that Anderson model (1968) does not include religion as a factor for choice of a particular system of medicine.

Studies related to use of traditional medicine among ethnic groups showed that ethnic groups had no influence on the use of traditional medicine. Pachters (1998) study among families for the treatment of common cold among children showed no preference practices among mother from ethnic minorities of African, American, Puerto Rican and West Indian Caribbean heritage's to traditional medicine. Mackenzie et al (2003) study showed that use of traditional medicine did not differ by ethnicity in a national probability survey of Complementary and Alternative Medicine users. Kakai et al (2003) studied the choice of health information among cancer patient using complementary and alternative medicine among three ethnic groups. Study revealed that Caucasian patients preferred objective scientific information from journal or newsletters from research institution and the Internet. Japanese patients relied on medicine and commercial sources including print and electronic media and provider. Asians and Pacific islanders used information sources involving person-to-person communication with their physician, social groups and cancer patients. This was related to education levels and it was reported that effect of patients ethnicity overrides their educational level in shaping their choices of health information. It was found that Caucasian females used traditional medicine.

Study by Reeve M.E (2000) among the Caboclo **community** of **the** Lower Amazon reported that traditional medicine for these people is **a** salient mark of ethnic identity. In a study by Cappuccio et al (2001) Black people of African origin were more likely to use alternative medicine than the whites. Najm et al (2003) study among the elderly of three ethnic groups of Asians, Hispanics and White non-Hispanic showed that Asians were higher users of traditional medicine.

Lasker N. J. (1981) in 'Choosing among therapies: Illness behaviour in the Ivory Coast', reviewed a wide variety of medical systems available to the in habitants of Ivory Coast. It was reported that ethnicity, religion and occupation are important individual characteristics, which predict choice of therapy. It was revealed that in the village ethnicity played a role 'gouro' (people indigenous to study area) were more likely to use the traditional system first as compared to others.

Income and Occupation

Source of income was found to influence the use of traditional medicine. HoS et al (1984) study on the role of Chinese traditional medical practice in Singapore revealed that patients belonged to the lower income group and were mostly unskilled labours. Djurfeld G et al (1973) study in a rural South Indian town revealed that social class was positively correlated with the use of allopathic practitioner (Kroeger.A1983).

But studies by Blais et al (1997), Eisenberg et al (1998), Furnham and Bhagrath (1993), Kelner and Wellman (1997), showed that use of traditional medicine was related to higher incomes. The latter can be explained by the

fact that they usually have to pay for traditional medicine from their own pocket, which might not be affordable for poorer patients (Kelner and Wellman 1997). This can be applicable in developed countries as studies in developing countries showed that use of traditional medicine was related to the lower income group. Study by K. Pillai et al (2003) in Kerala showed that the families who chose traditional medicine belonged to lower economic status.

There has been a dearth of studies, which showed that occupation is a direct determinant of use of traditional medicine. A study by Lee P.R (1981) on the factors related to choice of traditional Chinese medicine showed that farmers and businessman favoured traditional medicine.

Family Si7.e

The size of the family with relation to the use of traditional medicine has been under researched. The family size might affect the predisposition of its individual members to use health services. It has been found that for large families greater are the levels of utilisation. According to Fiedler (1981) this is due to two interrelated factors, increasing family size increases the probability of introduction of infection. It also increases the probability of over crowding, implying closer physical contact which tends to enhance the spread of infection. This in turn increases the incidence of illness and so greater level of utilisation. But there has been no study to support this view. It is also reported that extended families can behave more traditionally than nuclear families. But this has to be studied farther and this particular study will try covering this aspect.

CHARACTERISTICS OF THE DISORDERS AND THEIR PERCEPTION

Research into the aetiology of disease in a particular setting is one door by which anthropology enters the field.

Chronic or Acute

The more chronic the condition the more time has the complainant to recourse the different curing facilities (Kroeger A. 1983). Evidence points to the fact that chronic diseases are usually treated by traditional healing methods.

In India (1965), rural Nigeria (1979), Korea (1973) and urban Zambia (1976) traditional healers treated particularly chronic conditions. 90% of patients of traditional healers 'suffered from chronic self limited and marked minor psychological disorder in Taiwan' Lieban's (1967) study in Cebu reports that Cebunos resort to 'mananbal' (indigenous healers) for supernaturally caused illness. Blais et al, (1997), Eisenberg et al (1998), Kelnar et al (1997), Murray and Shepherd (1993) and Vincent Furnhan 1996 reported that traditional medicine is used for chronic condition. Kersnik J's. (2000) study in Slovenia revealed that traditional medicine was used for a chronic condition. Similar Findings was also reported by Astin (1998), Gordon.et al (1998) and Sharma (1992).

Severe or Trivial

Severe diseases seem to be treated predominantly by modern health practitioners, wherever possible.

Kleinman's (1980) study in Taiwan listed the various determinants of health care seeking. It was revealed that 'perceived' severity of sickness **by** family members appears to dominate. All the sickness episodes labelled by families as 'severe' received treatment from professional or folk practitioners.

In rural Mexico (1981) 21 persons with grave illnesses resorted to the modern system and eight to the traditional one. In most parts of rural Equador people with severe diseases resorted predominately to the modern system. However 71% of children under five years of age **with** terminal illnesses were presented to traditional medicine.

Kloos (1990) reported disease severity as an important determining factor for the utilization of health service. In a study among the elderly Mexican Americans by Apple white S.L. (1995) reported that though participants relied on modern medicine to treat serious injuries and major health problems, they still considered traditional folk healing in situation where modern health care was unsatisfactory or ineffective. Mitz dorf et al (1999) exploratory study evaluated patient's reasons far taking treatment in a hospital practicing traditional Chinese medicine. It was reported that disease severity was an important factor (long duration acute progression) along with other reasons to choose traditional medicine. Disease severity depended on the socio-economic status of the family for choosing the system of medicine for children affected with respiratory problems and diahorea in India (2003).

Aetiological concept

The aetiological concept among different communities **was believed** to influence the utilisation of traditional medicine.

Simmon's O.G. (1955) study among the Mestizo communities of coastal Peru and Chile revealed that the aetiology was important for the Choice of healers. Foster (1958) called this as folk dichotomy. It was reported (1966) reported that rural Guatemalans went to the doctor to gain relief from symptoms and to the folk healers to remove the cause of the disease. Djurfeld and Lindberg (1975) observed in an Indian town a 'bewildering and confusing variety of view on medical subject' and concluded people's concepts of disease aetiology contributed substantially to choice of health services (Kroeger.A1983). In Taiwan (1979) people with mental illness resorted more particularly to traditional healers. In rural Nigeria (1975) conditions like worry and sleeplessness were predominantly treated by traditional healers, where as infectious diseases were treated by modern facilities. In a study (1976) in rural Tanzania some people with folk diseases preferred to resort to traditional healers. In a study in rural Ghana it was revealed that modern medicine was mainly used for infections and digestive condition while traditional medicine was mainly used for musculo skeletal problems. In urban Ecuador (1981) illnesses with deemed supernatural causes, were treated by folk specialist while infection was treated at home.

Hielscher et al (1985) study on the concepts of illness and utilisation of health care services in rural Malian village reveals that it's the cause of illness that decides the utilisation of medical service in a pluralist medical setting. Steen T. W. et al study (1999) in Botswana on the health seeking

behaviour among T.B patients reported that T. B may be regarded as 'European disease' or as Tswana disease[1] and this has implication for treatment seeking. Patients who regard TB as Tswana diseases may use modern medicine for symptom relief but traditional medicine to treat what they consider the cause of the disease. In a study among the Caboclo community of Lower Amazon (2000) it was reported that understanding belief concerning disease aetiology is critical for individual treatment choices in a plural medical system. Bernstein el al (2002) reported that in Mongolia that patient's specific illness is important in deciding what type of treatment he will seek. Mishra et al (2003) study among the Samoans revealed that utilisation of the traditional healer or 'fofo' were based on aetiology i.e. Samoans used 'fofo[1] for biomedically defined muskulo keletal, neurological problems and Samoans sicknesses (ma[1] samoa).

CHARACTERISTICS OF THE SERVICE

These are labelled as the enabling factors i.e. the factors which facilitate the use of particular health services. Geographical Accessibility, communication between healers and patients, quality of care and costs are major enabling factors in the choice of services available.

Geographical Accessibility

The low degree of accessibility of modern health services in supposed to be major argument for the use of traditional resources in the health care delivery. The geographical accessibility of a health service can be measured by the distance travelled, travel time and travel costs.

In a study by Srivastava et al (1974) on the utilisation and pattern of demand for the CGAHS Ayurvedic dispensaries in Delhi reported that long distances and waiting time were major reasons for not using allopathic dispensaries. In rural Tanzania (1977), Ethiopia (1980), Ivory Coast (1981) accessibility of modern services was one of the major determinants in the abandonment of traditional services.

In Bangladesh (1981) it is revealed that traditional practitioner had a much better coverage than allopathic ones. Paul C. Y Chen (1981) while studying the use of traditional and modern medicine in Malaysia revealed that rural people often have to depend upon traditional medical care as it is within their geographical and economic reach.

The study by Ramachandran et al ((1983) on the movement for medical movement in Karnataka revealed that there are no significant differences in the distance travelled among various occupational groups but there was an association between the places visited for treatment and the places of contacts through visits to relatives. This suggests that long distance movement is not a matter of travel costs but essentially of overhead costs at the place of treatment. Kloos (1990) and Bender et al (1993) reported that rural families use alternate care because modern care is less available to them.

In a study by Adera T. D. (2003) in a Kishe settlement area in Ethiopia on traditional treatment of malaria revealed that, traditional medicine was used due to greater accessibility. In a study by Pillai et al (2003) it was reported that rural families in Kerala used alternative care

more often because Allopathic care is less available to them that their urban counterparts. Hill et al (2003) in a study in Ghana among children reported that accessibility was one of the reasons for preferring traditional medicine.

Appeal acceptability / Doctor - Patient interaction

The interaction between doctor or healer and his patients and the latter's family, friends, peoples previous experiences with services as well as factors ranging from waiting time all contribute to increase or reduce the appeal of particular services (Kroeger .A. 1983).

Studies showed that causes for communication barriers between the population and western trained physician was the cultures specific classification, which does not fit in the doctor's paradigm. This was reported in Tunisia (1977) and Nepal (1977).

Studies related to this aspect will be dealt in detail subsequently in the chapter titled patient practitioner interaction

Costs and Fees

High costs are frequently asserted to be major barriers to modern health facilities, where as traditional treatment is supposed to be cheap and within reach of poor. This was reported by Bharadwaj (1975) while studying the attitude towards different system of medicine in North India.

Wolinsky et al (1982) in a study of the salient issues in choosing new doctor selected socio-economic status and access as two variants while describing the important factors influencing the choice of new doctors. It was revealed that the individuals with lower socio-economic status but better access to medical care focus on the cost of an office visit.

The dynamics of payment for therapy to traditional healers has been studied by Nichter.M (1983) in rural south India. It was revealed payment to traditional practitioners involve the ideal of moral bonding. Ho. S et al (1984) has also revealed that cheaper cost of Chinese traditional medicine was a major reason. Aaron's (1999) and Applewhite (1995) reported that in developing countries traditional medication are used frequently both by those who cannot afford treatment by physicians trained in the biomedical tradition. In a study by Messerli (1999) in Switzerland it was found that non-compliance in modern medicine was a result of the high costs.

The above studies reviewed reveal that utilisation of traditional medicine is determined by predisposing, enabling and aetiological factors. But some areas need further understanding like the income of the utilisers with relation to the cost of treatment availed.

DOCUMENTED USE **OF TRADITIONAL MEDICINE**

Other than the numerous studies conducted around the world on the factors that lead to the utilisation of traditional medicine there are also studies, which have documented the use of traditional medicine.

Charles Leslie (1976) and Klienman's (1978) study in Asian Medical System have been notable contribution in the field of medical pluralism. The use of traditional or indigenous medicine in the African continent has been studied extensively by different authors Oyebola (1980), Oyeneye(1985) etc

Cosminsky et al (1980) provides evidence of utilisation of humoural medicine in Guatemala. Heggenhougen (1980) reveals that traditional medicine is used in Malaysia. The use of traditional medicine has also been

reported among the Asian community in Britain. Bhopal. R. S. (1986) has reported that traditional medicine was found to play a modest **but** not insignificant role within the context of total health care among the Asian community.

In a study by Kaona F et al (2000) among residents of the southern province of Mporokoso, Northeast province of Zambia revealed that residents used traditional medicine for the treatment of Malaysia. Use of traditional medicine was reported among obstetric patients by Ranzine.A. et al (2001). Hong C. D. (2001) reported that traditional Chinese medicine in utilised in Korea.

Adiputra N. (1992) study on Balineese traditional medicine revealed the reason why Balineise use traditional medicine. He reported thai traditional healers practice traditional medicine within the cultural framework of his group / community. Secondly the diagnostic techniques are familiar in the areas. Lastly the curative materials are taken from the familiar resources or environment. R. Frank (2002) article on the relationship between the patient and homeopathic physicians revealed that homeopathic medicine is used in Germany. Maimbolwa M.D (2003) reported that traditional medicine was used by women to facilitate childbirth.

The recent trend in utilisation studies of traditional medicine is to study its use with specific diseases. Ernst (2000) and Ben-Arye (2003) studies the use of traditional medicine among dermatological patients. This study report that complementary medicine is being used by the patients, with a belief to do everything to heal the disease. Studies by Kakai (2002), (2003)

and Henderson (2004) **reported the use of complementary medicine among** cancer patients. The use of complementary medicine was **used in** conjunction with modern medicine. **It** was used to **enhance the overall** quality of life, to reduce stress and strengthen the immune system.

Studies by Eisenberg et al (1993, 2000) among patients affected with HIV revealed that patients had used Complementary and Alternative Medicine for HIV related problems, which included dermatological problems, nausea, depression insomnia and weakness. The patients reported 'feeling better' 'feeling in control' and increased coping. These studies warrant further research into the area of traditional medicine on the efficacy of the traditional drugs.

HOME FRONT - INDIA

India with its rich tradition of multiple medical systems is known for the studies carried out by different author in the 1970's Banerji (1974-75), Bhatia et al (1975), Bhardwaj (1975) and Minocha (1980).

Tabor CD. (1981) has studied about the concepts of Ayurvedic medicine, which expresses the notion of health sickness in South Gujarat. Egnor M.T. (1983) study in Tamil Nadu of Southern India examines four different healing traditions practised in the region. This study revealed that the mythical and philosophical bases of this tradition share some common premises and communicates to the patients a common message concerning **the** nature of life.

Bhattacharyya D.P. (1983) examines the pluralistic nature of the psychiatric domain in Bengal, India. The paper critically analyses the concept of medical pluralism. Three varieties of pluralism are identified the social institutional pluralism of the diverse specialists, the cognitive pluralism of clients conceptual frameworks, and the pluralism resulting from the divergent perspectives of the client and specialist. The paper argues that all the three forms of pluralism is conceptualised in terms of actors structuring activities and thus it is an emergent product of social interaction.

Izhar (1990) studied the users of Unani medicine in a clinic in Aligarh town in India. This study revealed that two thirds of the patients patronised the clinic after going to the modern medicine. This study revealed that educated utilised the system of medicine.

The use of traditional medicine for specific disease like diabetes, arthritis, infantile diarrhoea and respiratory infection has been studied by Chacko.E (2003), Pugh. F. Judy (2003) and Pillai. K. Et al (2003).

Chacko (2003) studied the use of Ayurveda among diabetic patients in an urban setting in Kerala. This study revealed that 40% of the patients used Ayurvedic medicine for the treatment of diabetes. Ayurvedic medicine and folk tribal remedies were used as supplements to biomedicine. This study is different from other studies as it tries to understand the local medical knowledge and regional remedies, which have been tried and tested in the background of cultural capital, an area founded by Pierre Bordieu (1988).

Pugh. F. (2003) study in New Delhi provides a descriptive account of rheumatic disorders in India's Ayurvedic and Unani medical traditions. Data was collected from texts and secondary sources and highlights their congruent concepts of arthritis, related somatic concepts, aetiologies and treatments in the two systems of medicine. It reveals the parallels in the clinical practices of practitioners of both system of medicines and identifies a broadly shared model of arthritis that circulates between the practitioner and the clients. Pillai K. et al (2003) study in Kerala applied Anderson's model to understand the factors affecting decision to seek treatment in the alternate sysiem of medicme for cYvMren aftecYed WuVi acu\e resp\ralory infection and diarrhoea. The studies in India reveal that traditional Indian system of medicine finds patronage in urban setting.

Based on the review the researcher support lzhar (1990) statement that there is a dearth of studies in Great tradition medicine in India even after a decade.

Apart form lzhars study on the usage of Unani medicine in 1990 and practice of traditional medicine in Madras in 1981 by Ramesh et al there are no studies to specifically understand the patterns of Utilisation and Practise of traditional medicine.

This study tries to be different in a way that it ventures into two great tradition medicines i.e. Ayurveda and Unani in Hyderabad simultaneously. The study tries to capture both the practice and Utilisation of two systems of medicine. The studies the researcher came across during the review found that both the concept of utilisation and practice has been understood from a

single homogenous group i.e. either the practitioner or utilizers\clients but this study tries to analyse both the practitioners and patient with respect to belief frames and factors responsible for the utilisation and practice of the two system of medicine.

STUDIES ON PRACTISE OF TRADITIONAL MEDICINE

As mentioned earlier by the researcher it is indeed a thin line that separates studies on practice and utilisation of traditional medicine, as they are two related concepts.

Studies reviewed will be presented under two main sub-heading studies conducted on the practice of traditional medicine worldwide and studies conducted on the practice of traditional medicine in India.

PRACTICE OF **TRADITIONAL MEDICINE WORLD WIDE**

Jaspen (1976) studied the social organisation of Indigenous practices among the Rejangs of Sumatra. Jaspen's study included the folk doctors of Sumatra. The study included the occupational professionalisation, the medical examination, the diagnosis and treatment, the pathology involved for diagnosis among the folk doctors. The study revealed that the folk doctors were not full time professional workers who depended for their livelihood on the practice of medicine. They were primarily farmers but enjoyed "high social status[1] in the community due to this medical training. The diagnosis depended on **the** 'hot' 'cold' dichotomy and treatment was followed based on this pathology other than the doctors own active and

devoted concern for the patient. The conscious understanding and efforts of patient, relatives and friends are a vital factor in the therapeutic process.

It was found that, it was a custom for a Rejang doctor to train one of his own sons or nephews in his an of medicine, if he had the right personality and a sense of dedication or calling. One of the holistic attributes according to Jaspen was the 'transparency' the Rejang folk doctors maintained in the practice.

Otsuka.Y (1976) study of Kanpo medicine, Chinese traditional medicine in Japan revealed that the increasing incidence of serious side effects from synthetic drugs, the analytic nature of modern medicine and disregard of patients complaints in modern medicine are factors that promote the development of Kanpo medicine in Japan. Yasuo studied the preferences of Kanpo practitioner and academicians of Kanpo medicine. The study also reported the concerns shared by the respondents, which included continued drug supply, standardisation of drug quality, and objectification of diagnostics, co-operation of Western and Kanpo medicine, modification of health insurance to include traditional treatment, education and reassessments of important classics and initiation of large scale research institutes of Kanpo medicine.

Weisberg. H Daniel (1982) while studying the Northern Thai health care alternatives in Sri Muang Town reported about the presence of two spheres of health care discernible solely on type of medical technology or modern traditional dichotomies. The practitioner in the medical systems have been divided into the locally sanctioned and officially sanctioned

sphere on three bases (1) how a particular healer is validated as a practitioner (2) the form of organisation within a healer group, including the method of training and the manner in which healers interrelate and perhaps co-operate and (3) the style of interaction between the healer and the patient and family. Weisberg reveals that in the locally sanctioned sphere which constitute of herbalists and diviners jealousies are quite common between them but relationship are cordial. They however do not share esoteric information and formulas.

Duncan et al (1983) study on traditional medicine in Equador identifies the structural and operational characteristics of non-formal health systems, in terms of resources, terminologies, diagnostics, preventive and the therapeutic procedure. Data was gathered on the socio-demographic profile of the traditional healer and based on the information healers were classified into different types. It was revealed that the fathers influence is decisive in the initiation and training of the healer. Dreams and Oneiric experiences had also been reported in the initiation, training and practice of healing. The training and training process was through his life and daily practices. No fixed time frame is reported for the completion of apprenticeship. It was reported that the healer's clienteles comes from the same ethnic groups with the same ideology and interpretation of disease.

The traditional healers in Swaziland were studied by Edward green et al (1984) to explore possibilities for specific types of co-operation between modern and traditional health sectors. Edward Green et al distinguishes between the two varieties of healers that include the divine healer and the herbalist. The characteristics of the healers were studied, the training

background for both varieties of healers was looked into and the reasons for taking up the profession were also looked into. It was revealed that there is a certain amount of competition and mistrust among the healers and only 62% healers engaged in any sort of mutual referrals.

Coburn.D. et al (1986) article on Chiropractic in Canada describes and analyses the social history of the Chiropractic in Canada. It reports that while the Chiro practice in Canada has gained acceptance and recognition it has sacrificed many of its earliest claims to be an alternative healing art and to some degree chiro practice has become medicalised. This has in turn affected the scope of practice by moving toward a situation of limited mandate and this is being done for increased legitimisation. The Chiropractic is quite willing to refer any problems beyond their competence to regular medicine and is not against some of the therapies of regular medicine such as injection drugs and surgery as they once were.

Anderson R. (1984) exploratory study of a Mexican (Sabador) bonesetter covered three main issues i.e. (1) what does the Sabador treat (2) what methods are used (3) what success is achieved. The study revealed that the practice was limited to musculo skeletal pain or stiffness, cuts and bruises exclusively and used massage frequently as the method of treatment. It was found that on the whole the Sabador is a safe practitioner who provides at least some relief to nearly all his patients.

Ooi. G. L. (1991) study on the persistence of Chinese medicine in Georgetown a city in the state of Penang in Malaysia revealed that there was a reorganisation of traditional Chinese medical practice. Institutional

developments and adjustments observed among the traditional Chinese medical practitioners have created diversity. Such diversity is evident by comparing the practices that are based in shops and those which are Clinic based but also the newer and older practices.

Joralemon. D. et al (1993) study among the 'Curendero' in Northern Peru dealt with the lives and curing "metaphysics" of shamans (Curendero). The text also explores pre-hispanic and colonial sources for the symbolism of the rituals performed by shamans and the relationship between the shaman's practices and contemporary social reality.

Joralemon D. et al (1999) in his book exploring medical anthropology provides a framework for research on a healing tradition. He takes the example of the Shaman's in Peru and presents research questions.

Frank R (2002) study among the homeopathy physicians in Germany revealed three distinct patterns of homeopathic practice. In included segregating the patients into categories of homeopathic and biomedical patients (a) complementing a predominantly homeopathic practice with few biomedical strategies for diagnostics (b) focusing on homeopathy and condemning biomedicine with the exception of emergency medicine and surgery. The physician perspective on efficiency of homeopathy was collected. The study revealed that homeopathic physicians do not sacrifice central aspects of homeopathic concepts in order to gain legitimacy.

Studies by Bhatia et al (1975), Leslie (1979) in China and Ramesh et al (1981) in India, Frank R. (2002) in Germany, Unshuld P. U. (1975) in

Taiwan have reported the integration of modern techniques, which may include diagnostic techniques in the system of practice by practitioner of traditional medicine.

STUDIES RELATED TO THE KNOWLEDGE, ATTITUDE AND PRACTICE OF TRADITIONAL MEDICINE BY PROFESSIONALS OF MODERN MEDICINE.

The increased trend in the utilisation of traditional medicine around the world in recent times has prompted research regarding KAP among the professionals of Modern Medicine.

Easthope G. et al (2000) study in Tasmania Australia among general practitioner revealed a favourable attitude toward complementary therapies. Favourable attitudes were attributed to personal experiences of such therapies, patient endorsement and the holistic orientation of complementary medicine. The favourable attitudes were prevalent widely among younger physician who practised singly.

In a study by Perry R. Et al (2000) in Britain to ascertain the use and attitudes towards complementary medicine amongst general practitioner revealed that 13% had treated directly by using a complementary medical activity 31% had referred and 38% had endorsed one or more complementary therapies. Risberg T. et al (2004) study among the oncology professionals in Norway revealed though only a small percentage of physicians had a favourable attitude towards Complementary and Alternative Medicine, paramedics showed a favourable attitude.

Watanabe. S. et al (2001) survey among the doctors belonging to the regional medical association in Japan showed that nearly 73% of doctors practised Kamp (Japanese traditional medicine). Doctors who believed in the efficacye of Kampo tended to believe that other Complementary and alternative Medicine therapies were also effective.

Such studies among the health professional is important as Botting D.A et al (2002) put forward that the medical profession is involved in the political processes affecting legislation governing 'complementary medicine'. Botting D. A. el al (2002) has also made a critical review of published research studies dealing with the knowledge, use and attitudes of doctors to complementary medicine. According to Botting D.A. et al these studies also raise a number of concerns including lack of evidence to demonstrate effectiveness, possible harmful effects, in adequate knowledge of doctors and lack of statutory regulation for most therapies.

This has also been opined by Mukherjee P.K (2001) regarding the evaluation of drugs of traditional medicine of Ayurveda, Siddha and Unani. According to Mukherjee government of India and private sector are exploring all of the possibilities for the prefect evaluation of these system in order to effectively adopt the therapeutic approaches available in the systems of medicine and to help in generating data to put these products on the National health programme.

PRACTICE OF TRADITIONAL MEDICINE: INDIA

Studies on the practice of traditional system of medicine can be dated back to 1970's, which included, Alexander et al study on traditional healer in (1971), Bhatia J.C. et al (1971) on the role of Indigenous medical practitioner in two areas of India, and a latter study by the same author in 1975 on traditional healers and Modern medicine. Chutney C.S. et al (1973) survey of indigenous medical practitioner in rural area of five different states of India.

Basham A. L. article in Charles Leslie book Asian medical system (1978) covers the practice of medicine in ancient and medical India.

Montgomery Edward presented his findings of the study of private medical practitioner in Vellore Tamil Nadu in Asian Medical System (Charles Leslie ed. 1978). This study included the private medical practitioner belonging to modern medicine and traditional medicine. The organisation of practice range of services rendered (which included population of patients) referral services and socio-demographic character was collected. Montgomery proposes a model of a medical system, which constitutes of four variables rate of change in the practitioner population, collective rate of consultation or medical practice, rate of change in the patient population and set of medication.

According to Montgomery the model is intended to encourage studies of the ways in which changes in medical practice are causally related to equally important changes in other aspects of the medical system.

Data was collected from practitioner of two system of medicine i.e. Siddha system of medicine and Ayurveda in Ramesh et al (1981) study on the practice of traditional Indian Medicine in Madras. Information was collected regarding system of practice. Training background, characteristics feature of the patients seen, Diagnostic methods and attitude and opinion. The study revealed that the indigenous medical systems still remain a significant contributor to medical care of the people. The study reported that a number of favourable factors support the Indigenous Medical practitioner even though there is competition from modern practitioner. The factors included low cost factor, location of the centre as it increases demand and many provide dietary prescriptions, which are expelled by people of Indian culture when they are ill.

Kakar S. (1982) book on shamans, mystics and doctors deals with the psychological inquiry into Indian and its healing traditions. Kakar (1988) explained the role played by traditional medical practitioners in the primary health care and the factors that guide the people to avail these services. Anandhi et al (1999) conducted a study in rural area of Haryana to analyse the role of the indigenous private medical practitioners in reproductive health of the population. The authors emphasised the need for including the Indigenous medical practitioners in delivering reproductive health through training them adequately.

During the course of review on the practice of traditional systems of medicine, it was found that barring two or three studies in the great tradition medicine most of the studies were conducted in little tradition medicine or

folk sectors. The review revealed that while studying the practice of a system of medicine various aspects of the practitioner need to be covered which included, organisation of practice, training background. Range of services rendered in terms of diseases treated and population treated and the attitude and opinion of the practitioner towards the system of medicine practised vis-à-vis the modern system of medicine.

It was found that the studies focusing on the practice of traditional system of medicine in India in recent times were scare. The researcher however do not contend the fact that there may be unpublished studies conducted in India, which was not come across by the researcher. Another reason may be that, utilisation studies also try to cover the aspect of practice of the system of medicine. But as the researcher has already mentioned the basis for the segregation of the studies, it was found focused studies on practice were few in number.

OBJECTIVES OF THE STUDY

1. To know the client profile of the users of traditional system of medicine.
2. To explore the factors leading to the use/non use of traditional system of medicine.
3. To understand the strength and contribution of traditional system of medicine in the terms of numbers and range of diseases treated exclusively or as a complementary form of treatment.

4. To know the socio-demographic profile, organisation of practice, services rendered by the practitioner of traditional medicine.
5. To understand the belief frames, perception and opinions of patients and practitioner towards the traditional system of medicine.
6. To analyse the process of practitioner patient interaction and how the doctor and patients view and evaluate each others role.

SIGNIFICANCE OF THE STUDY

The 'quest for therapy' all over the world is an important research issue since it reveals essential elements of peoples social behaviour and provides in sights into their perceived needs for different kinds of health services (Kroeger, A. 1983).

Utilisation studies could offer great insights into how best to design and alter the health delivery system so as to improve health care services, which in turn increases utilisation of health care services.

In the recent years the growing need for research in the traditional system of medicine has been recognised by WHO which passed its first resolution in 1977 promoting development of training and research in traditional systems of medicine. There are many reasons cited for the promotion and development of traditional medicine. Its approach is unique and holistic. It's culturally, socially and environmentally close to people. It has a potential for wide application at low cost. Its use local resources, local

technology **and** labour. **It** has the **potential to contribute to scientific and** universal medicine.

The world health assembly has adopted a number of resolutions drawing attention to the fact that most of the population in various developing countries around the world depends on traditional medicine for primary health care. The practitioners for traditional medicine is a potentially important resource for **the** delivery of health care (WHO 1998).

