'Healing, Medical Power and the Poor: Contests in Tribal India'

A recent workshop in Surat on access to healing and medical intervention for tribal people brought together academics, grassroots workers and activists and revealed deteriorating traditional systems and inadequate and/or exploitative state and private interventions for these communities. Rather than exoticising and romanticising tribal communities, it is their pauperisation that needs to be addressed and remedied.

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The Centre for Social Studies, Surat, and the Centre for the History of Medicine, University of Warwick, UK held a three-day workshop from March 21-23, 2007 on the theme 'Healing, Medical Power and the Poor: Contests in Tribal India'. The workshop brought together academics, grassroots workers and activists to dialogue on health development work in tribal India, historically and in the current political climate.

David Hardiman began by introducing the theme of medical power as it relates to the tribal peoples of India. Since the late 19th century, an increasing number of groups have sought to provide healthcare for these people. The British colonial rulers were concerned above all with controlling and opening the tribal territories to exploit their forests and other resources, and they established dispensaries that catered largely for officials rather than the mass of the people. They were followed by protestant missionaries, who provided medical care as a means to gain the sympathy of tribal peoples with a view to ultimately converting them to Christianity. This process was initially contested during the early 20th century by Gandhian and other nationalists, with their own views on sanitation, cleanliness and health. After independence in 1947, the state extended its programme through primary health centres (PHCs) and various preventive campaigns – such as vaccination, inoculations, and DDT spraying to eliminate mosquitoes. Others entered the scene, such as committed NGO workers, catholic fathers and nuns, evangelistic faith healers, religious organisations, and political and quasi-political groups. Despite all this attention, healthcare in these areas is at best patchy, and generally highly inadequate.

In India as a whole, the tribal peoples today make up about 8 per cent of the total population of over one billion. They belong to a range of kinship-based communities associated with interior regions that are often hilly with poor soil. During the colonial period, they were excluded from large tracts of their homelands, which were reserved for government-controlled forests. Subsequently, many have been displaced through large-scale irrigation and other development projects. As a result of these processes, many are unable now to make a living from the low-grade land they retain, and have to work as migrant labourers outside their own region, for example as seasonal agricultural labourers and on construction sites in the towns and more prosperous rural areas. Their conditions of work are very bad, they live in temporary camps or slums, and wages are low and often paid only partially. Their general condition is characterised by poverty, social exclusion, susceptibility to exploitation, and poor health. The desire to provide improved health services for the tribal tracts has a number of causes. For some, such as NGO workers and a few dedicated doctors, there is a commitment to social service. For others, such as many official health workers, it is just a career posting which they have to fulfil on the orders of their employer, the government. Politicians have a vested interest in appearing to provide healthcare in such areas, for the scheduled tribes are important within the modern Indian political system. Since Indian independence in 1947, their vote has been decisive in a significant number of parliamentary and state assembly seats. In Gujarat, for example, 26 out of a total of 18 state assembly seats (14 per cent) are reserved for the scheduled tribes, which in tight elections would be enough to determine the result. For this reason, different political fractions of the dominant classes have a strong interest in extending their power and influence over the tribal peoples, and health and healing is a major weapon in their armoury in this respect. In addition, improved health profiles in such tracts help to open them up for economic exploitation by outsiders, as well as to provide a potential base for a growing market in internal tourism.

The keynote address was then given by Jan Breman, who raised the question as to why we should focus on the tribal people in such a workshop. Taking an *EPW* article of 1993 by A M Shah as his starting point,[1] Breman argued – contra to Shah – that it is important to distinguish tribal peoples from other poor and disadvantaged people in India. While Shah argued that the concept of the "tribe" was a colonial construct that worked to divide the Hindu community, Breman argued that caste Hindus have always seen the tribals as a people apart, labelling them with derogatory terms such as 'kaliparaj' ("black people") or 'janglis' (the "wild and untamed"). Today, rather than being integrated within the wider Hindu society on equal terms, they are accepted only in so much as they are prepared to accept their lot as a highly exploited and subservient working class. At best, they can be incorporated as a caste at the lower levels of the caste system. Breman therefore concluded that it is important to treat tribal people as a separate analytic category, in part because the history of the expropriation of their resources and subsequent social incorporation has its own particular quality, and in part because they continue

