J. Hum. Ecol., 12(1): 25-32 (2001)
PRINT: ISSN 0970-9274 ONLINE: 2456-6608
DOI: 10.31901/24566608.2001/12.01.04

Medical Pluralism and Pattern of Acceptance of the Different Medical Options Among the Dimasa Kacharis of North Cachar Hills in Assam[1]

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INTRODUCTION

Prior to the introduction of modern medicine during the British period, the Dimasa Kacharis like many other relatively isolated tribal communities used to depend solely on their traditional system of treatments and health cultural practices. Efficacies of modern medicine are unquestionable in tackling many diseases and health problems. The health status of a community is often understood by way of calculating the extant to which the people utilise modern medical facilities.

The tribal and rural communities of underdeveloped and developing countries do not utilise modern medicines upto the expectation. Acceptance of Western medicines by people who so far have been dependent on their traditional medical means may not take place particularly in the following contexts:

(i) If the Western biomedical concepts and the people's cultural knowledge and perception are conflicting;
(ii) If a particular type of disease is considered not to be an illness by the people; and
(iii) If a particular disease is believed to be caused by culture specific factors and not curable by modern medical remedies.

Fabrega (1971: 201) has discussed four sets of factors that may effect the acceptance of Western medicines. They are economic, socio-cultural, socio-demographic, and psycho-social. Logan (1973) has discussed the problem of acceptance of modern medicine by the Mexican peasents. The ordinary Mexican peasents interprete all medical phenomena in terms of humoral model. Both medicine and diagnosis are categorised in hot-cold binary oppositional plane. The Western medicines and practices which lately entered among the people also received the same modelistic lebellings. This folk categorisation of the Mexicans found to be the root cause for non-acceptance of what Western bio-medicine experts prescribe in many occasions. As per the folk belief there should be a conformity between the diagnosis and the type of medicines prescribed. Therefore, for a particular diagnosis if 'hot medicines' are culturally considered appropriate and the physician's prescription incidently happens to be 'cold' ---- the result will be a clear refusal. Often among many cultural groups certain illnesses are prevalent having no actual biological explanations but are only culturally recognisable. For instance, *koro* discussed by Chowdhury (1992) and several diseases among the Garifuna discussed by Cohen (1984) are of such type. Such culture specific illnesses are generally psychologically oriented for which the people exclusively relay on their culture specific remedies.

Ever since Farbega has published his review paper entitled 'Medical Anthropology' in *Annual Review of Anthropology* in 1971, concepts like 'illness behaviour', 'semantic illness model', 'explanatory model', etc., have become current in medical anthropological writings. Some of the important works in this area are Fabrega (1971), Good (1977), Manning and Fabrega (1977), Blumhagen (1981) and Kleinman (1978 & 1980). During the last two decades many works have been contributed towards the emergence of a new branch of medical anthropology known as 'Anthropology of illness and sickness'.

Healing and therapeutic intervention seeking attitude is one of the dimensions that goes into the construction of illness behaviour of people. Several studies (e.g., Bhasin, 1997; Hughes, 1968; Pigg, 1995) have shown that the

1. This paper was presented in the seminar on "Problems of Health and Nutrition among the Tribal People of Assam" held from 25th Feb. 99 to 26th Feb. 99 and organized by the Directorate of Assam Institute of Research for Tribals and Scheduled Castes, Govt. of Assam, Guwahati, India.

introduction of modern medicine among the people having their own traditional system of medicine leads to the situation of medical pluralism or multiple medical situation. In such a situation healing and treatment intervention seeking attitude is diverse. The people consider one kind of medical system for certain kind of diseases and the other kinds for certain others. Understanding of illness behaviour, especially the healing and treatment intervention seeking attitude, of the people living in multiple medical situation would lead to the understanding of the utilisation pattern of different kinds of health services. This would eventually help the medical planners and public health workers to formulate appropriate health planning for the people.

