

PLURALISTIC CARE AND THERAPEUTIC ITINERARIES AMONG A MIGRANT
TRIBAL COMMUNITY IN AN EASTERN INDIAN CITY

SUCHISMITA MISHRA,¹ YADLAPALLI S. KUSUMA² AND BONTHA V. BABU³

Abstract

In medical pluralism, issues of the selective use of one sort of healer over another and what makes people opt for a specific source of health care are important. In this article, we discuss the availability of different health-care alternatives, the conditions that lead the health-care seeker to choose them and 'therapeutic itineraries' among a migrant tribal community living in an eastern Indian city. A mixed methods approach, combining quantitative and qualitative research techniques, was adopted. Different sources of health care, conditions of illnesses for which people sought treatment and treatment-seeking behaviour in relation some common illnesses are examined. The source of treatment depends upon the type of illness, its symptoms and perceived severity. The reasons for pluralistic care-seeking are the failure of modern medicines and the perceived causes of illness. This has created dilemmas for people and often led to pluralistic care, which is sometimes pragmatic.

Key words: Medical pluralism, migration, acculturation, aboriginals, India

Introduction

In dealing with the anthropological analysis of illness and medicine, medical anthropology has started challenging the hegemonic claims of western biomedicine. Medical anthropological studies have revealed that, although modern medicine is widespread across cultures, its spread has not caused the disappearance of so-called traditional medical systems and local practices. Also, there has been no complete integration of traditional systems into modern systems or vice versa. Leslie (1992) revealed that all medical systems, both modern and traditional, are inherently dynamic and responsive to social and political change. Thus, medical pluralism has become a central concept in medical anthropology.

Early studies of medical pluralism emphasised that patients take a pragmatic view and see nothing inconsistent about liberally combining different forms of therapy in their quest for restored health (Nichter and Lock 2002). Lock (1990) showed that the dominant

¹ Department of Anthropology, Sambalpur University, Sambalpur 768 019, India.

² Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi 110 029, India.

³ Corresponding author: Health Systems Research Division, Indian Council of Medical Research, Ansari Nagar, New Delhi 110 029, India, Tel.: 91 11 26172832; e-mail: babubontha@gmail.com

medical system might be used to justify unequal social and political relations, for instance, by medicalizing socially produced health problems. The dominance and power of biomedicine or a state-supported system of medicine over other systems of care have been highlighted. Folk systems are open, as manifested by the eclecticism of both clients and practitioners, who adopt and adapt aspects from a range of co-existing medical traditions (Bhasin 2007). This openness of folk systems is manifested by the acceptance of inputs from other, alternative health systems, and also inputs from institutional sectors such as religion and the family. Hence, the traditional healer's role is situated at the interstices of religion, magic and the social system and gains its power from this position (Landy 1974). This contrasts sharply with the closed nature of biomedicine, which is 'discontinuous from ordinary social process' (Manning and Fabrega 1973) and is unaccommodating to alternative systems. Thus the origins of medical pluralism vary between different places, and pluralistic health-care behaviours are driven and influenced by diverse social, economic and cultural forces (Benoist 1996).

The tradition of medical pluralism has existed in India for a long time, particularly from colonial rule, which introduced the allopathic tradition of medicine (Bhasin 2007, 1997; Barratt 2008; Halliburton 2009; Khan 2006; Lambert 2012; Leslie 1976; Leslie and Young 1992; Nichter 1992). Many factors explain the co-existence of several systems of medicine and practitioners, including economic affordability, the availability of modern health care, cultural propensities and religious faith. Moreover, asymmetric power relations and dynamism exist both within and between multiple practices and systems, which differ from one society to another. In India, public health policy has developed to a great extent in a situation of medical pluralism (Government of India, 2003, 2011).

