POLICIES TOWARDS INDIGENOUS HEALERS IN INDEPENDENT INDIA

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Policies towards indigenous healers in independent India show considerable continuities with policies followed in the British period, varying according to the sex of the healer. Traditional birth attendants (dais) have been offered short periods of training by the State since 1902, whereas until recently male healers (vaids and hakims, and later homoeopaths) have been treated with official hostility. Current plans include the training of religious and ritual healers in psychiatric services as well as the employment of indigenous healers in new community health schemes. These changes are assessed in the context of a political economy of health services. This article is reproduced from 'Social Science and Medicine' 16:1835-1841, 1982.

Introduction

Many discussions of the potential role of indigenous healers in health systems ignore the historical dimension, apparently assuming that the proposals are novel and practicable. No-one should make this mistake in India, where there is the work of Leslie and Brass to draw attention to shifts in policy from 1820 onwards.[1] In this paper I want to elaborate on a small part of this topic by looking at official policy with respect to indigenous healers in the context of theories about the dynamics of relationships between indigenous and cosmopolitian medicine.

There are, in essence, three views of these relationships in India. The first is the naive scientistic: that the process is one in which the indigenous systems are steadily giving ground to the onward march of science, with only the areas where Western medicine is ineffective remaining for the indigenous practitioners. This was the dominant view of the British doctors in India; it remains common, though many Indian doctors express guarded sympathy and support for the relevance of indigenous medicine. The second view is the agnostic anthropological, best expressed in Leslie's phrase describing Asian medical systems as 'coexisting normative institutions', in which cultural processes of change are not simply unidirectional (with indigenous medicine being affected by cosmopolitan medicine but not vice versa) but multidirectional, with no predictions of necessary future patterns.[2] The third view is the political structuralist one, in which the superiority of Western medicine follows not from its scientific advances but because it is more closely linked to the class interests of the political leadership in the country.[3] I shall explore some of the strengths and weaknesses of these positions by taking a closer look at policies towards indigenous medicine in India, tracing the links between the British period and post-1947 policies, with particular focus on policy proposals made (and to a lesser extent implemented) since 1971.

Two caveats should be entered here. Firstly, there may be no clear relationship between official discussions of indigenous healers and the situation 'on the ground'. In particular the official mind tends to see the systems of indigenous medicine as discrete and discontinuous, whereas Leslie's model of healers occupying positions which shade into one another seems more plausible.[4] Secondly, there is a great deal of regional variation, not only pre-1947 when the Native States could follow policies radically different from those of British India, but also since Independence, when health policies have been constitutionally the sphere of the States.

The British Period

It is customary to see 1835 as a major turning point in British attitudes to Indian culture. This was the year of Macauley's *Minute* on educational policy, where he argued that European culture should provide the curriculum of schools and colleges. This strengthened the opposition to schemes which attempted a mixing of European and Indian cultures, or were designed to restore Indian culture to its presumed glory. In medical education it meant that the Calcutta 'Native Medical Institution' founded in 1822, would no longer teach aspects of *Ayurveda* (the Hindu medical scriptures, especially those of *Susruta* and *Caraka*) nor of *Unani* (the medical doctrines derived from Greek medicine and more closely linked to Muslim culture). While this move had obvious significance, it did not mean a total ban on such teaching, nor on co-operative relationships between the British Raj and indigenous practitioners as a class. As Hume has demonstrated, for example, in Punjab the Provincial Government employed

hakims (*Unani* practitioners) in the 1860s and 1870s, usually as vaccinators and health extension workers, and the University of the Punjab offered courses in *Ayurveda* and *Unani* medicine until 1907.[5]

One reason for the tolerance displayed by the State is that its own services, and practitioners trained in its medical schools and colleges, had a minimal impact before the end of the nineteenth century. The first four medical colleges (Bombay, Madras and Lahore following Calcutta by the 1850's) produced too few graduates to make much impact on the setting of practice for most indigenous healers, and were mostly employed in the growing State bureaucracy — in the army, the jails, the railways and so on.[6] The 1872 Census of Bengal, for example, enumerated only 3769 physicians, surgeons and doctors, but over 23,700 'Gobaidyas' and 'Kabirajes' (*vaids*, or *Ayurvedic* practitioners) and over 400 hakeems.[7] Prior to the establishment of the Indian Sanitary Commission in the 1860s there was no commitment by the State to provide health care services for its citizens, and there was a slow extension of that commitment beyond plague control and the provision of dispensaries. There was an awareness of the strength of the indigenous groups: plans to introduce medical registration in the 1880s were dropped because the Western doctors were too weak to defeat the expected hostility from the *vaids* and the *hakims*.[8]