The world health 'Traditional Medicine Strategy 2002-2003[1] takes care of the safety, efficacy, quality, availability, preservation and further development of traditional medicines. The strategy also envisages the integration of traditional medicine into national health care systems by facilitating members states to develop their own policies on traditional medicines.

But for making an effective and comprehensive policy involving traditional medicine, it is required to specify the efficacy and scope of traditional medicines vis-à-vis modern medicine. Another requirement is the study of the utilisation pattern of the traditional medicine by different populations to understand the services offered and the attitude, opinions shared by the users of traditional medicine. As this particular study tries to capture the client community and the practitioner of the traditional medicine, it can help the health policy planners to utilize the services of the practitioners in various public health programmes, so that it effectively reaches the clients utilising the traditional medicine.

This study tries to explore the factors leading to **the** use **and non-use** of traditional system of medicine. This analysis may contribute to understanding the continuity and change within the Indian society specifically relating to health culture.

METHODOLOGY

STUDY AREA

As has been stated earlier the study has been restricted to only two traditional systems of medicine i.e. Ayurveda and Unani. The present research was conducted in Hyderabad due to the following reasons:

1. The literature survey undertaken by the researcher revealed that the proposed traditional system of medicine i.e. Ayurveda and Unani were practiced and utilized in Hyderabad.

2. The State Board of the Indian System of Medicine and Homeopathy in Andhra Pradesh is located in Hyderabad, which helped the researcher when secondary information about different aspects was required. This also included the sample frame of the practitioners located in Hyderabad.

A brief profile of the organizational structure of the board, the educational facilities and the registration process in the state has been presented in the appendix.

THE UNIVERSE

Hyderabad is the fifth largest city in the country' spread out across an area of 217 square kilometers. The total population of Hyderabad is around 37 lakhs consisting of around 19 lakh males and around 18 lakh females. The population growth (decadal) is around +17.18%. The literacy rate is 79.04%. Hyderabad consists of a cosmopolitan profile with people from different states practicing different religions. Some of most prominent religions are Hinduism, Islam and Christianity. Different languages are spoken with the prominent ones being Telugu (the State language), Hindi, Urdu and English.

HEALTH FACILITIES IN HYDERABAD

A list of the government health facilities in different system of medicine available in Hyderabad are presented (Government of Andhra *Pradesh, 1998-99).*

Severn cA MeAvcme. \	No. of Hospitals and Dispensaries
Allopathy	82
Ayurveda	06
Unani	15
Homeopathy	09

Other than the government facilities, there are also numerous private and corporate Allopathic hospitals in Hyderabad but the same does not hold true for other systems of medicine.

THE SAMPLE

As the study was concerning both practice and utilization", the sample included practitioners and patients of Ayurveda and Unani system of medicine. The practitioner's sample was selected from the list of institutionally qualified registered practitioners of Ayurveda and Unani. The samples for the patients were selected from the patients utilizing the services of the sampled practitioners.

Sample for Practitioners

The list of registered Institutionally Qualified practitioners for both Ayurveda and Unani system of medicine was collected from the state board of Indian Systems of Medicine and Homeopathy, Hyderabad. This constituted the sample of practitioners within the Telangana* region. From this list the registered practitioners in the study area was short-listed. This consisted of 365 practitioners of Unani and 487 practitioners of Ayurveda in Hyderabad as on 30th October, 2001. As it was decided to choose 10% of the practitioners from Ayurveda and Unani a sample of 50 belonging to

* Utilization in this study is defined as the process where services (which include medicines /physical treatment, etc) are taken by the respondent after approaching a qualified practitioner of traditional system of medicine

Ayurveda, and 40 belonging to Unani were finally selected. As it was intended that the sample should be representative of the universe, the practitioner were selected from different zones of Hyderabad. But during the fieldwork it was found that tracing the practitioners from this sampling frame was not an easy task as only five Ayurvedic and three Unani practitioners were traced from the list. One of the main reasons included the change in the address of the practitioners. So finally the researcher visited the government Ayurvedic and Unani hospitals in Hyderabad and a snow balling technique was used to locate the practitioners in Hyderabad. Each practitioner was asked to identify five practitioners for the study.

The researcher ensured that there were no two similar references cited by two practitioners.

Sample for Patients

It was decided equal number of patients (i.e.around 100) would be covered for both the Ayurvedic and Unani medicine to understand the utilisation pattern. Patients were selected from practitioner who reported of treating more than five patients per day. This was ascertained during the interviews with doctor by observing the turnout and also going through the registration records whenever possible and wherever maintained. Though greater number of Ayurvedic practitioners reported treating more than five patients per day, patients were selected from only 33 practitioners as only 33 practitioners of Unani reported the same. The patients were selected at the rate of three patients from 33 practitioners of Ayurveda and 33 practitioners of Unani respectively.

[1] See registration process in appendix 1.

Thereby 99 patients using Unani and 99 patients using Ayurveda were selected. The total sample of 198 patients was selected randomly from each practitioner and only the second patient was selected fro the interview.

Efforts were taken by the Researcher to ensure, that 50% of patient sample were visiting the health care service for the second time. This was mainly done to capture detailed version regarding utilization behaviour, which included collection of belief frames, factors responsible for effective utilization, perceptions and opinion on traditional system of medicine.

TECHNIQUES OF DATA COLLECTION

Data for the study included both quantitative and qualitative information.

Schedule

Information was collected primarily by means of a semi structured schedule. There were two types of schedules. One was administered to the practitioners of Ayurveda and Unani medicine. The second type was administered to the patients using Ayurveda and Unani medicine. The schedule for the practitioners covered aspects like the socio demographic profile, the training background, the system of practice, Organisation of practice, the range of services rendered which included Patient load, Organisation norms of fees and Compliance behaviour of patients. Details of the patient practitioner interaction was also collected with the help of the schedule. The schedule for patients covered aspects like the client profile, the family particulars which included type of family and the socio-

demographic particulars of each individual of the family. **The** history of the current illness was collected which included duration of the illness, symptoms suffered, action taken from onset of symptoms and shopping under taken by the patient for treatment. Data was also collected on the health seeking behaviour of the family members. The current health provider patient interaction from the patient's point of view was also collected.

Case **studies**

Case studies were taken when in depth information was needed. Case study technique was particularly employed to elicit information on the health seeking behaviour and choice of therapy. Case studies proved to be helpful as they substantiate the data that was collected by various other means.

Interviews

Interviews with use of Interview Guides was also conducted. Interviews were conducted for practitioners of Ayurveda and Unani medicine. Interviews among the patients revealed the belief frames, attitudes, knowledge preference practices towards Ayurveda and Unani medicine vis-a-vis biomedicine. Information was also collected on the availability, quality and affordability of drugs in Ayurveda and Unani. The Reasons for choice of therapy and the qualities of Ayurveda and Unani medicine which distinguish it from other system of medicine.

Interviews with practitioners were conducted to elicit information on the attitudes, opinion, beliefs towards the system of medicine practiced, limitations and problems encountered during the practice, quality of drugs produced and the government efforts to uplift the traditional system of medicine. Data was collected on referral patterns, status of the system medicine in terms of changes to keep in pace with modern medicine and role of media in promoting the system of medicine.

LIMITATIONS OF THE STUDY

Tracing the practitioners was one of the major hindrances faced by the researcher as the addresses provided by the State Board of Indian Systems of Medicine and Homeopathy had changed and thereby practitioners were not available. Securing an appointment for the study was another major area of concern. Practitioners were not keen on allocating separate time for the interview. The practitioner wanted the interview to take place during consultation, which was a major hindrance, as the flow of information was obstructed when a patient visited the practitioner.

Collecting information from practitioners was a challenging task the aspect that a non-medical person was 'questioning' a medical person was met with initial resistance, but explanation from the researcher, which included the nature and scope of the study, reduced the resistance. Practitioners were interested to know why the study was conducted only within the Ayurveda and Unani system of medicine.

RECORDING AND VERIFICATION OF DATA

Data was recorded immediately in the schedules for the practitioner. Data collected from the patient were verified with the attendees of patients and from medical records were whenever possible regarding the authenticity of the information provided.

DATA ANALYSIS

Data was analyzed with the SPSS package

CHAPTERIZATION

Apart from a brief introduction dealing with explanations of medical pluralism, Traditional systems of medicine, the history of TSM in India, statement of objectives, detailed literature review and the methodology followed for the study the thesis contains five other chapters.

The second chapter contains a brief profile of Ayurveda and Unani.The third chapter will focus on both the traditional system of medicine and its practitioners.The profile of the practitioners will be dealt. It includes the organisation of practice, the training background, Range of services rendered, attitude and belief of practitioners of both system of medicine vis-à-vis biomedicine.

The fourth chapter will give a detailed account of the factor that lead to the use of both the systems of medicine. The patient profile, reasons for choice of therapy, belief frame, attitude and opinion of the patients will be presented. The health seeking behaviour and shopping for treatment will also be highlighted.

The fifth chapter will be regarding the Patient practitioner interaction. This s chapter constitute the findings of patient-practitioner interaction and how each of them evaluates the role of the other. The importance of this aspect in utilisation studies will also be highlighted. This will be followed by the last chapter, which will consist of the summary and conclusions.

Chapter- II

AYURVEDA AND UNANI: A BRIEF PROFILE

As the study is restricted Ayurveda and Unani system of medicine belonging to the great tradition of medicine a brief background profile of both the systems of medicine is presented.

AYURVEDA

Ayurveda is the name which the ancient Indians gave to their science of medicine. The word "Ayurveda" (in Sanskrit) 'Ayuh' means 'life' and 'veda' means 'knowledge of science'. Literally therefore, Ayurveda means the science of life. (Sharma, 1979). Ayurveda is the science by the knowledge of which life can be prolonged or its nature understood (Kutumbaiah, 1999).

The Vedas are earliest sacred books of India. They are four in number, viz., Rigveda, Samaveda, Yajurveda and Atharva Veda. The Hindus believe that they were never composed by man and were taught by the Gods to the sages by word of mouth from a period of unknown antiquity.

There was no Veda called Ayurveda. Its existence is a myth. Susruta calls it an 'upanga' of the Atharva Veda. It was raised to the status of veda and appended to the 'Atharva Veda' to give the science of medicine the necessary sanctity and authority.

ORIGIN

There are two prominent versions of its origin. The medical school traces its origin to Bharadvaja, who received it from God Indra. The surgical school traces its origin to Dhanvantari who received it from Lord Indra.

According to Charaka Samhita, Ayurveda emanated from the creator, Brahma who revealed it in its entirety to Prajapathi, 'Lord of the Creatures' who passed it to Indra. The sage Bharadvaja was asked by other sages to go lo God Indra to attain this knowledge for the good of mankind. He brought it to the terrestrial level. It was Bharadvaja who imparted this knowledge to Atreya. Sage Atreya discussed the topics of medicine with the scholars and sages in different symposia organized in various parts of the country. Most brilliant of his disciplines was Agnivesa, who documented these in a treatise- Agnivesa treatise. Afterwards this text was refined and enlarged by Charaka and became known as 'Charaka Samhita'.

Susruta Samhita provides another version of the origin of Ayurveda. Susruta along with the sages thus approached the immortal Lord Divodasa Dhanvantari, king of Benares, to appeal to him to provide relief from different types of sufferings which included bodily, mental, accidental and natural diseases. In response to the appeal, Dhanwantari instructed them in Ayurveda, a subsidiary branch of Atharva Veda. He told them that Brahma composed it in one hundred thousand slokas and a thousand chapters before he created man. He divided it with eight chapters, viz., Salya, Salakya, Kaya-Chikista, Bhutavidya, Kaumara-bhrtya, Agada-tantra, Rasayana tantra,

Vajikarana **tantra.** Brahma **first expounded Ayurveda to Prajapati, who** taught **it to** the two **Asvini** Kumars. From **these** twins. **Indra** and Dhanwantari obtained the knowledge (Kutumbiah, 1999).

Time Period of Origin

It is believed that both the Schools of thought of Atreya and Dhanwantari existed during the same time. The Atreya School referred cases to Dhanwantari School, but there is no mention of cases being referred from the surgical school to Atreya. It shows that surgical intervention was made only when all other methods of treatment fails. According to Kutumbiah (1974), the schools of Atreya and Dhanwantari are supposed to have been established in the 6^{lh} century B.C. It was known as 'Atreya Sampradaya' school of physicians, and 'Dhanwantari sampradaya' school of surgeons.

AYURVEDA LITERATURE

The basic principles, theories and material medica of Ayurveda are described in numerous medical treatises. The most prominent were the Charaka Samhita, Susruta Samhita and Astanga Samhita of Vagbhata. The Samhitas of Charaka and Susruta form the classics of ancient Indian medicine.

Charaka Samhita: Charaka Samhita stands as the finest document of the creative period of ancient Indian medicine. The Charaka Samhita conforms to the tradition of Astanga Ayurveda. The treatise consists of eight divisions. Sutra, Nidana, Vimana, Sarira, **Indry,** Chikitsa, Kalpa and Siddha

sthanas. It provides information from the generation of the fetus to the functioning as well as malfunctioning of adult body, on the basis of three humours.

Charaka's text is important and revolutionary as it developed a rational attitude towards these problems. Charaka emphasized working to Yukti (rationale). He advised to move always with knowledge and emphasized the process of investigation which is essential for arriving at scientific truth.

Susrutha Samhita: Susrutha Samhita was written by Susrutha, who probably was a contemporary of Charaka. This book is of tremendous value because in addition to medicine, it contains description of techniques of surgery, rhinoplasty and describes surgical instruments.

Astanga Samgraha: TheAstanga Samgraha of Vagbht summarizes the views of Charaka and Susrutha and added original scientific data concerning treatment of diseases.

FUNDAMENTAL PRINCIPLES

Ayurveda is based upon certain principles of physical, clinical and biological sciences. Ayurveda deals with the total human being comprising of 'tridoshas', 'dhatus', 'malas' and the relationship of its totality with the outside world of universe.

There are four key concepts in Ayurveda. These together guide the preventive, promotive and curative aspects of the practice of Ayurveda. These concepts are:

1. Pancha mahabhutas
2. Tridoshas
3. Dhatus
4. Malas

Pancha Mahabhutas: All objects in the universe including human body are composed of five basic elements of air, water, fire, earth and vacuum.

Tridoshas: Man is a microcosm of nature so the five basic elements present in all matters exist within each individual. According to the theory the five basic elements. Ether, Air, Fire, Water and Earth manifest as three humours known as tridosha, i.e. as 'vata', 'pitta' and 'kapha'.

Vata:From ether and air elements the bodily air called 'vata' is evolved. Function of vata or motion is to regulate proper use of energy by the different cellular structures of the body.

Pitta:Pitta comes from fire. It refers to energy and is concerned with the metabolic and biochemical processes which generate heat and energy within the body.

Kapha: Kapha comes from 'earth' and water. Kapha deals with cellular and intercellular structure of the human body.

The three humours not only govern the totality of all individuals but relate the individual to the cosmos. AH physical and mental functions of the body are governed by 'tridosha' and this theory is referred to as 'tridhosha theory'. A coordinated and balanced functioning of the three humours sustains life and helps keep good health.

When the body humours are disturbed, they disturb the body constituents which are 'dhatus'. Charaka speaks of disease as the imbalance of bodily constituents.

Dhatus'/Dhatus' refer to different vital body organs and parts. There are seven 'dhatus' in the body. These are Rasa (body liquids), Rakta (blood), Mamsa (muscular tissue), Meda (adipose tissue), Asthi (bone tissue), Majja (nerve tissue and bone marrow) and Shukra (generational tissue including sperm and ovum).

Malas:This refers to the waste products of the body. The food consumed by the human body brings into existence and builds further the above mentioned dhatus. During the metabolic process, each organ produces a specific waste as Mala as stool, urine, sweat, nails, hair etc. The Malas of food are faces and urine. The mala of rasa is kapha, that of blood is pitta, that of flesh is the waste in the apertures of human body e.g. dust of ears, eyes etc., of fat is sweat, of bones is hair and nails, of marrow is the waste matter in the eyes and oiliness of skin (C.S.V. II TS. 17&18). The theory of the waste products is that in proper measure, they serve to sustain the body and perform important functions, but when in excess of or below their proper measure they pollute the body ultimately destroyed it. According to

Ayurveda, diseases are of **three types - innate, exogenous and psychic.** Innate are those, which arise due to imbalance in three humours - vata, **pitta** and kapha. Exogenous disorders arise due to external factors, **such as** poison, polluted air, parasites, bacteria, viruses **etc. The third type of** disorder in psychic in origin. These are caused by unfulfillment of desires or facing the undesired (Verma V.1995).

DIAGNOSIS

In Ayurveda diagnosis is always done of the patient as a whole. The physician takes a careful note of the patient's internal physiological characteristics and mental disposition. He also studies such other factors as the affected bodily tissues, humours, the patients daily routine, dietary habits and condition of digestion. Details of personal, social, economic situation of the patient is understood. The diagnosis also involves the following examinations:

- General physical examination
- Pulse examination
- Examination of the faces
- Examination of tongue and eyes
- Examination of skin and ear including tactile and auditory functions

TYPES OF TREATMENT:

The treatment of disease can broadly be classified as

a) Shodhana therapy (Purification Treatment)

b) Shamana therapy (Palliative Treatment)
c) Pathya Vyavastha (Prescription of diet and activity)
d) Nidan Parivajan (Avoidance of disease causing and aggravating factors)
e) Satvavajaya (Psychotherapy)
f) Rasayana therapy (use of immnomodulators and rejuvenation medicines)

(a) Shodhana treatment aims at removal of the cusative factors of somatic and psychosomatic diseases. The process involves internal and external purification. The usual practices involved are Panchkarma (medically induced Emesis, Purgation, Oil Enema. Decoction enema and Nasal administration of medicines), Pre-panchkarma procedures (external and internal oleation and induced sweating). Panchkarma treatment focuses on metabolic management. It provides needed purificatory effect, besides conferring therapeutic benefits. This treatment is especially helpful in neurological disorders, musculo-skeletal disease conditions, certain vascular or neurovascular states, respiratory diseases, metabolic and degenerative disorders.

(b) Shamana therapy involves suppression of vitiated humours (doshas). The process by which disturbed humour subsides or returns to normal without creating imbalance of other humours is known as shamana. This treatment is achieved by use of appetizers, digestives, exercise and exposure to sun, fresh air etc. In this form of treatment, palliatives and sedatives are used.

(c) Pathya Vyavastha comprises **indications and contraindications in** respect of diet, activity, habits and emotional status. This is done with a view to enhance the effects of therapeutic measures **and to impede the** pathogenetic processes. Emphasis on do's and **don'ts of diet etc.,** is laid with the aim to stimulate Agni and optimize digestion and assimilation of food in order to ensure strength of tissues.

(d) Nidan Parivarjan is to avoid the known disease causing factors in diet and lifestyle of the patient. It also encompasses the idea to refrain from precipitating or aggravating factors of the disease.

(e) Satvavajaya concerns mainly with the area of mental disturbances. This includes restraining the mind from desires for unwholesome objects and cultivation of courage, memory and concentration. The study of psychology and psychiatry have been developed extensively in Ayurveda and have wide range of approaches in the treatment of mental disorders.

(f) Rasayana therapy deals with promotion of strength and vitality. The integrity of body matrix, promotion of memory, intelligence, immunity against the disease, the preservation of youth, luster and complexion and maintenance of optimum strength of the body and senses are some of the positive benefits credited to this treatment. Prevention of premature wear and tear of body tissues and promotion of total health content of an individual are the roles that Rasayana therapy plays.

Thus, health according to Ayurveda is balanced (inter-intra) state of all the Doshas, Dhatus and Malas. A healthy person enjoys equilibrium of the humour, the body tissue and excretory functions normally experienced by

man in the process of gratifying his sense, mind **and** soul. (GO1, **ISM** & H, 1991).

UNANI MEDICINE

The Unani system of medicine owes its origin in Greece. It was further enriched and developed by Arabs and Persians. 'Unani' is the Arabic name for 'Greece' which denotes the origin of the system.

It was the Greek philosopher-physician Hippocrates (460-377 BC) who relieved medicine from the realm of superstition and magic and gave it the status of science. The theoretical framework of Unani medicine is based on the teaching of Hippocrates. After Hippocrates a number of other Greek scholars enriched the system considerably. Of them, Galen (131-210 AD) stands out as the one who stabilized its foundation on which the Arab physician like Rhazes (Zakariya Razi, 850-925 AD) and Avicenna (Bu Ali Sina 980-1037 AD) constructed an imposing edifice. Some of the other luminaries are Avenzoar (IBn Zohar 1072-1162 AD). Ibn Nafees (1210-1288 AD), Ibhn el Beitar (1197-1248 AD), and Hussain (809-873 AD).

ORIGIN OF UNANI IN INDIA

In India, Unani system of medicine was introduced by the Arabs in 11^{lh} century. (Nizamia General Hospital, 2000) When Mongols ravaged Persia and Central Asian cities like Shiraz, Tabrez and Geelan, scholars and physicians of Unani medicine fled to India. The Delhi Sultans, the Khiljis, the Tughlaqs and the Mughal emperors provided state patronage to the

scholars and even enrolled some Unani scholars as **state** employees and court physicians. Some of the physicians who made notable contributions were Abu Bakar, Bin Ali Usman Kashmari. Sadruddin Damashqui, Bahwabin, Khwas Khan. Ali Geelani, Akbar Arzani, and Mohammed Hashim Alui Khan.

The system found immediate favour with the masses and spread all over the country and continued to hold and unchallenged sway for a long period even after the down fall of the Mughul empire.

During the British rule, Unani medicine suffered a setback and its development was hampered due to withdrawal of governmental patronage. But as the system enjoyed faith, among the masses it continued to be practiced. It was mainly due to the efforts of the Sharifi family in Delhi, the Azizi family in Lucknow, and the Nizam of Hyderabad that helped the survival of Unani medicine. Hakim Ajmal Khan (1868-1927) championed the cause of Unani system in India. The Hindustani Dawakhana and the Ayurvedic and Unani Tibbia College in Delhi are the two living examples of the Hakim's immense contribution to the multi-pronged development of the two Indian systems of medicine.

UNANI LITERATURE

The most famous works include, Hussain's (809-873 AD) 'Ten treatise on the eye' which is the very earliest systematic text book of ophthalmology. Avenzoar linked surgery, therapeutics and pharmacology into the homogenous whole. Rhazes in his treatise 'small pox and measles' gave a clear account of these two diseases for the first time. His compilation

'El-Harvi' runs in 25 volumes. Avicenna's "El-Quanoon" or 'Cannon of Medicine' has been the most famous books of world. It was the medical Bible for several Asian and European civilizations for more than six centuries. El-Majusi was the first Arab scholar who wrote extensively about surgery while Abul Qasim Al Zahravi was a great surgeon who wrote reference surgery book "El-Tasrif and he died in 1013 AD. 'El-Tasrif was translated into Latin and was a textbook in the universities of Europe. Another famous Arab surgeon was Ibn-el-Quff who wrote a book "El-Umda fi Sinaat-e-Jrahat". (Hussain et al 2003).

FUNDAMENTAL PRINCIPLES

According to Avicenna and other Unani physicians, the aim of the medicine is to preserve the existing healthful state of a person and to restore il when lost (Hussain et al 2003). In this system, the main object of therapy is to help and strengthen the 'Tabiyat Mudabbira el Badan" an inherent adjusting power of the body so that it may adjust its mechanisms and restore the norms of health which are lost. According to the Unani system of medicine the human constitution is composed of seven natural components, namely Elements (arkan), Temperament (mizaj), Humours (akhlath). Organs (aza) Power (quwa), Vital spirit (arwah) and Functions (afal). (Department of AYUSH, Government of India 2004).

1. Arkan (Elements)

2. Mizaj (Temperament)

3. Akhlat (Humours)

4. Aza (Organs)

5. Arwah (Spirit)

6. Quwa (Powers)

7. Afa'l (Function)

I) Elements (Arkan): These are four i.e. Air, Water, Earth and Fire. Actually these four elements represents several other elements found in the modern science. There are four states denoting the temperaments of these four elements

Air	Fire	Earth	Water
Hot & Moist	Hot & Dry	Cold & Dry	Cold & Moist

11. Temperaments (Mizaj):- The interaction between the chemical combination of four elements, produces various states which determine the temperament of an individual human being, plants, & minerals. Temperament (Mizaj) is simply defined as having the following states and their combinations:-

Hot	Single——Compound	Hot & Dry
Dry		Hot & Moist
Cold		Cold & Dry
Moist		Cold & Moist

Ill **Humours (Akhlat) :- The humours are actually the body fluids which are classified broadly in four. The fluids of the body contains various harmones, enzymes and humours etc. They are responsible for nutrition to the whole of body. These fluids are (a) Primary (b) Secondary.**

(a) Primary fluids are four humour i.e. blood, phlegm, yellow bile and black bile.

(b) Secondary fluids are harmones, enzymes, and plasma etc.

IV. **Organs (Aaza):-** Organs are composed of cell, tissues, nerves **and** blood vessels. Various organs of the body and health in disease condition of each individual affects the state of **health.**

V. **Pneuma-Gaseous material (Arwah):-** The Pncuma is a life force which carries of different powers, without which human body is dead. This is a source of life and vitality.

VI. **Faculties (Qawa):-** Faculties/Powers are of three kinds.

a) Natural powers

b) Psychic powers

c) Vital powers

VII. Functions (Afaal):- Includes movements of various organs. **It** is necessary **to ensure that various organs should be in proper shape and condition to perform proper functions.**

The chief contribution of **Hippocrates to medical realm is the humoral** theory, which passed on to Unani.The humoural theory presupposes **the** presence of four humours, namely blood (dam), phlegm (balgham). yellow bile (safra) and black bile (sauda) in the body.

The temperaments of persons are expressed by the terms sanguine, phlegmatic, choleric and melancholic, according to the preponderance of the humour in them. The humours themselves were assigned temperaments - blood is hot and moist, phlegm is cold and moist, yellow **bile** is **hot and dry** and black bile is cold and dry. Every person is supposed **to** have **the unique** humoural constitution, which represents his/ her healthy state. As long as these humours are in normal balance health is maintained and imbalance of humoral constitution results in disease.

According to Unani classics diseases are classified into four groups, viz., diseases due to altered temperament (Amraz-e Su-e Mizaj Sada) or metabolic diseases and others. Diseases due to altered humour (Amraze-Su-e- Mizaj Maddi) or infectious disease. Disease due to structural defects (Amaraz-e-Tarkeeb) which may be congenital and acquired. Diseases due to discontinuity of tissue (Amraz-e-Tafarruq-o-ltte) which require para surgical and surgical management (Nizamia General Hospital, 2000).

PREVENTION OF DISEASE: The factors are known as Asbab-e-Sitt-e-Zaiooriah (six essential factors), namely atmospheric **air and climate (Hawa-**e-Muhit), foods and drinks (Makool-wa-Mashroob), rest and activity of body (Harkat-wa-sukoon-e-badni), rest and psychological activity (Harkat-wa-

sukoon-i-Nafsani), sleep and wakefulness (Naum-vo-Yaqzah) **and retention** and elimination (istifragh-vo-Ihtibas).

DIAGNOSIS: The principles of diagnosis depend upon clinical observation of pulse (Nabz) and physical examination of excreta like urine (Baul) and stool (Oraz) etc.

TREATMENT: The various types of treatments in Unani medicine are:

1. Ilaj bil- Tadbees (regimental therapy)
2. Ilaj bil Ghiza (dieto therapy)
3. Ilaj bil Dawa (Pharmaco therapy)
4 Ilajbil Yad (Surgery)

1. Ilajbil Tadbeer (Regimental Therapy): Some drugless regimens are advised for the treatment of certain ailments i.e. Exercise, Massage, Hamam (Turkish Bath), Douches (Cold and Hot) and the Regimen for Geriatrics.

2. Ilajbil Ghiza (Dietotherapy): Different diets are recommended for the patients of different diseases.

3. Ilajbil Dava (Pharmaco-therapy): The basic concept of treatment is to correct the cause of the disease that may be Abnormal temperament due to

I. Environmental factors

II. Abnormal humours either due to internal causes or external causes which may be pathogenic micro-organism, through (a) drugs of opposite temperament to the temperament of the disease that is called Ilaj-

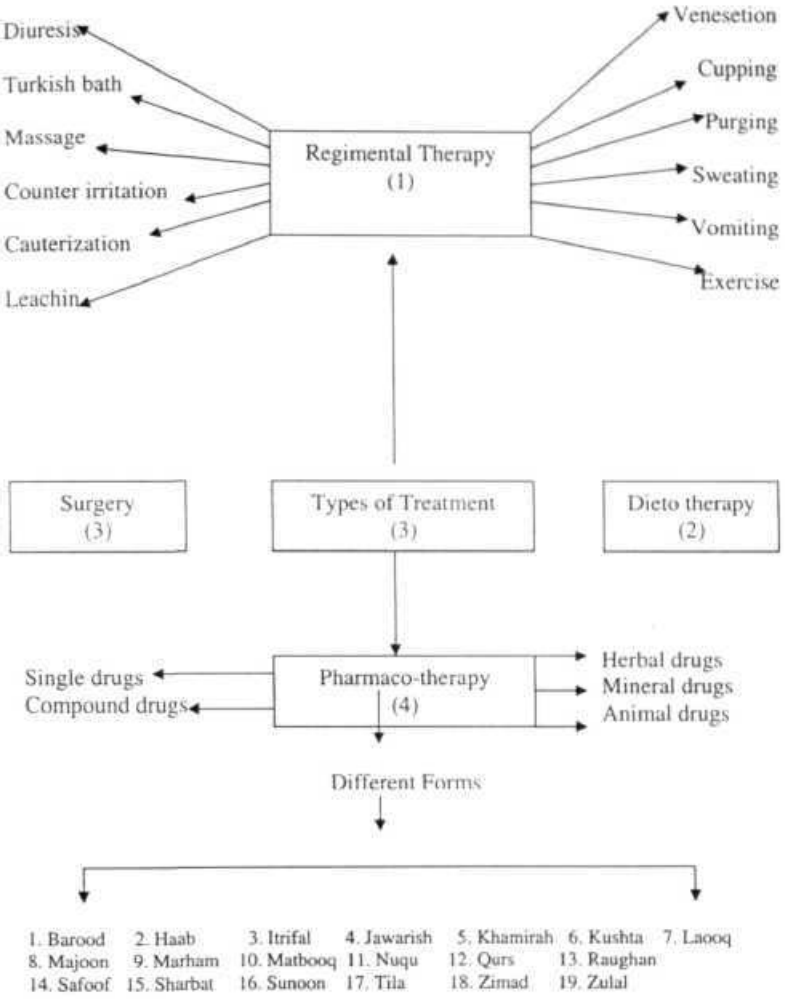
bil-zid or (b) drugs of similar **temperament** as of **the temperament of the** disease that is called as Ilaj-bil-misl.