Though there are several issues that can be explored under medical pluralism, a much-debated conundrum has been what leads to the selective use of one sort of healer over another? Also, what are the power dynamics across various groups of healers and health-care providers (Good 1994; Orr 2012)? This debate is especially relevant when certain communities favour traditional healing and have pressing public health problems, though existing health-care provision is inadequate and has problems of access. Indigenous populations and socio-economically disadvantaged groups are examples of such communities. Also, treatment-seeking behaviour may be counterproductive, perhaps

due to a lack of timely and rational actions and the greater influence of culture on care-seeking. People have complex relationships with health-care alternatives and are open to them, though this poses a dilemma in choosing a source of health care.

In this article, we discuss the availability of different health-care alternatives, the conditions that make the health-care seeker choose them and the ‘therapeutic itineraries’ of health-care seekers in different contexts among a migrant tribal community living in Bhubaneswar city. Therapeutic itineraries reveal the pathways taken by health-care seekers and the reasons for such choices.

Methodology

Study participants and research methods

The present study was undertaken in Bhubaneswar, the capital city of Odisha (formerly Orissa), a state in eastern India. Disadvantaged tribal-dominated *bustees* (‘slums’) were first identified after a pilot study, four being selected on the basis of the predominance of the tribal community within them. Most of these tribal families have migrated from hilly forest areas of Mayurbhanj District in the north of Odisha, with a few from its neighbouring *bustees*, and they have been living in Bhubaneswar for the past twelve years. All the households in the tribal *bustees* were enumerated, and information on the total number of family members, their ages, education, years of living in the urban area and occupation were collected from each household.

A mixed methods approach, combining both quantitative and qualitative research techniques, was adopted. Quantitative data were collected through interviews with the mothers of children aged 0-14 years by using a pretested questionnaire. 175 mothers were available to us during the study period, and they were interviewed for the collection of quantitative data. The mother tongue of this community is Santali, but a majority knew Oriya, the local language of the state. If the interviewee did not understand Oriya, another family member or neighbour who could speak both languages was used as an interpreter. Questions covered the different illnesses experienced by interviewees and members of their families, their treatment-seeking behaviour with regard to these illnesses and other related issues .

Regarding qualitative methods, in-depth interviews were conducted with members of the community (29 men and 21 women) and key informants (13 men and 13 women). During the selection and interviewing of key informants, the guidelines set out by Spradley (1979) and Hudelson (1994) were followed. The check lists for these interviews included questions on the availability, access and utilization of various health-care facilities, illness experiences and care-seeking behaviour. All the participants were identified after information gathered during the regular field visits of one of us (Suchismita Mishra) working as researcher during 2007 and 2008. All the participants selected for in-depth interviews knew Oriya, and hence all interviews were held in that language. Prior to interviewing, consent was obtained from each participant by explaining the purpose of the study. Interviews were audio-recorded with the consent of the participants.

Data management and analysis

The data obtained from the quantitative surveys were entered into a computer using Microsoft Excel, and analyses were carried out using SPSS for Windows v.20. With regard to in-depth interviews, the audio cassettes were played back and transcribed in Oriya and the field notes used as an adjunct. Later the Oriya scripts were translated into English. During the transcription and translation of the qualitative data, the guidelines set out by Mergenthaler and Stinson (1992) and McLellan, MacQueen and Neidig (2003) were followed. These notes were entered into a personal computer using Microsoft Word and content analysis was carried out. The data were coded inductively while reading and the coded data were subjected to thorough and repeated reading, the coded text being reorganized under various themes and inferences drawn by following constant comparisons.

Results

Sources of health care

The present study community possesses a medical system which includes traditional healers and their activities, as well as both formal and non-formal health-care institutions and their healing practices, which are a part of their society. The source of treatment

depends upon the type of illness and its symptoms. The sources of treatment are the *gunia* (traditional healer using herbal and magical treatment), government health-care institutions, including community-based mother and child health-care centres (*anganwadi* centres), private clinics (allopathic and homeopathy), the health personnel of other sectors like NGOs, Christian missionaries, etc. and medicines stores (pharmacies). When people were asked what they do when a child is ill, a majority of respondents replied that they take it to the doctor for treatment. On further probing, it is revealed that people are pluralistic and approach different sources of care depending on the type and perceived severity of the illness. The sources of health care are described below.