to be discriminated against and stigmatised. His address did not go unnoticed in the Gujarati press, which is known for its espousal of a strong Hindutva line, and which set about distorting what he had said to create sensationalist headlines. For example, the local Surat daily *The Gujarat Mitra* stated that Hardiman (sic) had claimed that "tribals are not Hindus". In fact, Breman had been trying to show the adverse ways in which many tribals are becoming Hinduised – but this subtlety was ignored. Their failure to even get the name of the presenter correct also revealed the shoddiness of their reporting. Following that, in a subsequent issue of the same paper, Swami Ambrishanand of the Hindu Milan Mandir challenged Hardiman – once again – to prove that tribals are not Hindus. The English language press in Gujarat, on the other hand, took a largely noncommittal line, avoiding controversy.

Indigenous Healing Systems

In the first thematic session, the focus was on the tribal systems of healing, particularly how such forms of healing have changed over time, and their role today. The myths and legends of the tribal people reveal that they suffered from a wide range of ailments – endemic as well as epidemic – in the past. They were left largely to their own devices when ill, with most healing being carried out by relatives and neighbours using herbal and other folk remedies. Tribal specialists ('bhagat', 'buvo', 'bhopa' or 'ojha'), who used herbal remedies, cauterisation, divination and exorcism, treated the more intractable cases. These people were highly respected and had considerable social power. These forms of indigenous healing have continued and evolved, and are still practised very widely in tribal areas to this day. Today, some of these healers practise a hybrid form of healing that combines ritual with various quasi-allopathic or complementary medical practices. In general, colonial officials, missionaries and the western-educated Indian elites have been unsympathetic towards such practices, though in recent years drug companies as well as forest officials have sought to exploit their knowledge of herbal remedies. Such healers do not generally like to impart their knowledge to others, and this can create tensions.

In his paper, Minoo Parabia argued that his investigations in tribal south Gujarat had revealed the use of over 2,000 species of medicinal plants, a number far higher than the plant remedies known about in ayurvedic medicine (in all, ayurvedic texts speak of about 650 plants, 250 of which cannot be properly identified). He estimated that in India as a whole, tribal people use about 6,000 species in their healing. There is here, he argued, a rich resource that is being under-utilised, especially as there is evidence that some of these plants can treat conditions that are considered incurable in allopathic medicine. As it is, modern development is leading to a rapid deterioration in the tribal environment, with a resulting destruction and loss of many of these plants. He himself is working on a scheme to enable tribal healers to be granted plots of forest land where they can grow and collect plants, process them, and then practise from a special centre at Ahwa in the Dangs.

In the next paper, S Kamegam provided a detailed account of a healing ritual performed by the Kani tribe of the Tamil Nadu-Kerala border region, which is known as 'Chattrupattu'. This is a community-based ritual that is designed to rid the whole social space of malign influences. Despite the advent of modern medical facilities, the ritual continues to be popular, as it satisfies a demand for community-based healing over and above the more individualistic forms of healing provided by allopathy. The main problem with it is that it costs a lot to perform, as the ritual specialists have to be provided with a considerable amount of paraphernalia.