The drugs used are mostly of the Plant origin. Some drugs of Animal and Mineral Origin are also used. Patients are treated either by single drugs (crude drugs) or by compound drugs (formulations of single drugs).

There are two types of compound drugs used in the treatment of diseases i.e. Classical compound drugs which are in use for the hundreds and thousands years and Patent/Proprietary compound drugs which have been formulated by the individuals or institutions as per their research and experiences.

After complete examination of the patient, treatment is started. The treatment not only normalize the existing imbalance but also improves the natural defence mechanisms of the body so as to minimize chance of future disease. Thus the treatment is generally both curative and preventive in nature and effective.

FIGURE 2.1 TYPES OF TREATMENT IN UNANI SYSTEM OF MEDICINE



Chapter-UI

PRACTITIONERS AND PRACTICE: A PROFILE

In order for a holistic coverage of the topic chosen for the present study, as has been stated earlier, both the practitioners of the systems of medicine and their clients have been studied. While dealing with the practitioners, the characteristics of the practitioners as well as the organization of their practice are attempted. This chapter covers these aspects relating to practitioners.

SOCIO-DEMOGRAPHIC PROFILE OF PRACTITIONERS

The social characteristics of the practitioners such as sex, age, religion, educational level, income etc are analyzed to relate these characteristics to the organization of practice. Some of these social background characteristics could also be related to quality of services. More over this information would reveal which social groups are involved and which ones dominate the practice of these systems of medicine and the changes that are occurring in this regard.

DISTRIBUTION ACCORDING TO AGE

Majority (28.8%) of the respondents belonged to the age groups of 31-40 years. There were a significant (26%) percentage of Ayurvedic practitioners who were below 30 years when compared to Unani practitioners. It is interesting to note that the practitioners were almost equally divided between the 40-50 to 51-60 age groups in both the system of medicine. The data indicates that a majority of (56%) practitioners of

Ayurveda have entered the profession in recent years while the majority of the Unani practitioners had joined the profession two to three decades back. This reveals that Ayurveda is chosen as a profession by the younger generation but this is not evident in Unani. This trend may be due to the fact Ayurveda is 'popular' in today's world than Unani. This was supported by majority of Unani doctors who reveal that Ayurveda received patronage from the government in terms of funds and exposure, which in turn increases the popularity for the system of medicine. This in turn attracts the youth to choose it is a profession as a livelihood is guaranteed with Ayurveda but the same cannot be felt for Unani.

TABLE- 3.1: DISTRIBUTION OF PRACTITIONERS ACCORDING TO AGE GROUPS

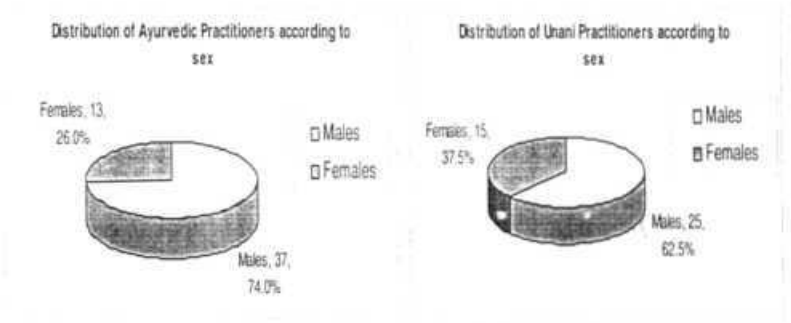
SI No	Age Groups	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Below 30 years	13	26	00	00	13	14.4
02	31-40 years	15	30	11	27.5	26	28.8
03	41-50 years	06	12	18	45	24	26.6
04	51-60 years	15	30	10	25	25	27.7
05	61 years +	01	2	01	2.5	02	2.2
	TOTAL	50	100	40	100	90	100

DISTRIBUTION ACCORDING TO SEX

A little more than two third (68.9%) of the practitioners were males, but nearly one third of them were females. This shows that women do choose to learn traditional medical systems, but not as much as men. The proportion of Unani women practitioners is higher **than** women

practitioners in Ayurveda. This is due to the demand for services of women doctors in Muslim community. This demand stems from the explicitly defined gender roles in Islam restricting the females to discuss any 'gynecological problems' with the male practitioners. The female Unani practitioners claim that their decision to take up the profession also helps the women of their community to seek appropriate health care while also adhering to social norms.

CHART-3.1: DISTRIBUTION OF PRACTITIONERS ACCORDING TO SEX



DISTRIBUTION ACCORDING TO RELIGION

Majority (96%) of the ayurvedic practitioners were Hindus while only 4% were Muslims. 97.5% of Unani practitioners were Muslims and only one practitioner was a non-Muslim. The identity of Ayurveda as a Hindu system of medicine and Unani as a Moslem system largely determines this trend. This trend reveals that people tend to identify themselves with aspects closest to their life style be it religion, language or region. However, there are also other reasons for the domination of these systems of medicines by either Moslems or Hindus. One has to

possess a certificate of proficiency in Arabic to join Unani and this may have restricted the entry of members of non-Moslem communities into this course. According to Ayurveda practitioners, this makes Unani medicine 'of the Muslims and by the Muslims'.

In instances where a shift in the ethnic loyalty was seen like, Muslims practicing Ayurveda it was because they were not proficient in Urdu, in spite of that being their mother tongue.

TABLE- 3.2: DISTRIBUTION OF PRACTITIONERS ACCORDING TO RELIGION

SI No	Religion	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Hindu	48	96	1	2.5	49	54.5
02	Muslim	2	4	39	97.5	41	45.5
	TOTAL	50	100	40	100	90	100

DISTRIBUTION ACCORDING TO EDUCATIONAL QUALIFICATION

Only 30% of the practitioners possessed a master's degree. 34% of Ayurvedic practitioners and 25% of Unani practitioners respectively hold a master's degree qualification.

TABLE-3.3: DISTRIBUTION OF PRACTITIONERS ACCORDING TO EDUCATION

SI No	Educational Qualification	Ayurveda		Unani		**Total**	
		No:	%	**No:**	%	**No:**	%
01	Batchelor	33	66	30	75	**63**	**70**
02	Masters	17	34	10	25	**27**	30
	Total	50	100	40	100	90	**100**

Those who had private practices fell the need for a master's qualification. The master's degree was thought to help acquisition of knowledge and skills relatively early in their careers particularly with reference to a set of diseases which are commonly believed to be effectively cured with ayurveda or unani medicine. This may then help improve their practice, for people would prefer consultation with 'specialists'

The government practitioners also reported thai a 'master's degree' definitely would help them for their career growth in the form of promotion and increments in their in payment. The need for a masters degree as indicated by the private practitioner can be attributed to the strict competition in the private practice and lack of secure income unlike the government set up where the monthly salary is more or less looked upon as 'constant' and secure financial backup.

FATHER'S OCCUPATION

Data on father's occupation was collected to see whether it had any influence on the decision of the respondents to take up traditional system of medicines as a career. It was found that fathers of (10) respondents were practitioners of the respective system of medicine

practiced and another 7.9 % of respondent's fathers were medical personnel. That is either, they were pharmacists or multipurpose health workers etc. Though it cannot be definitely concluded that the father's occupation is the only determinant factor for selection of a profession it can be believed that the incidence for selecting a similar profession is high among the respondent whose father's profession coincided with their own. This behaviour can be interpreted in the lines, that children try to want to imitate their parents in growing years, which in turn develop interest and aptitude in them to take up the same profession or a profession close to their parent's profession. This may also be due to the parental pressures on the wards for they believe their wards can establish themselves early if they too choose the professions of their own, as they can exploit the popularity of their services and social networks and earn the good will.

TABLE-3.4: DISTRIBUTION OF PRACTITIONERS ACCORDING TO FATHERS OCCUPATION

SI No	Father's Occupation	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Rtd/ Govt. Sector	21	42	20	50	41	45.5
02	Rtd/ Pvt. Sector	06	12	02	5	08	8.8
03	Business	02	4	04	10	06	**6.6**
04	Agriculture	10	2	07	17.5	17	18.8
05	Medical Personnel	06	12	02	**5**	08	7.9
06	Practitioners	05	10	05	12.5	10	11.1
	Total	50	100	40	100	90	100

INCOME

Majority (42.3%) of the practitioners earned income ranging from two to four lakhs per year Compared to the Ayurvedic practitioners (18%), more number of Unani practitioners (22.5%) **earned** an **income of** more than five lakhs. This data shows that a sizeable percentage of Unani practitioners earned a better income than their ayurvedic counterparts. This may be because 62.5% of the Unani practitioners in the sample had private practice besides their employment in government sector and their income from private practice substantially contributed to their total in come.

TABLE-3.5: DISTRIBUTION OF PRACTITIONERS ACCORDING TO INCOME

SI No	Income	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Below 2 lakhs	20	40	14	35	34	37.7
02	2.1-4 lakhs	21	42	17	42.5	38	42.3
03	4.1-6 lakhs	4	8	6	15	10	11.1
04	Above 6 lakhs	5	10	3	7.5	8	8.9
	Total	50	100	40	100	90	100

MAIN SOURCE OF INCOME:

Majority of the respondents earned their income mostly from their practice. Those in government service, salaries were the main source of

income But 10% of those who had private practice besides their employment in government hospitals reported income from their private practice as the significant source of income. Only three fifth of the female respondents reported that their husbands salary was the main source of income, while two fifths revealed that the income received from their respective practice was the main source of income.

ORGANISATION OF PRACTICE

TYPE OF PRACTICE

It was found that more than half (54.5%) of the practitioners had both government and private practice. While nearly equal percentage (23.3%) of practitioners either worked only for the government or practiced privately. 40% of Ayurvedic practitioners practiced privately while only 2.5% of the Unani practitioners worked privately This reveals that Ayurveda finds patronage in private sector also.

TABLE-3.6: TYPE OF PRACTICE

SI No	Type of Practice	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Private	20	40	1	2.5	21	23.3
02	Government	6	12	14	35	20	22.2
03	Both	24	48	25	62.5	49	54.5
	Total	50	100	40	100	90	100

REASONS FOR TAKING UP GOVERNMENT PRACTICE AND PRIVATE PRACTICE:

Information was collected as to why respondents had both types of practice. The reasons cited ranged from better source of income, exposure, to utilize time available to serve the society. Majority of the practitioners revealed that additional source of income was a major factor for taking up two types of practice.

NUMBER OF YEARS SINCE COMMENCEMENT **OF PRACTICE**

19% of the practitioners commenced practice from 10 years, which suggest they got into profession during the last 10 years. 55% of Unani practitioners commenced practice from 16 to 25 years. Nearly 93% of Unani practitioners have been in practice for more than 11 years while only 72% of Ayurvedic practitioners have been practicing for more than 11 years. This data shows that Ayurveda and Unani have been finding patronage in Hyderabad for more than three decades. This means that traditional system of medicine has catered to health needs of individuals in Hyderabad and thus in turn will help to arrive at conclusion as to whether the utilisation pattern in terms of patient profile, range of services rendered have changed from then to date.

TABLE-3.7: NUMBER OF YEARS SINCE COMMENCEMENT OF PRACTICE

SI No	Years	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Less than 10 years	14	28	3	7.5	17	18.8
02	10-20 years	16	32	17	42.5	33	36.7
03	21-30 years	11	22	16	40	27	30
04	Above 31 years	9	18	4	10	13	14.5
	Total	50	100	40	100	90	100

COMMENCEMENT OF PRACTICE AFTER AWARD OF DEGREE

Nearly three fourths (76.6%) of the practitioners started practicing immediately after the award of degree. It was found that 80% of Ayurvedic practitioners commenced practice immediately as compared to 72.5% of Unani practitioners after the award of degree. This reveals that Ayurveda manages to find patronage "early" when compared to Unani

TABLE-3.8: COMMENCEMENT OF PRACTICE AFTER AWARD OF DEGREE:

SI No	Commenced Practice after award of degree	Ayurveda		Unani		Total	
		No:	%	**No:**	%	**No:**	**%**
01	Yes	40	80	**29**	**72.5**	**69**	**76.6**
02	No	10	20	**11**	27.5	**21**	23.4
	Total	50	100	**40**	**100**	**90**	**100**

Reasons were explored as to why practitioners did not **start practice** immediately after the award of degree.

TABLE-3.9: REASONS AS TO WHY PRACTICE WAS NOT STARTED

SI No	Reason	Ayurveda		Unani		**Total**	
		No:	%	No:	%	**No:**	**%**
01	Domestic responsibilities	7	36.9	8	40	**15**	**38.5**
02	Further studies	4	21	3	15	**7**	**17.9**
03	Desired a government job	6	31.6	8	40	**14**	35.8
04	Any other	2	10.5	1	5	**3**	**7.8**
	Total	19*		20*		**39**	**100**

* Multiple responses

It was **found** that Domestic responsibilities were cited mostly by female practitioners as they revealed that they got married and started a family. So social responsibilities took most of the time. Not getting into a government job was also cited revealing the important 'status' attached to the government job.

TRAINING

Information was collected regarding any additional training received by the practitioners during practice. A little less than three fourths of the respondents did not receive any formal training. Among the Unani practitioners, nearly 42.5% received training. It was found that among the practitioners of Ayurveda and Unani. only those practitioners working in government institutions received additional training.

TABLE-3.10: TRAINING REC1EVED

SI No	Training Received	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Yes	9	18	17	42.5	26	28.8
02	No	41	82	23	57.5	64	71.2
	Total	50	100	40	100	90	100

Details of the training received revealed that training was either refresher or reorientation courses in the current system of medicine practiced. Another area where the practitioners were trained was on child welfare and family planning methods. The government departments have imparted all the trainings.

The trainings received by the practitioners have been 'helpful' to them as it, helps them in improving their skills and refreshing their memories. The training imparted by other departments come in handy while conducting public health programmes, camps etc.

An area where the private practitioners were lagging was in training, as they did not receive any training from any source. According to them it would be helpful and encouraging if they were included in training programmes. The scope of receiving training seemed very low, as there were no agencies involved in training. Another factor that discouraged the private doctors to receive training from private sources was the payment factor, as they need to pay from their pocket for any training.

HOURS OF WORK

Majority (64.4%) of the respondents worked between seven to 10 hours. 16.7% practitioners worked for less than six hours while 18.9% practitioners worked for more than 10 hours. 27.5% of Unani practitioners for more than 10 hours as compared to 12% of Ayurvedic practitioners.

TABLE-3.11: Hours of work

SI No	Hours of work	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Less than 6 hours	13	26	2	5	15	16.7
02	7-10 hours	31	62	27	67.5	58	64.4
03	More than 10 hours	6	12	11	27.5	17	18.9
	Total	50	100	40	100	90	100

During discussion with practitioners, it was found that "female practitioners' had reported working for fewer hours than 'males'. This may due to the social responsibilities in the hume trout. Many of the female practitioners were found informing that 'they will have no time to focus on family' if their working hours were increased.

CONSULTATIONS

More than three fourths (78.9%) of the practitioners do not go for consultation. Some of the most common reasons cited for not taking up consultations by the practitioners were lack of time, not needed. 24% of Ayurvedic practitioners go for consultations while only 17.5% Unani practitioners undertake consultations. The researcher also fell it that the concepts of consultations have not yet gained momentum in traditional medicine when compared to allopathic medicine. Consultation in traditional medicine was restricted to practitioners practicing in nursing homes unlike allopathic where the services of a doctor is taken in every

field be it radiology, anesthesiology etc. This could be mainly attributed due to a lack of specialists as the number of specialization in both system of medicine is limited. Moreover, the specializations are in broad areas rather than to a limited field as in the case of allopathic. The recognition as a specialist by professional colleagues is also limited to a certain extent as it is felt specializations are more or less 'self acclaimed' due to the limited scope for numerous specializations within the traditional systems of medicine. Its found that this trend is more prominent when practitioners claim specialist status without a master's qualification. Moreover the desire for general practice by treating a range of illness for greater popularity and economic gains among the practitioners encourage solo practice. This reveals that traditional medicine is dominated by 'solo practice' unlike allopathy where consultations are the order of the day.

Majority of the practitioners who reported taking up consultation visited only two places. Only one Ayurvedic practitioner visited three places.

TABLE-3.12: CONSULTATIONS

SI No	Consultation	Ayurveda		Unani		Total	
		No:	%	No:	%	**No:**	**%**
01	Yes	12	24	7	17.5	19	21.1
02	No	38	76	33	82.5	71	78.9
	Total	**50**	100	40	100	**90**	100

TABLE-3.13: NO OF CONSULTATIONS

SI No	No. of Consultations	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Below 2	11	91.6	7	100	18	9.47
02	3-5	1	8.4	-	-	1	5.3
	Total	12	100	7	100	19	100

REASONS FOR CHOOSING PARTICULAR SYSTEM OF MEDICINE

Some of the major reasons reported by the practitioners for selecting the current system of medicine were personal choice, family pressure, source of income and failure to secure a seat in Biomcdicine thereby restricting their choice. The preference to select TSM*, as a career is lower compared to choosing biomediciiie as a career, as majority of practitioners opined that they selected TSM only when they were left with 'no choice'. No specific difference was noted among the Ayurvedic and Unani practitioners.

* TSM in the Study refers to Tradilional systems of medicine (i.e.Ayurveda and Unani).

TABLE-3.14: REASONS FOR CHOOSING PARTICULAR SYSTEM OF MEDICINE

SI No	Reasons	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Source of Income	10	14.2	11	15.5	21	14.9
02	Personal Income	12	17.2	5	7.0	17	12
03	Family pressure	16	22.9	25	35.2	41	29.0
04	Failure to secure a seat in biomedicine	30	42.8	27	38.0	57	40.5
05	Any other	2	2.8	3	4.3	5	3.6
	Total	70	100	71	100	141	100

ATTITUDES AND PERCEPTIONS OF GOVERNMENT PRACTITIONERS TOWARDS EXCLUSIVE PRIVATE PRACTICE

Perceptions towards having private practice were collected from those practitioners who practiced only in Government Institutions'. 50% of the practitioners reported they would want to start private practice while 50% reported that they are 'satisfied' working in the government. While a little less than two third of the Unani practitioners reported

* See page 85, Table 3.6

wanting to start private practice only 16.6% Ayurvedic practitioners stated the same. This shows that the scope for taking up private practice seemed to be greater among unani practitioners.

The practitioners who preferred starting private practice cited various reasons. Responses included multiple responses where the respondents cited even two or more reasons:

TABLE-3.15: REASONS FOR HAVING PRIVATE PRACTICE

SI No	Reasons	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Better facilities	2	15.4	4	16.6	6	16.2
02	Competitive	1	7.7	3	12.5	4	10.8
03	No time rules	4	30.8	7	29.1	11	29.7
04	Better source of income	6	46.1	10	46.1	16	43.2
	Total	13*	100	24*	100	37	100

*Multiple responses

ATTITUDES OF PRIVATE PRACTITIONERS TOWARDS GOVERNMENT PRACTICE

Perceptions and preference towards having government practice were collected from those practitioners who had only private practice 55% of the Ayurvedic practitioners did not want to have government practice and the reasons cited for this included rules and regulations to be followed, no time flexibility and constraints. 45% of Ayurvedic practitioners revealed they would like to government practice, as it is a

source of 'security', 'constant income'. This data reveals that there is a feeling of 'insecurity' among the private practitioners.

PRIVATE PRACTIONERS AND ORGANIZATION OFPRACT1CE

Additional information was analyzed for respondent in private practice relating to hours of work, place of practice, organization norms of fees etc. This information was collected from two categories of private practitioners, i.e., practitioners who had only private practice and practitioners who had both private and government practice * so the information was collected from 70 practitioners.

HOURS OF WORK

It was found that among the Ayurvedic practitioners, who worked only in the private 40% worked only for less than six hours. While 45% worked for
7 to 10 hours. 15% worked for more than 10 hours. Two third of the practitioners who worked for both set up worked for 7-10 hours. Compared to Ayurveda (12.5%), 44% of Unani practitioners working in both set ups worked for more than 10 hours.

TIMING OF WORK

The time of work was collected from practitioners majority of the practitioners working only privately worked during morning hours and late evening. The practitioners who worked for the government worked only in the evening and late evening so as not to interfere with work time

* refer page number 85, Table 3.6

patterns in the hospital. No significant differences were found for the private practitioners. The female Unani practitioners reported to reach back home 'early' so as to take 'care of home*.

TABLE -3.16: Timings of Work

SI No	Timings of Work	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Morning Hours 9 a.m. to 12 noon	7	15.9	12	46.1	19	27.2
02	Afternoon Hours 1 pm to 3 pm	5	11.3	7	26.9	12	17.2
03	Evening Hours 3 pm to 7 pm	18	40.9	5	19.2	23	32.8
04	Late Evening Hours 7 pm to 9 pm	14	31.8	2	7.6	16	22.8
1	Total	44	100	26	100	70	100

REASONS FOR SELECTION OF THE **PARTICULAR TIME OF WORK:**

Reasons for selection of the particular time of work revealed that majority of the practitioners selected the time keeping the 'availability of patients'. 27% of Unani practitioners reported that the time as suitable for practice as compared to 11.6% of Ayurvedic practitioners.

TABLE-3.17: REASONS FOR SELECTION OF THE PARTICULAR TIME OF WORK

SI No	Reasons	Ayurveda		**Unani**		**Total**	
		No:	%	No:	%	No:	%
01	Patients Available	35	40.6	30	**40.5**	75	**46.8**
02	Suitable for practice	10	11.6	20	27.0	30	18.7
03	Time available	30	34.8	20	27.0	50	31.2
04	Any other	11	12.7	4	5.5	15	9.3
	Total	86*	100	74*	**100**	160*	100

* Multiple response.

PLACE OF PRACTICE

Majority (71.5%) of the practitioners practiced in clinics compared to 18.2% Ayurvedic practitioners there was a greater percentage (26.9%) of Unani practitioners who practiced from their residence. Only 9.0% and 3.9% of Ayurvedic and Unani practitioners practiced in Nursing homes/ hospital thus showing that both the traditional system of medicine have still not gained popularity in Nursing Homes as far as place of practice is concerned.

TABLE-3.18: PLACE OF PRACTICE

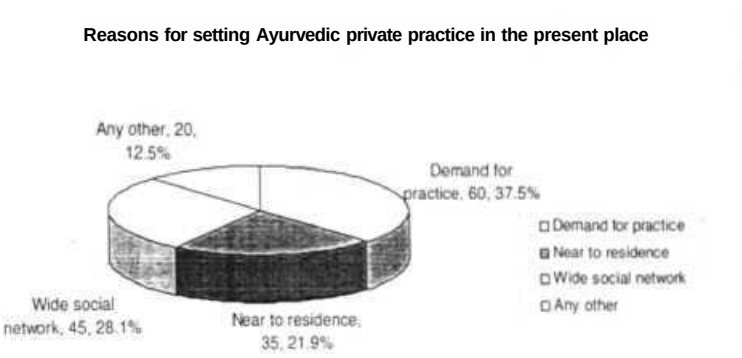
SI No	Place of Practice	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Residence	8	18.2	7	26.9	15.	21.4
02	Clinic	32	72.8	18	69.2	50	71.5
03	Nursing Home	4	9.0	1	3.9	5	7.1
	Total	44	100	26	100	70*	100

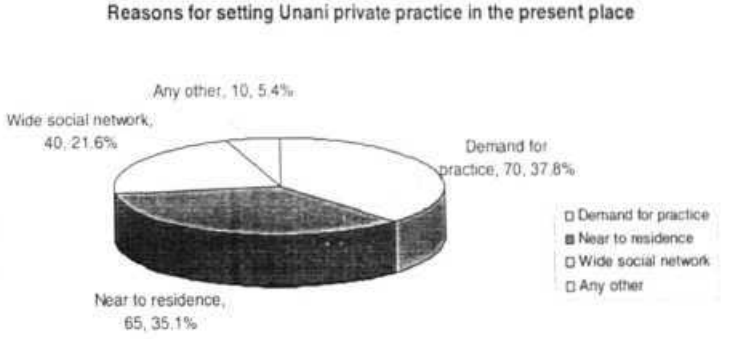
*** Only 70 practitioners practice either privately or private and government.**

REASONS FOR SETTING PRIVATE PRACTICE IN THE PRESENT PLACE

Data revealed that 'demand for work' was one of the major reasons cited by the Ayurvedic practitioners followed by 'wider **social network'.** The Unani practitioners cited 'Near to residence' as the major reason. . The females cited this reason **thus revealing** the **dual role 'the females' play, that of the practitioners and 'woman' of the house**

CHART - 3.2: REASONS FOR SETTING PRIVATE PRACTICE IN THE PRESENT PLACE





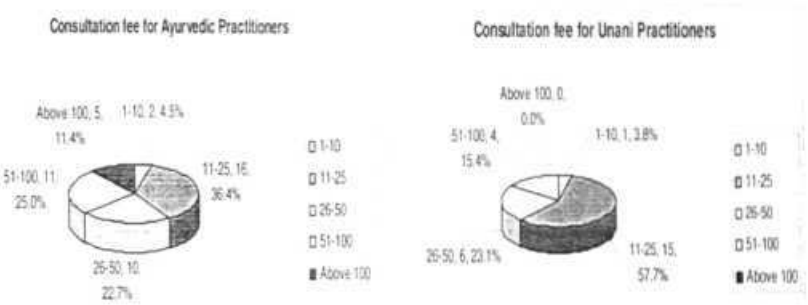
ORGANISATION NORM OF FEES

Consultation fee

Majority of the practitioners charged a consultation fee of below Rupees Twenty Five. But compared to 15.4% of the Unani practitioners

25% Ayurvedic practitioners charged a fee in the range of Rupees 51-100. There were a significant percentage (11.5%) of Ayurvedic practitioners who charged above Rupees 100/-. This shows **that the** consultation fee of Unani practitioners are much **lower** as compared to Ayurvedic practitioners thereby making them available to all income groups.

CHART- 3.3: CONSULTATION FEES



Basis for fee structure

Majority of Ayurvedic practitioners revealed that the 'fee' is constant and it is arrived based on experience of the practitioner, the 'area' where private practice is set up. More than one fourth of the (30.8%) Unani practitioners revealed that the 'fee' is also dependant on the type of case, this may be because the time spent with each patient is calculated and also 'drugs' are given by Unani practitioners.

TABLE- 3.19: BASIS FOR FEE STRUCTURE

SI No	Basis for Fee structure	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Constant	**17**	36.4	**14**	53.8	**31**	**44.3**
02	Type of case	5	**11.4**	8	30.7	13	18.6
03	Experience of practitioner	**17**	38.6	4	15.3	21	30
04	Any other	5	11.3	--	--	5	7.1
	Total	44	100	26	100	70	100

Majority of practitioners revealed that in some 'circumstances' like the economic conditions of the patients, there is a concession of fees. This trend was reported more among the Ayurvedic practitioners.

YEAR OF ESTABLISHMENT OF SETUP

TABLE - 3.20: YEAR OF ESTABLISHMENT

SI No	Year of Establishment	Ayurveda		Unani		**Total**	
		No:	%	No:	%	No:	%
01	Prior to 1980	2	4.5	1	3.9	3	4.2
02	1981-1990	3	6.9	4	15.4	7	**10**
03	1990-2000	31	70.5	19	73.0	50	**71.6**
04	After 2000	8	18.1	2	7.7	**10**	**14.2**
	Total	44	100	26	100	70	100

Information revealed **that** maximum **percentage of Ayurvedic practitioners 70.5% and 73%** Unani **practitioners set up private practice between** 1990-2000. 18.1% of Ayurvedic **practitioners have set up practice after** 2000. as compared to 7.7% **of Unani practitioners who set** up practice after 2000. This shows that there is more **number** of Ayurvedic practitioners setting up private practice as compared **to** Unani practice.

FACILITIES AVAILABLE

Information was collected on the facilities available in the place of practice which included a waiting room, patient registration, instrument for diagnosis, stethoscope, B.P. metal drug availability in the place of practice.

Majority of Ayurvedic and Unani practitioners reported thai a waiting room was available. But the aspect of patient registration was more organized in the setting of Ayurvedic practitioners.

Drug Availability: It was seen that as compared to Ayurvedic practitioners, medicines were available among Unani practitioners

TABLE- 3.21: FACILITIES AVAILABLE

SI No	Facilities	Ayurveda		Unani		**Total**	
		No:	%	No:	%	**No:**	%
01	Waiting Room	36	47.5	22	**4.7**	58	**44.6**
02	Registration	28	36.8	10	18.6	38	29.2
03	Drug Availability	12	15.7	22	40.7	34	**26.1**
	Total	76*	100	54	100	130	**100**

* Multiple responses.

Drug availability meant where **the practitioners prepared the** medicine. This shows that the prevalence to prepare medicine was greater among Unani practitioners. According to the Ayurvedic practitioners, **there are numerous** products in **the market so they needn't lose** time in preparing medication.