Traditional healers. The first contact of the present study community for health care is the traditional healer, referred to as *gunia* by this community. The traditional healer is contacted for the majority of illnesses. People usually prefer to go to the *gunia* to seek herbal and magico-religious treatment for illnesses like jaundice, piles, menstrual problems like white discharge and pain during menstruation, loose motions, vomiting and headaches. However, amalgamating concepts also leads to pluralistic care-seeking itineraries. For example, if an illness is not cured after seeking treatment from an allopathic doctor, that illness is attributed to the anger of the ancestors or the interference of spirits preventing the modern medicine from acting on the illness. In such cases, people visit the *gunia* for spiritual and traditional remedies and then continue the allopathic treatment, with a belief that the medicine (allopathic) will work after the *gunia's* intervention. Some participants reported that allopathic doctors also advised them to consult the *gunia* before seeking treatment from them (the doctors). However, people perceived that herbal medicines are no longer available due to deforestation and that these diseases are therefore not being cured to the same extent as in earlier times. This has been cited as one of the reasons for preferring an allopathic doctor to a traditional healer. It was also a practice for patients to stay with the *gunia* in his house in the case of some illnesses, where they perform some rituals and follow certain practices as prescribed by the *gunia*.

The quantitative data collected from mothers support the above findings. In the case of serious illnesses which allopathic medicines have not cured, people consult traditional healers. A considerable number of people (41.1%) consulted traditional healers in the

case of fever, as this is believed to be a manifestation of several illnesses that are caused for spiritual or magical reasons. About 37% of informants said that they consult a traditional healer in cases of diseases attributed to the evil eye or spirits. Also, a few people consulted traditional healers for other illnesses like loose motions (14.3%), jaundice (9.1%), vomiting (4.6%) and white discharge (1.7%). About 14% of mothers reported that they consulted traditional healers when modern medicines failed to cure the illness. A very small proportion of people (1.1%) said they consult the traditional healer for all illnesses.

Government allopathic institutions. People go to government hospitals for the treatment of serious and acute illnesses like diarrhoea and malaria. Quantitative data reveal that 46% of participants visited government allopathic clinics for any illness. Mostly, mothers sought treatment from this health-care source for fever (21.7%) and diarrhoea (10.9%). Conversely, a considerable proportion of mothers (29.14%) have never visited government allopathic hospitals. However, in qualitative research we found that people prefer to visit government clinics at night, as private clinics are not available during that time. Some private hospitals are open even at night, but they are very costly. Also, people prefer to use the services of government hospitals if faced with a financial crisis. However, there are also several reasons why they do not usually go to government hospitals, including the fact that they are far away from where they live, the apathy of the staff in government hospitals and the inconvenience of the opening times of some such hospitals.

Private allopathic clinics. The majority of mothers reported that they sought treatment for their children from private allopathic doctors in cases of fever (88.6%) and diarrhoea (76.6%), as people believe that these diseases are serious and life-threatening. A few mothers (3.4%) reported that they also sought treatment there for malaria. A few mothers (3.4%) stated that some minor illnesses, like scabies, colds, wounds, etc., were also treated by private allopathic doctors. Only 1.7% of mothers stated that for every illness of their child, they consult a private doctor. Qualitative inquiry revealed similar findings. The locations of the private clinics are convenient for the study population, and usually people visit private allopathic clinics located close to where they live.

Homeopathic institutions. The tribal migrant population in the present study also use homeopathic treatments. Around 15% of informants reported that they visit a private homeopathy clinic, mainly when seeking treatment for young children, particularly for mild illnesses. People prefer to take children to them, as the taste of the pills is sweeter, and the children easily ingest the medicine. Also people believe that homeopathic medicine is more suitable for infants and children.