THE DIMASA KACHARIS: AN OUTLINE

The Dimasa Kacharis are one of the offshoots of the Kachari race. The Kacharis are currently divided into a number of distinct ethnocultural groups (e.g. Boro, Rabha, Sonowal, Tiwa, Dimasa, etc.) and distributed throughout Assam and some of the neighbouring states. The Dimasa Kacharis are hill dwelling people. Their activities largely revolve around forest based resources. Nowadays, the Dimasas are primarily concentrated in the North Cachar Hills District of Assam. Of course, they are also inhabiting the adjoining areas like Nagaon and Cachar districts of the state as well as the neighbouring states like Nagaland (Kohima) and Meghalaya.

The Dimasa Kacharis who are concentrated in the North Cachar Hills have kept themselves in relative isolation from the mainstream of Indian life, untill recently. Therefore, their way of life to a great extent remained far more conservative than their brethrens inhabiting outside the district (Roy, 1997).

The Dimasas believe in a number of malevolent spirits who according to them inflict diseases and many of the related problems (Table 1). All such spirits are believed to reside in different places like water pool, *jhum* field, forest, tree top, etc. It is held that these spirits always seek opportunity to harm man by inflicting diseases and misfortunes. Such beliefs among the people are very strong. Among the Dimasas whenever someone suffers from an ailment, a shaman (diviner) is consulted. He is the person who can magically detect the responsible spirit causing the troubles. Following such a detection the spirit is appeased as part of the curative actions. Such appeasement rituals differ from one another as different spirits are involved. Different type of livestock are required to be sacrificed in such rituals (Table 2). The type and the quantity of livestock that are required in such rituals are sometimes fixed and sometimes are determined by coercive action of the shaman. The compulsory sacrifice of livestock makes the Dimasa rituals very expensive.

Table 1: Benevolent and malevolent spirits known to the Dimasa Kacharis

Bairagi	Khalendao
Bamun	Khandeo
Baudum	Kharaoba
Banglai	Khorongbaji
Bauraja	Khorongnar
Dakhinsa	Khukri
Daologajaodi	Khowafaiba
Daujidaimba	Laigamongdi
Daujor	Londisa
Dermiraja	Madaima
Dikhongnarni	Maiafergerba
Dilaojik	Maian
Dinarni	Maijaugdi
Gaglabo	Moledao
Gathar	Mungreng
Goromali	Najar
Gorosali	Phaimadi
Hagrani	Phaisnadi
Haklini	Pudumaniban
Hajagore	Remdi
Hajokhote	Rengbangdi
Haledao	Saini
Helepdi	Saingkharao
Hamlai	Sakainjeek
Hapai	Sakaini
Heremdi	Simangkhuba
Jagrandi	Simsimdi
Jaudeedimba	Thaibangfa
Jompara	Thaibangma
Kali	Umbao
Kalengjera	

At present the Dimasa Kacharis inhabiting North Cachar Hills have come in direct contact with various current trends. The modern education, economic pull and push, mainstream political hub-nub, etc., are constantly knocking their doors. These days there has been considerable occupational diversification among the Dimasas. Everywhere one can easily locate a

Table 2: Some common malevolent spirits and the livestock required for their propitiation

S.No.	*Spirit*	*Livestock required*	*Approx. expenditure (in Rs.)*
1.	Bairagi	(hen-2, duck-1, egg-3)	100
2.	Daujidaimba	(egg-15/30,etc)	70
3.	Daujar	(hen-2, egg-2)	70
4.	Dakhinsa	(hen-9, egg-3)	200
5.	Dikhongnarni	(pig-1, hen-1, duck-1 plus egg according to the number of family members)	500
6.	Jompara	(hen-1, cock-1, pigeon-2)	80
7.	Hagrani	(either hen-1; or hen-2, duck-1; or hen-3, egg-3)	50 to 200
8.	Haklini	(pig-1, cock-1)	400
9.	Halebdi	(hen-1)	25
10.	Hapai	(either duck-1, hen-2, egg-1, chicken-3; or duck-1, hen-2 egg-4)	100 to 200
11.	Haremdi	(goat-1, hen-2, egg-10)	300
12.	Khorongbaji	(pig-1, hen-1, cock-1)	400
13.	Khorongner	(pig-1)	350
14.	Londisa	(hen-5)	150
15.	Madaima	(hen-3)	100
16.	Mungreng	(goat-1, chicken-2)	500
17.	Padumaniban	(goat-1, hen-5, pigeon-2, egg-5)	500
18.	Sainni	(either goat-1, hen-1, egg-4; or goat-1, duck-1, cock-1)	200 to 300
19.	Singkharao	(goat-1)	200
20.	Sakainjeek	(either goat-1, hen-1, egg-10; or hen-1, duck-1)	200 to 400
21.	Simangkhuba	(pig-1)	300