According to many practitioners, the preparation of medicine **by** the practitioners is one area where traditional system of medicine differs from allopathy , this aspect indirectly effects the popularity of the system of medicine as the scope for Pharmaceuticals reduces But according to practitioner this is a 'boon' to the patient and 'bane' to the system of medicine. This aspect is subsequently dealt in the chapter while discussing the practitioners perceptions on the quality of drugs.

NEED FOR AN APPOINTMENT

It was found 50% of Ayurvedic practitioners responded there was a 'need' to take an appointment while another 50% responded in negative. This shows that Unani practitioners are more 'accessible' but not 'organized' as Ayurvedic practitioners as far as 'appointment' for patient visit are concerned.

TABLE- 3.22: NEED FOR AN APPOINTMENT

SI No	Need for an appointment	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Yes	22	50	10	38	32	45
02	No	22	50	16	62	38	54.3
	Total	44	100	26	100	70	100

PRACTICE OF INTEGRATIVE SYSTEM OF MEDICINE

Integrative medicine has been an important area of concern among the practitioners of traditional medicine. The practice of integrative medicine can be understood at two different levels:

a) Integrative medicine at the individual level

b) Integrative medicine at the structural level

[a] Integrative medicine at the individual level:

Integrative medicine at the individual level refers to the process where a qualified TSM practitioner practices allopathy besides the system of medicine in which he received training. This aspect has been debated among various sections of practitioners of TSM as they feel this type of practice will affect the popularity of the TSM.

Data was collected from all the respondents regarding the practice of Allopathy. 47.7% exclusively practiced the system of medicine they have been trained in. There were no differences among the Ayurvedic and Unani practitioners regarding this aspect.

TABLE- 3.23: PRACTICE OF INTEGRATIVE MEDICINE

SI No	Exclusive practice of the system of medicine	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Yes	24	48	19	47.5	43	*All*
02	No	26	52	21	52.5	47	52.3
	Total	50	100	40	100	90	100

It was found that exclusively practicing the system of medicine was influenced by the years of practice. As the age of the practitioners increased, resort to modern medicine is restricted. The practitioners who resorted to allopathy in the initial years of treatment stated to have done so for the following reasons: a) the demand of the patients for various reasons like for quick relief b) inability to refuse the patients as they were attempting to establish themselves. Further they were themselves not completely ready to accept the effectiveness of treatment available in the system of medicine they were trained, but carried a feeling that allopathy is 'superior form'. This feeling in them was attributed to their training, as they say the confidence has not been instilled in this regard during their professional training.

Those who have exclusively adhered to the system of medicine they were trained in also resorted to allopathy one time or the other. It was stated by these practitioners that once they achieved established practice, clients were selective in that only those suffering certain specific diseases approached. Such patients approach them only after trying allopathy and so expect treatment with their system of medicine. This made them to resort to exclusive treatment. However, those who preferred exclusive treatment staled that they might use modern medicine in life threatening situations themselves or refer the cases to allopathic specialists.

b) Integrative Medicine at Structural Level:

Practitioners of TSM stated possibility of integrated medicine in two different ways at structural level. One of this relates to making available under one roof all the different systems of medicine. An example of private hospital, which has started this model, was reported. But they desired that this model should be adopted in government sector

for this will improve the popularity of the traditional systems of medicine as well.

Some of the respondents believed that integration is possible through imparting of training to all the doctors both in Modern medicine and TSM as it will help the practitioners to "judiciously treat" the patients from the TSM as well as Modern Medicine. This behavior of the patients using both TSM & Modern medicine for specific diseases has been reported in different studies conducted around the world. (Kakai (2002) (2003), Henderson 2004).

REFERRAL SYSTEM:

Information was collected from practitioners on the referral pattern followed in terms of the nature of diseases bringing about the referrals.

Pattern of Referral:

It was found that referral happened at two levels. The first level of referral occurred within the current system of medicine and the second level occurred outside the current system of medicine, i.e. to different traditional system of medicine or modern medicine.

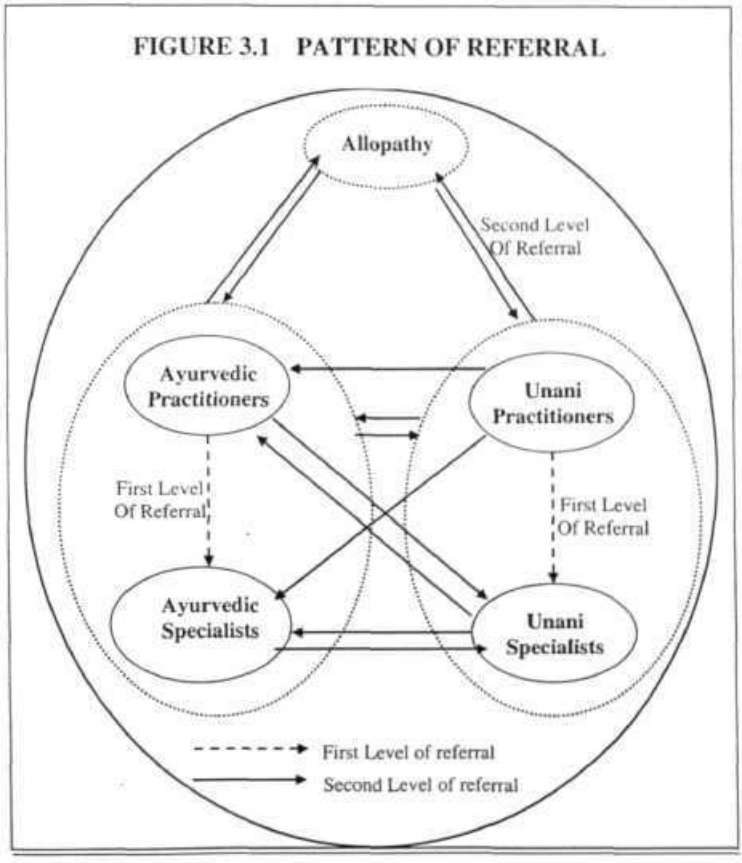
When the referral is within the current system it is from a generalist to a specialist on most of the occasions. Further referral takes place only after the assessment of the patient and the course of treatment.

In case of the second level referrals, i.e. referrals across the systems of medicine one interesting finding have been made. Ayurvedic practitioners or Ayurvedic specialists when referring any case to the Unani system, recommends utilization of the service of a specialist of that system, but a similar finding is not there when referral happens to Ayurveda

practitioners by the Unani practitioners. It was found that this behaviour was mainly due to perceptions of •hierarchy" among the Ayurvedic practitioners, as they perceived themselves to be superior to Unani practitioners.

The Ayurvedic practitioner believes that services of the Unani practitioner need not be encouraged. But in circumstances where there is a felt need, the services of a Unani specialist exclusively will only be recommended. The pattern of referral can be diagrammatically represented as follows

FIGURE 3.1 PATTERN OF REFERRAL

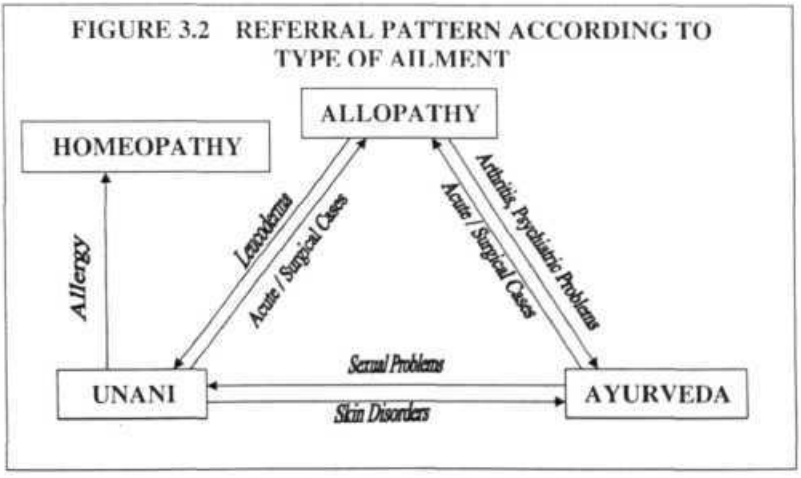


Nature of illness and Referral **Paths**

It was found that commonly referral in Unani happens for skin diseases allergic cases, acute and severe surgical cases. Referrals in Ayurveda happen for acute, severe surgical cases and sexual problems.

. Allopathic practitioners tend to refer cases of leucoderma to Unani practitioners and to Ayurveda for arthritis and psychiatric disorders. Unani practitioners tend to utilize the services of ayurvedic practitioners for skin disorders particularly eczema while ayurvedic practitioners use the service of unani specialist for sexual problems. It was found that there was a strong belief among the ayurvedic practitioners that the main focus of unani medicine pertains to sexual problems but no concrete basis for origin of this belief was found. Referral from ayurveda and unani happen to allopathy for acute surgical cases.

FIGURE 3.2 REFERRAL PATTERN ACCORDING TO TYPE OF AILMENT



ASSOCIATIONS

Information was collected from **the** practitioners regarding the various associations present in Hyderabad and role undertaken by the Associations.

Unani Associations

There are six associations in which two are national associations meant for the Unani practitioners spread across India. The Associations are

(a) Andhra Pradesh Unani Medical Officers Association
(b) Post Graduate Unani Medical Officers Association
(c) All India Unani Tibbi Conference
(d) All Indian Medicine Practitioners Association
(e) All India Unani Tibbi Congress
(f) Old Boys Association
(g) Unani Medical Graduates Association

According to the Practitioners the first two associations are meant for looking after the welfare of Medical officers employed by the government hospitals. This includes raising concerns in areas of promotions, salaries and benefits etc. The second association as the name implies specially cater to the Unani practitioners who are post-graduates. The next two associations are national level associations. According to practitioners, these associations try to promote the system of medicine at the national and international level, by encouraging members to submit paper and holding conference.

The old boys association according to the Unani practitioners belong the non-institulionally qualified practitioners. The Unani medical graduates association is meant for all the Unani practitioners.

These associations according to practitioners try to promote and develop the medicine by conducting medical camps for the government in preventive health by undertaking immunization. These associations also serve as a platform for encouraging fellow practitioners to share the best practices. The All India Association try to bridge the gap between the government and system of medicine as many practitioners feel that government still docs not recognize the potential of Unani medicine.

Ayurvedic Association:

(a) Andhra Pradesh Ayurvedic Medical Officers Association
(b) Post-Graduate Ayurvedic Medical Officers Association
(c) Ayurvedic Medical Graduates Association

The Ayurvedic Association also works under the same principles as highlighted in the Unani association.

REACH AND NATURE OF SERVICES

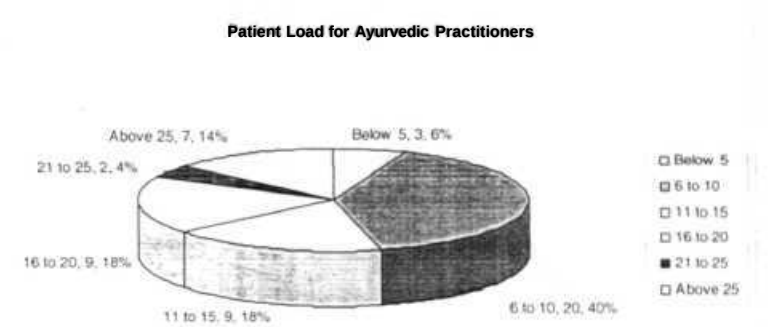
The reach of services is observed in terms of patient loads for practitioners of these two systems of medicine and the nature of services in terms of categories of illnesses treated and also categories of services rendered like medical care, health advice etc.

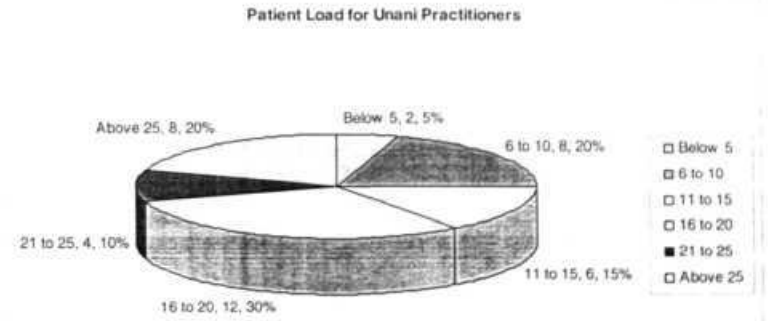
PATIENT LOAD:

Majority (40%) of the Ayurvedic practitioners reported a patient load of ten per day. A little less than one third of the Unani practitioners

reported seeing 16-20 patients per day respectively. 14% and 20% of Ayurvedic and Unani practitioners reported having a patient load of more than 25 patients/ day

CHART- 3.4: PATIENT LOAD





MALES AND FEMALES PATIENT LOAD:

Information was also collected on the number of males and females attended per day. Some of the major findings were 17.5% of the Unani

practitioners never reported of male patients. This was attributed to the fact that as they specialized only in 'gynecological problem' and thereby male patients were not encountered. According to some Muslim female Unani practitioners it was also a 'decision' not to attend to male patients, as they 'do not feel comfortable' discussing matters with the opposite sex. This may be because the 'religion' limits the interaction between the two sexes.

Another interesting finding at the government Unani institutions, was that arrangements were made at the patients registration especially for 'Muslim' patients to refer them to the practitioners of the same sex. This clearly demonstrates the role of religion in determining the practice and utilization of health care.

TABLE- 3.24: MALE PATIENT LOAD

SI No	Male patients	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Nil	-	-	7	17.5	7	7.7
02	Below 5	27	54	11	36.5	38	42.3
03	6-10	16	32	13	32.5	29	32.2
04	11-15	5	10	5	12.5	10	11.2
05	16-20	2	4	4	10	6	6.6
	Total	50	100	40	100	90	100

TABLE- 3.25: **FEMALE PATIENT** LOAD

SI No	Female patients	Ayurveda		Unani		**Total**	
		No:	%	No:	%	**No:**	**%**
01	Below 5	33	66	**19**	47.5	52	**57.8**
02	06-10	13	28	11	27.5	**25**	**27.8**
03	11-15	3	6	5	12.5	**8**	**8.9**
04	16-20	-	-	5	12.5	**5**	5.5
	Total	50	100	40	100	**90**	100

CHILDREN:

There was a significant percentage of Ayurvedic practitioners (34%) and Unani practitioners (25%) who did not attend to children. According to the practitioners, there are usually less children 'utilizing' Ayurveda and Unani, as there is a belief among people that medicines are not palatable and children cannot follow dietary restriction. Another explanation put forward by the Unani practitioners is that there are some diseases, which do not affect children below 12 years like sinusitis, osteoarthritis, hypertension etc. therefore chances for encountering children may be low.

TABLE- 3.26: CHILDREN PATIENT LOAD

SI No	Children load	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Nil	17	34	10	25	27	30
02	Below 5	32	64	20	50	52	57.7
03	6-10	1	2	10	25	11	12.3
	Total	50	100	40	100	90	100

AILMENTS TREATED:

Information on ailments **treated was understood** by analyzing **the most** frequently reported **ailment in a day** and types of ailment treated. The information was analyzed under **these two broad** categories so as to capture any variations, which in turn decreases the chances to miss an illness. This is evident in the data available which highlights different categories of illness in both the unit of analysis.

FREQUENTLY REPORTED AILMENT/ DAY:

The most frequently reported ailment in a day was used as a unit of analysis for two reasons. Firstly it was found that the recall 'for a day' was more precise for practitioners. Secondly it was found that the practitioners generally had a tendency to combine most of the illnesses into broad categories, which restricts the presentation of individual variations. Though efforts were made by the researcher to break down the categories of illness some were presented as it was reported.

Majority (34%) of Ayurvedic practitioners reported 'arthritis' as the most frequently reported ailment / day. This was followed by equal (16%) percentage of respondents reporting 'stroke' and 'common ailment' as the most frequently reported illness/ day. This shows **that** Ayurveda is utilized for 'common ailments' because it is 'accessible' and 'available' for the patients as patients usually use the most available and accessible health services for common ailments.

TABLE- 3.27: FREQUENTLY REPORTED DISEASE/ DAY

SI No	Disease/ Day	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Acidity	2	4	--	--	2	2.2
02	Allergy	1	2	--	--	1	1.1
03	Arthritis	17	34	9	22.5	26	28.8
04	Asthma	4	8	2	5	6	6.6
05	Common Ailment	8	16	3	7.5	11	12.3
06	Gynaecological	6	12	9	22.5	15	16.6
07	Lucoderma	--	--	11	27.5	11	12.3
08	Stroke	8	16	--	--	8	8.8
09	Sinusitis	--	--	5	12.5	5	5.6
10	Hypertension	3	6	--	--	3	3.3
11	Piles	1	2	1	2.5	2	2-4
	Total	50	100	40	100	90	100

Leucoderma was the most frequently reported illness for Unani practitioners. This may be due to fact that Central Research Institution in Unani medicine located at Hyderabad conducts research for leucoderma and thereby the utilization of Unani for this illness is high. According to Unani practitioners, 'famous' allopathic doctors also refer leucoderma patients to Unani.

The frequency of number of illnesses frequently reported in a day is high for the Ayurvedic practitioners compared to Unani practitioners as hypertension, stroke, allergy and acidity were not reported by a single Unani practitioner.

TYPE OF AILMENTS TREATED:

Data on the type of diseases treated by practitioners revealed that though some illnesses were not frequently reported in a day, they were treated by the practitioners. For example, though emotional disorders were not reported in the most commonly reported illness in a day it featured in the type of illness treated.

TABLE- 3.28: AILMENTS TREATED

SI No	Ailments	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Gastric Intestinal Ailment	20	11.5	15	15	35	12.7
02	Common Ailment	14	8.0	5	5	19	6.9
03	Respiratory Ailment	25	14.3	10	10	35	12.7
04	Liver ailment	15	8.6	10	10	25	9.1
05	Skin disorder	15	8.6	35	35	50	18.2
06	Gynecological problem	35	20.3	15	15	50	18.2
07	Rheumatic Disorder	40	22.9	10	10	50	18.2
08	Emotional and Nervous Disorder	10	5.8	--	--	10	3.6
	Total	174*	100	100*	100	274*	100

* Multiple responses.

Data revealed that among the Ayurvedic practitioners, 'rheumatic disorder' and gynecological problems were frequently reported. While among the Unani practitioners, skin disorders were also reported. One interesting finding was emotional disorders were also reported by Ayurvedic practitioners. Ayurvedic practitioners reported that psychiatric disorders were usually referred by allopathic practitioners to the patients.

INFORMATION RENDERED ON PREVENTIVE HEALTH AND MEDICAL CARE

Majority of both Ayurvedic and Unani practitioners rendered information on preventive health and advise relating to medical care like diet restrictions, methods of drug consumption etc. According to practitioners preventive health is an important aspect of both Ayurveda and Unani. *'Swasthavritta'* and *'Sadvritia'* of Rasayana in *'Swaslhaurjaskara'* highlight the code for maintaining better health (Venkatacharya, 1999). Unani medicine lists out six essential factors *'Asbab-e-sitta-e-Zcurooiali'* for preservation of health (Nizamia Tibbi college, 2000) 'Diet and nutrition' is an important aspect in Ayurveda and Unani. It is believed in Ayurveda *"Aaharam lo Vi ha rani"* which means, it is food that causes disease.

According to Unani physicians other than 'food' being an essential factor for maintaining health, dietotheraphy *'illaj bil ghiza'* (Hussain S.J, 2002) is one type of treatment advocated and practiced, where dietetic regulations are emphasized as part of treatment.

TABLE- 3:29: INFORMATION ON PREVENTIVE HEALTH AND MEDICAL CARE

SI No	Information	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Hygiene	40	21.8	21	19.0	61	20.8
02	Diet and Nutrition	48	26.3	39	35.4	87	29.8
03	Importance of Immunisation	15	82	10	9.0	25	8.0
04	Cause and prevention of disease	45	24.0	15	13.7	60	20.4
05	Method of Taking Drugs	35	19.2	25	22.9	60	20.4
	Total	183*	100	110*	100	293*	100

* Multiple responses.

Regarding medical care rendered by Ayurvedic and Unani practitioners, it was reported that 'dietary restriction' to be followed was one of the important information given. Method of taking drugs was also commonly reported as the alteration in time and dosage effect the line of treatment. It was found that information on immunization was also an important information provided by practitioners. According to practitioners, any information that helps the patients to have a healthy life could be passed even if it is not a part of the system.

SERVICES RENDERED IN PREVENTIVE HEALTH:

It was found that practitioners having clinic in "rural" and 'slum' areas only rendered services on preventive health. This was mainly from the allopathic system of medicine. Il was found that nearly eight Ayurvedic practitioners had clinics in slums and four Unani practitioners had clinic in slums.

TABLE- 3.30: SERVICES RENDERED IN PREVENTIVE HEALTH

SI No	Services	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Immunisation for Pregnant Women	4	30.8	4	40	8	34.8
02	Immunisation for Children	5	38.4	4	40	9	39.2
03	Immunisation for Diseases	4	30.8	2	20	6	26.0
	Total	13	100	10	100	23	100

According to practitioners, patients belonging to lower class and rural area cannot go to many practitioners for this service only and it also becomes 'difficult' to explain to the 'patients' that this service is not available in the clinic. It was reported that these services formed a major part of the services rendered thereby the 'income' factor cannot be

ignored. According to Unani practitioners, the medicine recognizes inoculation and immunization as preventive measure against diseases.

PRACTITIONERS PERCEPTIONS AND OPINIONS REGARDING UTILISATION BEHAVIOUR OF PATIENT

According to practitioners the patient load has been increasing in the years. The practitioners reveal that earlier patients of TSM belonged to lower economic background but now even the educated and upper income group have started realizing the positive effects of the traditional systems of medicine and utilize them for various illnesses.

According to most of the practitioners the patient approaches TSM "only after trying every other system of medicine'. When they find no relief in any other system of medicine they approach Ayurvcda or Unani for relief of symptoms. Patients prefer 'utilizing TSM' for specific diseases only or rather utilize it only for chronic disease as they have 'beliefs' regarding 'the system of medicine'

Earlier patients used to ask for 'injection' but now the trend has reduced considerably and this is a positive aspect as it shows that patients treat TSM separately from biomedicine. But according to practitioners the traditional system of medicine is still equated with 'herbal medicine' as Ayurveda medicine is known 'chetla mandulu' and Unani 'jadi bhutiyon ka dawai'.

COMPLIANCE BEHAVIOR OF PATIENTS:

The compliance behavior was understood by enquiring about the percentage of patients who followed the instruction of practitioners in

terms of completion of full course of **treatment,** following dietary restriction **and** method of treatment.

Completion of full course of treatment: Data showed that any aspect of patient health behavior **concerning treatment depended on the** 'convincing' capacity of the practitioner and briefing the patient about the ill effect of different aspects. It was found that older **and** experienced practitioners spend time **with** patient regarding importance of completion of treatment, method of taking the drugs and the role **the diet** plays in restoring the 'normalcy' of the body.

Reasons for non-compliance: The practitioners revealed that there arc various reasons why patients do not strictly comply to the system of medicine. The practitioners reveal that the patient in today's world want a "quick cure' so cannot 'wait for a long time' for relief of symptoms. So they stop the treatment and start taking biomedicine. Following diet patterns depends on the 'life style' of the patient, some people cannot imagine following dietary instruction and the females feel it is additional burden for them to cook separately, so forego this aspect. Nearly 60% practitioners reveal they inform the patients about the pros and cons of not adhering to the rules. According to practitioners when a person does not come back for 'follow up' they assume he has improved and when they do come back for follow up 'the mere gait' and 'appearance' of patient reveals to the practitioners whether he has followed the system of medicine.

Practitioners reported **that they** have 'no problem' when they find that their patients resort to any other system of medicines for current problem.

PERCEPTIONS AND OPINIONS OF PRACTITIONERS REGARDING THE CURRENT SYSYTEM OF MEDICINE PRACTICED

The perception of the practitioners on various issues like commercial drugs, availability of traditional resources in Hyderabad, level of development vis- a- vis biomedicine etc was collected .

PRACTITIONERS PERCEPTIONS ON COMMERCIAL DRUGS

Discussion with the practitioners of Ayurveda and Unani was carried out regarding the quality, affordabilily and availability of commercial drugs.

Availability:

Information regarding the availability of drugs was collected in terms of demand vs. supply. According to the Unani practitioners, there is a 'dearth' of drugs and this is attributed to the lack of pharmaccuticals/ drug manufacturers for Unani drugs. There are only two 'popular and established' drug manufacturers, one is the 'Hamdard' group of industries and another is 'Ahmed and Co' located at Hyderabad. The practitioners reveal that one of the reasons that the pharmaceautical sector is lagging behind in Unani is that there is a belief that this system of medicine is limited to Muslim population only. So the income generated in this sector will be less as 'Muslim form a minority in the population'. According to the practitioners the government should promote the production of the drugs.

According to practitioners marketing of Unani drugs are not on par with the 'ayurvedic drugs'. The marketing strategies undertaken by the

manufacturers is not substantial, enough to make the drugs **easily** 'available'. Another important aspect which was reported by the Unani practitioners was that the Unani **drugs** are available **only** in 'select pockets' of Hyderabad and this may be **one** factor which hinders **the use** of the medicine as 'patient have to come **all** the way to **these** selected pockets to buy these drugs'.

Ayurvedic practitioners reported that there is sufficient **supply** of Ayurvedic drugs. The practitioners revealed presently **there** is a **trend** for the use of 'Ayurvedic drugs' as the concept of healthy living is being promoted in a large way. The growing demand of Ayurveda is encouraging drug manufacturers to take up production of drugs. According to the practitioners the promotion of Ayurvedic drugs take place at a large scale with the help of print and electronic media.

Quality:

The practitioners were of the view that the licensing and standardization of both Unani and Ayurvedic drugs should be strengthened urgently at the national and state level. According to the practitioners the standardization of drugs would definitely help the system of medicine to achieve a 'scientific status'.

But though standardization of drugs are happening, complete full proof system for standardization may not be possible as the practitioner of TSM can officially prepare medicine by themselves. Though guidelines are issued for preparation, the aspect of truly following the guidelines seems questionable. **This** behavior can be looked at as a 'boon' and 'bane' for **the** system of medicine. It is a boon for **the** patients as the practitioners personally prepares the medicine thereby ensuring,

that the products used in the preparation are not of inferior quality. This will be a bane as this may reduce the popularity among manufacturers as they feel discouraged from taking up productions. There is a concern among the practitioner that this trend of preparing medicines encourages the practitioners to maintain 'secrecy' among fellow practitioners for selfish interest, which in turn hinder the growth of medicine.

According to practitioners 'patenting* of drugs should be encouraged among the practitioners and Pharmaceuticals. The Unani practitioners reported that quality of drugs depend on the raw products used in preparation of the drugs and the procedure followed in preparing the medicine. According to Unani practitioners there are many products which are exported from different countries, but in recent time due to different 'policies' of the government, the quantity of raw of products exported do not satisfy the need thereby forcing the manufacturers and practitioners to use products with similar properties as substitutes. Another aspect reported is that there is an effort to cultivate some medicinal plants in India, but this may not provide the desired effect, as practitioners believe if the climatic conditions are different in both the countries the product may vary in quality, if artificial environments are maintained variation of the produce will result. The 'elaborate' procedures outlined in texts which should be followed for production of drugs does not seem 'possible and viable' in today's 'fast world' as nobody can wait for so long and this in turn effect the quality of drugs.

Ayurvedic practitioners revealed that the raw products that are used in medical preparation should be 'picked' for the process during 'specific time of the year' keeping different 'astrological events' as landmarks. But in today's 'world nobody follow the guidelines prescribed in the text'

so as to survive in the market and this may drastically effect the quality of drugs. Commercialization and mass appeal has brought about a considerable change in the appearance of drugs and according to practitioners, this may also affect the quality of drugs.

Affordability:

According to Ayurvedic practitioners, Ayurvedic drugs are 'costly'. This may be due to many reasons, which also include 'commercialization' and 'profit making' motive of the manufacturer. According to the Unani practitioners, the drugs are not 'costly'.

OPINION ON AVAILABILITY OF **AYURVEDIC AND UNANI** RESOURCES **IN HYDERABAD:**

Ayurvedic Resources:

Majority of the Ayurvedic practitioners reported there arc sufficient healing resources in Hyderabad. But one of the major concerns of some of the practitioners was the 'genuinity' of this V number of resources in Hyderabad. According to the practitioners, now days there is a general trend of the public to utilize 'ayurveda' due to 'healthy living concepts with herbal products' and 'quacks' are encashing on this opportunity and opening clinics under the name of Ayurveda in every corner of the city.

Though the clinic will help in increasing the popularity, it will also affect the system of medicine negatively if the authenticity is not checked before utilising the medicine. According to Ayurvedic practitioners, stringent measures should be taken by state before licenses are issued to clinics, measures should be developed to take care of the quality of care at these centers.

Unani Resources:

According to Unani practitioners there is a dearth of Unani resources in Hyderabad as compared to Ayurvedic resources. Another important concern shared was Unani medicine remains concentrated in select areas of the city. According to Unani practitioner's government should promote Unani by opening clinics in different parts of the city. Majority of the practitioners feel that Unani medicine is 'marginalised* as it is 'promoted' as a medicine for the Muslims only but in actuality that is not true. According to practitioners this may be one of the reasons why Unani practitioners do not open clinics. The Unani practitioners opined the view that there is a huge 'potential' within Unani medicine, which needs to be tapped.

TABLE- 3.31: AVAILABILITY OF RESOURCES - PRACTITIONERS RESPONSE

SI No	Availability	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
01	Sufficiently Available	45	90	15	37.5	60	66.6
02	Excess	2	4	-	-	2	2.2
03	Dearth	3	6	25	62.5	28	31.2
	Total	50	100	40	100	90	**100**

LEVEL **OF** DEVELOPMENT **VIS-A-VIS BIOMEDICINE:**

Majority of the practitioners for Ayurveda and Unani were of the view that the development of both Ayurveda and Unani vis-a-vis biomedicine was less. The most common reasons cited by **the** practitioners were lack of state patronage and lack of funds **for** development.