Pharmacies (medicines stores). People bought medicines from medicine stores for minor illnesses like cold, scabies, cough, loose motions, fever, etc. The quantitative data revealed that they seek treatment for diarrhoea (43.4%), fever (15%), colds (8.6%), headaches (5.1%), stomachaches (4.6%), scabies (2.9%) and wounds (1.1%). Sometimes they seek treatment by showing a prescription given by the allopathic practitioner (usually the list of medicines) related to previous episodes of illness and buy the medicines accordingly. But often they explain their (or their family member's) medical condition (symptoms) and seek medicines from the pharmacy. In both the cases, the vendor takes only the cost of the medicine and offers a free consultation. People see this as a positive factor in seeking care from them, and these shops are very close to where they live and are open till late at night.

Other health-care providers. People also seek treatment from other allopathic sources of health care such as non-governmental organisations and Christian missionaries. Usually paramedical workers are available there and offer treatment for minor illnesses. Services and some medicines are provided for free. Also, these personnel visit areas that are nearer to where patients live.

The government has established an *anganwadi* centre in one of the tribal *bustees*. An *anganwadi* is a community-based mother and child health-care centre managed by a community health-worker paid by the government. It provides vaccines and some staple food regularly to children, and occasionally medicines for minor illnesses like colds, coughs, and scabies for free. However, as these centres do not deliver health-care services regularly, people usually do not rely on them.

Home remedies. Home remedies usually involve herbal medicines which are known to most of the adult members of this community and which are used as a remedy for mild and non-serious illnesses like scabies, colds, etc. Some people use home remedies for

some serious illnesses like dysentery, jaundice and measles; however, they use them cautiously only after consulting their elders. Quantitative data reveal that home remedies are used to treat most common childhood illnesses in this community, i.e., scabies (46.9%), and colds and coughs (42.9%). About 19% of mothers revealed that they use home remedies to cure diarrhoea. Other illnesses for which home remedies are used are measles (14.9%), wounds/boils (10.9%), jaundice (7.4%) and stomachache (2.9%). The qualitative data revealed that only home remedies are used for some illnesses like measles and jaundice, as it is believed that modern medicine will aggravate these illnesses. However, there were only a very few elderly individuals who knew about these herbal medicines.

Spiritual care. Worshipping gods and goddesses (including Hindu gods and goddesses) and ingesting holy water (usually water with *tulsi* leaves (*Osimum sanctum*) and *prasad* (a food item that is considered holy, as it has been offered to a god or goddess) are often observed as treatments for several illnesses, particularly for serious and long-term illnesses. This practice is due to the influence of neighbouring Hindu communities. People visit a nearby temple to Shiva and receive this holy water, or sometimes they are given it by Hindu priests. Also, they ask the priest to perform some rituals, which people refer to as *manasika*. Only spiritual-based care along with some home remedies is sought for certain illnesses like measles, and no other treatment was noticed. Allopathic treatment is strongly prohibited for measles. It is believed that allopathic medicine cannot cure this illness, and moreover allopathic treatment, particularly injections, are perceived as contraindicative to measles.

Health-care seeking by illness

A brief description follows of treatment-seeking behaviour for some common illnesses, based on the qualitative data collected. These illness-wise descriptions illustrate the pluralistic nature of medical care among this migrant community.

Malaria. People reported knowledge of how to treat malaria using herbal medicines. First they consult the *gunia* to confirm the presence of malaria. Qualitative enquiries revealed that they prefer to go to the *gunia* for this reason rather than have a blood sample taken in the laboratory to test for malaria. It is believed that the *gunia* can detect

malaria by testing urine. People take herbal medicines like *jungle chilly* (a local herb, whose leaves taste bitter) ground with pepper to treat malaria. They usually wait up to seven days after taking herbal medicine, and if the illness has not receded, then they consult an allopathic doctor for treatment.

Scabies. In cases of scabies, people seek herbal treatment because they believe that only herbal medicines can offer a complete cure for skin illnesses. It was reported that allopathic doctors can also treat this illness; however, it is also believed that the disease will recur if non-vegetarian food is eaten.