Dimasa teacher, a politician, a business man, etc. Many new institutions and amenities have also been inducted into their life. The entry of modern medicine system is one of them.

MEDICAL PLURALISM AMONG THE DIMASA KACHARIS

Introduction of modern medicine system among the Dimasa Kacharis could not replace the traditional medical knowledge and practices of the people altogether. Instead, both the modern medicine and traditional system of medicines are coexisting as necessary supplements to one another. According to Bhasin (1997:43) "Medical pluralism may be defined as the synchronic existance in a society of more than one medicine system grounded in different principles or based on different world views". A Dimasa now avails a number of medical options, namely allopathic, homeopathic, traditional herbal medicines, traditional magico-religious means in order to adjust to crisis situations resulting from ailments. In this context to know what option is considered for what illness and the pattern of selection of the different healing and therapeutic options are of immense value from the point of medical anthropology. Apart from academic interest such knowledge will be benificial for medical planners and administrators engaged in modern system of health care practices and delivery.

MATERIALS AND METHODS

Data for this study were collected during the course of field work between 1993 and 1994 undertaken among the Dimasa Kacharis inhabiting four villages, namely Gidingpur, Khowtemdisa, Longsep and Natun Simplangdisa of Maibang area in North Cachar Hills District, Assam.

The incidence of diseases or ailments that occured during one calender year among the inhabitants of the four villages were recorded through house to house survey. In total 80 cases of ailments suffering from different diseases, namely stomach complaint, fever, malaria, respiratory trouble, jaundice, dysentery, tuberculosis, etc., were found (Table 3). Along with other relevant information the sequence in which the different therapeutic and healing options were considered or availed by the people during the course of an illness episode were recorded.

In a pluralistic medical situation, where a number of medical or treatment options are available, if an ailment continues for a prolong period of time then a number of treatment options

either at random or at any fixed order of sequence (like 1st Doctor, 2nd ritual, 3rd something else which have been denoted here as 1st choice/1st intervenion, 2nd choice/ 2nd intervention, 3rd choice/3rd intervention, respectively) are considered. Simultaneously two or more options may also be considered. The Dimasa Kacharis are living in a pluralistic medical situation. Therefore, what are the different treatment options that are generally consider by the people against their illnesses and in what preferential order such options are chosen are important areas of study for medical anthropological research.

RESULTS AND DISCUSSION

In this investigation we have recorded some 80 cases of patients suffering from different diseases or health problems, namely stomach related problem, fever, malaria, cold, jaundice, tuberculosis, boils, toothache, influenza, headache, bone fracture, etc. The different therapeutic and healing options considered by the people as investigated in this study, categorisally presented in table 3.

The Dimasa Kacharis in their 1st choice or in their 1st intervention in majority of cases (n=54; 67.5%) have considered doctors' medicine (medicine prescribed by physicians). The pharmacy medicines (i.e. medicines purchased from pharmacy without consultation of physician) were considered in 13.75 per cent of cases, and only in 12.5 per cent of cases the people have considered herbal medicines. The number of cases in which the people have performed rituals in their 1st therapeutic intervention during their illness episode are very few (n = 5; 6.25%).

