Locating Religiosity in 'New Medical Pluralism': A Case Study of Religious Medical Practices in Malabar, Kerala

Abdurahiman P.C
Ambu G

The current study aims to understand the relevance of religious healers in the context of the health crisis in Kerala. Despite having high HDI, the state is experiencing morbidity rates above the national average owing to the increase in chronic as well as infectious diseases, and mental illness. The limitations of biomedicine in curing chronic and lifestyle diseases put forward debates about the integration of modern medicine and complementary medicine, which Cant and Sharma (1999) call as the 'new medical pluralism'. In this context, the study interrogates this binary model of healthcare through pragmatic religiosity and illustrates the role played by religious healers in healthcare delivery. The study argues how current integrated medical system creates disparities in access and care through institutionalisation and how the non-institutionalised medical practices could play a role in bridging the gap. These gaps are a result of a reductionist understanding of health and this study advocates for the need to locate health within a larger socio-cultural context.

Keywords: *Medical Pluralism, religious healers, religiosity, institutionalisation.*

Introduction

The Kerala experience in health care has received widespread accolades for having a high Human Development Index (HDI) comparable to that of developed nations while sustaining a relatively low economic status. The recently published National Family Health Survey 5 (2022) exemplifies the trend of Kerala topping for health indicators in the country. The 3.5 crore population of the state enjoys high life expectancy and literacy rates, low mortality and poverty levels, and a high sex ratio. Early studies on the state's standard of living, disease patterns and health care indicate a health transition (Aravindan and Kunjhikannan, 2000; Panicker, 1999). Health transition encompasses demographic and epidemiological transition concepts located in demography and medical geography. Demographic transition can be explained as a historical trend within a society where high birth and death rates reduce over time with developments in socio-economic fabric. Demographic transition is presented as the explanation for epidemiological transition, which is the historical shift in morbidity patterns where chronic diseases replace infectious diseases. But this transition was seriously debated in the 90s because of the rise in new epidemics in the State and scholars like Panicker pointed out that Kerala has a dual crisis, "both diseases of poverty and diseases of affluence" (Panicker, 1999). From the 1970s, the life indicators of the State had undergone immense changes which brought down mortality rates and population growth rates. Despite these advances, the morbidity rate in the State is on an upward trend and scholars have attributed this to better health services and higher health consciousness (George, 2008). Murray and Chen (1992) point out that the 'perception of being sick' or perceived morbidity is high in societies with higher health conscience. George observes that perceived morbidity is very high in Kerala and is a characteristic of a medicalised society. On the contrary, Kabir and Navaneetham (2006) argue that the high levels of morbidity among the poor and illiterate suggest that the morbidity is more real than perceived.

The rise in diseases of affluence in developed countries has stirred up conversations about the inadequacies of modern medicine in addressing the health issues of 'modern life. These challenges have

urged them to look into traditional/complementary medical systems for solutions and make policy decisions to incorporate them into modern medical practice. The growing influence of the traditional medical system can be attributed to how its practice can address challenges put forward by the epidemiological transition. Traditional medical therapies include longer sessions that discuss the patient's lifestyle, their living surroundings, as well as their spiritual and mental well-being, which is in direct contrast to biomedical practitioners who evaluate the patient primarily based on their physical symptoms (Cant and Sharma, 2000). The dominance of the biomedical model is the result of policy interventions by the government. For example, in the case of France, any practice of unqualified therapists is illegal, and in countries like Britain and Germany they are tolerated, but not supported by the state through licence and funding (Ibid). The Alma Ata Declaration (1978) by the World Health Organisation laid down the importance of integrating traditional and complementary systems of medicine to improve universal healthcare access. The case of India is a stark contrast to the above examples because the traditional medical systems (Ayurveda, Yoga, Unani, Siddha, Naturopathy and Homoeopathy) are recognised and funded by the state. In 1995, the Indian government established an independent department under the Ministry of Health and Family Welfare for Indian Health Systems (IHS) and Homoeopathy. In 2003, this department was renamed AYUSH and in 2015, the Government of Kerala started its own Department for AYUSH.