In his paper, Amit Mitra adopted a sceptical tone towards the whole subject of indigenous medicine. He said that our knowledge of it came originally from colonial officials and missionaries. The classic work on tribal medicine was written by the Norwegian missionary Bodding, who worked amongst the Santals of Jharkhand from 1889 to 1933. Bodding, he argued, tended to exoticise indigenous beliefs about disease and healing, focusing in particular on beliefs about witchcraft and evil spirits. He also propagated romanticised beliefs about the healing powers of forest plants and herbs. As it is, since the 1940s, the Santals have relied mainly on allopathic healers, who provide "fast" medicine such as injections and saline drips – normally at a very high price. Many of these are quacks without formal qualifications. In a survey that he carried out in Dumka district, he found that 45 per cent of tribals consulted a private doctor with some form of qualification, 19 per cent went to quacks, 5 per cent went to a government establishment, 2 per cent used a medical shop only, while only 2 per cent consulted the 'ojha' and 'jaributi' (traditional healers). The remainder (27 per cent) failed to get any treatment at all. Mitra argued that the forest environment in Jharkhand has deteriorated to such an extent that no healing herbs are effectively available. Calls for indigenous medicine to be revived take no heed of this present reality. They rely on romanticised notions of a tribal past that in itself can be questioned. The paper proved controversial, both in terms of its critique of colonial forms of knowledge and the extent to which its findings were more widely applicable. It was argued that Bodding was a careful ethnographer whose findings have been reinforced in subsequent anthropological studies, and also that divination and exorcism continue to be widely practised in tribal regions to heal psychosomatic problems. This latter area was ignored in the paper that had focused only on physical ailments and their treatment. Also, it was argued that Mitra had failed to show how and why allopathic treatment has become more popular in recent decades.

Scientific Medicine and Faith Healing

There were two papers in this panel, one by David Hardiman on Christian therapies in tribal Gujarat, and the other by Pradip Chattopadhyay on Christian and nationalist healing for the Santals of Bankura and Birbhum districts of West Bengal. In his paper, Hardiman argued that the missionaries began to focus on the tribal regions of Gujarat from the 1880s onwards. The relevant missions were all protestant – there were no Roman catholic missions working in these areas until the 1960s. They found that they could win sympathy and converts through medical work, and they therefore invested much energy and finance in establishing dispensaries and hospitals. They were the first people to provide biomedical care for the tribals in any systematic way. The missionaries often insisted that Christian converts renounce the indigenous healers, who they viewed as their rivals, and this could give rise to local conflicts. The foreign protestant missionaries won very few converts in tribal Gujarat, largely because of such conflicts. This has changed in recent years as Indian Christians, mainly from south India, have won a wider base through a

very different form of therapy – that of faith healing. Although this can in one sense be seen as a form of indigenisation – with Indian pastors using methods that are understood and appreciated by tribal peoples – we may understand it also as the assertion of an alternative form of healing that is every bit as "modern" as allopathic medicine. Faith healing by bodies such as the Pentecostalists has come to the fore in recent years as much in the rich countries of the west as in the poor and underdeveloped tribal belts of India. Moreover, it likewise has a global presence, as reports from tribal villages in India of miraculous cures through faith are consumed as narratives of healing by a worldwide Christian audience through the internet.[2] In his paper, Pradip Chattopadhyay argued that the santals have had a holistic understanding of health, in which healing is rooted within the community. In recent years, however, fractures have appeared in this holistic approach, with the emergence of more individualistic health-seeking behaviour and the growth of a medical market place.

In the discussion that followed, Jan Breman argued that allopathic medicine focuses on the individual in isolation from a social context, and thus fails to satisfy a continuing desire for community-based healing. The popularity of healing dramas performed by evangelical Christians should be understood in such terms. On the whole however, such healing performances are likely to be strongest in situations in which the community retains some integrity. In the case of the highly depressed and exploited halpatis of the plains regions of south Gujarat, it is hard to find any great sense of community solidarity or even strong religiosity and he had heard some people say that "my god is my liquor". They drink to dull the physical and mental pain of their lives, they lack access to either indigenous or allopathic forms of healing, and most die before the age of fifty, often through liver cirrhosis. The problem here is above all one of intense exploitation and grinding poverty. Large numbers of displaced and migrant tribal people live such lives in India today.