Table 3: Medical and magico-religious option selection pattern according to the order of choice

Diagnosis	*1st choice*						*2nd choice*						*3rd choice*						*4th choice*					
	Total cases	*%*	*Option*				*Total cases*	*%*	*Option*				*Total cases*	*%*	*Option*				*Total cases*	*%*	*Option*			
			D	*Ph*	*H*	*R*			*D*	*Ph*	*H*	*R*			*D*	*Ph*	*H*	*R*			*D*	*Ph*	*H*	*R*
Stomach pain	10	12.5	4	1	5	-	4	9.30	3	-	-	1	2	11.76	1	-	-	1	1	10.00	-	-	-	1
Fever	33	41.25	24	6	-	3	22	51.16	2	-	-	20	10	58.82	-	-	-	10	6	60.00	-	-	-	6
Bee-bite	1	1.25	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bone fracture	1	1.25	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Malaria	13	16.25	11	2	-	-	4	9.30	2	-	-	2	1	5.88	1	-	-	-	1	10.00	-	-	-	1
Respiratory com.	1	1.25	-	-	1	-	1	2.32	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cold & fever	3	3.75	3	-	-	-	1	2.32	1	-	-	-	1	5.88	-	-	-	1	-	-	-	-	-	-
Jaundice	2	2.5	2	-	-	-	2	4.65	-	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-
Dysentery	2	2.5	-	-	2	-	1	2.31	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
T.B.	1	1.25	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Boil	2	2.5	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Toothache	1	1.25	-	-	1	-	1	2.31	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Physical weakness	2	2.5	1	-	1	-	2	4.65	1	-	-	1	1	5.88	1	-	-	-	-	-	-	-	-	-
Influenza	1	1.25	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Headache	2	2.5	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Unrecognized	5	6.25	5	-	-	-	5	11.62	1	-	-	4	2	11.76	1	-	-	1	2	20.00	-	-	-	2
Total	80	100	54	11	10	5	43	100	12	2	-	29	17	100	4	-	-	13	10	100	-	-	-	10

Abbrreviations: D = doctor/physician (medicine taken in consultation with doctor/physician);
Ph = pharmacy/medical shop (medicine purchased from medical shop and taken without consultation with any doctor/physician);
H = herbal medicine;
R = ritual/magical performance

Out of the total number of 80 cases in 43 (53.75%) cases the people found to have gone for second therapeutic or healing intervention. In their second intervention the performance of ritual tops the list (67.45%) to follow doctors' medicine (27.90%) and pharmacy medicine (4.67%). But, in no case herbal medicine was considered by the people in their second intervention.

The number of cases in which the people have gone for third intervention are only 17 (21.25%) out of the total of 80 cases. The different medical and magico-religious options considered in their third intervention were only doctors' prescriptions (23.52%) and rituals (76.47%). But in no occasions the other two categories of options (i.e. pharmacy medicine and herbal medicine) were considered.

The number of cases in which the people have considered fourth intervention are only 10 (12.5%) out of the total of 80 cases. In all these cases only rituals were performed, and so were for any other subsequent interventions. Of course, only in a few occasions the people have gone beyond the fourth intervention during any illness episode.

Regarding the therapeutic and healing option selection pattern by disease type, in the case of some specific diseases certain specific type of options were overwhelmingly preferred particularly in their 1st intervention. For instance, for malaria doctors' prescriptions were preferred, and for stomach related complaints herbal medicines were mosly considered. However, the general trend is that initially the rational medicines (i.e. doctors' prescription, pharmacy medicine, herbal medicine, etc.) were mostly preferred, when in late choices performance of rituals were dominant.

In this study we have investigated some 80 cases of patients among the Dimasas suffering from diseases like stomach related problem, fever, malaria, cold, jaundice, tuberculosis, boils, toothache, influenza, headache, bone fracture, etc. Here we have studied the therapeutic and healing option selection pattern of the people for the above mentioned diseases. The results regarding the pattern of acceptance of therapeutic and healing options by the Dimasas can be generalised and discussed as follows:

(i) Initially in most cases of ailments, intervention with rational medicines is preferred. However, this trend generally holds true for diseases like fever, malaria, cold, etc. For stomach related problems the people overwhelmigly consider herbal medicine and for diseases like headache the people prefer rituals.

(ii) As time passed and the ailment continues newer choices or options are considered, which ultimately in most cases terminate into ritual performances.