A change to greater hostility can be dated from about the end of the century. By this time the cream of the Western doctors in India — the Indian Medical Service, (recruited in Britain though 5% Indian by 1913) was more conscious of its claims to a scientific legitimation: the number of Indian medical graduates and licence-holders was substantial, and they were offering a real challenge to the primacy of indigenous healers in the major towns; and there was the growth of a new middle class which provided new financial opportunities for both groups.[9] The early twentieth century saw considerable political conflict as the rising bourgeois nationalist movement embraced the cause of Indian cultural renaissance as well as the idea of science. The Indian National Congress included leading indigenous practitioners in its ranks as well as modernisers like Nehru. Even within the Imperial Government there were those willing to lend their prestige to new private medical schools, some of which combined indigenous and Western techniques in 'integrated' courses. The general argument used was that it was necessary to improve the training of indigenous practitioners because "for many years to come they will constitute the medical attendants of by far the largest portion of the Indian community".[10]

As Indians gained positions in Ministries after 1919 they were expected to implement policies based on this kind of view, but their scope was limited by severe financial restrictions and their impact was further reduced by pressures from the Indian Medical Services, whose members provided the senior medical civil servants. The new Legislative Councils supported the 'Indian' systems of medicine on both patriotic and economy grounds, but Ministers in several Provinces (e.g. Punjab and Bombay) resisted this and used their limited funds to attempt to bring 'modern scientific medicine and surgery within reasonable reach of all', spending only small sums on research into the indigenous systems and for improved training.[11] As a result, relatively few indigenous medical colleges were given State patronage; the schemes of medical registration excluded those who had not received Western medical training; and the Government of India restricted its activities to an investigation into the pharmacopeia of indigenous drugs.

With the rise of medical registration for the cosmopolitan doctors after 1912, the pressures on indigenous medicine increased. Doctors who offended the imported British ethical codes and collaborated with indigenous practitioners, either in their new colleges or in daily practice, were threatened with deregistration. The wedge between cosmopolitan and indigenous medicine was driven deeper by the disputes over the recognition by the General Medical Council in London of Indian medical degrees; which occupied much of Indian medical politics in the Inter-war period.[12] When the Indian Medical Association was established the early leaders, also prominent in nationalist politics, called for the admission of indigenous practitioners (if they were 'sincere'). By the mid-1930s, when these leaders were being incorporated into the new Indian Medical Council and other positions of influence, they had already drawn back from these positions because such policies might lead to a loss of their international recognition. Indigenous practitioners were first registered in Bombay in 1938, but they were on a separate register from that of the cosmopolitan doctors. They were accepted on the basis of experience or apprenticeship, and only after a 4 year delay was qualification to become the only means of registration. The Bombay Government was well ahead of other Governments, and even here an amendment in 1949 weakened their

legislation and admitted new practitioners on the basis of experience. Nevertheless, the Bombay Act was held up as the model for legislation after 1974.

The inter-war period thus showed gains and losses for indigenous practitioners. On the one hand, there was the establishment of colleges, rather than the less respectable *guru chela* form of apprenticeship which had previously been the sole training method. Several of these colleges were well-funded, especially in Delhi, Madras and the Princely States of Mysore and Hyderabad, for example. The indigenous practitioners also had the support of the reports of special Goverment committees set up to consider policy towards them.[14] On the other hand, their subordinate position relative to cosmopolitan medicine was reinforced by registration patterns, and previous stategies of raising status (e.g. by procuring a scientific facade through joint teaching and practice with cosmopolitan doctors) had received a severe blow. The weakness of the indigenous practitioners was partly a result of their own internal divisions. Not only were there the two main groups separated by linguistic, theoretical and religious differences, but there was also the newer group of homoeopaths, established particularly strongly in Calcutta and Bengal. In addition, each group had a variety of career patterns, usually locally specific, with little agreement about diagnosis or techniques. Often a noted local teacher would prepare his own commentary on the traditional texts, and a school which grew up around one teacher would deride and vilify that around another.[15] These divisions particularly affected elite practitioners, whereas the average healer might be very different—but evidence about them before the 1960s is slight and highly unreliable. Finally, there was the growing ideological split between those who wanted *integrated* teaching of cosmopolitan science and indigenous therapeutics, and those who considered the *pure* indigenous training sufficiently scientific. This divide dominates the post-Independence debates.[16]