But according to Unani practitioners the development of Unani is less compared to development of Ayurveda too. The reason cited was funds are given according to the size of minority population in the country. So only 15% of the budget for the traditional system of medicine is allocated for Unani.

USE OF MODERN EQUIPMENT AND LEVEL OF CHANGE:

. The practitioners of Ayurveda and Unani supported the use of modern technology and instruments like, stethoscope, sphygmomanometer, x-rays, and laboratory facilities. On being asked regarding the use of these technologies which is not a "part of the system of medicine' practitioner opined the view, these technologies 'help only in facilitating the treatment process' and do not go against the principles of both the system of medicine.

According to practitioners even if they follow the traditional methods of diagnosis like examining the pulse, manual examination of urine and stool and questioning, the patients are not satisfied. As today's patients are more inquisitive and patient expectations arc high about the method of diagnosis the modern technology is helpful to 'satisfy the curiosity' of the patients. This also helps in developing a better perception of the system of medicine. Use of modern technology cannot be exclusive part of only biomedicine on one Ayurvedic practitioners opined 'science is universal' modern equipment is applications of sciences.

According to practitioners the examination and diagnosis of disease by the use of modern technology and dispensation of drugs are some of the areas where change has occurred in both the system of medicine.

LIMITATIONS OF TRADITIONAL SYSTEM OF MEDICINE

No system of medicine is 100% perfect in dealing with **all kinds of** human diseases. Both the system of medicine was **reported to have** limitations. According to Unani practitioners *Abul Qasim al Zahravi* was a great surgeon who wrote *"El-Tasrif* a reference surgery book (Hussain .S.J.2003) but it is not being used extensively. Though "Sushruta' was the first person to conduct 'Rhinoplasty' the aspect was not propagated due to reasons unknown. Scholars have reported that surgery was abandoned during the Buddhist time period

TABLE- 3.32: LIST OF LIMITATIONS

SI No	Limitation	Ayurveda		Unani	
		Yes	No	Yes	**No**
01	Course of Rx for acute diseases	✓		✓	
02	Surgical Intervention	•			✓
03	Dealing with Accident and osteological problems	✓		✓	
04	Life support for terminal illness	✓		✓	

ROLE OF GOVERNMENT TO PROMOTE AYURVEDA AND UNANI: PRACTITIONERS OPINION

The practitioners listed out 'areas' where government can promote the use of Ayurveda and Unani. The practitioners were in union in informing that the government has a major and a very important role in promotion of Ayurveda and Unani according to the practitioners the government should propagate the system of medicine urgently as

according to the practitioners there is a huge population who has no knowledge about Ayurveda and Unani.

Education:

According to practitioners the government should begin propagation at the schooling level to the students as this increases the knowledge about the existence of Ayurveda and Unani. **According to** Ayurvedic practitioners "every student who passes from school know what 'pencillin' is and know who is Alexander **Fleming or William** Harvey are, but how many know what 'Ashwagandha' and who are Charaka or Sushruta is". The Unani practitioners shared a similar view.

State patronage can also be extended by opening up more hospitals there by making it more accessible. Enhancing the facilities in the established hospitals. Encouraging the presence of Ayurvedic and Unani practitioners in allopathic hospitals, which may improve the relationship among the other professionals, as the goal of both the profession is the same.

Another concerned shared by both the practitioners was that the teachers who are selected to teach in the medical colleges of **traditional** medicine should be thoroughly screened for they have **a** great role in developing the potential of the future doctors of traditional medicine.

Research:

The government should support research and development in both the system of medicine in order to achieve scientific recognition. The state **should provide platforms for practitioner to show their experiences** in **national and** international medical conferences of Allopathic medicine.

Cultivation of Medicinal Plants:

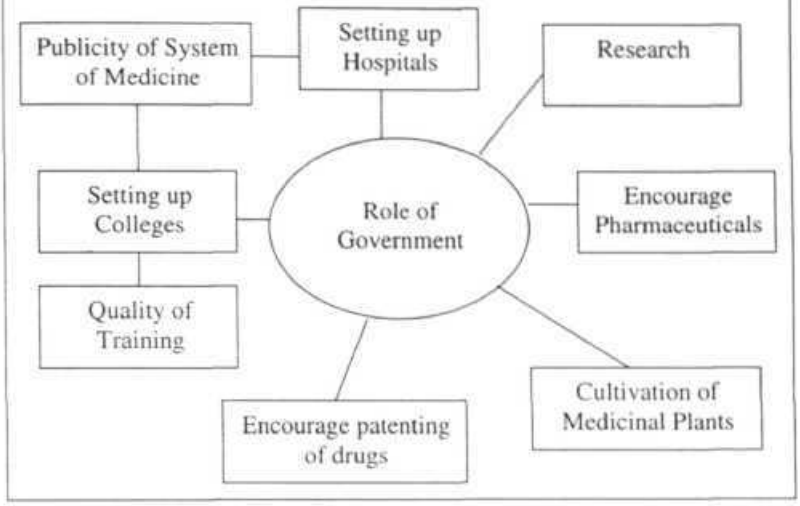
Another area where state patronage is required is encouraging the people to take up 'cultivation of medicinal plants' by granting loans as according to practitioners, there is a dearth of raw materials for production of drugs.

Pharmaceuticals:

According to the practitioners the government should encourage Pharmaceuticals to take up production of Ayurveda and Unani drugs. But according to the Unani practitioners, production of Unani drugs is the need of the hour. Marketing is also essential for promotion of products, with the help of media.

The government should take stringent measures against the quacks setting up clinics in the state, as this will go a long way improving the system of medicine.

FIGURE 3.3: ROLE OF GOVERNMENT



Thus it can be concluded that the practice of TSM is popular and find patronage in Hyderabad. It is still identified by its religious history. The practice is trying to accommodate new changes in the areas of examination and diagnosis by the use of modern technology to keep pace with changing times. The role of the different association was to look into the welfare of the patients and promotion of the system of the medicine.Promotion of a system of medicine depend on the political forces and state patronage. This calls for understanding in in the framework of political economic approach to health care.

Chapter-IV

UTILIZATION: FACTORS EXPLORED

Studies conducted throughout the world have documented that the attributes of the individual, of the disorder and also the service, influence the utilisations of the health service. The present study tries to understand the utilisation patterns of Traditional Systems of Medicine[1] in Hyderabad, which is known for its diverse medical traditions. The pattern of utilization is explained in terms of: a) who utilises (demography and socio-economic profile of patients) b) reasons for seeking care c) the stage of illness at which the care is sought through an understanding of illness behavior of patients in case of different illnesses. This study would represent the 'patterns of utilisation of Traditional Systems of Medicine' of the urban milieu of the country, as Hyderabad is known for its assorted demographic and cosmopolitan profile.

CLIENT **PROFILE**

The study of the patients' socio-demographic and economic features, according to Kroeger's (1983) model is categorised as predisposing factors that influence utilization of any health system.

DISTRIBUTION OF CLIENTS BY AGE GROUPS

Data revealed that majority of the respondents (56.4%) belonged to

[1] Traditional systems of medicine - **In the chapter refer** to Ayurveda and Unani only.

the age group of 21-40 years. The percentage of respondents decreased with increasing age. This trend appears to be similar to findings in other studies relating to utilization of modern systems of medicine. Kopparty 11988,1994), Ramadevi (1994). The reason for this is that relatively greater percentage of members of this group report morbidity. The 21-40 years age group being the 'economically productive' age group there will be less delay in seeking health care amongst them. Further, the social recognition of illness in their case is quicker. However, choice by a relatively greater percentage of members in the age group of 21-40 years in this study can also be due to independent choices made, as they need not depend on the family for any financial help while approaching a health provider of their choice. Most of the respondents in this age group stated to be 'aware' of 'negative side effect of biomedicine' and hence would want to try out health choices' with "minimum side effects'. This may have also contributed to the trend observed in the study. Similarly the fact that this particular age group has an extended 'social network' increases their exposure to wider health choices.

Among the users of Unani, 25.3% belonged to 31-40 years age group which is less compared to 31.4% among the users of Ayurveda. It was found there were no patients in the age group of 0-10 years in Ayurveda and only negligible percentage of patients of Unani for the same age group. This may be because both Ayurveda and Unani drugs are not 'palatable' by children. According to respondents 'palability' is difficult because of the 'taste' and administration of drugs, as most of the drugs are in 'bhasma' (powder form) or in 'Lehyam' (semi solid form) it is difficult to convince the children to consume the drugs and also difficult to ensure that they are

consumed. Instances have been reported where children were not **able** swallow the drugs as they did not know how to do the same. Another reason reported by **the** utilizers was the dietary restrictions prescribed in both **the** systems of medicine. It is generally thought that these **are very difficult to be** practiced by children

The percentage of respondents in the age group of 41-50 years is low for Unani as compared to Ayurveda. Data revealed that the percentage of clients declined after 40 years comparatively for both systems of medicine, respectively. The reason may be that the tolerance thresholds of the 'aged' being 'low' they would want to get back to 'normalcy' at the 'earliest'. As it is also believed that both Ayurveda and Unani systems take longer duration for symptom relief, there is a tendency to choose allopathy for quick relief.

It may also be noted that as the age increases 'dependency' on 'significant others' more particularly on family members increases. This may influence the use of traditional system of medicine, generally and more particularly for the following reason. The preference to use traditional systems of medicine is more for chronic diseases and thus requires many consultations with the providers in frequent intervals. This affects the old, since the required support to take them to the providers so often may not be available as 'availability' in terms of 'resources and time' is dependent on the members of the family. Thus the decisions by the young relating to choice of traditional systems for treatment in case of their older kin is influenced by the access factor.

The data on age groups and utilization reveals that the traditional medicine particularly attracted the members in the age group of 21-40 years. The treatment from this medicine is not preferred in the case of children and less preferred by older age groups is also evident.

Table 4.1: DISTRIBUTION OF RESPONDENTS ACCORDING TO AGE GROUPS

SI. No.	Age Groups	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	00-10 years	-	-	1	1.0	1	0.5
2	11-20 years	15	15.1	10	10.1	25	12.6
3	21-30 years	20	20.2	36	36.4	56	26.2
4	31 -40 years	31	31.4	25	25.3	56	28.2
5	41-50 years	22	22.3	16	16.1	38	19.1
6	51-60 years	7	7.0	10	10.1	17	8.5
7	61+ years	4	4.0	1	1.0	5	2.5
Total		99	100	99	100	198	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO SEX

Women utilizing traditional system of medicine have been reported in many studies conducted around the world. (Dickinson 1996, Thomas et al 2001, Ong et al 2002). There are reasons cited for this behaviour. One of the earliest and simplest reasons is that female usage simply reflects higher rates

of consultation among **women for medical care generally (Royal College of General Practitioners 1986).**

Dickinson (1996) reports that women appear **to be attracted most to** methods promoting general good health whereas men tend to favor an emphasis on the management of an immediate condition. Recent works postulate that women favor a variety of life style programmes which include dietary changes, relaxation and various form of exercise etc., and **that these** lifestyle factors were primary motivators for the use of complementary medicine amongst women but not men (Ong et al 2001). Ong et al (2003) have suggested that women are more likely than men to be **satisfied with the** outcome of traditional medicine. It is in the light of these observations that the data relating to sex and utilization of the traditional systems in the present study is analyzed.

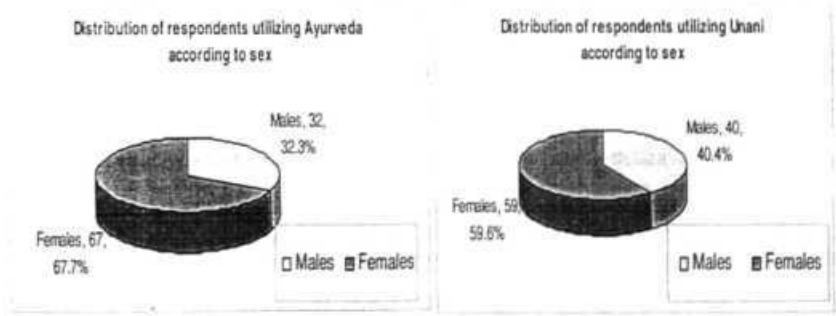
Majority (63.6%) of the respondents utilising traditional system of medicine were females as compared to males (36.3%). However, as compared to females using Unani medicine (59.5%), 67.7% of females used Ayurveda.

According to the respondents, the males mostly being the 'bread winner' would prefer to report back to work at the earliest and would prefer 'medicine' that will being about a "quick relief. At a micro cosmic level the construction of gender roles is evident as female respondents feel that men should not suffer and should be relieved of their suffering at the earliest

thereby facilitating the **men folk to opt for a health care where** normalcy is restored at the earliest.

It was found that utilisation of Traditional system of medicine according to sex depended on the type of illness. Women afflicted with chronic illness' revealed that they cannot 'afford' to 'fall sick'' quite often due to the dual responsibility of taking care of home and children and this would direct them to a health service, where the illness could be completely removed from the roots, and as traditional system of medicine is believed to bring about 'permanent cure', the tendency to utilize them increases. It was also found that women believe that gynecological problems are better treated with Traditional system of medicine add to the greater percentage of women utilising TSM. Studies have shown that women are 'tradition bound' and tend to behave traditionally in all aspects of life, which also includes health care behaviour, thereby increasing the tendency to utilise traditional health choices as compared to men.

Chart 4.1: DISTRIBUTION OF RESPONDENTS ACCORDING TO SEX



DISTRIBUTION OF RESPONDENTS ACCORDING TO EDUCATION

It was found that education was directly related to utilisation of Ayurveda and Unani. Nearly equal percentage of patients of Ayurveda (50.8%) and Unani (52.5%) were educated up to high school level.

Among the 'illiterates patients' there was an increased percentage of Unani patients (9%) as compared to the Ayurvedic (5%) patient. This reveals that 'Unani is popular' among the illiterates also. Nearly one fourth of the respondents using Ayurveda are graduates as compared to 18.2% of Unani patients revealing that 'educated' utilise Ayurveda.

Table -4.2: DISTRIBUTION OF RESPONDENTS ACCORDING TO EDUCATION

SI. No.	Educational	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Illiterate	5	5.0	9	9.0	14	7.0
2	Literates	4	4.0	7	7.0	11	5.5
3	1-12 years High	50	50.5	52	526	102	51.5
4	Graduate	25	25.3	18	18.2	43	21.8
5	Post-graduate	11	11.2	10	10.2	21	11.7
6	Any other	4	4.0	3	3.0	7	3.5
Total		99	100	99	100	198	100

The patronage among the educated may be due to the 'world wide popularity' Ayurveda is receiving in recent times. There by revealing Ayurveda and Unani medicine is popular among the educated class. According to them the negative side effects of Allopathic medicine" is one major reason for utilising traditional medicine.

DISTRIBUTION OF RESPONDENTS ACCORDING TO RELIGION

A little less than three fourth of the patients of Ayurveda were 'Hindus' and another one fourth was Muslims. Where as more than half (55.5%) of the patients of Unani were Muslims while nearly 40% are Hindus. The reason behind this pattern may be because there is a belief that 'Ayurveda' finds its origin in "AtharvaVeda\ which is one of the holy texts of 'Hindus'. So there is a general tendency for Hindus to utilize and 'prefer' Ayurveda to Unani. Like wise as the origin of Unani medicine is traced to Persia and Greece these is a tendency for Muslim to utilize Unani more. The most common responses found among the patients of Ayurveda and Unani was 'that they have been hearing of Ayurveda and Unani' in their families from a long time so preferred using them. Compared to both the system of medicines, it was found that 'Unani' medicine had 'client' practicing different religions there by revealing it may be more 'known' to different ethnic groups. Conversing with the practitioners in their respective 'mother tongues' increases the comfortability of the patient. It was found that majority of the Unani practitioners were conversant in Telugu/ Hindi/ Urdu while Ayurvedic practitioner were mostly conversant only in Telugu and in rare instances were conversant in Hindi. So it can be pointed out that

this also contributes to greater number of **clients from different ethnic groups** utilising Unani medicine, which is not evident otherwise.

Table - 4.3: DISTRIBUTION OF RESPONDENTS ACCORDING TO RELIGION

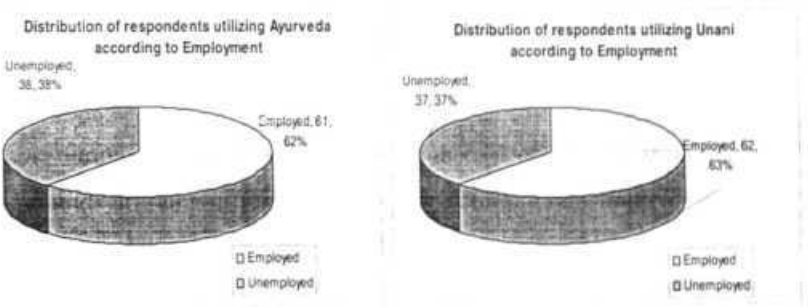
SI No.	Religion	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Hindu	12	72.7	40	40.4	**112**	56.5
2	Muslim	25	25.3	55	55.6	80	40.5
3	Christian	-	-	3	3.0	3	**1.5**
4	Any other	2	2.0	1	1.0	3	**1.5**
Total		99	100	99	100	198	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO EMPLOYMENT

It was found that majority of the patients of Ayurveda (61.6%) and Unani (62.6%) were employed. Thus showing that 'economically independent' group utilised 'traditional system of medicine'. Though further analysis showed that majority of the employed were working in the government and private establishments no significant difference was noted in the type of employment and utilization behaviour. The tendency for the employed to utilize traditional medicine may be due to the 'lay network' one is exposed to in the work place. The wider the scope of 'social network' wider is the knowledge of health care choices inclusive of the traditional

health choices. Choice also depends on the 'previous positive experience' of a patient of Significant other' or of the ' member(s) of ones' social network'. The frequency of encountering 'previous positive experience is more in case of those employed due to the greater number of colleagues from different backgrounds utilizing different health choices for similar problems. But this does not mean that the choices of the respondents are 'forced choices' but they are informed choices as they are economically independent to finally decide which system of medicine to utilize.

Chart - 4.2: DISTRIBUTION OF RESPONDENTS ACCORDING TO EMPLOYMENT



FAMILY PARTICULARS

The characteristics of the patients 'family[1] influences the decision of the respondents to utilise a health service. Illness requires social recognition for any decision of medical care. Health decision are not always 'individual decision' but 'decisions of the family which is taken after enquiries relating

to **different resources of medical care, and hence this discussion on family** characteristics.

TYPE OF FAMILY

Table-4.4: TYPE OF **FAMILY**

SI. No.	Family type	Ayurveda		Unani		**Total**	
		No:	%	No:	%	**No:**	%
1	Nuclear	48	48.5	72	72.7	120	**60.6**
?	Joirt	47	47.5	22	22.3	**69**	**34.9**
3	Any other	4	4.0	5	5.0	9	**4.5**
Total		99	100	99	100	**198**	100

Majority of the respondents belonged to the nuclear family. During discussion with respondents it was revealed that families who are exposed to traditional systems of medicine either by a family member who was a traditional practitioner or utilized TSM earlier, the tendency to utilize TSM reportedly increases. This behaviour was more evident among nuclear families utilizing TSM. It was also observed that the 'increasing attention towards the traditional system of medicine in the health scenario prompts **the** urban population of utilize the traditional system of medicine.

There were a little **more** than one third (34.7%) of respondents who belonged to the joint family. There were a greater (47.5%) percentage of Ayurvedic clients (22.2%) as compared to **the** Unani client who belonged to **the** joint family. Though the proportion of joint families constitute of **only**

34.7%, it is still high when compared **to the** preponderance of **joint families** in Hyderabad. The tendency **for** individuals belonging to joint families **to** utilise Traditional systems of medicine may be because of the 'preference **of** traditional medicine' among the older generation. The preference of TSM among the older generation rests on the firm belief that 'old is gold' as well as its reference on the origin which is traced to 'sacred' and 'Vedic' **text in** Ayurveda.

Majority of Unani respondents have reported to be hearing of the Unani 'Nuskas' from their grandparent from a very early time. Finally it can be concluded living in joint families influence decision to seek treatment from TSM, as 'continuity of tradition' in joint families is more dominating. Continuity of tradition can be seen in terms of continuity of practices and continuity in value systems. Continuity in practices leads to continuity in health practices, where as continuity in 'value systems' leads to significant place for the authority of senior members in the decision-making, health decisions not excluded.

Mohd Aslam (30) is a young educated man working for a private company as an accountant. Aslam lives in a lineally extended family. His father runs a shop that is a family property handed over to this father. One of Aslam's brothers assists his father in running the shop.

According to Aslam though his Grandparents are 'old' they do not require physical any 'help' in daily activities. His grandparents are still the final decision makers in the 'household' regarding all important matters of

family. Aslam's grandmother is very particular, **that the customs and** traditions are followed in the family whether it is relating to marriage, **birth** or any other events in the family. Aslam revealed that other than the formal traditions during ceremonies the 'tradition' of providing home remedies for any health problem is also strongly embedded in his grand mother. According to Aslam there has not been single instance in the family, where his grandmother has not provided or 'nuska[1] for any health problem in the family whether it was a common ailment or a chronic ailment. According to Aslam the next health choice of his grandmother is the Unanni Hakim.

Aslam reveals that any further health choices is decided only after the first two choices fails and this has the been happening since the time he can remember and nobody question this behaviour in the family. The behaviour is accepted without any descent mainly because most of the times 'these health advises' have been helpful and il does not 'harm' anybody by practicing it. But it will definitely affect the value systems of the family if it is not practiced as the 'power of authority' vested to the grandmother is threatened by not adhering to it.

So Aslam justifies that it seemed only 'natural' for him to approach a Hakim when he was suffering from eczema. Initially the problem started with two skin eruptions on his hands as soon as the itching started his grandmother forced him to apply turmeric on the eruptions but after repeated use of the same for around two weeks there was no considerable relief for the same .On the other hand the itching increased and two new eruptions were spotted .The eruptions started oozing with blood and pus .It was then

Aslam decided to approach a health provider and as usual his grandmother compelled him to approach the Unani hakim in the neighborhood. Though initially Aslam had doubts about approaching the hakim he thought he would give a try before approaching an allopathic doctor. This was mainly done to satisfy his grandmother who otherwise will be deeply offended. But fortunately the Unani medicine has been giving considerable relief as the itching has reduced. According to Aslam though the medicine took nearly ten days to give considerable relief he is happy availing the treatment because it is a type of herbal treatment and also because his act of approaching the Unani doctor has kept his grand mother happy. Aslam reveals these small acts help in keeping the family bound together and in the process the traditions are kept alive. Aslam reveals that the tendency to approach 'Unani' medicine is strong in his residence due to his grandmother's influence.

FAMILY INCOME

The annual income of the family was collected as it has been found that it affects the decision of utilizing health care service. Majority (67.7%) of the patients belonged to the middle-income group, whose annual income ranged between. 51, 000 - 3,00,000 Rupees. It was found that 19.2% of Ayurveda clients and 28.3% of Unani clients belonged to the lower income group with an annual income of less than Rs.50,000 while majority of the patients of Ayurveda 72.8% and 62.7% of Unani patient belonged to the middle income group. This data shows that though there are a minor

percentage of patients belonging to the upper income group, Ayurveda and Unani is still utilized and preferred by lower and middle-income groups. But compared to Ayurveda, Unani has a greater percentage of patients belonging to the lower income group and Ayurveda had a greater percentage of patients belonging to middle income group.

Table -4.5: FAMILY INCOME

SI. No.	Income	Ayurveda		Unani		Total	
		No:	%	No:	%	**No:**	%
1	Below 50,000	19	19.2	28	28.3	47	23.8
2	51,000-3 lakh	72	72.8	62	62.7	134	67.17
3	Above 3 lakh	8	80	9	9.0	17	8.5
Total		99	100	99	100	198	100

Case studies of patients revealed that other characteristics of family like the educational status of the family and average age of family also affects the use of traditional medicine. The following case study illustrates **this.**

Satyavati (75) is an illiterate widow staying with her son and his family comprising of his wife and two sons aged 25 and 28 years. According to her both her grandsons are educated and both of them are 'English doctors' (A colloquial term of Allopathy). According to Satyavati she has

been suffering from arthritis from four years. Initially she went to two allopathic doctors, because her son forced her to but there was no relief, as according to her these English medicines produce only temporary relief. Satyavati then started taking treatment from an Ayurvedic doctor from the past two years. According to her now, she has to depend on somebody while approaching her doctor due to her age. But now Satyavati reveals that her grandson want her stop the ayurveda treatment and in one instance forcibly took her to an Allopathy doctor and the treatment was started, so she started taking the Allopathy medicine since two months. Satyavati reveals that after she started taking the allopathic drugs she started having side effects like her body became heated up and the process of digestion was affected and she developed acidity. According to her its because of the strong English medicines she started having all the side effects above all she reports the pains have increased after stopping the Ayurvedic treatment which forced her to return to the 'Ayurvedic doctor'. Her grandsons keep blaming her telling that she did not take the medicine and that is the reason why the pains had reoccurred. But Satyavati feels that the Ayurvedic drugs are suitable for her than allopathy. According to Satyavati it may be due to the 'English education' that her grand children are receiving and the 'young age' that contributes them to 'believe' in the system of medicine, she feel the 'young' still do not realize the potential of the 'old' system of medicine.

ACCESSIBILITY

Accessibility to health services has two connotations: physical and financial. Physical access refers to the distance traveled. However the factor

of distance is also analyzed in terms of travel time, and waiting time to consult the practitioner. Both of these have direct influence on the treatment costs due to increased travel costs, and loss of income due to absence from work. The notion that entry into the system is affected by the distance the would-be patient has to travel to receive care has been strengthened by Shannon et al (1969). He hypothesized that distance served as a measure for several aspects like the physical distance, as well as the time and money costs of travel. In this particular study accessibility of health services was understood in terms of 'distance traveled' by the patient.

Table -4.6: DISTANCE TRAVELED

SI. No.	Distance Traveled	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Less than 5 km	84	84.9	**55**	55.5	139	70.3
2	6 to 10 km	9	9.0	19	19.2	28	14.2
3	11 to 15 km	**3**	3.1	16	16.3	19	**9.5**
4	16 to 20 km	2	2.0	6	6.0	8	4.0
5	More than 20 km	1	1	3	3.0	4	2.0
Total		99	100	99	100	198	100

A little more than two thirds (70.3%) of the respondents reported to be within a radius of five kilometer from the health source they have utilized. This highlights the fact that a 'geographically close' health resource is preferred. Geographical accessibility increases the scope to visit the doctor as frequently when in need there by avoiding the waiting time to see the

doctor. Majority (84.9%) of patients revealed that Ayurvedic resources **are** available at a distance of less than five km from the residence. Slightly more than half of (55.5%) of the Unani patients traveled the same distance. This reveals that patients seeking care from Unani system had to travel greater distances than those choosing Ayurveda. As the two systems of medicine are specifically chosen for certain category of illnesses some members showed no concern to the distance factor. The distance traveled for 'stigmatizing' condition like leucoderma and skin diseases was not only for assured relief but also with an intention to conceal the identity of the effected.

Zaheera (16) is a young girl who is studying in the 12th standard According to her parents she is a very brilliant and intelligent girl. She is also a very religious girl and read the holy quran everyday and also takes classes for young Muslim children on the Holy Scripture. According to her parents this a 'divine gift' received only by a few which requires lot of attention and patience. According to her parents this activity brings about lot of changes in the body also. Zaheera's mother revealed one day she noticed a small white patch on the Zaheera face between the eyebrows. Initially some 'ointment' was applied then thinking it was an allergic reaction, then they approached allopathic doctors who prescribed some ointment and vitamin tablet stating it as a vitamin deficiency. There was no relief even after consuming the medicines. So another allopathic doctor was approached who diagnosed it as 'Leucoderma' According to the parents they were 'shocked' as Zaheera was a 'young girl' and this 'condition' will be a hindrance for her life in every way, especially when she would be of

'marriageable age'. So her parents approached a popular and famous skin specialist for treatment but to no avail, there was no sign of the patch reducing in size, but another small patch appeared on the neck. Meanwhile Zaheera's father came to know of the 'Unani' medicine from his colleagues, which was revealed to be very suitable for then ointment. Zaheera and her family are located at a distance of 25 km from this health service. But according to her parents they did not want to waste any further time and rushed to this hospital in search of cure. According to Zaheeras mother they have been coming here for six months and the patch seem to be reducing on being asked whether the distance traveled to health service was not an hindering factor, she opined the 'health' and 'future' of the child is more important than any thing else and they would travel even longer if there is a 'quicker cure' for the problem. According to her mother this is also a 'blessing in disguise' as people in the locality are not aware that the family visits the hospital for the problem.

HEALTH SEEKING BEHAVIOR

The health seeking behavior was understood by analyzing the illness suffered and the various actions undertaken by the respondents to treat the current illness. This was mainly done to see at which stage of the illness treatment from traditional medicine is sought.

NATURE OF ILLNESS

To understand the utilisation pattern it is essential to know the illnesses for which Ayurveda and Unani treatment was utilized. It was found

that **the** respondents of **Ayurveda and Unani reported 11 broad categories of** illnesses.