Measles. Only spiritual or ritual-based treatment is sought in cases of measles, along with some restrictions on the movement and diet of the sick person. People do not seek treatment for measles from allopathic doctors, since they believe that the disease will then be suppressed inside the body and will not come out of it, and ultimately the patient will suffer from bodily aches. For this reason, foods like popped rice, *neem* leaves with rice water, parboiled rice, some pulses and sour food items like mango curry, *handia*, *amda* fruit, etc. are prescribed to facilitate the rashes coming out of the body, so that the patient can obtain relief from bodily aches. In addition, some home remedies are followed.

Jaundice. For jaundice, people usually seek herbal treatment for various reasons: for example, it is believed that, if a doctor treats them and gives an injection, the illness will be suppressed and there is a chance of its recurrence in the future. The high cost of treatment is another reason for not seeking treatment from an allopathic doctor. People seek herbal treatment for small amounts of money, and sometimes the *gunia* does not take money from them for treating the illness. It is believed that this disease will only be cured permanently by taking herbal medicine.

Vomiting. It is believed that vomiting occurs due to the effect of the evil eye. If someone sees a child while it is eating and if the child develops some illness like vomiting, it is often attributed evil eye. It is also believed that vomiting is due to a disturbance in the stomach that occurs by poison being formed inside the stomach due to the evil eye. Usually for this illness traditional healers are consulted, who pretend to suck the poison out of the patient's body and spit it out.

Preference for shifting to home area during illness

It was observed that these migrants often return to their home areas for a short period to seek treatment, particularly for serious and long-term illnesses. They consider their home area to be good for their health owing to its natural surroundings like the fresh, good-quality air and the food available there. It is always thought that, whatever food they consume in the alien land of the city, is not good for their health. Most importantly, ancestors are believed to be living in their home areas and to protect them from various misfortunes, including ill-health. In addition, migrants can receive financial and emotional support from their relatives and friends living in their home area. Thus, it is perceived that their home area is good for their health, as well as for receiving treatment. Recourse to the home area is often reported in cases of long-term illnesses and if the condition is not responding to allopathic treatment sought in the city. Additionally, factors like finance, social ties, familiarity with both modern and traditional health systems, the perceived competence of traditional healers and complementary medicine in rural areas of origin lead to this move back to the home area. Informants said that traditional healers (*gunias*) back home are more effective than those living in the city. Apart from these beliefs and perceptions, the government health system in their tribal area back home is friendlier to them. People are well acquainted with the primary health centres and their staff there, and they receive both treatment free of charge and free medicines. Doctors and other staff in these institutions are cooperative. People feel comfortable with them, compared with the health-care staff in the city. All these issues influence patients in moving back home in the case of serious illnesses, contrary to the general practice of seeking treatment for serious illnesses in cities by the rural population.

Reasons for pluralistic care: therapeutic itineraries

Pluralistic care-seeking is common. In this section we attempt to understand the reasons for seeking pluralistic care. Generally, if the medicines prescribed by private doctors did not show any improvement in the condition, especially fever and loose motions, within two to three days people changed the source of treatment to government doctors in many cases. It was believed that the *gunia* can treat some evil eye- or spirit-affected illnesses. If the illness was not cured even after consulting an allopathic doctor, they consulted the

gunia and after that continued the same (allopathic) medicine for cure of the illness. For illnesses like scabies, coughs and colds, first they consulted the elderly, who suggest herbal medicine, and if there was no relief, then allopathic treatment was sought. Some people performed *manasika* (spiritual care) in temples to speed up their recovery when the illness had not been cured for long time even after consulting doctors. Sometimes, due to a fear of surgery, people change the allopathic treatment to herbal medicine if the disease is not life-threatening. If the doctor asks the patient to undergo minor surgery, the latter might hesitate and shift to herbal medicine, which is less costly and less threatening.