Different patterns affected female healers—whose history still has to be told. The presumption is that all indigenous healers were male and this is certainly implied by the medical texts and most offical comments. However, many female healers were recorded in the early Censuses, (see Table 1) and some modern fieldwork reports refer to female healers.[17] To be sure, few of these would have had access to the "high culture" learning of the elite male practitioners, but that was true of many of the male practitioners too. The main reason why female healers were invisible to male enquiries was probably that their clientele was almost entirely female. The only group who do appear in the historical discussions are the traditional birth attendants (*dais*), who are recorded separately in the nineteenth century Censuses, and in several early discussions of caste, midwifery is described as the hereditary occupation of the women of particular untouchable castes.[18]

Apart from sporadic training by missionaries in the middle of the nineteenth century, the first serious attempts to train indigenous midwives came in 1902 when money raised in Queen Victoria's memory was put into a fund for this purpose.[11] A sum of Rs 40,000 was available each year, and training followed a scheme first developed in Amritsar in which the *dai* was paid a fee for attending the classes and was expected to attend regularly, to report cases, and to call in the teacher when she had difficult deliveries. Simple examinations were held, and the successful completion of a course

Table 1 Practitioners in selected provinces. 1901 Census

		Bengal	Bombay	Madras	N.W F.P. Punjab	UP
With a diploma, licence or certificate	M	4123	1172	507	946	711
	F	170	43	19	78	50
Without any diploma etc.	M	33899	3648	17441	7198	6750
	F	1258	243	1501	665	789
Midwives	M	144	—	—	—	312
	F	21036	1891	4753	6422	11341
Compounders, nurses etc.	M	2016	2127	2599	2602	1854
	F	945	705	328	315	324
Total medical	M	41912	6770	21267	11225	9941
	F	23480	2882	6609	7511	12517

Notes: These are recorded as 'actual workers': dentists, occulists and administrative personnel (including members of the IMS) are included in the total but not in the other categories shown: vaccinators are included with compounders etc.: and the figures include some feudatory States.

could lead to a diploma and to registration. There are no complete figures for the numbers being trained in any year, but it is clear that a limit was set by the shortage of female doctors or of public health nurses (lady health visitors) to carry out the training. These schemes were based on the following assumptions; that institutional deliveries were very unpopular amongst Indian women (they remain so today); that midwifery was a hereditery occupation amongst certain low castes (the situation is almost certainly more complex than this); and that the *dai* was expected to deal with the menial, polluting, aspects of the delivery. Several features made it acceptable for the State to become involved in *dai* training, in particular, there was no band of Western personnel whose interests were threatened by such training. The *dais* themselves were so poor and of such low status that they could be persuaded into training schemes with relatively little difficulty; and few people thought that the *dai* had any skills worthy of being retained. In all these ways the male healers were different, and this largely accounts for the different policies pursued with respect to them.

Policy After 1947

One of the most obvious ways in which the Congress Governments after 1947 followed the precedents established by the British Raj is in the sphere of health policies. The new Government of India had two sets of proposals to deal with the health problems of the new India : those provided by the National Planning Committee, established by Congress itself in 1938; and those of the Bhore Committee, established in 1943 by the British to plan for reconstruction after the War was over. There was considerable agreement— for example in the proposal that the health service should be free at the point of contact for patients— but where they differed, the post-war Governments followed Bhore rather than the NPC. This was particularly true with respect to the training of part-time village level health workers — a corner-stone of the NPC proposals but toally ignored by Bhore. On relationships with the indigenous healers both reports were ambivalent, but Bhore was more hostile. The NPC resolved that

> An attempt should be made to absorb the practitioners of the Ayurveda and Unani systems of medicine into the State health organisation by giving them further scientific training where necessary. .Medical training in every field should be based on scientific method.[20]

By contrast the Bhore Report pointed out that the indigenous systems had nothing to say about public health, preventive medicine, obstetrics or advanced surgery, and described the systems as archaic and out-side the onward march of world science. Bhore's policies involved

> a country-wide extension of a system of medicine which, in our view, must be regarded as neither Eastern nor Western but as a corpus of scientific knowledge and practice belonging to the whole world and to which every country has made its contribution. [21]

Proponents of the indigenous systems were able to exploit the ambiguities of these proposals by claiming that science was not the preserve of the cosmopolitan doctors since *Ayurveda* was already scientific; and that only racial bias and a lack of objectivity prevented cosmopolitan medicine from learning from the Indian systems. [22]