The AYUSH report published by the Kerala Planning Board in 2017 clearly outlines the current health crisis in the State. The report observed that the healthcare sector of Kerala is facing some unique challenges like the return of eradicated diseases, the outbreak of communicable diseases, rapid privatisation, increase in costs of treatment and lack of human resources in the sector among many things. The report makes policy suggestions to provide more funding and research into the traditional medical institutions to tackle the health crisis in the State. Although bio-medicine dominates the healthcare sector, people still rely on various IHS for various ailments and the proponents of integration of medical systems argue for further

institutionalisation of IHS. Prasad points out that the institutionalised forms of medicine themselves can marginalise and alienate the sick and poor from health services. For him, there is a gap in studying the social and internal factors which lead to disparities in the healthcare system (Prasad, 2007). He classifies the health providers in India into three: qualified allopathic doctors, IHS doctors, and finally, unqualified health providers. In this scenario, the study aims to investigate the relevance of non-institutionalised health care in the context of "new medical pluralism". The study primarily focuses on the persistence and relevance of religious healing practices while various systems of institutionalised medicinal practices are legitimised and promoted by the state and the civic body. It is the intention of this study to understand further why people choose the services of a religious healer in the presence of established integrated medical institutions.

Area profile

This study was conducted in the Pulikkal panchayat in Malappuram, a district in the Malabar region of Kerala state. The village of *Pulikkal* is situated in the Kondotty block in the Malappuram district. The *Pulikkal* Panchayat with an area of 28.7 Square Kilometre and a total population of 51,648 (ICDS, as cited in pulikkal panchayat development report 2022), has the second-highest density of population in the Kondotty block. The sex ratio of the panchayat is 996. Men outnumber women in population as well as in literacy. The principal occupations of people in the panchayat are agriculture, construction, and open-cast mining while a vast portion of people work in various sectors in Gulf countries. The health infrastructure of the Panchayat consists of an Ayurveda hospital (1), homoeopathy dispensary (1), primary health centre (1), veterinary sub-centre (1), private allopathic hospital (3), private Ayurveda hospital (2), private allopathic clinic (5) and private homoeopathy clinic (2). The village is easily spotted as it is situated on the Calicut-Karipur Airport road. The Panchayath was formed in 1962 when the boundaries were redrawn. One story about the origin of the name *Pulikkal* says that the region was rich and plentiful with Tamarind trees, called *Puli* in Malayalam, so the region derived the name from it. The Muslim community is the largest population in the Panchayath and holds ownership over the major

share of resources. But among the community itself, a large share of the population belongs to the backward socio-economic category. This is mainly because of the historical deprivation of resources, a feature not limited to Pulikkal but the entire Malabar region (Panchayat Development Report 2022).

Methodology

The research was conducted by interviewing participants hailing from Pulikkal Panchayat in the Malappuram district. The interviews were semi-structured and in-depth, allowing the researchers to gain information that met the research goals. Participants were selected based on their relevance to the study and their location within the healthcare system. The participants were divided into healthcare consumers and providers. Health care providers were further divided into biomedical practitioners, traditional Indian health medical system practitioners and traditional healers. The interview began by asking the participants questions to understand their background and then touched upon issues of accessibility as well as attitude towards and health, healthcare system. These interviews tasted so minutes to 1 hour and the participants were given pseudo names to protect their privacy. The following section will detail the medical praxis in pulikkal from historical sociological perspective.