Table -4.7: ILLNESS SUFFERED

SI. No.	Current Illness	Ayurveda		Unani		**Total**	
		No:	**%**	No:	**%**	No:	**%**
1	Asthma	7	7.0	**5**	**5.0**	12	6.0
2	Acne	6	6.0	**10**	**10.1**	**16**	8.0
3	Back ache	10	10.	**5**	**5.0**	**15**	7.6
4	Gynecological Problems (Leuchorea, Menstrual Problems etc.)	18	18.1	**9**	**9.0**	**27**	**13.7**
5	Hepatitis	-	-	**2**	**2.0**	**2**	1.0
6	Joint Pains (Arthritis)	21	21.3	**17**	**17.2**	**38**	19.2
7	Lucoderma	9	9.0	**20**	20.3	**29**	14.9
8	Sinusitis	4	4.0	**3**	**3.0**	**7**	3.6
9	Skin Infection (Ezcema, Fungal infections, etc.)	11	11.3	**14**	**14.1**	**25**	12.6
10	Stroke (Hyper Tension, Paralysis, etc.)	2	2.0	-	-	**2**	1.0
11	Any other (Common ailments like fever, cough etc.)	1	1.0	**8**	**8.0**	**9**	4.6
Total		99	100	**99**	100	**198**	100

Relatively majority (21.2%) of Ayurvedic patients reported using Ayurveda for Rheumatic and Arthritic related problems but Unani medicine was utilized by a majority of patients (20.2%) for 'Lucoderma'. It was also noted that Ayurveda and Unani were utilized for common aliments also. Compared to Unani grater number of Ayurvedic patients (18.2%) utilized Ayurvedic treatment for common ailments. The illnesses reported by the Ayurvedic and Unani patients were more or less the 'same' except in case of 'paralytic strokes' and Hepatitis', where Ayurveda was used for the former and Unani for the later. This commonness to utilize both Unani and Ayurveda for more or less for the similar problems may be because majority of the patients conceptualize and equate both the systems of medicine to "herbal medicine'. This issue is more elaborately dealt subsequently in this chapter while dealing with 'conceptualization of great tradition of medicine'

DURATION OF ILLNESS

Data was collected regarding the duration of illness for which treatment was sought.

Majority of the patients in Ayurveda (61.4%) and Unani (55.3%) reported that their illnesses had existed for more than six months. The illnesses lasting for more than four years were mostly Asthma, Arthritis, Chronic Back Aches and Lucoderma.

Table -4.8: DURATION OF ILLNESS SUFFERED

SI. No.	Duration of Illness	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Less than 10 days	6	6.0	5	5.0	11	**5.5**
2	11-30 days	7	7.0	21	21.3	28	**14.1**
3	More than one month to 6 months	25	25.3	19	19.2	44	22.3
4	7 months to one year	22	22.2	32	32.3	54	27.3
5	More than one year to 2 years	21	21.2	7	7.0	28	14.2
6	More than 2 years	18	18.1	15	15.2	33	16.6
Total		99	100	99	100	198	100

CLASSIFICATION OF REPORTED ILLNESS

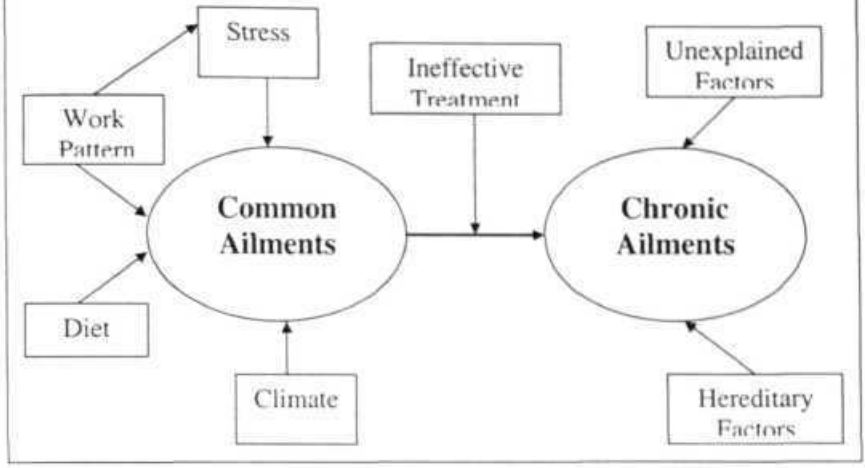
Different explanations were cited by the respondents on the types of illnesses. Respondents generally categorized illness in terms of: 'Illnesses which were normal' 'illnesses which appear suddenly', 'common aliment', 'chinna rogalu' and 'pedda rogulu", and illnesses which remain for long time

Respondents cited numerous **causes** for an illness. As Kleinman (1980) point out individuals are likely to have quite vague and indefinite models of explanation for their illnesses, depending on past experience of the patient and her/his circle of kin and friends. Further, these explanatory models do change after their repeated encounters with the physicians and others. In the present context the concepts of explanatory model developed by interpretative anthropologists cannot precisely be used, as the explanations are for various sets of diseases rather than to a specific disease category.

According to respondent's common ailments are caused due to external influences like climate variation, diet, work patterns etc. Chronic ailments were defined as illnesses, which affected the internal parts of the body. Chronic illnesses are caused due to 'unexplainable factors' or mostly due to 'hereditary factors'.

Respondents reported that common ailment if not treated effectively will develop into chronic ailments as the cause still remain in the body and the internal parts are affected causing symptoms to reoccur and manifest as 'bigger illness'. An example cited was that of common cold and cough. According to some respondent if the 'cold and cough' is not treated and if it goes on reoccurring it will effects the lungs and this will develop into Asthma.

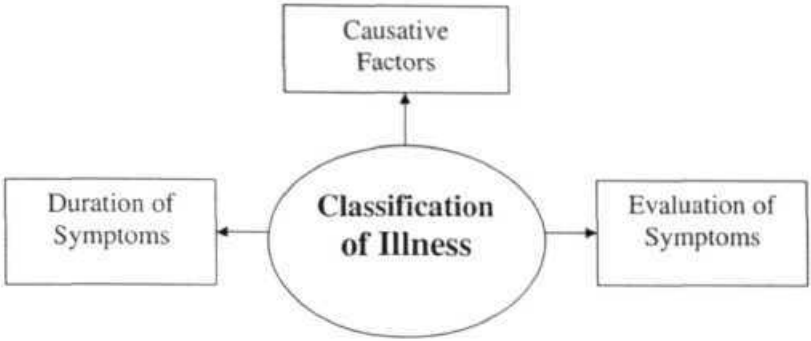
Figure 4.1: PERCEPTIONS OF RESPONDENTS FOR CAUSATIVE FACTORS OF ILLNESS



The respondents opined that, the tendency for the common ailment to develop into serious illness increases with the presence of 'Hereditary factor'. For example the tendency for skin allergies of a patient to develop into eczema is high if it is not treated and if there is a family history of the same

Other than the causative factor for classification, the evaluation of symptoms and the duration of symptoms are also important factor for classification of illness.

FIGURE 4.2: CLASSIFICATION OF ILLNESS BY USERS OF TRADITIONAL SYSTEMS OF MEDICINE



In common ailments, the symptoms do not last for more than two-three days but where as in chronic aliments the symptoms keep on reoccurring after certain time period intervals and if it reoccurs even after six months then it is termed as chronic ailments.

Table-4.9: CATEGORY OF AILMENTS

SI. No.	Ailments	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Common Ailment	38	38.3	22	22.3	60	30.3
2	Chronic Ailments	61	61.7	77	77.7	138	69.7
Total		99	100	99	100	198	100

An effort was made to classify the ailment reported by patients under broad categories of common and chronic aliments

Data showed that majority of Ayurvedic and Unani patients sought treatment for illness caused to be chronic. But it was found that the reasons why Ayurveda and Unani was used for 'common ailment[1] is different from the reasons why Ayurveda and Unani was used for 'chronic Ailments'. (This will be dealt in reasons for choice of therapy according to type of illness).

ACTION TAKEN AFTER ONSET OF SYMPTOMS

Table -4.10: ACTION TAKEN AFTER ONSET OF SYMPTOMS

SI. No.	Action taken	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Self Medication	70	70.7	60	60.6	130	65.6
2	Medication on Advice of health provider	24	24.3	29	29.3	53	26.8
3	No Action	5	5.0	10	10.1	15	7.6
Total		99	100	99	100	198	100

Majority of Ayurvedic (70%) and Unani (60%) patients used self medication before approaching a health provider. This finding supports Kleinman (1980) health care Model, which constitutes the popular health sector. According to Klienman's the 'popular health sector is the largest part' which is general body of knowledge managed entirely at the household level. On discussion with patient it was found that self-medication was majorly carried out by Allopathic medicine. But instances were also reported, where Ayurvedic and Unani drugs were used. This behaviour was evident only among the patients who had previously used the system of medicine for the similar problem or had been exposed to the system of medicine by a family member.

Sandhya (25) is a married working woman living with husband and two children. Sandhya was suffering from some indigestion problem. According to her, she immediately had an Ayurvedic medicine for relief. Sandhya stores some Ayurvedic medicine for minor ailment and use it whenever needed and most preferably as the 1st choice of self medication. When asked how she knows of the utility of medicine she replied that earlier when she was faced with the similar problem she had approached an Ayurvedic doctor who had prescribed the same medicine. According to Sandhya another factor that prompts her to self medicate with Ayurvedic drugs is that her maternal uncle was a practitioner and thereby she came to possess some knowledge about ayurvedic medicine. But to Sandhya her problem did not subside with the self-medication so she came to an Ayurvedic practitioner. According to her she always prefer to go to an Ayurvedic practitioner first as the system of medicine is 'safe' and she has

been using it for a long time. But according to Sandhya when her children aged (7) and (4) Years is affected, usually an allopathic doctor, is preferred as she feels her children will not be able to 'consume' the type of medicine due to the bitter taste.

TYPE OF HEALTH PROVIDER APPROACHED

Table -4.11: TYPE OF HEALTH PROVIDER APPROACHED

SI. No.	Type of Provider	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Bio medicine	12	50	14	48.3	26	49.0
2	Ayurveda	6	25	5	17.3	11	20.7
3	Unani	1	4.2	4	13.8	5	9.5
4	Homeopath	4	16.6	2	6.9	6	**11.3**
5	Any other*	1	4.2	4	13.7	5	9.5
Total		24	100	29	100	53	100

"Any other refers to herbalist/magi co religious healer

Only 26% of the respondents approached a health provider immediately after the onset of symptoms. Thus, it is evident that majority have either resorted to self medication or have preferred not to take any medication. Information on type of health provider visited revealed that Allopathic doctors were the first choice for most respondent among both the Ayurvedic and Unani patients. However, it was interesting to note among the Unani patients 17.3% visited an Ayurvedic doctor before utilizing Unani system of medicine. But only one Ayurvedic patient utilized the services of

an Unani doctor first. The data highlights that though an Allopathic doctor is the first choice for many, Ayurveda and Unani are also approached by quite significant proportion as their first choice

SHOPPING FOR PRESENT ILLNESS

Table - 4.12: NUMBER OF PROVIDER APPROACHED PRIOR TO UTILIZING THE SERVICES OF THE CURRENT PROVIDER

SI. No.	No: of Provider	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Nil	14	14.2	10	10.1	24	12.1
2	One	13	13.2	5	5.1	18	9.0
3	Two	20	20.2	8	8.0	28	14.2
4.	Three	19	19.2	16	16.1	35	17.6
5	Four	19	19.2	14	14.2	33	16.6
6	Five	4	4.0	22	22.2	26	13.2
7	Six	6	6	16	16.2	22	11.2
8	Above six	4	4	8	8	12	6.0
Total		99	100	99	100	198	100

The 'shopping for treatment' is analyzed in terms of number of health providers consulted for the present illness prior to availing the services of current health provider. A little less than one-third of the respondents approached five or more providers. The data also showed that the number of providers consulted were more for the unani patients. 22.2% of the Unani patients consulted five health providers before approaching the

current health provider. Whereas majority of the Ayurvedic patient (20.2%) consulted two health providers before consulting the current health provider.

Savithiri (45) is a housewife and holds a bachelor's degree in Science. Savithirs husband is working for a famous Pharmaceutical company as the general manager. Savithiri is suffering from Asthma from the past 5 years. According to Savithiri initially the problem started as 'wheezing' and 'recurrent' 'colds'. Then the wheezing in creased and she used to initially take Allopathic medicine to control the symptom. According to Savithiri she became and 'Asthmatic' and started having severe breathless attacks. She initially went to an Allopathic doctor who used to give her medicine but according to her this medicine gave her only a 'temporary relief. So she switched to another allopathic doctor who put her on to an inhaler. She has been using the inhaler for the past three years. According to her the treatment was effective but her husband was 'transferred' so she again had to change the provider. According to her by then it was nearly two years she was on allopathic drugs and her husband 'felt' it was not good to be taking allopathy for a long time as it may produce side effect. She was suggested to either approach a homeopathy or Ayurvedic doctor but she chose the former, as he was 'close by' to the home. But Savithri revealed that after she chose the homeopathic doctors the symptoms increased and she resorted back to an allopathic doctor to control the symptoms. But again she changed the doctor as the doctor was far way and as there was no relief in symptoms. Then her friend suggested she visit Ayurvedic doctor, as it may be 'helpful'. But Savithri was against the idea as she heard that she has to follow strict dietary restriction, for which she was not prepared and was managing with

allopathic drugs. But according to her the frequency of attacks increased, which effected her normal functioning also. Assistance was also required to even stand up during attacks. So it was then she decided she would approach an Ayurvedic doctor.

In the meantime she also approached the 'Bathini goud brothers' and was under treatment for asthma but of no avail. So she finally decided to approach an Ayurvedic doctor and according to her she feels much better after starting the treatment for the past six months .She feels its the best line of treatment she has received so far, as the frequency of breathless attack have reduced considerably . According to her the hardship like dietary restriction she follows is helping her and moreover it s nothing compared to the 'difficulty' she has during the attacks and thereby will follow the treatment.

MOST RECENT TYPE OF PROVIDER CONSULTED PRIOR TO AVAILING THE SERVICES OF CURRENT PROVIDER

More than half (51.3%) of the patients consulted allopathic health providers prior to the one from whom they are presently obtaining treatment. But as many as 10% have reported to have approached a folk herbalist or a magi co-religious healer

It was found that (76.8%) Unani patients consulted Ayurvedic practitioner before shifting patronage to Unani medicine. This shows that patients have left the 'realm of Ayurveda[1] for seeking treatment, but this was

not noticeable among Ayurvedic patients as far as seeking Unani treatment was concerned. This trend cannot be confidently asserted as the data was analyzed for the last provider consulted rather than 'all the type of providers consulted" before approaching the current health provider.

Table -4.13: RECENT TYPE OF HEALTH PROVIDER APPROACHED

SI. No.	Type of Provider	Ayurveda		Unani		Total	
		No:	%	**No:**	%	**No:**	%
1	Allopathy	41	48.3	48	53.9	89	51.3
2	Homeopathy	23	27.0	15	16.8	38	21.8
3	Ayurveda	11	12.9	6	6.8	16	9.2
4	Unani	-	-	12	13.5	12	6.8
5	Herbal / folk	3	3.6	2	2.3	5	2.9
6	Any other	7	8.2	6	6.7	13	7.5
Total		85	100	89	100	174	100

It was also found that two practitioners of the same system of medicine were consulted for the current illness. 12.9% and 13.5% of Ayurvedic patients and Unani clients, respectively reported that the previous health provider they consulted was of the same system of medicine. The reasons listed for this behaviour included: difficulties of access due to distance, inability of the provider to give sufficient attention; 'high' treatment cost. It was also found that the referral pattern contributed to this as the practitioners frequently referred their patients to a specialist of the same system.

Syed Bin Afzal (40 Years) in a middle age man working with the government as a clerk. Afzal is a diabetic since two years and he has been on Allopathic drugs from the day he was diagnosed as suffering from diabetes. According to him though he has been taking the medicine the 'glucose count' has in creased and he has been advised to take insulin. But his friends advised him to try out the Unani medicine before he takes 'insulin'. So after enquiring with his peer group and his family regarding Unani doctor he approached a Unani doctor. But according to Afzal in the very first visit to the Unani doctor, the doctor reviewed the case and referred him to an Unani specialist who specialized in treating Diabetes. According to him he is under treatment from the past two months and the glucose count is relatively under control.

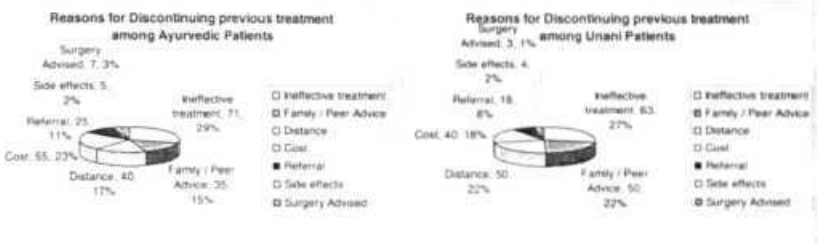
REASONS FOR DISCONTINUING PREVIOUS TREATMENT

Multiple reasons were reported by patients for discontinuing the treatment from previous provider.'Ineffectiveness' of the previous treatment was the major reason followed by 'treatment cost', side effects and 'distance' in this regard. Family advise was reported by 16.6% of respondent, but it was found that compared to Ayurvedic patients, Unani patients reported this reason more often. This reveals that 'role of family[1] was important particularly in case of those choosing treatment from Unani practitioner. 'Referral by the previous provider' was also cited as a reason, but this was mostly in case of Ayurvedic patients than unani patients.

'Surgery' being prescribed was also one of the reasons for discontinuing treatment. A very significant percentage of patients among

those who have been advised surgery did not perceive 'surgery' as an 'ultimate choice' to their ailments. This perception may be facilitated due to the presence of alternate forms of treatment, which do not encourage surgery and due to the perceived risks involved in surgery.

Chart –4.3: REASONS FOR DISCONTINUING PREVIOUS TREATMENT



REASONS **FOR CHOOSING AYURVEDA / UNANI FOR CURRENT ILLNESS**

Reasons for choosing the system of medicine for the current illness were found to be by and large multiple. However that the previous treatment was ineffective as the reason or one of the reasons was stated by only 25.9% and 30% of ayurvedic and Unani respondents respectively. This concludes that treatment for Ayurveda and Unani is sought not just for 'cure' but also for 'better cure'. 'Better cure' on many occasion meaning removal of 'real cause'.

'Accessibility' of the facility as one of the reasons was reported by greater number of Ayurvedic patient that Unani. thereby revealing that 'Ayurveda' is more accessible and available than Unani. The treatment being 'relatively in expensive' was reported by Ayurveda and Unani patient. But this characteristic is better understood in comparison to the treatment availed in an Allopathic Clinic.

Table -4.14: REASONS FOR CHOOSING AYURVEDA / UNANI FOR CURRENT ILLNESS

SI. No.	Reasons	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Faith in the system	55	21.9	45	22.5	100	22.2
2	Accessibility	75	29.8	35	17.5	110	24.3
3	Family Advice	35	13.9	40	20	75	16.7
4	Previous treatment ineffective	65	25.9	60	30	125	27.8
5	Individual Reasons (Positive previous experience. try it out)	21	8.5	20	10	91	9.0
Total		251	100	200	100	451*	100

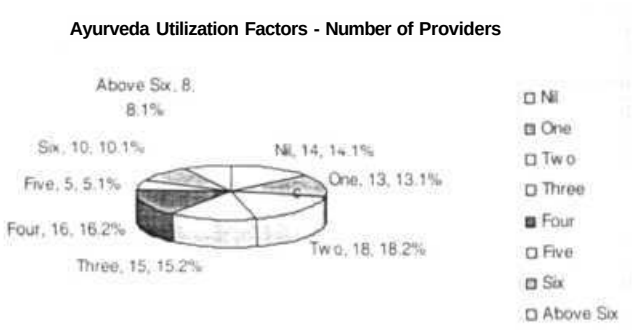
* Multiple responses

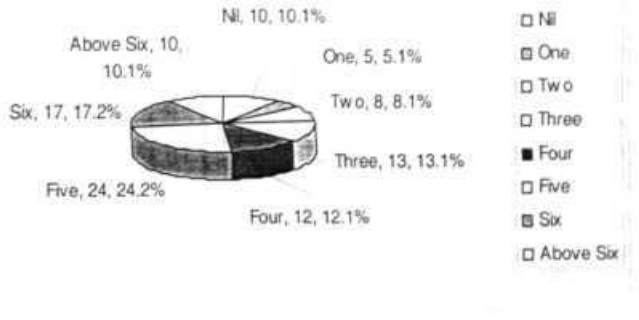
Date showed that 'faith in the system' of medicine is also an important reason for choosing the current system of medicine. This reveals that belief frames perceived by the individuals influence the utilisation of health care as

belief frames goes a long way in strengthening **the** 'faith in the system of medicine'.

CHOICE OF THERAPY

Chart -4.4: NUMBER OF PROVIDERS PRIOR TO APPROACHING TRADITIONAL SYSTEMS OF MEDICINE DURING THE ILLNESS





While trying to understand the illness behaviour it was found that for 14.1% Ayurvedic and 10.1% Unani patient used Ayurveda and Unani as the 1st choice of treatment after the onset of symptoms. For majority of the Ayurvedic patients, 'Ayurveda was the 3rd choice and Unani was the 6th choice of treatment.

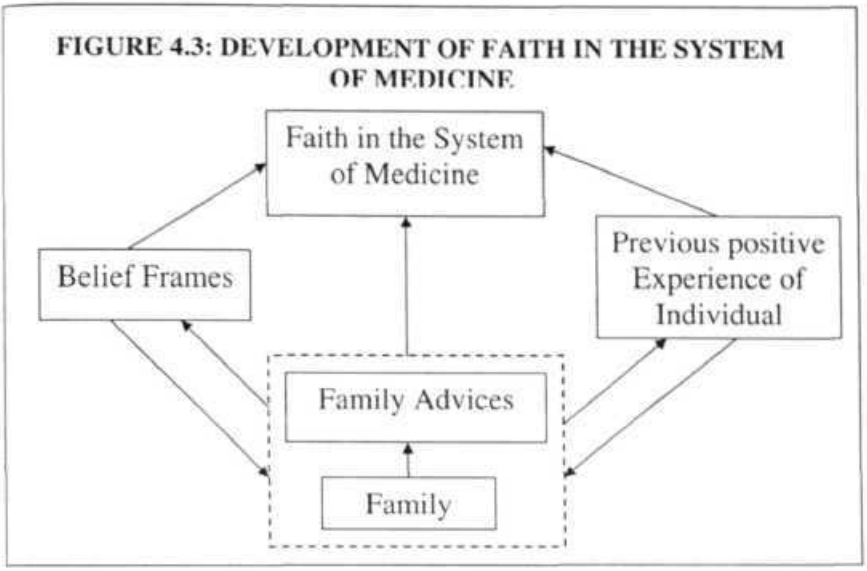
It is attempted to segregate the reasons for selection of these systems as the first choice of treatment and also for not preferring them as a first choice.

FIRST CHOICE OF THERAPY

No significant differences were found for the patients of Ayurveda and Unani while choosing the respective system of medicine as the lsi choice of treatment. "Faith in the system of medicine' and 'accessibility' was two major reasons cited by respondents while utilizing it as the 1st line of treatment.

It was found that 'faith in the system of medicine is a conglomeration of various features. It includes previous positive experience of the individual or of the significant other in the family. The 'previous experience' increases the incidence of 'family advices', which further strengthen the 'faith in the system'. The belief frames held by the individual are not always conceived by the individual himself on his own, but by being a part of the family. This again positively contributes in increasing the 'faith in the system'.

FIGURE 4.3: DEVELOPMENT OF FAITH IN THE SYSTEM OF MEDICINE



'Faith in the system' is crucial while deciding the line of treatment as when 'faith' is strong, it acts as a determining factor rather than as a contributory factor. Thus in such cases, the determining effect of 'accessibility' particularly diminishes.

Information collected form the respondents who did not utilise Ayurveda and Unani as the 1st choice of treatment showed that perceptions like 'slow cure', dietary restriction etc. relating to these systems were major factors that hindered the use of the system of medicine initially. Lack of knowledge of the systems and also problems of accessibility was reported in this regard. .According to respondents the reason for choosing the current

system of medicine later, was 'ineffective treatment[1], family pressure and peer group advice. Instances were also noted where respondents were not satisfied with the 'previous treatment' as 'side effects' were encountered and reoccurrence of symptoms when 'medication' was 'stopped' was reported. According to respondent the suffering undergone by the patients during an illness prepare them mentally to take up 'hardships' like following 'dietary restriction' 'long treatment[1] etc. so as to attain a cure.

Ashish is 33 years old married software professional. He has been suffering from acidity from one year according to him he developed the problem due to his irregular eating habits, which include eating late and snacking with fast foods.

Ashish initially started taking antacid on his own, but the 'Antacid' gave him only temporary relief and he started developing severe pain in the abdomen. So after self-medicating he approached an Allopathic doctor who prescribed some drugs which also included 'antacids' for a period of 15 days. But Ashish reveals that even after using the medicine required there was no relief and symptoms reappeared after medication was stopped. According to Ashish the problem started to aggravate as he started to develop new symptoms like 'vomiting' which according to the doctor was due to gastritis. Ashish reveals that the problem started affecting him so badly that he even had to absent himself from work In the meantime Ashish started to seek information about the problem from his colleagues and on the advice of one his colleague who had experienced a similar problem he visited a popular health clinic.

According to Ashish the practitioner in **the** clinic collected a history of the case and also inquired about his lifestyle. Ashish was given a treatment for two weeks and was also advised to avoid certain foods which were acidic and was recommended to bring about a change in his eating habits. According to Ashish the drugs prescribed was to restore the body to normalcy and 'diet restriction and change in lifestyle' were prescribed for retaining the normalcy. According to Ashish the symptom had reduced after 15 days of treatment. He returned to the practitioner for 'a follow up' as advised. Another set of drugs was prescribed to be consumed for a fortnight. Now after one month of treatment and maintaining the dietary pattern Ashish experiences a 'great' relief from the symptoms and believes that 'the regime has also improved his total well being'. When questioned whether he would continue to follow the diet regimen Ashish replied he will definitely 'continue' to do so as this has only benefited him by keeping the symptoms at bay and obviously it is better than taking 'Allopathic drugs' all the time. According to Ashish its better to enjoy life by not consuming some foods than consuming all the foods and also a load of drugs as definitely these drugs in the long run is bound to show some negative side effects.

CHOICE OF THERAPY ACCORDING TO ILLNESS

The reasons for choice of Ayurveda and Unani differed with relation to the illness suffered (i.e.) the reasons why Ayurveda and Unani were chosen for 'common ailments' was different from reasons when Ayurveda and Unani was chosen for a chronic illness'.

The respondents approached Ayurveda and Unani for common ailments when the treatment facility was 'accessible' i.e. 'close by' and due to 'faith in the system of medicine'.

Shaheeda (28) is a young married lady suffering from fever since two days. She wanted to approach a doctor for availing treatment. According to her she usually approached the clinic i.e. the Unani clinic that is 'close' to her home. According to her she uses the clinic only because it's close to her home as she need not waste her time 'traveling' and can avail treatment quickly. According to her the Unani medicine has given her relief whenever she has used it and will approach another doctor only if there is no relief of symptoms Shaheeda reveals that all her family members also utilized the facility as its is near to the residence

The respondents approached Ayurveda and Unani for chronic ailment due to assured 'permanent cure' and removal of the illness from the roots. Another important reason was to avoid the 'side effects' caused by continued use of drugs in chronic conditions when they were under allopathic treatment earlier.

Respondents felt that these systems were suitable and preferred for 'chronic ailments'. According to Dr.Syed Arbar (2000) this may be due the fact that 'complaints in chronic ailment are tolerable' so people may be ready to use new health choices on a trial basis and also the long term use of other system of medicine cause side effects, so to overcome this effect patients start utilizing Unani. According to patients utilisation of Ayurveda and Unani may be restricted for some ailments due to the belief prevalent in the society which include that traditional medicine 'take a long time to cure'.

PATTERNS OF RESORT

The pattern of resort was understood in terms of whether Ayurveda and Unani were being used exclusively as a form of treatment or a as a complementary form of treatment for the reported illness. Exclusive form of treatment is referred as a practice where only Ayurveda / Unani are used for treatment in the current illness. Complementary from of treatment is referred to as a practice where Ayurveda or Unani is being used as a complementary form of treatment i.e. in conjunction with other system of medicine.

Table -4.15: TYPE OF TREATMENT

SI. No.	Type of Treatment	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	Exclusive	35	35.4	20	20.2	55	27.8
2	Complementary	64	64.5	79	79.8	143	72.2
Total		99	100	99	100	198	100

Data revealed that majority of respondents utilize TSM as complementary form of treatment. But the tendency of Unani patients (79.7%) to utilize Unani as a complementary form of treatment in greater than that of Ayurveda practice (64.6%). According to the Unani patients this is mainly because Unani medicines are available only at select places and it may not be possible to procure them immediately after the drugs are exhausted. In such cases allopathic drugs are consumed as stop gap arrangement to control the symptoms.

The tendency to utilize Ayurveda or Unani as a complementary form of treatment was greater in chronic illnesses. The patients reported that they use Ayurveda / Unani to cure the illness from roots but utilize Allopathic to 'control symptoms'. It was reported that during severe attacks of illness, the 'tolerance level' for 'pain and discomfort' reduces thereby increasing the tendency to utilize allopathy to control the symptoms. This behaviour may also depend on the age of the patient as children and the old generally have less tolerance.

Anjum (65) is a widow living with her sons family. Anjum has been suffering from chronic backache from four years. According to her she had initially started self medicating for a month on the advice of her son but when she found no relief in the symptoms she was taken to an Allopathic doctor who prescribed her drugs for a fortnight but according to her there was no relief. According to Anjum nearly six allopathic doctors were visited in her quest for "an effective cure'. Anjum reveals that this journey of visiting the doctors resulted only in loss of money' but the only beneficial aspect was one of the doctor diagnosed the problem and revealed that 'there was a disc prolapse' and only surgery will reportedly bring about a cure. In the meantime Anjum also became aware of the medicine which needs to be consumed when the pain becomes 'intolerable'. Anjum reveals at some instance the 'pain becomes unbearable 'that she can neither 'sit nor stand' and then one of the 'pain killers' help her to get back to normalcy. When the family was debating whether to go ahead with the 'surgery' a relative suggested she approach an Ayurvedic practitioner for a consultation.