The debate over these issues became heated over the first 10 years of Independent India. The 1946 Health Ministers' conference endorsed the Bhore proposals, and ignored the NPC proposals, with the sole exception of its resolution on indigenous practitioners. This was elaborated to include expenditures on

(a) research into the indigenous systems;

(b) the establishment of new colleges and schools;

(c) the establishment of post-graduate course in Indian medicine for graduates in Western medicine;

(d) the absorption of *vaids* and *hakims* after scientific training where necessary, as doctors, health workers etc.;

(e) the inclusion of departments and practitioners of Indian medicine on official boards and councils. [23]

In the face of this strong political pressure, the Government of India followed British precedents and established a committee, under a cosmopolitan doctor (Chopra); most State Governments were similarly slow to act.

By 1947, then it is possible to discern three main organised groups contesting the medical domain in India, the cosmopolitian doctors with a stranglehold on the medical bureaucracy, the 'pure' indigenous practitioners; and the 'integrated' practitioners. A fourth, less organised group campaigned, at least in the 1970s, for the freedom

of unqualified and unregistered practitioners to practice as cosmopolitan doctors. (This group probably best represented the interests of the majority of practitioners in India at the time.) The three main groups have all failed to achieve their own preferred solutions, and most of the issues have recurred again and again in the main policy-making arenas. There are four main topics on which battles have been fought: (1) whether to incorporate indigenous practitioners in the State medical service, or whether to train a separate cadre of community health workers; (2) how to register existing practitioners and those graduating from the indigenous colleges, and how to prevent unregistered practice; (3) whether indigenous colleges should include Western scientific training and an introduction to cosmopolitan therapeutics; (4) whether access to 'allopathic' medicines should be restricted to those registered on the 'Western' medical registers. There were subsidiary issues— for example whether State funds should be used to support training in the indigenous systems or indigenous hospitals— which were agreed in the early period: in fact something under 5% of the Plan health expenditures have been allocated to the indigenous systems of medicine, though these allocations have been consistently underspent.[24] I shall deal with the four more important issues in turn.

1. The Incorporation of Indigenous Practitioners: The cosmopolitan doctors were opposed to any such involvement. In the immediate post-Independence debates they had the support of Nehru and his Health Minister (Rajkumari Amrit Kaur) in arguing with Bhore that all practitioners should have the basic MBBS qualification; if they then chose to practice other forms of medicine that would be up to them—as is the case in the UK. In general it was argued that it was impossible to *integrate* the various systems without causing chaos. However, this was the solution which Chopra proposed: his report recommended that all students should be taught the elements of all systems (like the Chinese solution, at least during the 1970s).[25] Once again the international standing of Indian doctors was used as a powerful argument for rejecting such a move; and the variety of skills and backgrounds of the indigenous practitioners was seen as a reason why no more than perhaps 2% of them could be used in the national health services. While the Government of India thus expressed its hostility, the States were free to act on their own, since health was constitutionally their affair, subject to certain ill-defined constraints with respect to standards of medical education, and health Ministers made their autonomy clear in 1954.[26]

In addition, it was clear that the training of auxiliary medical personnel was regarded as a perferable alternative means of extending rural medical care. A scheme proposed in 1952 was discussed in the 1954 Central Council of Health and in general, those supporting the health auxiliaries were those opposed to the involvement of the indigenous practitioners.[27] However, this proposal was refined and reduced over the next few years, until it was dropped completely.

The early 1970s saw a resurgence of discussions concerning the inclusion of indigenous practitioners. This followed the *'Gharibi Hatao'* election success of Indira Gandhi in 1971. In 1972 the Minister of Health announced a scheme to enlist registered medical practitioners in *Ayurveda, Unani, Siddha* and homoeopathy after a short period of training (4 months), to provide them with a kit containing medicines for common ailments, and thus "to provide medical services to the entire rural area within as short a time as possible, say about three to four years".[28] Apparently this scheme received the strong backing of the Prime Minister, and sanction by the Task Force of the Planning Commission, but when the Health Minister was replaced after nine months, little more was heard about it. However, in retrospect, it can be seen as forerunner of schemes proposed in 1975 by the Srivastav Committee, and in the plans currently being implemented, which are loosely based on the Janata Government proposals made in 1977. The Janata manifesto called for the organisation of "a cadre of medical, paramedical community health workers (CHW) among whom the trained practitioners of indigenous systems of medicine will be a part".[29] In practice, it was decided that the community should choose who was to be the new CHW and they were merely to be advised that the use of an existing indigenous practitioner would be wise. In fact the choice of the CHW has been a highly political decision, heavily influenced by the doctors who were to do the training, and it seems that relatively few CHWs are, in fact indigenous practitioners, whether trained, registered or not. Once again, the offer being made to the indigenous practitioner (fulltime or part-time) was not very attractive, since he would be recruited at the bottom of the medical hierarchy. However, the training schemes included the possibility that the CHW be trained or equipped in indigenous techniques

and therapeutics, and some States recruited indigenous graduates to do the training.