From Sorcery to Modern Health Care: Initiations Towards Modern Medicine

During colonial rule, Pulikkal was a part of the district of Malabar, which was an administrative district under the Madras Presidency (1800-1947). Post-independence, Malabar was part of the Madras state (1947-1956). Kerala state was formed in 1956 by integrating the princely states of Travancore and Cochin with the Malabar province, and Pulikkal became a part of the district of Malappuram. Lekshmi et al. (2014) argue that the health indicators in the princely states were better in comparison to Malabar. Travancore was very early in implementing steps to promote western medicine from the beginning of the twentieth century. Princely states were cautious about public health, and a vaccination department was established in Travancore in 1865 (Devassy, 1961). The state also took several measures to prevent the spreading of communicable

diseases during festivals, and vaccination became compulsory for prisoners, public servants and students through the royal proclamation of 1879 (Panikar & Soman, 1984). The parasite survey conducted in Travancore with the assistance of the Rockefeller Foundation helped to prevent filariasis and hookworm in the State (Ramankutty 2000). The Annual Medical Report of the Travancore envisages the preventive form of health care and several curative methods employed under the princely State.

In contrast, the health indicators of Malabar lagged behind the princely State. According to Mamatha, the popular reformation movements increased the pace of medical care developments in Travancore; any such pressure was absent in Malabar. The financial interests of the colonial government guided the State's concern in promoting western medical infrastructure. The majority of the people in Malabar relied on traditional practices of medicine for healthcare (Mamatha, 2014). The health scenario of Pulikkal was similar to Malabar, where most people relied on an indigenous medical system.

> *"I remember the time in Pulikkal during my childhood, of Thangals who are the most elite among the Muslims in Malabar. They used their own kind of sacramental healing methods. Pregnant women in pain were given 'holy water' on a Pinjaanam (Plate) in which Arabic scriptures were written. It was believed that drinking the holy water would ease the delivery for the women. Likewise, our community rarely went to any kind of institutional health care. We had full faith in our religious leaders"*: Ahmedkutty

Thangals are an endogamous community in Kerala, India, of Yemeni heritage, who claim direct descent from the Prophet Muhammad's family. Due to their sacrosanct status, many *thangals* work as religious healers and are accepted among Sunni Muslims, thus they are part of the informal mental health care system in Malabar. People approach *thangals* for a "magic cure" (Lang, 2014, p.907) for their mental ill health along with their financial, familial, professional, psychological, or sexual problems, and the thangal intervenes in all areas simultaneously. What distinguishes their approach from other medical and religious practitioners is that patients expect *thangals* to

help with disparate aspects of a complex problem at once (Lang, 2014). Until the late 1970s, people in *Pulikkal* predominantly relied on traditional medical practitioners in the absence of modern institutionalised medical care and diseases like measles, cholera, jaundice, T.B., and malaria were very fatal (Panchayat Development Report 2022).

> *"The major occupation in our Panchayath was agriculture and small scale trade. The families had more than 5 children. Poverty was at its peak in those days in the region. Many communicable diseases such as Cholera and Malaria spread all over Malabar during those days. Many customary practices such as providing food to all attending the funeral services originated as a cause of poverty in the Malabar region. The oil boom in the gulf countries came as a blessing to our region"* : Raffeque

The Malabar region accounts for the largest number of migrants in the MiddleEast and by the 1970s the backward regions in Malabar witnessed a trend of migration to gulf nations. This trend coincides with the international oil boom in the Middle-East. According to the 'Sample Survey Report' published by the Economic and Statistics Department, Kerala, out of a total 1084650 employed migrants in six Arab gulf countries, 515833 (47. 55%) hail from the six districts of Malabar. The poor families in Pulikkal Panchayath saw the invitation of gulf countries as an opportunity and blessing. In the early half of the 1979s in the twentieth century, Unni Moitheen was the first person to migrate to the gulf from Kottappuram, near Pulikkal Panchayath in Kondotty Taluk in Malappuram district. In the next years ahead, he was followed by lakhs of people, men in majority, moving out of their nativity in Pulikkal Panchayath in search of Jobs in the Gulf countries such as Saudi Arabia, UAE, Qatar and Bahrain. The aftereffect of the migration of labour from the Malabar region was so vast that it became a decisive factor in the socio-economic and cultural life of the region. The remittance from the gulf predominantly influenced on the family relationships, land value, consumerism, education, healthcare, religion, food habits, wages, dressing, weddings, women's status, politics as well as the customs and practices in the region (Abdurahiman,

2014). *Pulikkal* Panchayath which comes in the geographical boundaries of this region experienced the waves of this effect. The Gulf migration and its subsequent remittances enriched the possibilities for accessing the modern health care system.