According to Anjum she has started **taking Ayurvedic treatment from the** past four months and there has been a comparative relief of symptoms but Anjum reveals that when the pain increases, she consumes an allopathic 'painkiller' for instant relief as she cannot **bare the pain.** According **to** Anjum during her younger days when she developed any sought of pain she never used to consume any medicine and continue doing her daily activities, but now she feel she has 'lost' the 'capacity' to bear the pain which may be due to her age and this justifying her use of 'pain killers' while availing treatment for traditional medicine.

A significant proportion used Ayurveda and Unani as an exclusive form of treatment for the current illness. This may be because patients 'have tried many other systems' before approaching the current system of medicine and therefore are vexed of using other system of medicine and now would want to use only 'Ayurveda' or 'Unani'. It may also be due to the perception that Ayurveda and Unani are more effective only when they are exclusively used.

Finally it can be said that it is the 'tolerance level', belief frames, type of illness and characteristics of the respondents that decide whether TSM is used as a 'complementary' or 'exclusive' form of treatment.

SOURCE OF KNOWLEDGE OF MEDICINE

There were significant difference for the source of knowledge of Ayurveda and Unani. Majority of Ayurvedic patients reported that 'Media' was an important source of knowledge thus revealing that 'Ayurveda' is

promoted in Media. This can be attributed to the 'n' number of ad campaigns brought out by pharmaceutical to promote the products. For **the** Unani patients 'Family" was reported as the most important source of knowledge of medicine revealing that 'Unani' remains within the 'families'. Books as a source was reported by Ayurvedic patents more often than the Unani patients.

CONCEPTUALIZATION OF GREAT **TRADITION OF MEDICINE**

Redfield (1956) coined the terms 'great and little tradition' to contrast the formal literate tradition of an urban elite with largely oral and informal tradition of the peasant community. Thus great and little traditions are complementary aspects of a single civilization. The contrast between 'great' and "little" tradition corresponds in large part with the urban / rural division, since the great tradition is maintained by an urban based elite and little traditions by rural communities.

Leslie (1977), classifies the two systems of medicine i.e. Ayurveda and Unani as the 'great tradition medicine' based on the origin and rich conceptual history which can be traced to 'ancient' and 'seared texts' Leslie reports these two traditions share general features of social organization and theory but still maintain their individual characters. According to him the need to maintain the integrity of the separate tradition is to avoid assumption that all significant early medical science originated in Greece and South Asia.

An attempt was made by the researcher to understand the patients' 'conceptualization of two systems of medicine". It was based on two main aspects, that is the origin and conceptual history of both the systems of medicine .The researcher tried to understand whether the patient traced the origin of both the system of medicine to ancient texts, whether both the system of medicine has a rich conceptual history and on what basis it is different from modern medicine. Attempts were also made to understand if the clients believed the two systems of medicine shared common general feature.

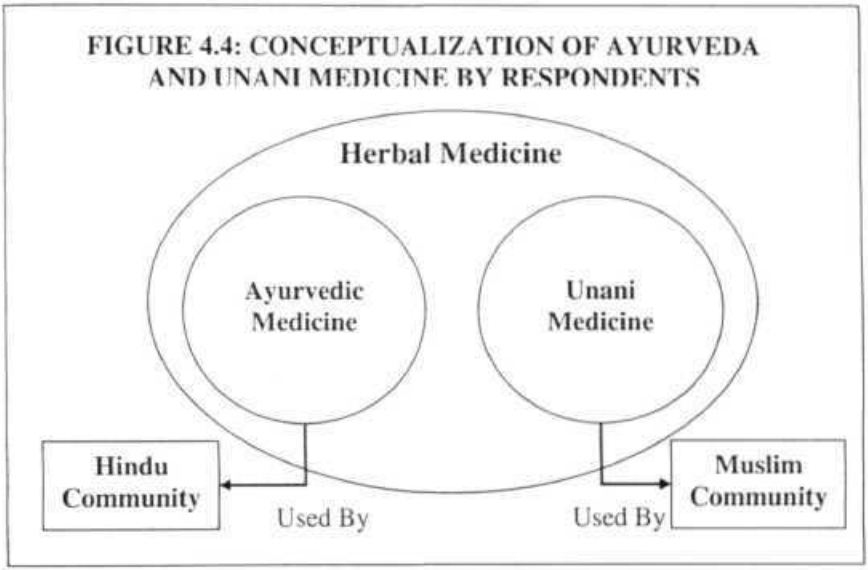
The conceptualization of the "great tradition of medicine' depended on the 'cognition of the client', which was influenced by various factor like education, income, and place of residence. It was found that clients of the lower income group and lower middle income group perceived 'Ayurveda' and 'Unani' as herbal medicine' i.e. doctor gave medicine made from herbs to clients. The tendency to equate both the system of medicine to 'herbal medicine' may be due to fact that 'home remedies' also contain the same constituents. This aspect of 'home remedies' being a part of little tradition people often interpret the 'two system of medicine as little tradition of medicine'.Clients from this group are not aware of the origin and lack knowledge in its fundamental aspects. But for the upper income group 'Ayurveda' and 'Unani' are separate 'systems of medicine' with its own rich body of knowledge for etiology, cure and prevention.

According to majority of respondents Ayurveda / Unani are referred to as *'jade bhootiyon ka dawai'* or *'chetla mandulu'*. All the clients

distinguish it from Allopathy based on the aspect 'these drugs contain herbal products while allopathic drugs contain chemical product'.

Though the clients equate both the system of medicine as herbal medicine, they differentiate it based on the 'community that uses it'. According to clients Ayurveda is an 'herbal medicine used by Hindus' while Unani is an 'herbal medicine used by Muslims'.

FIGURE 4.4: CONCEPTUALIZATION OF AYURVEDA AND UNANI MEDICINE BY RESPONDENTS



BELIEF FRAMES

The belief frames towards Ayurveda and Unani was vis-à-vis biomedicine collected from the patients of Ayurveda and Unani. During the

course it was found that there were no significantly different belief frames for Ayurveda and Unani.

VIEWS AND PREFERENCES

Long term treatment - There is a general belief that treatment in traditional system of medicine is for a 'long term". The respondent feel this is due to the fact that these medicine 'do not suppress the symptoms like allopathy but remove the 'illness from the roots thus bringing about 'permanent cure' According to respondents to 'gain' something one has to the 'take the hardships to the enjoy the fruit'.

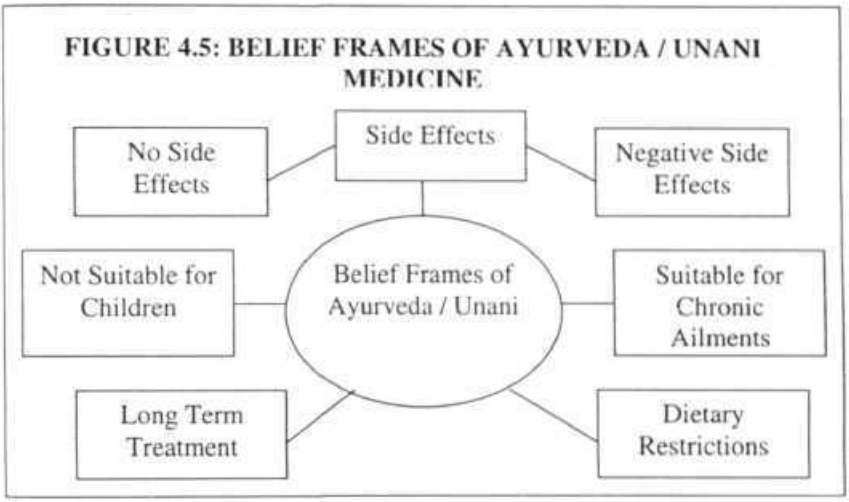
Dietary restriction - According to patients there are numerous 'dietary restriction' to follow when compared to biomedicine while taking treatment. According to respondents this may be one of the factors which hinder the utilization of the system of medicine as it is very difficult to follow any restriction in today's world.

Suitable for 'chronic ailments' - There is a general belief that traditional medicine is suitable for chronic ailments only. This is strengthened due to another belief that the treatment is long and there is slow relief so this suits only for ailments which prolong for a longer time period.

Side effects - There is a belief that traditional medicine also produce side effects like producing heat in the body', 'makes blood thinner' but according to respondent they are not life threatening as the side effects' produced by biomedicine. But there are a significant percentage of respondents who believe that there are no side effects

Not Suitable for Children - According to respondents, traditional medicine is not suitable for children as the treatment is long and the restriction on diet, makes it difficult for children to utilize these systems of medicine. It is also believed due to the 'age ' children cannot withstand the symptoms produced in any illness so a quick cure is required. According to patient 'palatability' of the drugs also restrict the use by children as according to patient 'Lehyams' 'Churnams' are difficult for children to consume.

FIGURE 4.5: BELIEF FRAMES OF AYURVEDA / UNANI MEDICINE



One striking observation during the course of the study was the belief among the patients which separates the two system of medicine is 'Ayurveda is meant for the Hindus' while 'Unani is meant for the Muslim[1] this may be because of the origin and founder of the system of medicine.

PERCEPTIONS AND OPINIONS

Perceptions and opinions of the patients were collected on various aspects of Ayurveda and Unani medicine, as it is **believed that** perception and opinion determines the utilization of health of service.

STATUS **OF AYURVEDA AND UNANI**

The status was assessed based on availability of facilities with proper infrastructure.

Table - 4.16: STATUS OF AYURVEDA AND UNANI

SI. No.	Status vis-a-vis Biomedicine	Ayurveda		Unani		Total	
		No:	%	No:	%	No:	%
1	On par	30	30.3	19	19	49	24.7
2	Less	65	65.7	80	81	145	73.3
3	More	4	4.0	-	-	4	2.0
Total		99	100	99	100	198	100

Majority of the respondents of Ayurveda (65.7%) and Unani (81%) revealed that the status of Ayurveda and Unani is less compared to Biomedicine. No respondent reported that 'status of Unani is more than Biomedicine', but 4% of Ayurvedic reported that the 'status' of Ayurveda is 'greater' than Biomedicine. 30.3% of Ayurvedic and 19% of Unani patients reported that the status was on par with 'Biomedicine'.

The patients 'Ranked' **the** system of medicine **in** Hyderabad **and it** was found that Biomedicine ranked **first and Unani was ranked only fourth** i.e. after Ayurveda and homeopathy.

Table -4.17: RANKING OF DIFFERENT SYSTEM OF MEDICINE

SI. No.	Rank	System of Medicine
1	1st	Biomedicine
2	2nd	Ayurveda
3	3rd	Homeopathy
4	4th	Unani

According to patients in today's world 'the status' of Ayurveda is increasing due to the world wide interest on 'Ayurveda' but this trend is still not observable for Unani. According to patients this may also happen in India if the 'west' shows interest towards 'Unani' as according to Sir C.V. Raman. 'We in India have been brought up to look for inspiration form the west'.

AVAILABILITY OF HEALTH SERVICE

Majority of the Ayurvedic patients feel that Ayurvedic health care facilities are sufficiently available in Hyderabad. Most of the respondent could recall the presence of at least one clinic near their respective residences. The same was also reported by the Unani patients regarding Ayurvedic facilities. But on the other hand majority of the Unani patients feel that Unani health care

facility is not sufficiently **available,** in Hyderabad. **Unani facilities are** mostly concentrated in 'select pockets' or rather 'Muslim dominated pockets'. According to respondents this may be **one of the factors, which hinders the** utilisation of Unani medicine

Table -4.18: Availability of Health Service

SI. No.	Availability	Ayurveda		Unani		**Total**	
		No:	%	No:	%	**No:**	%
1	Sufficiently availability	75	75.7	36	**36.4**	**111**	**56.0**
2	Not available	24	24.3	63	63.6	87	**44.0**
Total		99	100	99	100	**198**	**100**

TREATMENT

The treatment process was documented under subheadings namely method of treatment and treatment cost.

METHOD OF TREATMENT

The method of treatment is important factor which determines the utilisation pattern as it is finally the patient who 'decides whether the treatment should be followed'.

Time period of Treatment

Majority of the respondents of Ayurveda and Unani reported that the treatment is a lengthy process, but 'patients feel this is needed in some cases where the cause has to be removed from the roots'. The treatment becomes 'cumbersome ' due to 'various instructions', which include 'dietary restriction'. According to patients this becomes difficult to be followed in 'today's fast world', as nobody has time or patience to ensure it is practiced. According to patients this may be one of the reasons why 'traditional system of medicine are not utilized'. Greater percentage of Unani patients reported 'parhez' (dietary restriction) is an important factor for non-utilisation.

No: of Drugs & Administration of Drugs

Another major area of concern among the patients of Unani and Ayurveda was the number, and method of taking the drugs. According to patients different types of drugs are provided during treatment which include, *bhasmas Jehyams, halwas,* . The patients reported that the method of taking the treatment is 'time consuming' as against the allopathic medicine where 'medicines are easily popped[1]. Mostly Unani patients have reported this. According to Ayurvedic patients various ayurvedic Pharmaceuticals are producing drugs which can be easily consumed.

Appearance of Drugs

During the study it was found the 'appearance of drugs' was also a reason for non-utilisation, as majority of the patients reported that the initial appearance of the medicine 'put off the attitude of the patients, which affect the consumption. According to patients thought efforts have started by pharmaceutical companies to overcome this barrier it has a long way to go.

It was found that the "aspect of appearance of drugs' was mainly reported by Unani patients than Ayurvedic patients. Thus revealing the fact that the process of 'treatment' in Ayurveda has began undergoing a change due to worldwide interest in Ayurveda and the role of Pharmaceuticals in promoting the system of medicine. It was reported by Unani patients that 'Unani medicine' is still not being promoted in lines with 'Ayurveda[1] and this is one area where the Government role becomes important.

TREATMENT COST

Majority of the Ayurvedic patients reported that the 'treatment cost[1] is high in Ayurveda as compared to unani, this is again attributed to the lengthy process of treatment and commercialization of'Ayurveda[1].

It can be concluded that the utilization of Ayurveda / Unani depend on the profile of the utilizers, the belief frames, the nature of illness suffered and different features of both the system of medicine. It was found that traditional systems of medicine is used more prominently for chronic illnesses, but the trend of using it for common ailments is also on the rise. The effective and subsequent promotion of a system of medicine depends on the success of treatment, which mainly rely on comparative relief of the symptoms. The perception and views on the system of medicine go a long way in utilizing a system of medicine as initial entry into the system is guided by the belief frames which are perceived, by the individual or his family.

Chapter- V

PATIENT - PRACTITIONER INTERACTION

The patient-practitioner interaction is significant, as an effective patient-practitioner interaction results in a 'satisfied patient' returning from the healthcare.

Authors have analyzed the process of interaction between the patient-practitioners in different ways. The participant and non-participant observation technique in clinical setting was used extensively in social science research. Interaction process analysis technique was also developed in this regard. In this method, the researcher observes an instance and sets up a tally sheet to organize and enumerate the behavior he watches. A system for coding the behavior of a group is developed having some known or ready made set of categories into which one could fit in the observation.

Doctor-Patient Interaction Analysis (DPIA) was developed for observing the interaction between doctor and patient in clinical settings. Several categories were developed for coding the doctor-patient interaction based on the views expressed by the patient and doctors on what type of behaviour they expected from each other. Six categories for doctor talk and six categories for patient talk were developed. Three categories for coding the period spent in physical tests, non-verbal activities and distraction were retained. Some studies have tried to understand the patient practitioner

interaction based on **the outcome of the patient-practitioner process, which** includes the patient satisfaction.

Patient satisfaction is an important enabling factor for it facilitates the use of particular health serve and positively contributes for future use of the health services. Studies (Fiedler 1981) have revealed that various characteristics and practices of providers contribute to patient satisfaction. Patient have reported to be satisfied and inclined to utilize services when providers,

(a) gave more information
(b) counseled patients
(c) explained payment plans
(d) were happier and had a favorable attitude towards the patient
(e) spent more time with the patient

The different techniques of analysis for doctor-patient interaction reveals that the qualities of physician and the communication between the patient and practitioner form the backbone for the analysis of the Doctor-Patient interaction.

STUDIES RELATING TO PATIENT-PRACTITIONER INTERACTION

Studies reviewed here will include studies on both modern and traditional medicine. This is mainly **due** to **the** fact **that studies** revolving around patient-practitioner interaction in traditional medicine were limited **and** many studies compared the relationships between practitioner of

traditional medicine and their client vis-à-vis modern medicine men **and** their patients. So it was also felt by the researcher that the finding in the interaction process between the practitioner and patient in the realm of traditional medicine becomes relevant only when discussed in the context of modern medicine.

Chen C.Y. (1981) while studying the traditional and modern medicine in Malaysia reveals that in contrast to the practitioner of modern medicine, the traditional medicine mans approach to diagnosis and healing is very 'personal" and 'supportive'. The traditional medicine man tends to enquire in great detail into the patients family and social background, requiring details of the patient's problems, life, family and enemies. According to Chen this is an important aspect of the cultural and historical forces that influence the development and acceptance of traditional medicine in Malaysia.

Wolinsky (1982) applied Andersons generic model and assessed the intent to which traditional practitioner of health service utilization are directly associated with individuals identification of the important factors in their choices of new doctor. The study revealed that 'doctors affective behaviours' i.e. 'doctors manner and personality' was the second highest recorded reason for selecting a new doctor. Although the data demonstrated that individuals seek affable physicians when choosing a new doctor, Wolinsky stated that it may be reasonably assumed that patients are more likely to maintain their liaison with or re choose affable rather non-affable physician. This supports the models of consumer satisfaction, which posit that the affective qualities of the physicians are more important than their

instrumental qualities in determining consumer satisfaction. Wolinsky et al goes on to suggest further policy changes based on these studies, which include modest changes in medical school curriculum which should focus on good communication and interaction skills rather than on information retrieval, as this permits the doctor to alleviate patients concerns and anxieties which in turn motivate patient compliance with treatment regimens and preventive behaviour.

Lasker J (1981) study in the Ivory Coast revealed that there was usually very little conversation during medical visits. Several young doctors indicated that it was not necessary to explain matter to patients. Several authors have put the responsibility for inadequate communication on the physical such as the use of 'inappropriate verbal consulting styles' or certain non-verbal behaviour.

Weisberg D.H. (1982) while studying the Northern Thai health care alternative revealed that the relationship between the healer and the patient and the family is crucial for choosing the healer. Healers of the 'locally sanctioned sphere' have to practise an understandable form of care and must approach patients and families in a polite and palatable manner.

Mathew (1983) pointed out certain problematic areas in clinician-patient communication, including incompatible frames of references as to what information should be shared, socio-linguistic differences between the two parties involved, the degree of shared knowledge (especially technical knowledge) between doctor and patient and the social distance between the

two given their difference in status and role and the constraints of the institution in which they interact.

According to Oyeneye. Y (1983) Traditional medicine has a fairly long history in Nigeria, traditional health care systems in popular due to its acceptability to a large proportion of rural and urban dwellers. This acceptance is not only due to its efficiency in the treatment of some health problems, but offer both social and mystical explanation for the cause of illness and due to its close proximately of people. African healers have been cited for their grater openness to patient and for their lesser social distance, when compared with hospital personnel.

Mathew remarks the extent to which patient and practitioners successfully exchange information is affected by the degree to which their realities are mutually compatible. Doctor ignorance of native illness concepts and an attitude of superior were reported by Lewis (Kroeger 1983) in a Mexican village and four Indian populations in Equador (1981), which results in communication problems.

Different authors point out that some of these differences are due to the differences between biomedical and lay definition of ill health, i.e. between disease and illness. According to Kleinman (1978) biomedicine views biological data as being more 'real' and clinically significant than either social or psychological data. Diseases are seen as abstract entities with a recurring identity in whatever socio-cultural setting they appear. Illness by contrast refers to the subjective response of the patient and those

around him their perception and origin of **the event and how it effect them,** unlike disease illness is a wider, more diffuse concept patterned by social, psychological and cultural factors.

Kleinman (1978) pointed out for successful diagnosis and treatment it is essential to understand the patient explanatory models of illness as these models are usually influenced by social and cultural factors. Their medical training largely influences physician interpretations of their patient ill health. In addition to their experiences, personality social background, subsequent training and rank in the medical hierarchy all play a part in what information is gathered from and communication to the patients they care for. Helman (1985) while trying to understand the clinician-patient communication in the context of primary care reveals the role of clinicians 'Health belief model' in communicating with patients. This model includes knowledge assumptions about how patients view their own ill health. This will serve as an indicator of the success of communication and a predictor for successful communication, compliance and patient satisfaction in the future.

According to Helman physicians should elicit their patients explanatory models and then compare these with their own health belief model. This will reveal evidence of 'typifications' or stereotyping, both of which may be barriers to successful communication.

But this approach advocated by Helman cannot be applied to large population, as the range of explanatory model for the patients will be many in number for a single disease. In utilization studies in clinical setting the

handicaps of facing patients with different illnesses results in larger number of explanatory models and corresponding health belief models

If on one hand, one of the important reasons for abandoning modern medicine was the patients ignorance of the doctors paradigm which result into a communication gap, on the other hand studies report the mutual understanding between local healer and patient was based on shared knowledge and assumption.

Kroeger (1983) reports that in service based studies in traditional medicine (which focuses on the healer and his patient) congruence between healers and clients can be anticipated since this is the reason why people have resorted to those healers. This behaviour has been observed in India (1975) and Taiwan (1980).

In a study by Merzouk M. (1995) in Algeria reported that in a society that is predominantly religious and rural the 'kindness and warmth' of the care provider is the most important reason for use of providers.

Studies (Furnham et al 1993, 1996, 1988, 1996 et al) reported that traditional medicine clients were more dissatisfied with modern medicine for a variety of reasons related to doctor-patient interaction, including communication difficulties and perceived a lack of concern for their well being. The success of a satisfying personal relationship in traditional medicine is often considered to be one of the most important reasons for the use of traditional medicine.

In a study by Messerli et al (1999) in Switzerland it was reported that allocating sufficient time for consultation was one of the important reasons for utilisation of traditional therapy.

In a comparative study of Doctor-Patient interaction using DP1A (Doctor Patient Interaction Analysis) in small, medium and large hospitals revealed that the doctors conversed more in small and large hospitals than in medium hospitals where as the patient talk was little less in small hospitals. This happens because in the small hospital patients suffer from minor illness and they do not have much to explain about their illness. In small hospitals more time was spent by doctor in giving instruction regarding treatment and in medium hospital in enquiring about illness and in large hospitals in releasing the patient's tension and other talk.

Comparing the "patient-talk' it appears that in large hospitals the patients spent more time in seeking orientation, help and showing disagreement. In medium hospitals the patient spent more time in explaining their illness.

Behavioural components of doctor-patient relationship were identified as (1) patients need (2) effective medical care (3) professional ethics (4) normative behaviour. Different sub topics were outlined for each category. A behavioural scale was used to analyze the findings. The doctors rating revealed that they had high moral character and a sense of regard for patients. They had enough skill to treat the patients and they always gave instructions about treatment. But at the same time they were somewhat detached from the patient and the patients feel they were treated more like

cases. The patients rated doctors high on their behavior, medical **attention,** interest taken and treatment provided, but they rated them little low on communication of diagnosis.

Using the studies as a background the researcher developed a checklist after informal discussion with patient and practitioners as to what they expect from each other during the interaction.

PATIENT EXPECTATIONS

All patients reported that the practitioners should be pleasant, should have a sympathetic attitude, should enquire about the illness and collect the case history. The practitioners should clarify the doubts and queries and give a patient hearing.

PRACTITIONERS EXPECTATION

Practitioners expected the patient to explain the illness, without concealing any information should have confidence on the practitioner and treatment regimen and should clarify any doubts and queries.

PATIENTS OBSERVATION

Majority of the patients reported that the practitioner had a general talk with them. According to the patients this is usually done by the doctors to make the patients feel comfortable and ease out the 'tension' and 'anxiety' the patient feels. The general talk generally involves asking the

name, place of stay, occupation and about family attributes. This activity is undertaken by 'experienced' practitioner as they understand the importance of making the patient comfortable in an unfamiliar environment.

This behaviour is observed among the practitioner of traditional medicine and not among the doctors of modern medicine. The patients opine that practitioners of traditional medicine 'perfect the art of medicine' by years of practice which only comes through age in the process making them aware of the social responses to illness. But this does not seem to be valid in modern medicine. According to patients even young doctors can master modern medicine, by studying the various specializations and sub-specialization. This tendency is not exclusively attributed to the personal characteristic of the practioner but also on the 'nature' of the system of traditional medicine. This prescribes that the illness and effected individual should be seen in 'totality' and not exclusive of each other. While in modern medicine the 'disease' is seen as a separate entity caused due to certain factors. The role of doctor is limited to explore the factors and try to control them thereby giving little importance to emotions of the patients.

According to patients the type of ailment decides the level of communication between 'patient and practitioner'. Majority of patients opined that for every illness whether minor or major, the symptoms and illness history is collected by the practitioner. But the level of information collected may vary, i.e. the history for minor ailment may be less compared to chronic ailments. The patients reveal that the practitioners of modern medicine do hot ever bother to collect the history and symptom for minor

ailments. This behaviour reduces **the interest among the patients as they feel** 'delineated' from the treatment process.

The patients reveal that the level of information gathering on the illness is greater among the practitioner of traditional medicine when compared to their counterparts of modern medicine. Majority of the patients reveal that information rendered regarding the treatment, prevention and care for the illness is an important area in traditional medicine which differentiates it form modern medicine. According to the patient major part of the communication in the interaction process between a practitioner and patient in traditional medicine revolves around prevention and care in terms of dietary restriction and personal hygiene. According to patients this corresponds to the individual's own concepts of health care, which to a great extent is governed by food. The patients revealed that instructions are given to each individual based on his body constitution, which is not found in modern medicine.

Doubts and queries are encouraged by practitioner depending on the time available, which also depends on the experience of the practitioner. Majority of the patients reveal that when the practitioner is experienced he has not time to clear the doubts and queries.

More than three fourths of the respondents reported that the practitioner were 'pleasant'* with them. But it was found there was 11.1% of Ayurveda patients and 12.1% of Unani patients who revealed **that the**

" 'pleasant' was described by patients as a behaviour of the practitioner, which make the patients feel important and the patient feel satisfied after the consultation.

practitioner they consulted **were not 'pleasant' to them. The patients opined** that the socio-economic background they belonged **to** influenced **the** behaviour of the practitioner towards them. This was reported by Pendlenton et.al. (1980) while studying the patient-practitioner interaction.

Table 5.1: REASONS OPINED BY PATIENTS FOR THE PRACTITIONERS NOT BEING PLEASANT

REASONS	AYURVEDIC PATIENTS		UNANI PATIENTS		TOTAL	
	NUMBER	%	NUMBER	%	NUMBER	%
Uneducated	1	5.8	1	8.3	2	6.9
Poor	15	88.3	10	83.3	25	86.2
Not important	1	5.8	1	8.3	2	6.9
Total	17	100	12	100	29	100

34.3% Ayurvedic patients and 41.4% of Unani patients reported that they would approach the same practitioner even if he was 'practicing' some other system of medicine for the current problem. This reveals that the 'qualities' of physician overruled, the decision to select the practitioner based on the system of medicine practiced.

Affability of the practitioner was reported as an attribute for selection of practitioner for the current problem. But it is interesting to note that availing the services of the practitioner for all the health problems would not be influenced by the 'affability' of the physician, exclusively but also by the system of medicine he practiced. This was ascertained by a significant

percentage of patients who revealed that selection of the physician would depend on **the** system of practiced. This supports **the fact that** selection of practitioner also depends on the system of medicine **they practice** and illness classification the patient uphold.

PRACTITIONER'S OBSERVATIONS

The practitioners revealed that they expect their patients to be cooperative and should trust their doctors. A major area of concern shared by the practitioners of Ayurveda and Unani was that the significant percentage of educated patient doubts the diagnosis of the practitioner and there by hesitate the treatment prescribed by the doctor. According to practitioner this is evident due to the number of 'questions', which precede the interaction process regarding the treatment.

According to the practitioner this behaviour 'stems' from **the** fact **that** 'traditional medicine' is an alternate form of medicine and the tendency to immediately compare the diagnosis and treatment regimen prescribed by the allopathic practitioner is high. This in turn affects the 'morale' of the doctor and the channel for 'disinterest' towards the patient creep in the practitioner. The practitioner feels 'the patient-practitioner' relationships should be based on mutual trust and respect towards each other.

Majority of the practitioners reveal that this behaviour is due to the 'huge importance' attached to allopathy. The practitioners feel the entire government,' society, and the medical fraternity, which include the

practitioners of Allopathy, practitioners of traditional medicine are responsible for the trend.

Significant percentage of the practitioners opined that the patients should share all the information regarding the illness. The practitioners reveal that in some cases 'patient conceal information from them', which bring about mistrust and also hinder the process of treatment.

It was found that a majority of the practitioners had a general talk with the patient to make them comfortable and all the practitioners collected case histories from the patient. 26% of Ayurveda and 12.5% of Unani practitioners sighted communication problems. The nature of communication problem was majorly due to the lack of knowledge of the language spoken by patient. This was reported by a greater number of Ayurveda practitioners. This in turn affects the communication process and information shared becomes restricted. According to practitioner in most instances they can understand the problem but can't communicate in return, which is crucial for an effective patient-practitioner communication. This may in turn inhibit further use of the system of medicine. As has been stated earlier, this also explains the tendency of various ethnic groups availing the services of Unani practitioners as compared to Ayurvedic practitioner. It was found that Unani practitioner were fluent with three important languages spoken in Hyderabad i.e. Hindi/ Urdu/ Telugu which was not found among the Ayurvedic practitioner.

Thus it can be concluded that an effective patient practitioner interaction depends on the qualities of the patient, practitioner and the nature

of **the** system of medicine, **which in turn promotes the utilization of the** system of medicine.