Private Practitioners

The third session of the workshop was on private practitioners. Gauri Raje presented a paper on private doctors in the Dangs district of Gujarat. The doctors that she studied are a very individualised group, with no strong community base in the area. They come from various parts of India, and belong to many different castes. Some, who have had full medical training and are more scrupulous in their practice, are highly respected, tending to cater for the local social and political elites. Others are poorly qualified, or lack any qualifications at all (one even claimed to have forgotten where he had qualified from!). They treat a range of acute illnesses, such as fevers, respiratory infections, as well as general "weakness" (a common complaint). These doctors rely mainly on penicillin injections and saline bottles. Their abilities are not taken for granted, and a botched treatment can lead to a sudden end to practice. They tend to divide areas of work among themselves, being often fiercely possessive of "their" villages. They often give treatment on credit, taking from 40 per cent to 50 per cent in interest, thus establishing themselves in a patron-client relationship towards their tribal patients. The tribals do not however assume that such doctors are better in all circumstances, and many illnesses are still treated by local healers – the bhagats. The quacks do not in general intrude into this sphere of healing. In general, it is believed that private medicine is superior to state medicine. If treatment is given free of charge, as at a Primary Health Centre, it is assumed that the doctor has no liability to cure properly, and that the medicine will be no good.

In his paper, M Saji examined the problems faced by tribal people who take advantage of reservations to gain medical training. He found that they are often discriminated against in medical colleges, finding it hard, for example, to clear the oral tests conducted by high caste examiners. They also face discrimination when they start to practise. He argued that the dominant medical discourse in India makes it very hard for tribals to gain legitimacy within the medical system. Constant questions are raised about their alleged incompetence on the grounds that ineptitude is rewarded over and above merit for political reasons.

Non-governmental Work

Continuing in the tradition established by the missionaries and then nationalists, many non-governmental organisations are now involved in health projects of one sort or another in tribal areas. Bina Sengar provided a history of one such group, Archvahini in Gujarat. The project was initiated in 1977 by doctors associated with the Sarvodaya movement, with one base initially in Mangrol on the banks of the Narmada. They believed in providing high-quality allopathic treatment in a

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pleasant and caring environment. They have with some success fought the notion that "good" allopathy lies in the use of injections and drips, and have gained a reputation in the area for providing effective cures by other forms of treatment. Anil Patel, currently in charge at Mangrol, is a strong advocate of allopathic treatment, stating that he is prepared to be open minded about non-allopathic remedies, but only if they have been proved through clinical tests. Asish Satav, a Gandhian, then talked about his own work in Melghat, a tribal area of eastern Maharashtra. He talked about the severe health problems found in this backward tract, with high infant mortality, acute malnutrition, widespread tuberculosis, anaemia, malaria and AIDS. There is also serious addiction to alcohol and tobacco amongst the tribal people of that area. He described how his project provides all-round clinical and preventive care, and also runs a campaign to persuade people to give up liquor and tobacco. In both cases, dedicated work by committed doctors had achieved admirable results in particular localities. The question that arose in the discussion was to what extent such models could be duplicated on a wider basis, given the severe lack of such dedicated medical workers in India in general. What happens when the charismatic individuals who run such schemes depart the scene or retire?

There were also short presentations of four NGO health projects in Gujarat. Sonal Shroff spoke about a project among tribal people who were displaced thirty-five years ago by the Ukai dam on the Tapi river in south Gujarat. The displacement area is a particularly depressed one, with a large proportion of the population relying on migrating out annually to earn their livelihood. Shroff pointed out that most NGO and other health projects are village-based, which means that migrants have no access to such facilities for most of the year. Being considered "non-residents" in the plains regions where they work, they are unable to access effective healthcare there. Ketan Zaveri spoke about his work for the Bhansali Trust, and Shubhalaxmi and Dhare about their work for SEWA. SEWA is a trade union of women working in the informal sector, and it works mainly to facilitate access for its members to government healthcare. However, it also encourages self-medication through herbal remedies and ayurvedic treatment. Ashwin Shah and Harsha Shah then talked about their work at Kharel in Navsari district. Although this area is in close proximity to a number of medical centres, the local halpati community as well as the incoming tribal migrant labourers make very little use of such facilities. Instead, they rely on their own devices, such as branding with a hot iron. There is very high malnutrition caused by poverty, and high rates of infant mortality. The doctors found it particularly hard to persuade the halpatis to make use of their facilities, due to – so they said – their poverty, ignorance and superstitious beliefs. Alcohol addiction is a particularly grave problem amongst the local tribals, and most die before the age of 50.