> *"In the period before the gulf migration, we in Pulikkal completely depended upon the religious healers. Using 'scriptured Pinjaanam (a traditional type of vessel with holy encryptions)', blowing chanted powder on the patient and tying chanted threads on the hand of the patient were commonly used in these healings. People also depended on Ayurvedic treatment. But over time, the scenario has changed. People depend more on Allopathic treatments. Among them, the families of the migrants go more to private hospitals. When my father became ill of old age, I took him to the nearest private hospital here in Pulikkal. When he died there, my relatives criticised and asked me the reason why I took him to such a local hospital and that I should have taken him to some multi-speciality hospital anywhere in Malabar"*: Basheer

The social welfare measures introduced by the Government of Kerala in the latter half of the twentieth century made definite implications on the health care system in the Malabar region. Preventive and curative care at both public and the individual level was introduced in Malabar. This improvement had a direct relationship with the mortality rates and life expectancy rates in this region. But the gulf migrants have brought new behavioural patterns in approaching medical care. The study revealed that there was a shift in the pattern of accessing healthcare for the migrant families from public to private hospitals. This became a norm of social status. Even for non-migrant families, the expectations are that they go for better healthcare facilities (accordingly an expensive healthcare facility). Over the last two decades, many new modern hospitals including multi-speciality hospitals have emerged in the Malabar region. In *Pulikkal* there are now three Allopathy hospitals, three Ayurveda hospitals apart from many medical stores and clinics.

Diseases of poverty to diseases of affluence

By the end of the 20th century, the national trend was that of declining mortality rates and increasing survival rates of the population. The case of Kerala was very paradoxical. While Kerala was outperforming other states in HDI and low mortality rates, Kerala had very high morbidity rates. The 60th NSS revealed that the morbidity rates of Kerala are much higher than the national average. The prevalence rate of morbidity (in a span of reference period of fifteen days) in India was 91/1000 per population while Kerala stood at 242/1000. In India, this period also marked the rise in chronic and lifestyle diseases and reduction of communicable diseases, a feature of epidemiological transition, while Kerala saw a rise in infectious diseases like dengue fever and diarrhoea, leptospirosis, different types of new fevers (tomato fever, black fever, swine flu, tick fever,scrub typhus, monkey fever). This period also saw an increase in lifestyle and chronic diseases such as diabetes, hypertension, cardiovascular diseases and cancer (Aravindhan and Kunhikannan, 2000). The state report of 2015-16 National Mental Health Survey reveals the prevalence of substance-related disorders, common mental disorders and high risk of suicide, while constitute the major threats to Kerala's population (Shibukumar & Thavody, 2017).

"It was very common for children to die at a young age here. I have seven siblings and two of them passed away at the age of two and one. All of us, excluding my youngest brother, were born at our ancestral home. Hospital services were not very active then and it was very common for people to die of diseases like malaria, fever, jaundice etc. There was a time when a lot of people died of measles in a year and an Ustad who had karamat (refers to supernatural wonders performed by Muslim saints) instructed to do baith (a kind religious prayer with chanting) continuously for 40 days and then conduct an annadanam on the last day for eradicating the illness. This pathiri nercha (offering) is still practised in our Kottappuram Jumu Masjid": Fazal

"In the old times there was very little to eat at home, especially during karkidakam (monsoon month) because people could

not go to work. In my childhood there was just one restaurant in Pulikkal but now there is one in every corner. People eat all kinds of junk food and they are not healthy. Now there is a medical shop in front of every restaurant. Most of them are very idle and on their phone most of the time. So what happened? Now almost every one out of three people have sugar and pressure": Koya