Chapter- VI

SUMMARY AND CONCLUSIONS

The present study focused on the different aspects of practice and utilisation of Ayurveda and Unani in Hyderabad. For this purpose fieldwork was conducted for 18 months. The study covered 50 and 40 practitioners of Ayurveda and Unani medicine respectively. They were selected by following a snowballing technique. It was decided equal number of patients would constitute the sample for patients. Patients were selected from practitioners who reported treating more that five patients per day. 198 patients were selected who were distributed equally within both the systems of medicine

The literature review served as a background to arrive at the objectives. The review dealt with different studies relating to utilisation and practice of traditional systems of medicine. The studies focusing on different frameworks to understand the patterns of practice and utilisation of a health service helped to identify the factors leading to the use of a health service.

The objectives which have been discussed in different chapters included knowing the client profile of the users of traditional system of medicine, exploring the factors leading to use of traditional medicine, knowing the strength and contribution of traditional systems of medicine in terms of number and range of diseases treated either exclusively or as a complementary form of treatment, understanding the socio-demographic profile, organisation of practice and services rendered by practitioners. It was also intended to know the belief frames of both clients and

practitioners towards the system of medicine and to understand the process of patient practitioner interaction.

The broad areas that were covered to understand the practice of traditional system of medicine was the socio-demographic profile of the practitioners, organization of practice, reach and nature of services, perceptions and opinion of practitioners.

Study revealed that a majority of Ayurvedic practitioners entered the profession in recent years while majority of Unani practitioners joined the profession two to three decades back.

Male practitioners dominated the practice of traditional system of medicine. Ramesh et al's (1981) study reported that the male domination of a practice effects the utilisation of the system of medicine as far as females are concerned but in this study it was found women out numbered the men among the users of traditional medicine. The proportion of female practitioners in Unani medicine was greater when compared to Ayurvedic medicine. This was mainly attributed to demand for services of women doctors in the Muslim community, which is due to explicitly defined gender roles in Islam restricting the females to discuss any gynaecological problems, with the male practitioners.

Only two religious ethnic groups are involved in the practice of both the system of medicine. Majority of Ayurvedic practitioners were Hindus while Unani practitioners were mostly Muslims. This demonstrates the religious affiliations of the traditional systems of medicine.

The organisation of practice was studied to understand various features like nature of practice, number of years of communal practice, training, hours of work, consultation, practice of integrative medicine, referral system and some exclusive feature of private practice were covered.

Ayurveda managed to find greater patronage in the private sector and relatively 'early' when compared to Unani. Little less than three fourth of respondents did not receive any additional training. Greater number of practitioners of Unani worked for more than 10 hours as compared to Ayurvedic practitioners. This could be attributed to the greater patient load, the services and roles taken up by practitioners in their practice. The practice of traditional systems of medicine is dominated by solo practice and the concept of consultation-based practice is lacking. This is because there is a lack of specialists as the number of specialization in both system of medicine is limited. Moreover, the specializations are in broad areas rather than to a limited field as in the case of allopathic. The recognition as specialist by professional colleagues is also limited to a certain extent as it is felt specializations are more or less 'self acclaimed' due to the limited scope for numerous specializations within the traditional systems of medicine. This aspect is more prominent when practitioners claim specialist status without a master's qualification.. Thus, the limited numbers claiming specialist status and lack of recognition by professional colleagues for such claims limit the evolution of consultation based operations of practice. The desire for general practice by treating a range of illness for greater popularity and economic gains among the practitioners encourage solo practice.

It was found that more than half of the practitioners practiced integrative medicine. It was found that exclusively practicing the system of medicine was influenced by years of practice. As the age of practitioners increased resort to modern medicine is restricted. The benefits of practicing integrated medicine or exclusively practicing the system of medicine trained in. needs to be researched.

There are different associations for the practitioners of Ayurveda and Unani in Hyderabad. The Associations are meant to look after the welfare of medical officers employed in government hospitals. The main aim of the association was to promote the system of medicine by conducting medical camps and by encouraging fellow practitioners to share the best practices and holding conferences.

Some exclusive features of Private practitioners regarding organization of practice revealed that majority of the practitioners set up private practice in the last decade revealing the growing demand for traditional medicine in the private sector. Most of the private practitioners worked along the lines of modern medicine with most of clinics having waiting rooms, patient registration and using modern diagnostic apparatus. This was mainly done to improve their image in public and to keep in demand.

It was found there were certain features, which were found to be exclusive to each system of medicine. It was found the practice of Ayurveda was 'formalized' to a greater extent than Unani. This could be mainly attributed to the nature of practice. It was found that Ayurvedic practitioners had established and strong methods for patient registration, the need for appointments **were** stressed, their role was limited to only

prescription of medicine (i.e. not preparing medicines themselves like Unani practitioners). The Ayurvedic practitioners are less inclined to prepare medicines themselves, in view of availability of patented drugs by multinationals.Referral systems followed by the Ayurvedic practitioners followed a specific pattern. "Hierarchical" perception dominated while utilizing the services of Unani practitioner for referrals.

It may be these features that considerably help Ayurvedic practice to find patronage in the private sector and in setting practice relatively earlier than Unani. Partially it could also be due to a greater number of Ayurvedic practitioners with master's qualification that positively contribute in bringing about this pattern. Which in turn, helps in increasing the popularity of Ayurvedic medicine and explains the greater number of practitioners practicing in clinics as far as the place of practice is concerned.

If being 'formalized' was one of the exclusive features of Ayurvedic practice, it was found that the high fee charges and 'communication problems' were a part of the Ayurvedic practitioners to a greater extent than Unani which could be a inhibiting factor for utilisation.

The practice of Ayurveda being formalized could be restricted only to the nature of practice as it was found that services rendered were more or less similar for both practitioners of ayurveda and Unani.

The reach and nature of services was understood by ascertaining of the patient load, ailments treated, information and services rendered in preventive health. Ayurvedic practitioners reported a patient load of 10

per day while majority of Unani practitioners reported a patient load for 20 per day. It was found that considerable number of Unani professionals never reported of male patients. For some of them who were mostly females it was a personal decision not to attend to male patients, which was probably influenced by religious sentiments. Even at the government Unani Institution it was found that arrangements were made at the patient registration especially for 'Muslim' patients to refer them to practitioners of the same sex. This demonstrates the role of religion in determining the practice and utilisation of health care.

There was a significant percentage of both Ayurvedic and Unani practitioners who reported not attending to children. This was mainly influenced by the belief frames believed by the clients of traditional systems of medicine and also that certain ailments receiving treatment from traditional medicine may not affect children. Ayurvedic practitioners treated more ailments when compared to Unani practitioners. It was found that 'common ailments ' (like fever, cough, cold etc) were also treated by practitioners. This trend was never reported in earlier studies.

It was found that majority of practitioners rendered information on preventive health and Medical care. But as far as services rendered in preventive health, it was found that the place of clinic decided the trend. It was found that practitioners having clinic in rural and slum areas rendered services on preventive health. The services rendered were immunization for pregnant women, children and immunization for diseases from the allopathicmedicine.

Practitioners opined that Ayurvedic resources are more available than Unani resources in Hyderabad. The level of development was not on par with biomedicine basically due to the lack of government patronage.

Ayurvedic drugs are more easily available and this is attributed to the large number of pharmaceutical companies promoting ayurveda. But this was not reported for the Unani drugs as only two Pharmaceuticals were mentioned by the practitioners in Hyderabad to be producing Unani drugs . It was also believed that the marketing strategies of Unani drugs are not on par with the Ayurvedic drugs. The quality of drugs produced is an important area of concern. According to practitioners the licensing and standardization of both Ayurveda and Unani drugs should be strengthened at the state and national level. Both practitioners of Ayurveda and Unani encourage use of modern equipment. Practitioners of Ayurveda and Unani listed a list of limitation of traditional system of medicine. This could contribute to a large extent utilisation and non-utilisation of a system of medicine. Like it was found that clients discontinued allopathic medicine as 'surgery was advised' and chose traditional systems of medicine as surgery is not encouraged in this system of medicine resulting in utilization. Failure to treat acute and severe cases lead to utilization of Allopathic medicine. The role of government to promote Ayurveda and Unani was highlighted in the areas of education, research, cultivation of medicinal plants and Pharmaceuticals. The practice of traditional medicine needs to be strengthened in the areas of training, consultations and referral patterns. Effective and standardized method for controlling the quality of drugs produced by practitioners needs to be established. Strengthening the networks among the fellow practitioners would definitely go a long in developing and improving the practice of traditional medicine in

Hyderabad. State patronage could be imparted through public education, by means of local journals, newspapers, seminars, and conferences and through use of media. **Creating public awareness, education at the** 'school level' will definitely increase the knowledge **level and bring** about positive attitude towards **the** traditional systems of medicine.

The broad areas that were covered in the utilisation of Traditional systems of medicine included knowing the **client profile, accessibility of** health care, the health seeking behaviour, the choice of therapy and patterns of resort.

Majority of the reviewed studies on utilization revealed that predisposing factors (especially the socio-demographic profile) influenced the use of health care services. But most of the studies did not explain why these factors influenced the use. This particular study attempted to cover this aspect.

Traditional medicine particularly attracted the members in the age groups of 21-40 years. Various reasons account for this behaviour. First and foremost is that relatively greater percentage of members of this group report morbidity and there will be less delay in seeking health care amongst them as they mostly happen to be the economically productive group and independent choices are made. Similarly the fact that this particular age group having an extended 'social network' increases their exposure to wider health choices. The negative side effects of biomedicine were one of the reasons to try out traditional health care. Negligible percentage of children and the old using traditional medicine was mainly due to 'non palatability' of drugs and tendency to choose a medicine for 'quick relief due to low tolerance levels **among the old.**

Women out numbered the men among the users of TSM. This tendency as has been suggested in other studies too may be because women are 'tradition bound' and tend to behave traditionally in all aspects of life including health care behaviour.

More than half of the clients of both Ayurveda and Unani belonged to the same religions ethnic group to which both the systems of medicine traced their origin. There has been a dearth of studies to show the role of religion in choosing traditional medicine. But in this study it was found religion influenced utilisation and clients identified Ayurveda and Unani as 'Hindu' medicine' and 'Muslim medicine' respectively. Educated respondents utilized traditional system of medicine supporting the studies, which reported that education had a positive relationship with the use of traditional medicine. This could be due to the growing 'world wide interest' in traditional medicine, which promotes healthy and safe life style practices.

Ayurveda and Unani was more preferred by client whose families belonged to middle income groups, revealing that Hyderabad still attracts only members of middle income group unlike in developed countries where the rich favour traditional systems of medicine.

But it was found that greater number of 'more' educated clients utilized Ayurveda than Unani and similarly greater number of clients of lower income group utilized Unani. This may be because of the nature of practice of Ayurveda, which as stated earlier was more 'formalized' than Unani. So thereby attracting the 'more' educated. But it cannot be conclusively believed that this is the only reason for this behaviour thus throwing open areas for further research. In this study it was found that

utilization was influenced by predisposing factors as reported by Kroeger (1983)

Patients seeking care from Unani system had to travel greater distances than those choosing **Ayurveda.** **Ayurvedic** resources were available at a distance of less **than five kilometers from the residences of** patients, while only slightly **more than half of Unani patients traveled the** same distance. But it was found that when traditional treatment is considered as being essential for recovery as in the case of ailments related to external appearances like skin infections and more specifically Leucoderma 'distance' does not affect utilisation. This reveals that the type of ailments and illness suffered overrides the influence of enabling factors as far as 'accessibility' in terms of distance traveled is concerned.

Health seeking behaviour was understood by knowing the illness suffered, duration of illness and various actions undertaken by the respondents to treat the current illness. It was found that respondents utilized traditional systems of medicine for 11 broad categories of illness. It was found barring minor variation Unani and Ayurveda were utilized more or less for the similar problems. It was found this trend was majorly attributed to cognition of clients as majority of patients conceptualized and equated both the systems of medicine to 'herbal medicine' and differentiated them only on the basis of the 'community that eventually utilized/ both the systems of medicine.

Self-medication was the most preferred action after the onset of symptoms. This supports the pathway models (Suchman 1965, Chrisman 1971), which stressed that, lay consultations/ referral and self medications

were some of the action preferred by the patients before taking professional help.

It was found respondent's classified illness based on **the** causative factors, evaluation and duration of symptoms, supporting Klienman's (1980) observation that respondents **are likely** to **have quite vague and** indefinite models of explanation of their illness depending on past experience of the patient and her/ his circle of kin and friends.

It was found that majority of respondents utilized traditional systems of medicine for chronic ailments than common ailments. It was accessibility and faith in the system of medicine, which prompted utilisation of traditional systems of medicine for common ailments while it was belief frames that encouraged utilisation of traditional systems of medicine in chronic conditions. This trend of using traditional systems of medicine for common ailments was never reported in earlier studies.

It was found traditional systems of medicine were majorly used as a complementary form of treatment. This was influenced to a large extent to illness suffered. In some instances clients resorted to modern medicine to gain relief from symptoms and used traditional medicine to remove the cause of illness. This was more particularly found in chronic illness where symptoms keep reappearing at certain intervals. This corresponds to earlier findings that characteristics of the disorders and their perceptions also decide the choice of health care. But it was also found certain enabling features also contributed to this behaviour like the availability of Unani drugs only at 'select places' of Hyderabad encouraged utilization of allopathic drugs which can be easily and immediately procured for controlling the symptoms.

Resort to medical care in pluralistic settings reveals two basic patterns (Maureen D.L. 1984) i.e. multiple therapeutic use and illness specific use

In this particular study if on one hand it was found that majority reported taking treatment from traditional medicine for chronic illness showing illness specific trend then on the other hand used multiple therapies for controlling the symptoms. Thus not arriving at a conclusive pattern of resort as both types of resort seem to be prevailing.

Information on type of health providers visited revealed that Allopathic doctors were the first choice for respondents among Ayurveda and Unani patients. It was also found that for majority of Ayurveda patients, Ayurveda was the third choice while Unani was the sixth choice of treatment revealing that Ayurveda is approached faster than Unani medicine. This reveals that 'Healer Shopping' is also found to be prominent in Hyderabad. This is basically for effective cure and Suchman's model stresses that this behaviour is undertaken till a 'diagnosis wanted' by the patients is achieved.

The health seeking behaviour revealed that there was a hierarchy of resort to health care i.e. the most popular health care was resorted initially which was followed by traditional health care. Though it was found there was a hierarchy of resort ,around 10% of respondents resorted to traditional systems of medicine as the first choice of treatment, which was influenced to a great extent by belief frames and accessibility.

This supports earlier contentions that in plural medical systems the use of different healing resources does not necessary consist of choosing between equally effective 'alternatives'. Rather it involves the choosing of the therapeutic resources 'appropriate for the ailment' which to a large extent is guided by belief frames.

Belief frames, accessibility, family advice, previous treatment ineffective and positive previous experience were the most commonly reported reasons for choosing Ayurveda and Unani for the current illness.

The belief frames of respondent relating to Ayurveda and Unani were more or less similar, which included 'permanent cure' 'dietary restriction' 'suitable for chronic ailment', 'side effects' and 'not suitable for children'. It was found that belief frames had a significant role in the utilisation/ non-utilisation in different stages of illness of Ayurveda and Unani.

Ayurveda was promoted to a greater extent by the media as 'media' was reported as main source of knowledge of medicine while 'family' was reported to be an important source of knowledge of medicine for Unani patients. This reveals the Unani still remains in families thus highlighting an effective area of promotion of Unani medicine.

Majority of them rated traditional systems of medicine below biomedicine and they ranked biomedicine above all systems of medicine. This reflects the public opinion towards traditional systems of medicine and according to practitioners the role of government becomes significant in promotion of any system of medicine. This justifies the practitioners

opinion that policies should be made to promote the system of medicine from the 'schooling level' which in turn increases the knowledge levels of traditional systems of medicine from the initial years of education.

Some of the concerns **shared by the** respondents on treatment which has policy implications included availability and appearance of drugs. It was found availability of drugs in 'select' areas and appearance of drugs was also a reason for non-utilisation. Both the aspects were mainly reported by Unani patient revealing that Unani medicine is still not being promoted in line with Ayurveda and Pharmaceuticals has an important role to play in these aspects.

Kroeger's Model (1983) classifies the patient practitioner interaction as a major enabling factor in the choice of service. Majority of the patients were satisfied with the Nature of communication between themselves and the practitioner. The communication primarily involved general talk to ease the anxiety the patient feels, collecting the history of illness and giving instruction on prevention and care. The qualities of the practitioner were reported as an important factor that determines the interaction process. It can be believed that effective patient-practitioner interaction cannot be exclusively attributed to the personal characteristics of the practitioner but also on the 'nature' of the system of traditional medicine as traditional systems of medicine highlights that the illness and effected individual should be seen in 'totality' and not exclusive of each other. A major part of communication revolved around prevention and care in terms of dietary restriction and personal hygiene which to a large extent corresponds to the individuals own concepts of health care which is governed by food. Earlier studies report that if ideologies shared by the practitioner and clients match to a certain extent it increases the interest

among the patient and they feel encouraged to be a part of the entire treatment process, which was found to be true in this study.

Around one fourth of the respondents reported that 'affability' of practitioners depended on the socio-economic background of the patients i.e. if they were from upper income group the practitioners were reported to be pleasant to them highlighting some areas that need to be strengthened. This calls for stressing on the importance of effective practitioner-patient interaction in educational curriculum imparted to the students of traditional systems of medicine in the colleges.

Though patients were satisfied with practitioner-patient interaction. Practitioner reported that significant percentage of educated patients doubt the diagnosis of the practitioner and this behaviour is attributed to the belief that traditional systems of medicine are an 'alternate form of medicine'. This behaviour is strengthened due to the huge importance attached to Allopathy which requires government intervention to promote the system of medicine.

Communication problems were sighted by practitioners due to lack of knowledge spoken by patient. This was reported by Ayurvedic practitioner revealing an aspect that need to be worked upon by Ayurvedic practitioner of Hyderabad. This probably also explain the tendency of greater number of clients from different ethnic groups utilizing Unani as it has been reported in studies, conversation with the clients in their respective mother tongue increases the 'comfortability' of patient which is essential for an effective practitioner patient interaction.

This study reveals that predisposing factors enabling factors, **the** illness and the structure of the decision making process during illness episodes is such that it prompts patients to consult a variety of healing traditions for particular illness episodes and to utilize over their lifetimes the full range of healing resources available.

It can be concluded that both practice and utilisation are two sides of the same coin and both are believed to influence each other. But the extent to which each other influences each other needs to be researched further.

The significance of traditional medicine in health care has been recognized both at the international and national level. This is evident by the various strategies set up at the international level and national level to promote traditional medicine world wide.The Indian government developed a separate national policy on traditional systems of medicine and Homeopathy 2002.

The Government of India has stated that one of the objectives of this policy is to promote good health and expand the outreach of health care to our people, particularly those not provided health cover, through preventive, promotive and curative intervention through Indian system of medicine and Homeopathy (National Policy on Indian System of Medicine and Homeopathy 2002).

But only recognition is not sufficient for promotion of a system of medicine. It requires multipronged strategies for the upliftment of traditional systems of medicine. This may be possible by acting upon concerns revealed by research studies and to encourage further focused

studies to explore areas that need to be strengthened which will definitely throw light on ways to take up intervention to promote the practice and utilisation of traditional systems of medicine in the country.

Though the objective of this study was to describe the practice and to understand the utilization patterns of traditional medicine in Hyderabad, during the course of study some areas were revealed that could be worked upon for strengthening of the practice and promoting the utilisation of traditional systems of medicine in Hyderabad.

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APPENDIX

Appendix-l

Administrative Structure of the State Board of Indian systems of medicine and Homeopathy.

The Commissioner is the head of the board of Indian Systems of Medicine and Homeopathy in the state. Three additional directors one each for Ayurveda, Unani and Homeopathy and a Deputy Director (Administration) reports to the commissioner. Further there are regional deputy director Hospitals, Colleges, Research Department, Pharmacies, Deputy Superintendent and Drug Inspector for each system of Medicine respectively. They report to the Additional director of the concerned system of medicine.

Educational Setup

There are two Government Ayurvedic colleges and one privately managed college in the state. There are two Unani colleges one is a Government College and the other is a privately managed college. The college offers both the graduate and post-graduate courses.

The intake of students for the under graduate course in the government Ayurvedic colleges are 110 students every year. 50 students are enrolled for the under graduate

course in the government Unani **colleges. For the post graduate courses 28 students are** enrolled in both the government Ayurvedic and Unani College respectively.

Registration **of practitioners within the State**

The State Board of Indian Systems of Medicine and Homeopathy carry out the registration of the practitioners. The registration of the practitioners is mandatory to undertake professional practice. There are two categories of practitioners registered every year the first category is the Institutionally qualified practitioners and the second is Non Institutionally qualified practitioners. The Institutionally qualified practitioners are registered after successfully graduating from the course work. This study is limited to the institutionally qualified practitioners who are registered after successfully graduating from the course work.

Within Andhra Pradesh the registration of the practitioners of Indian Systems of Medicine and Homeopathy is carried under two boards. The Board of Indian Medicine and the Andhra Board. The Board of Indian Medicine covers the practitioners of the Telangana region of the Andhra Pradesh. The Andhra board covers the practitioner of Andhra and Rayalseema regions of Andhra Pradesh.

On Discussion with officials of the Indian Systems of Medicine and Homeopathy no clear answer was given as to why registration was carried out under two boards. **But** it **is** believed that this was done to simplify the process of registration within the state.

University of Hyderabad
Department of Anthropology
Doctoral Research

TRADITIONAL SYSTEM OF MEDICINE; PRACTICE &UTILIZATION: A STUDY IN THE CITY OF HYDERABAD.

Schedule For Practitioners

1.PERSONAL DETAILS

1.1 Name

1.2 Age_____

1.3 Sex
1 .Male 2.**Female**

1.4 Marital Status
1.Married 2.unmarried 3.widowed 4.divorced

1.5. Religion
1.Hindu 2. **Muslim** 3.christain 4.Any **other**

1.6. Caste
1.SC2.ST3.BC4.OC

1.7. Fathers **Occupation**

1.8. Main source of income

2.TRAINING

2.1. System of medicine trained _____
1 .Ayurveda 2.Unani

2.2. Educational qualifications_____
1 .Bacherlors in TSM 2.Masters in TSM

2.3. Year of Award of degree _____

2.4. Year of registration _____

2.5. Did you receive any other training in the current system of medicine /other system of **medicine**

l.Yes2.No

2.6. If Yes Details of training;

2.6.1 System of training

2.6.2 Duration of training

2.6.3 Why did you take the training[0]

3.SYSTEM OF PRACTICE

3.1. Number of years of practice

3. 2 Did you start practicing immediately after the award of degree?
l.Yes2.No

3.2.1 IF YES why

3.2.2 IF NO why not

3.3 DO you exclusively practice the system of medicine you have been trained in?
l.Yes2.No

3.3.1 If yes why

3.3.2 If no, in **what** circumstances do you follow other **systems of medicine** And what system of medicine you practice.

3.4. Views on integrative system of medicine.

3.5. Any specialization claimed **in the current system of medicine practiced.**

3.6 Any Specific reasons for choosing this particular system of medicine l.Yes2.No

3.6.1 Source of income
3.6.2Personal choice
3.6.3Family pressure
3.6.4Nothing specific
3.6.5Any other (please Specify)

4.ORGANISATION OF PRACTICE

4.1. Type of practice
1.Private 2.Govemment 3Both

4.1.1 If both why?

4.2 Hours of work in a day?
Timings. . . . . .—
4.2.1 Any particular reasons for selection of this particular time of work

4.3 Do you go for consultations 1 .Yes 2.No

4.3.1 IF Yes how many places

4.4 Place of practice

1.Residence 2.Clinic 3.Hospital 4.Any other

4.5 If private practice

4.5.1 Year of **establishment**

4.5.2 **Facilities available :**

4.5.3 Waiting room

4.5.4 Patient registration

4.5.5 Equipment available.

4.6.Do the patients need to take an appointment before they visit you? 1 .Yes 2.No

4.7 Any Specific reasons for setting practice in this present place 1 .Yes 2.No

4.7.1 Demand for practice
4.7.2 Near to residence
4.7.3 Wide social **network**

4.7.4 Any other (specify)

4.8 If only private practice would you like to have government practice. 1 .Yes 2.No

4.8.1 IF Yes . Why?

4.8.2 If no why not?

4.9 If only government practice would you like to have private practice. 1 .Yes 2.No

IF Yes why?

4.9.1 Better facilities
4.9.2 Competitive
4.9.3 No time rules.
4.9.4 Any other (please specify)

4.10.Income

4.11 .Any other source of income .

5.RANGE OF SERVICES

5.1 Patient Load
5.1.1 No: of patients attended /day
5.1.2 Males
5.1.3 Females
5.1.4 Children

5.2 The **most frequently reported disease in a** day_____

5.3 **Type of diseases treated**

5.4 Do you give **information on preventive health & medical care?**

5.5 Organization Norm Of Fees

5.5.1 Minimum Consultation fee/patient_____.

5.5.2 On what basis do you fix the fee.

5.5.3 Do you give fees concession in any circumstances 1 .Yes 2.No

If yes, circumstances

5.5.3.1 Economic condition of the patient
5.5.3.2 Review for the same problem
5.5.3.3 Regular patients
5.5.3.4 Any other (specify)

5.6 Compliance Behavior Of Patients

5.6.1. Do you take any measures to ensure that the patients adhere to the rules laid **down** by the system of medicine while undergoing treatment? 1 .Yes 2.No

5.6.6.1 If yes what are they?

5.6.2 What percentage of **patients strictly adhere to the rules &regulations of the** system of medicine

5.6.3 **What** do you **think are the constraints from the patient's point of view to adhere** to the rules?

5.7 Do you refer your patients to any other system of medicine
1.Yes2.No
If yes under what circumstances,

5.8 How do you react **when** you **find your patients resort to some other system of medicine for the current problem.**

6.PATIENT -PRACTITIONER INTERACTION

6.1 Do you **have a general talk with your patient's 1 .Yes 2.No?**

6.2 Do you take the history of the illness? 1 .Yes 2.No

6.3 Do you ever have communication problems with your patient?

l.Yes2.No

If yes is it regarding?

6.3.1 Language spoken

6.3.2 Lack of clarity of symptoms expressed

6.3.3 Any other

6.4 Do you clarify the doubts raised by the patients?

6.5 How much of time do you **spend with each patient?**

6.6.Did any of your patients return to meet you casually **after taking the treatment.**

1.Yes **2.No**

7. ATTITUDES AND OPINION

7.1 Do you personally use the System of medicine?

7.2 Does your family utilize your services?

7.3 Are you satisfied in this field?

7.4 What do you think Is the public opinion on both the system of medicine and doctors of the system of medicine?

7.4 **Problems encountered during the** practice?

7.5 Vies on **the government** efforts to uplift the traditional system of medicine?

7.6Factors that hinder the use **of medicine as** far **as** the **patients are concerned.**

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TRADITIONAL SYSTEM OF MEDICINE: PRACTICE &UT1LIZATION: A STUDY IN THE CITY OF HYDERABAD.

Schedule For Patients

1. CLIENT PROFILE

1.1 Name _____

1.2 Ace _____

1.3 Sex_____

1.4 Marital status _____

1.5 Religion_____

1.6 If Hindu. Caste_____

1.SC2.ST 3.BC 4. OC

1.7 No: of years of schooling completed _____

1.8 Current Occupation: 1.Govt. service 2. Pvt Service 3.business /self employment 4.**Professional** 5 **.Any** other (specify)

1.9 Present Place of residence
Address

1.10 Distance from the health service in K.M

2.FAMILY PARTICULARS

Name	Relation with HOH	Age	Sex	Marital status	Education	Occupation	**Income**

2.1 Family type _____

3. CURRENT ILLNESS HISTORY

3.1 Since how lony have you been suffering with **the** current illness in_____days?

3.2 Initial symptoms suffered

3.3 Actions taken from the onset of symptoms
1 .self-medication 2. Medication on the advice of the health provider 3. No action
4.Any other (specify details)

In case of two

3.4 Details of the health providers consulted prior to the current health provider.

Name of the doctor	System of medicine practiced	Duration of treatment	On whose advice consulted the Health Provider	Reasons for choosing the health provider.	Reasons for discontinuing the treatment

3.5 Would you approach the provider whose treatment you **are receiving currently for** all your general health problems . **1** Yes 2.No

3.5.**1 If no for which illnesses do you come?**

3.5.2 **If** yes.
Reasons for choosing the current health provider.

3.6 Fees paid to the health provider for each consultancy.

4. CURRENT HEALTH 1'kON H)Kk PATIENT INTERACTION

4.1 Did the doctor have any general talk with you?

4.2 Did the doctor enquire about your illness, symptoms and details?

4.3 Did the doctor give you instructions /details about the treatment, care &prevention

4.4 Did he clarify your doubts & queries 1 .Yes 2.No

4.5 Was he "pleasant" with you 1 .Yes 2.No

4.5.1 If no why do you think he was not pleasant.

4.6 IF this doctor were 'practicing' some other system of medicine would you **have** Approached him? 1 .Yes 2.No

4.7.1 If yes why?

4.7.2 If no why not?

5. HEALTH SEEKING BEHAVIOUR OF FAMILY MEMBERS

5.1 Did **any** of **your family members suffer during any illness from the past** six months?

(Take the recent two)

Refno	Relationship with HOH	Age	Sex	Actions Taken After The Onset Of Illness	Diagnosis of illness
				a.	
				b.	
				c.	
				d.	
				e.	
				a.	
				b.	
				c.	
				d.	
				e.	

5.2 Can you provide the details of the health providers approached?
(Repeat the same aspect if there arc two cases of morbidity)

Ref 1.

Name of the doctor	System of medicine practiced	Duration of treatment	Reasons for choosing the health provider.	Reasons for discontinuing the treatment

Ref 2.

Name of the doctor	System of medicine practiced	Duration of treatment	Reasons for choosing the health provider.	Reasons for discontinuing the treatment