These presentations brought out the fact that NGOs are faced with a variety of local problems, and that they adopt many different approaches to healing. Some adhere strictly to allopathy; others are more eclectic in their approach. Much depends on the particular political and ideological leanings of each group. Some are much more successful than others. It was pointed out in the discussion that the government has been depending increasingly on NGOs to carry out fundamental health work in India. In this, the Indian government is merely following wider directives laid down by bodies such as the World Bank and World Trade Organisation that have an ideological commitment to decreasing governmental welfare programmes.[3] Funds are being increasingly channelled into the NGO sector, allowing for the proliferation of many sub-standard, or even bogus NGOs. It also absolves the government of responsibility for healthcare. NGOs may lack the appropriate qualifications and facilities for the tasks they take on, and they are also not accountable to the electorate. Although it is clear that government health projects are often mistrusted – for good reason – it was agreed that NGOs can never be an adequate substitute for systematic health schemes implemented by the state.

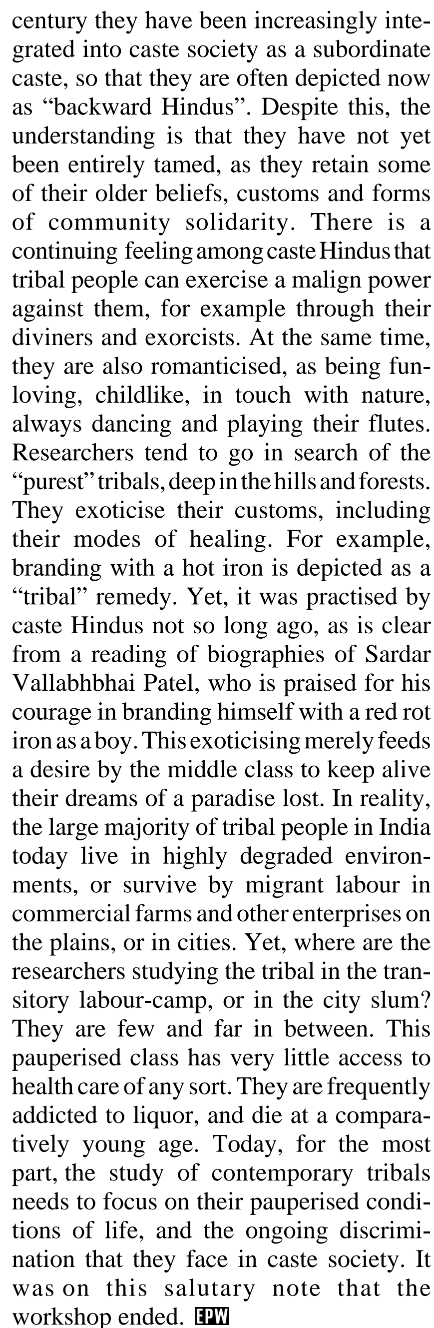
Nomads and Women

There were two papers in the last thematic session – one on migrant cattle herders, and the other on women's health. Chakraverti Mahajan spoke on the transhumant gujjar pastoralists of Jammu and Kashmir. This Muslim community was designated a "criminal tribe" by the colonial state, and although they were denotified in 1952, they still continue to be regarded with suspicion by the police and authorities. In 1991 they were designated as a scheduled tribe. Their annual migration to pastures in the Himalayas has been replaced increasingly by migration to places in the plains, for example to the Punjab and Haryana. Being often on the move, they used in the past to take care of their own health needs. Today, they tend to be suspicious of state medicine. For example, during the recent polio vaccination campaign they refused to allow their children to be vaccinated, on the grounds that it led to impotence and sterility. After they threatened the vaccinators, the police were called and the children were vaccinated by force. Nowadays, they tend to look to quacks for treatment, haggling with them over the treatment and price of medicine. In the discussion, Jan Breman commented that qualified allopathic doctors generally adopt a haughty attitude towards their patients, diagnosing and prescribing without debate. Quacks are different; they are more interactive with their patients, debating the problem and negotiating the treatment. They sell their medications, making them seem efficacious and they may even bargain. This makes them more approachable for people such as the gujjars.