Majority of people in Malabar relied on traditional forms of medicine including Ayurveda, Unani, Siddha and folk medicine through a vaidya or a hakim (Mamatha, 2014). The change in this trend occurred after the 1980s when the number of people accessing modern medicine significantly increased in Pulikkal with the development in the health sector both private and public. The development in health care facilities is not just a result of the money flow from the gulf; rather the awareness towards health care and better living conditions been vital in this development. Better education, especially for girls in the Muslim families have helped the families in *Pulikkal* to be informed about modern health practices and care. Modern medicine characterises health objectively and defines disease as a standard deviation of biological functioning (Mishler, 1981). It explains disease as an anatomical or physiological interference of the body. Risse argues that the profession of modern medicine suppresses the subjective experience of the patient and reduces it through the aid of technologies of chemical and physical examinations (Risse, 1999 as cited in Bury, 2001). In Malabar, the gaining prominence of modern medical treatment coincided with the rise in multi-speciality hospitals. This change in health infrastructure also coincided with the shift in disease pattern from infectious to lifestyle and degenerative diseases which lead to high morbidity rates in the state.

The increase in degenerative and lifestyle diseases with subsequent increase in morbidity seriously challenged the efficacy of the biomedical model and the objective nature of its diagnosis and prognosis. Another reason for the crisis is the shift in the demography; the rising number of ageing population demanded care and management as opposed to cure and treatment. Since the logic of the biomedical model was built around the identification and curing of

infectious diseases, the shift in disease pattern led to debates on integration and medical pluralism.

> *"In our society, Ayurveda is the last resort for people. Most of them shift between different allopathic hospitals. By the time they reach us, they do not have health or money or people to care for them and ayurveda is their last refuge. If we are able to provide care for people who come to us at the last moment, it will be better if they come to us sooner. Our current health system is like fighting fire, like how we tend to it after there is fire. Instead of this fire fighting, if we are able to make simple changes in our lifestyle, we will be better off. Almost 90 percent of people resort to allopathy in the beginning, but things are changing now".*
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> "*The major treatments which we provide are for diabetes, ortho, stroke and lifestyle diseases. For diabetics, we provide a 14-day cell activation therapy. We do not focus on reducing glycemic levels but focus on activated pancreas through mild exercises and specially prepared oil. Unfortunately, the most number of drugs sold are for diseases which cannot be cured. We are actually proving that diseases which can't be cured are controlled using lifestyle modifications".*: Riyas, Ayurveda Hospital Owner

The limitations of biomedicine in curing chronic and lifestyle diseasesz bought the discourse of medical pluralism. Cant and Sharma argue that this discourse is called 'new medical pluralism', which they contrast with the previous as "pre-modern". They elaborate that the new medical pluralism is situated around the relations between the state, the biomedicine and the consumers (Cant and Sharma, 1999). The discourse of medical pluralism in Riyas's narration entails several conflicts of health seekers as consumers of healthcare and why they find refuge in traditional medical systems. Bharadwaj points out that the people's experience in this new medical pluralism is pronounced by three types of tensions: a) objective biomedical evidence vs. experimental evidence of traditional medicine b) limitations of biomedicine vs. legitimacy of traditional medicine c) the demand for quick relief and cure vs. long therapies in traditional medicine

(Bharadwaj, 2013). The practitioners of traditional medicine incorporate the probing technologies of biomedicine (Blood tests and Imaging tests such as X-ray and CT) to resolve these tensions of consumers. Bharadwaj argues that such adaptations are done to expand and protect their client base from other therapies, hence the diagnostic model which they practise largely falls within the realm of biomedicine (Ibid). Riyas (Ayurveda hospital owner) explains the use of traditional methods for the prognosis of chronic diseases and lifestyle diseases while using modern medical technologies for diagnosis.