Discussion

Treatment-seeking behaviour varies from culture to culture, as illness and care-seeking are patterned by culture. Humans try to learn how to treat diseases and in doing so have acquired a vast complex of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals and symbols that interlock to form a mutually reinforcing and supporting system (Kshatriya 2004). Various socio-cultural factors are associated with the selection and changing of sources of treatment. In the present study herbal-based treatment is preferred to allopathic treatment in cases of minor ailments, as the former is less expensive. It is to be noted that about eighty percent of the world's poor and rural populations rely on traditional or herbal medicines for primary care (World Health Organization 2002). In the case of these tribal migrants, for minor illnesses herbal-based treatment is given priority, and traditional healers or the elderly from the community are consulted for the appropriate herbal medicine. Fear of injections and surgery, the cost of treatment and an inability to communicate freely about certain illnesses are the reasons given for avoiding allopathic treatment and preferring herbal medicines. Generally people change the source of treatment if the illness is not cured by the initial treatment.

The severity of the illness often tempts people to change from one source of treatment or system to another. Yoder and Hornik (1994) also underline the change in treatment-seeking behaviour in the context of the severity of the illness. During severe illnesses, people prefer to go to the government hospital, mainly owing to the costs involved in

receiving treatment from private providers. The perception of severity is the basic factor which influences the treatment-seeking pattern. People seek treatment from multiple sources for a single illness. Their interpretation of the illness also determines the type of treatment they seek.

The present study considers population, health and illness from the cultural point of view. A cultural interpretation is appropriate even for those illnesses for which the community accepts the modern biomedical explanation, and thus the concepts are not separable from their own sense of logic. Illnesses are classified on the basis of cultural explanations (for example, perceived aetiology) and severity. Treatment-seeking behaviour is often based on this classification of illnesses. Green and Britten (1998) showed that subjective meanings influence how patients integrate treatments with everyday life, and other studies have also shown that lay beliefs about medication differ from standard biomedical interpretations (Jones 1979; Donovan and Blake 1992; Verbeek-Heida 1993; Marinker 1997; Conrad 1985; Mishra et al. 2012). Cultural ideas play a central role in determining who needs medical care, when and for what conditions or illnesses and with what results (Hahn 1995). Thus, the interpretation of an illness and its perceived causes determine the choice of types of care, be it bio-medical, traditional or spiritual (Rashid et al. 2001). Thus, due to variation in the severity and type of illness, treatment is sought from different health-care sources, in addition to the overwhelmed influences of culture. Hence the existence of different types and traditions of health care, which is the basis of medical pluralism.

Bhasin (2007) defined medical pluralism as the synchronic existence in a society of more than one medical system grounded in different principles or based on different world views. In this study population, the health-care pattern is characterized by pluralistic care, including home remedies, consultation of traditional healers for both herbal and spiritual treatment, government health centres and private health-care services which include both allopathic and homeopathic treatment. In this regard, Khare (1996) explicates the practice of medicine in India and describes not only how India manages multiple traditional and modern medical approaches, languages, therapeutic regimens, etc., but also how this leads us to a sustained moral, social and material criticism from within. The addition of pharmaceuticals to a repertoire of traditional remedies is not

uncommon, and, universally, people tend to see nothing inconsistent in their use of both. Users follow local concepts of illness and treatment and focus on relief from symptoms, with the criterion of effectiveness uppermost in the valuation of the medicine (Leslie 1980; Ngokwey 1995). The management of and seeking care for measles in several communities demonstrates how local concepts of illness influence treatment-seeking behaviour (Odebiyi and Ekong 1982; Mishra et al. 2012). In an earlier article we reported beliefs about illness aetiologies, illness experiences and folk systems of the management of illness related to measles in this community (Mishra et al. 2012). Similar cultural constructs and related illness-management practices have been noted for several illnesses in several cultures (Murdock 1980; Young 1982; Hahn 1995).