Ratnawali presented a paper on the health problems of women in tribal south Gujarat. She argued that they still depend to a large extent on their traditional remedies, such as divination, exorcism, herbal remedies, branding with a hot iron, and incisions into the skin. For childbirth, women resort mainly to 'dais' (traditional birth attendants), whom they generally trust more than doctors to deliver their babies. The dais cannot however cope with difficult cases. The dais use local herbal remedies (e g, placing herbs on the womb to facilitate delivery), although in many cases they have in recent years received some medical training as well. There are also so-called "female health workers" who are responsible for family planning; they take women to be sterilised, and generally lack any medical skills. The general picture is one of severe deficiency in any modern medical facilities for tribal women. Ratnawali said that she had found that when good facilities are made available, tribal women generally make use of them willingly.

Pauperised Tribal of Modern India

In the final discussion, Jan Breman spoke with great feeling of the contradictory attitudes that high caste and elite people adopt towards tribal people. Over the past



century they have been increasingly integrated into caste society as a subordinate caste, so that they are often depicted now as "backward Hindus". Despite this, the understanding is that they have not yet been entirely tamed, as they retain some of their older beliefs, customs and forms of community solidarity. There is a continuing feeling among caste Hindus that tribal people can exercise a malign power against them, for example through their diviners and exorcists. At the same time, they are also romanticised, as being fun-loving, childlike, in touch with nature, always dancing and playing their flutes. Researchers tend to go in search of the "purest" tribals, deep in the hills and forests. They exoticise their customs, including their modes of healing. For example, branding with a hot iron is depicted as a "tribal" remedy. Yet, it was practised by caste Hindus not so long ago, as is clear from a reading of biographies of Sardar Vallabhbhai Patel, who is praised for his courage in branding himself with a red rot iron as a boy. This exoticising merely feeds a desire by the middle class to keep alive their dreams of a paradise lost. In reality, the large majority of tribal people in India today live in highly degraded environments, or survive by migrant labour in commercial farms and other enterprises on the plains, or in cities. Yet, where are the researchers studying the tribal in the transitory labour-camp, or in the city slum? They are few and far in between. This pauperised class has very little access to health care of any sort. They are frequently addicted to liquor, and die at a comparatively young age. Today, for the most part, the study of contemporary tribals needs to focus on their pauperised conditions of life, and the ongoing discrimination that they face in caste society. It was on this salutary note that the workshop ended. EPW

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Notes

1 A M Shah, 'The Tribes – So-called – of Gujarat: In the Perspective of Time', *EPW*, Vol 38, No 2, January 11, 2003.

2 For example, see a report by the Friends Missionary Prayer Band from Bajipara village in Gujarat. 'Rengavathi Ben who was suffering from prolonged sickness for 16 years was miraculously healed'. www.members.tripod.com/tamilchurch/fmpp, accessed on June 22, 2002.

3 For example, the official website of the World Bank states about NGOs (which it calls 'Civil Society Organisations', or CSOs): "The World Bank has learned through these three decades of interaction that the participation of CSOs in government development projects and programmes can enhance their operational performance by contributing local knowledge, providing technical expertise, and leveraging social capital. Further, CSOs can bring innovative ideas and solutions, as well as participatory approaches, to solving local problems." http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/CSO/0,,contentMDK:20092185~menuPK:220422~pagePK:220503~piPK:220476~theSitePK:228717,00.html