Traditional medical systems like Ayurveda and Homoeopathy had adopted several coping mechanisms to compete and survive with the growing popularity of modern medicine. Apart from borrowing technologies of diagnosis from modern medicine, the traditional medical sector underwent commercialisation which opened up possibilities of health tourism. This shift led to an escalation of medical expenditure in the State. The KSSP (Kerala Sastra Sahitya Parishad) study on health transition of rural Kerala revealed that the health expenditure rose exponentially during the period mainly because of the rise in prices of drugs and other factors included the rise of doctor fees as well as expenditures like laboratory and diagnostic tests. The decadal (1986-1997) average of medical expenditure rose from 16 to 165 rupees and the out-of-pocket expenditure has increased 517 percent (88 to 548 rupees) (Aravindhan and Kunhikannan, 2000). The steep increase in prices of drugs was due to the policy interventions of the central government to deregulate the cost of drugs and this decision increased the prices of essential drugs by 250% (Thayyil and Jayakrishnan, 2008). The cost of medical care has increased in all sectors including modern medicine, Ayurveda and Homoeopathy. Modern medicine is the most expensive of all, followed by Ayurveda and Homoeopathy and the increased similar proportions of 852%, 816% and 789% respectively. Aravindhan and Kunhikannan note that the practitioners of Ayurveda and Homoeopathy are trained similarity to biomedical doctors and are aware of their social status and income, therefore any change in modern medicine would impact the traditional health sector (Aravindhan and Kunhikannan, 2000).

Thinking ahead of 'new medical pluralism'

"The number of people going to see thangals and usthads have not reduced. I feel that the number of people going to seek help from thangals and ustad have only increased. But people don't usually talk about seeking any help from them. There are many ustads with great Karamat and have the blessing of Allah. I know many people who have been to see ustads and have had good results. I had a relative who had a severe back pain but his condition was significantly improved after visiting an Ustad in Valanchery. He had seen many doctors and even tried ayurveda but could not get better. They are blessed with knowledge passed down through generations": Noushad

Our study has revealed that the practice of religious healing is very prominent in Pulikkal which aligns with existing scholarship about religious practices in Malabar (Osella & Osella, 2000, Claudia Lang, 2014). In the larger social context of bio-medicinal hegemony, the discourse of religious healing practices are devalued and judged as obstacles to achieving modernity (Claudia Lang, 2014). In his study about religion and modernity among Muslim middle-class of Kerala, Shafeeq has located it in the village of Pulikkal and other regions of Malabar. He points out that the process of modernisation in the region coincided with increasing religiosity. He understands this shift through the religious rituals and very noticeable display of religious symbols (Shafeeq, 2016). This is in contraction with the modernity project which argues that the religious institutions take a backseat while the processes of rationalisation, standardisation of knowledge production, and techno-centrism takes front seat. Therefore the medical praxis in this region needs to be located within the context of 'new medical pluralism' and growing religiosity.

"Like the old times, the practice of 'manthrichu oothal' (the ritual practice of chanting verses from Quran and Hadees, and blowing into water, which is supposed to heal the person who drinks it), tying sacred threads and amulets, and exorcism are still common in present times. There is still a great demand for Ustads and Thangals, and people travel for kilometres to

meet them. Sometimes they ask patients to recite verses from Quran and Hadees to stop their suffering. But you know…people don't just go to meet only them. They go to see all kinds of doctors these days. These people also see allopathic doctors for the same problems": Majeed

"People come to me for various problems. Some come to me because they are weak in their mind, for others it might be problems at work or home, or sometimes for serious diseases like cancer and heart issues and even for rashes. Couples who are not able to conceive children also come to me. Even diabetic patients come to me for my help. These people come to me after all the doctors failed them and English medicines have not been working for them": Yusuf Sakafi

The entanglement of 'new medical pluralism' and religiosity in this region creates a complex medical praxis in the context of the current health crisis in Kerala. As the narrations demonstrate, the fluid nature of health-seeking behaviour of people can be explained through pragmatic religiosity. Quack lends these drawings upon Bourdieu, Young and Gadamer to argue that religious actions are not necessarily linked to orthopraxis and orthodoxies but are embedded in everyday life through beliefs and desires (Quack, 2013). As Quack argues, people's health seeking behaviour should be understood as the result of a strong desire to get well soon in any possible way and it explains why people approach religious healers over practitioners of bio-medicine. She contrasts this mode of religiosity with the scholastic mode of religiosity. The scholastic mode of religiosity is a religiosity held by representatives of biomedicine and some patients who engage in ideological opposition between religious beliefs/practices and secular medicine. This conflict is located within the religious framework but it is isolated from superstitious and illegitimate practices. Quack points out that people operating within this religiosity make value judgements of rationalities specific to religious traditions (ibid). The proponents of 'new medical pluralism' who see integration of medical systems assume scholastic rationality in choosing which health system to seek care for in the current health crisis. Bourdieu warns that this rationality is a fallacy of theologians and social scientists who