There was no suggestion that the CHW should be a trained *dai*, which is not surprising. given the low estimation of these women. Nor were women with other backgrounds chosen in spite of the experiences of various voluntary schemes which suggested that women were more reliable, acceptable and suitable for this work. Instead, a new *dai* training scheme was introduced, which was essentially just a return to the earlier schemes which had been allowed to lapse in the 1950s. Like the CHWs, they were to be trained at the rate of 1 per 1000 population, and there may have been a feeling that this was the women's proper place. Unlike the CHWs, however, the trained *dais* were not to be given a regular honorarium but only compensated if they referred women to antenatal registration. So far no evalutation of the *dai* training has appeared, though one is planned for 1981.

The impact of the latest schemes is thus twofold. On the one hand, it has meant the inclusion of more indigenous practitioners into State employment: on the other hand, it has created a new band of practitioners who see themselves as potential doctors. Voluntary schemes have also been unwilling to involve the local indigenous healers except in a peripheral way. Once again, the stated reasons have been that the indigenous healers are not relevant in the services which are regarded as high priorities — maternal and child health, or community health services, and there is undoubtedly some strength in this argument.

2. What to do about registering or banning unqualified practitioners: The years following Independence also saw debates about the proper course of action to follow with respect to unqualified practitioners, with moves to outlaw their practice being seriously considered in 1955 and 1959. The discussions in 1955 were inconclusive: another committee was established (the Dave committee) and its report in 1958 (recommending the continuance of integrated courses and the establishment of country-wide registration schemes) was left for States to decide whether to implement. [30]

The 1956 Act which re-established the Indian Medical Council (now called the Medical Council of India) prohibited unregistered medical practice, but the Government of India advised State Governments not to implement that clause. In 1972, after a whole series of discussions in the Central Council of Health, States were advised to follow Kerala's proposal to amend their legislation so that those practising 'modern medicine' for at least 10 years would be registered on a separate list and allowed to continue (but be barred from prescribing dangerous drugs, doing surgery, obsterics or radiotherapy). No further unqualified practitioners would then be allowed to practise. The Indian Medical Association called this a "quacks' charter", and managed to prevent any move on this front — but they could not prevent unqualified and unregistered practitioners from continuing to provide 'modern' medical services.[31]

The 1950s and 1960s saw the slow but steady extension of registration schemes designed to register those currently practising indigenous medicine, but to forbid any new practitioners who had not gained registrable qualifications. As with the model for this legislation, the 1938 Bombay Act, there was considerable pressure against the enforcement of the penal clauses and moves to pass later amendments to include a new set of unqualified practitioners.[32] Even after the 1970 Central Government Act establishing a central policy on standardising the registration of indigenous practitioners, some States were still registering on the basis of experience only, while others insisted on the acquisition of a registrable qualification.[33] By 1977 there were 93 colleges providing *Ayurvedic* education, with a total intake capacity of over 3600 per year; 14 *Unani* colleges with an intake capacity of 485 per year; and one *Siddha* college with 50 places a year.[34] However, the total registered as practitioners on the basis of institutional qualifications was much greater than this suggests. It would appear that registration boards take a relatively lenient view of claims to qualifications, or that there is massive double registration (see Table 2).

Table 2.

Registered practitioners in Indian systems of medicine and homoeopathy. 1977

	Institutionally qualifed	Not institutionally qualified	Enlisted
Ayurveda	117765	105344	—
Unani	10262	20138	—
Siddha	1559	16569	—
Homoeopathy	19.871	74166	51397
Total	149457	216217	51397

Source : *Pocket Book of Health Statistics of India 1978.* Central Bureau of Health intelligence. New Delhi, 1979.