With regard to modern health care, availability and ease of access are important determinants of treatment-seeking behaviour. In the present community, only a small proportion of people accessed government health facilities. Many marginalised societies like the present study community experience low access to modern health care, usually due to health system-related factors (Babu et al. 2010). Studies of tribal communities revealed that factors like scattered settlements of the population, the scattered location of health facilities and tribal culture are responsible for low access to health care. In addition, the behaviour of health-care staff may not always be favourable towards tribal communities. Health-care staff, particularly in places where these groups are in a minority, can be indifferent towards them (Babu et al. 2010). Thus the situation for urban migrants may be worse compared to conditions in their rural areas. In addition, the areas where these poor urban migrants live fall outside the coverage of government health services largely due to their illegal status and the migrants' fluidity of movement. Another form of allopathic medical care is buying medicines from a pharmacy, which is cost-effective, as consultation charges are not imposed. If migrants seek treatment from a clinic, they may have to wait longer to see a doctor. Van der Stuyft et al. (1996) supported this view about pharmacists and emphasized that pharmacists frequently dispense advice as well as medication but generally do not receive professional training. Due to the lack of free medicines, too much waiting time and the lack of co-operation from hospital staff, people often hesitate to go to the government hospital and seek treatment from pharmacies, as they believe in using allopathic drugs for certain illnesses.

Studies have highlighted the weakness of the government sector and the satisfaction with the private sector (Gilson, Alilio and Hegyenhongen 1994; Babu et al. 2000).

The duration of the illness also sometimes decides the provision of treatment. Unmet expectations from allopathic medicine also influence the change of treatment from allopathic to spiritual and other sources. Before consulting a doctor, people seek the help of a traditional healer to find out whether the evil eye or a spirit is involved. People perceived that seeking medical treatment without consulting a traditional healer is not desirable. Bastien (1982) and Green (1985) emphasized that individual treatment choices are shaped by the type of disease, the seriousness of the illness, and whether treatment is sought for physical symptoms or for the 'ultimate' (social and supernatural) cause of the illness. As Cosminsky (1977) reports for a Guatemalan plantation, pluralistic behaviour is pragmatic, often based on trial and error, perceived effectiveness, uncertainty about the cause of the illness and expectations of quick results. In this community, however, empirical and pragmatic behaviour is due to the main role played by belief in the supernatural or the spiritual in curing. The present migrant tribal community has been changing at a certain rate along with their concepts of health and illness. Cultural values thus have a profound impact on perceptions of illness among the present study migrant community in an urban area. Cultural exchange with non-tribals is nonetheless bringing about some change in their concepts and views. Thus this community, with their traditional perceptions alongside modern facilities, are trying to adjust to the modern world, which for them means an urban culture. However, in some cases avoidance or delay in seeking medical care needs an approach which takes into account their perceptions about health and illness. The present study reveals that people also seek treatment by trial and error, often changing the source or system of treatment, even when the cause of the illness is uncertain. This pragmatic approach to seeking treatment is seen among modernizing communities like these tribal-urban migrants.

Conclusions

Thus medical pluralism, or the synchronic existence of different health-care systems in a society, is grounded in different principles and different world views. The continuation of dynamic traditional healing practices alongside modern medical practices is prevalent

among these migrant tribal populations. Migration to urban areas and subsequent exposure to the newer environment, newer knowledge, different people (non-tribals) and facilities, though less accessible to these migrants, lead to a greater reliance on modern health care. However, these newer forms of exposure and knowledge have not led to the replacement of traditional cultural treatments. The present situation has created dilemmas for our informants in choosing sources of health care and often leads them to adopt pluralistic care, which is sometimes pragmatic. The failure to deliver government health-care services in urban areas is also a reason for the existence of other sources of health care in this community. Also, people often return to their home areas in seeking treatment (either from traditional healers or from medical systems), particularly for long-term illnesses. This recourse can be situated in the context of socio-economic disadvantage, persisting alienation in the newer urban environment and health system-related factors in urban areas, coupled with the absence of efficient and knowledgeable traditional healers. The medical system of a community or a region includes health beliefs, skills, practices and other available resources. Now, the government's policy is conducive to mainstreaming various traditions of Indian or alternative systems of medicine within the public health-care system. Traditional medicine nonetheless still remained a source of care for many people. The richness behind traditional forms of medicine should be emphasised more by policy-makers so that both traditional and allopathic health care can be exploited in fulfilling the health needs of this disadvantaged segment of the urban population.

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