assume that the people understand the world similarly to them (Bourdieu, 1990 as cited in Quack, 2013).

The study reveals that the health scaning pattern in Pulikkal is driven by pragmatic religiosity. Despite the intervention of state mechanisms to promote an integrated healthcare system for coping with the current health crisis, the people approach religious healers and institutionalised health providers simultaneously. Bharadwaj argues that both traditional and modern medical systems borrow techniques of diagnosis and prognosis to prevent the loss of their clientele. She points out that the integration of modern diagnostic technologies in alternative medical institutions and allopathic hospitals providing acupuncture and chiropractic services should be seen as a process of collaboration, negation and accommodation. According to her, IHS thrive by pointing out the shortcomings and failures of allopathic treatment in the context of chronic diseases (Bharadwaj, 2013). However, the process of institutionalising IHS has resulted in the compartmentalisation of their services like modern medicine, thereby losing their holistic nature. The fieldwork reveals that Ayurveda hospitals provide specialised treatments for specific ailments through experts in respective categories such as Toxicology (Visha Chikitsa), Pediatrics (Balachikitsa), Geriatrics (Rasayana) and ENT specialist (Salakya Chikitsa). By employing technologies of science for diagnoses such as X-ray, blood tests and ECG, Ayurvedic treatment locates disease within the rationality of cartesian dualism which separates the mind and body. The categorisation of treatment in Ayurveda has turned the patient experience similar to that of an allopathic hospital, thereby making it more secular.

> *"Majority of people who come to me are women and most of them want solutions for disturbances of their mind. For some it is because they can't conceive a child or feel lonely because their husbands went to work in the gulf or because of recurring nightmares or because of diseases which won't go away. Men also come to for problems at work, property conflicts, unemployability, indebtedness and for also problems in their sexual life. Causes for these ill fortunes are sometimes badha koodal (spirit possession) evil eye or the house is located at a*

place it is not inhabitable for humans or it is because their house is located on the path of jinn and it's trapped there because there is no proper ventilation. There are remedies for each problems which includes reciting verses of Quran and Hadees every night, take nombu (fasting), give food for yatheem (orphans) for 40 days, tied sacred thread, give more ventilation in houses, manthrichu oothiya vellam kudikkuka (the ritual practice of chanting verses from Quran and Hadees, and blowing into water.), badha ozhippikkuka (exorcism)". Imbichi Koya Thangal

Institutionalised healthcare systems which operate under cartesian rationality, separate health from a holistic and spiritual category to universal categories of normal and abnormal, and located it in anatomy and physiology of the body. Halliburton argues that the process of universal categories of mental health such as "tension" and "depression" replacing spirit possession as idioms of distress, signals an erosion of cultural context (Halliburton, 2005). Lang argues that this psychological categorisation is seen as an important marker of "modernity" and "the West" (Lang, 2014). Although there is a shift in the usage of idioms of distress, the understanding of the illness is rooted in religiosity. Quack argues that people's health seeking behaviour do not necessarily function within doctoral purity but is guided by pragmatism and the desire to get well soon (Quack, 2013). Hence, pragmatic religiosity explains the preference of religious healers because of its culturally embedded quick remedies offered by the healers in contrast to periodic sessions offered by psychology.