3. Whether indigenous training should be 'pure' or 'integrated' : Immediately after Independence the supporters of 'integrated' medicine were successful in several parts of the country in establishing colleges and ensuring that the qualifications of their graduates were registrable. However, the counter-attack came fairly quickly. At the 1954 meeting of the Central Council of Health, representatives of most of the North Indian States (including Bihar and UP, the largest) supported the move by the Bombay Government to introduce 'pure' training in Indian medicine. Again the supporters pointed to the 'popularity' of the indigenous practitioners; the tendency in the integrated courses to spend too much time on Western medicine; the incompatibility of the indigenous and the cosmopolitan systems; and the availability of indigenous graduates for rural practice. The opposition argued that science was universal; that it was a crime allow the 'unscientific' to practise in rural areas simply because they were cheap: that there was an absence of senior *vaids* or *hakims* to take teaching positions; and that indigenous practitioners actually used Western drugs and treatments. [35]

These disputes have largely been won by the supporters of the 'pure' school, and by 1975 there was increasing concern expressed by and about the estimated 50,000 integrated practitioners, whose anomalous position with respect to registration and to drugs legislation left them particularly exposed.[36] However, to a considerable extent this was a Pyrrhic victory; most graduates appear to perceive their training as second-rate and it is widely argued that they actually practise using cosmopolitan drugs. In other words, the attempt to reach parity of status has not yet been successful.

4. How to control the use of 'allopathic' drugs : Finally, in spite of an agreement in 1958 that only those with Western medical qualifications would be permitted to prescribe the drugs listed in the 1945 Drugs Rules, this too was not implemented. This was complemented by an apparent unwillingness to make serious attempts to enforce general controls on pharmacists and pharmaceutical companies, so that there is little or no effective control over access to any drugs in India. This alone tends to nullify almost all the other decisions with respect to indigenous healers. As Neumann and others have shown most 'unofficial' healers, whether registered as *vaids* or not, tend to prescribe largely from the cosmopolitan pharmacopeia.[37] With relatively free access to these drugs, there are continually new practitioners becoming established on the basis of experience. Indian political culture seems to accept as legitimate the claim that they have rights to a livelihood in this way. One of their strongest arugments is that they provide services where cosmopolitan doctors are unwilling to go — in the rural areas. Nevertheless, many of them actually practise in urban areas, but through their links with politicians they seem to be able to prevent punitive action against themselves and to be able to make powerful political cases for the amendment of hostile legislation.[38]

Conclusion

One of the difficulties of making clear assessments of the nature and effect of Government policy with respect to indigenous healers is that there is no clear line being followed. On the one hand, it is clear that indigenous medicine is essentially marginalised, with many of its practitioners part-time, dealing with a limited range of ailments, drawing heavily on the cosmopolitan pharmacopeia and perceiving cosmopolitan medicine as superior. Government policy, particularly in terms of employment and expenditure, reinforces this trend. On the other hand, there is a trend towards greater respectability, with the extension of registration schemes, the recognition of indigenous contributions by the international agencies and in CHW training, and some steady expansion of employment. The failure of attempts to suppress or control unqualified practitioners, and the loop-holes in registration schemes, mean that the cosmopolitan and qualified indigenous practitioners alike are theatened by 'unfair' competition which is outside their control, so that the formal commitment to the modernisation of medical care in India is very different from the reality.

There seem to be a few threads which can be drawn out of this, however. Firstly it is clear that indigenous practitioners of all kinds do provide an alternative which the Government has to come to terms with whenever its legitimacy is weakened. The greatest advances have come in the period when the new Republic was being established; when Congress was reasserting its supremacy after its losses in the late 1960s; and during the Janata regimes since 1977. Secondly, it is clear that the alternative solution to the problem of providing a cheap extension of Government health services to rural areas — the employment of para-medical personnel or community health workers — has been preferred. This has been premissed on the idea that they will be more controllable, and less likely to claim the status of 'doctor'—when of course

this is the major complaint of the cosmopolitan doctors and the major aim of many CHWs.

In terms of the arguments with which I opened this paper it is clear that all of them have their weaknesses. Indigenous practitioners are not dying out, they are infiltrating Government and retaining considerable popular appeal, even in urban areas. On the other hand, their impact on cosmopolitan medicine is a great deal less than the influences the other way, and the indigenous systems remain subordinate. Yet to argue that cosmopolitan medicine alone meets the needs of the ruling class is also inadequate, since the very political support which the practitioners can generate by virtue of their positions means that politicians woo them assiduously, even if they no longer have a coherent ideological position which commands much support. It is much easier to see how women healers are being marginalised and excluded from positions of influence than to draw clear pictures of the nature of the changes amonst the men.

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