The fieldwork illustrates cases of people with chronic ailments and life-threatening conditions approaching religious healers. Turner points out that, through the epidemiological transition, 'stress' has replaced the 'germ' as a major cause of modern illness and in this context, the concept of cure is replaced by care and rehabilitation. The sociological perspective becomes more relevant in managing chronic illness than biomedicine (Turner, 1995). The failure of biomedicine to address rising chronic illness can be largely attributed to culturally disembedding the illness from the social setting. While the institutionalised healthcare systems suggest lifestyle and medicinal

interventions, they do not offer a holistic approach which locates the larger questions of mortality, spirituality and mental well-being.

As institutional mental care arises from the categorisation of normal and abnormality, it is limited in understanding mental health issues from a cultural and historical context. Mental health practitioners and Indian policymakers limit their understanding of mental healthcare to the biomedical realm and exclude the religious (Quack, 2012). Psychology and biopsychiatry classify people with mental illness as deviants; the social stigma arising from such a classification creates cultural taboos which affect the social life of the mentally ill. Our field data shows that these taboos interfere with various aspects of the mentally ill, such as social isolation, unemployability and low prospects of marriage. Religious healers play an active role in addressing mental health issues by locating them in social and cultural contexts. Lang points out that this role played by healers helps in the process of therapeutic modernisation (Lang, 2014) which Appadurai and Breckenridge argue is a form of local modernity (Appadurai & Breckenridge, 1988).

The state policies on deregulating drug prices and commodification of healthcare, especially allopathy and ayurveda, have increased the cost of treatment (Thayyil and Jayakrishnan, 2008). The use of modern technological devices for diagnosis has also contributed to the rise in the cost of treatment in allopathic hospitals. Similar trends can be observed in traditional medical systems, especially in ayurveda, who adopted biomedical techniques for diagnosis. The institutionalisation of traditional medical systems has also contributed to the increase in the cost of treatment. Ayurvedic hospitals have undergone infrastructural changes over the decades. The practitioners who work in these institutions have received formal education and demand the same social status and income as their biomedical counterparts receive (Aravindhan and Kunhikannan, 2000).

The majority of people in Pulikkal Village belong to socio-economic backward category and are daily wage workers. The commodification and institutionalisation of the healthcare system have adversely affected the accessibility of healthcare services. The rise in chronic illnesses has significantly affected this population's ability to seek help in institutionalised healthcare. The inability of allopathic

hospitals to cure chronic and lifestyle diseases and the escalation of the costs of treatment have put a huge burden on the working class. The traditional medical systems which thrive on this failure of biomedicine to address the health crisis poses another challenge to the working class. For example, The ayurvedic mode of treatment for these chronic ailments demands strict rules (*pathyam*) for lifestyle and requires admission for long periods. These requirements for treatments come in conflict with their occupation and keep them out of their paydays. For Prasad, the binary of modern medicine and traditional medicine aids the domination of ruling classes and dominant social groups. He argues that the non-institutionalised form of medical care serves the needs of the economically and socially deprived section (Prasad, 2007). The fieldwork reveals that the religious healers do not have fixed nominal fees for their service and put the onus of paying the fees on the people who seek their help. The clients can pay fees with respect to their social and economic status.

Conclusion

The prevalence of religious healing practices reveals the fallacy in the attempt to resolve the health crisis faced by the state. The health praxis of people approaching non-institutionalised healthcare should be located within the concept of pragmatic religiosity and not be seen as a tendency of moving away from modernity. Religious healing practices should be seen as complimentary to both traditional and biomedical systems as it accommodates and bridges the gap between the spiritual and the social world. As it encompasses the subjective experience and locates it within the cultural and historical context, it opens up new ways of addressing the current health crisis.

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Abdurahiman P.C
Cholangottil House
Pulikkal P.O
Malappuram Dt. Kerala
India
PIN: 673637
Ph: +91 9895331686
E-Mail: rahmanktpm@gmail.com
ORCID: 0009-0009-8782-710X
&
Ambu G
Ushas, C-25A
Thripadagiri
Karyavattom P.O
India
PIN: 695581
Ph: +91 8547845399
Email: ambug.94@gmail.com
ORCID: 0009-0009-4629-9195