(iii) Choice of healing and therapeutic options during the course of an illness episode is sequential. This means only one type of option is availed at a time. Nevertheless, in many occasions the people have considered rational medicine and ritual almost simultaneously. But while recording data we found it difficult to say wheather consultation of medical expert and performance of ritual were simultaneous or not. This is because sometimes the people consult physician and shaman simultaneously but they do not consider their prescriptions at the same time; othertimes both consultation of practitioners and consumption of their medicines differ. In field situation often it has been observed that the people have made contract for performance of ritual only to be performed several days after the patient become well.

(iv) The different options sequentially chosen by the people in their 1st, 2nd, 3rd and 4th choices can be represented as follows:

Choice	->	1st	2nd	3rd	4th
Options	->	Dr>Ph>H>R	R>Dr>Ph	R>Dr	R
No. of cases	->	n = 80	n = 43	n = 17	n = 10

Abbrreviations:
Dr. = medicine taken in consultation with physician;
Ph = medicine purchased from pharmacy without consultation of physician;
H = herbal medicine;
R = ritual;
most preferred > least preferred.

From the data analysed two prominant trends are visible. First, the people, even though suffering from an identical disease, have considered different medical options. For instance, for malaria though in majority of cases the people have preferred modern medicines in their first choice, yet other available options were considered. In this regard factors like economic and educational status of the people, access to and easy availability of the type of medical facilities, sex and age

status of the patient, etc. could have determining influence. Indeed, it was observed during field investigation that people living far away from any urban center, consequently far away from modern medical facilities, often choose traditional medical option even for the disease like malaria. The economic factors have considerable bearing in choosing or not choosing a particular kind of medicine. Dimasa traditional curative practices like ritual performance and herbal medicine are not totally inexpensive. But, for purchasing of modern medicine cash is required. And since cash is always scarce among the Dimasas living in a kind of non-monetized economy, consideration of modern medicine is often not possible. Sex and age factor also play important role in choosing treatment options. In many societies particularly in underdeveloped countries babies and young children occupy such a subordinate position in the family that they are brought for medical care much less often than adults (Stever, 1961:335; c.f. Glaser, 1968). In this regard it has been argued that paediatrics is an underdeveloped branch of modern medicine in many countries.

The second visible prominant trend is that for certain diseases the Dimasas overwhelmingly consider certain type of medicines. Every ethnic group has their own beliefs and practices involving disease/illness and their remedial measures and cures. The medical cognition of the group is basically defined by such cultural knowledge. The Dimasa Kacharis do not exhibit much variation in this regard. In certain cases when symptoms are recognisable in traditional terms and the cures are traditionally known, the Dimasas generally go for the traditional option. From among the diseases covered in this investigation, for headache 'rituals', for malaria 'modern medicines', and for stomach related complaints 'herbal medicine' have been the usual preference of the people. However, there are other cases of diseases not covered in this investigation for which the people prefer their traditional remedial measures. For measle (*bersi*), any orthopaedic complaint, infantile diarrhoea, pregnancy and delivery related problems, the Dimasas generally prefer traditional medicines.

For orthopaedic cases the Dimasas do not prefer modern physicians out of fear of being operated. Of course, there are several wellknown traditional bone setters among the Dimasas upon whom the people have good faith. Specific kind of infantile diarrhoea and delivery related problems are believed to be caused by evil spirits. Therefore, to get relief from such problems specific rituals are only performed. Similarly for *orisjava* (a traditionally recognised ailment seems to be equivalent to haemophilia) the people perform *orispuja*. Modern medicine to interven this problem is never considered as it is believed that such a practice would annoyed the supernatural being responsible for it.

At the beginning we have argued that introduction of modern medicine is not often easy, particularly for those communities who have got their own system of traditional medicine. However, even if modern medicine is inducted such introduction can not replace the existing system altogether. This leads to a situation of medical pluralism. In such a backdrop the disease perception of the people gets segmented vertically into two distinct categories – diseases curable by modern medicine and diseases curable by traditional measures. The Dimasa Kacharis do not show any exception to this norm. In this regard Hughes' (1968:92) observation is quite appropriate, as he writes "in many instances modern medicine does get accepted; and one of the reasons is its demonstrably greater effectiveness in the treatment and prevention of many diseases. But even such acceptance is often compromised by the existance of alternative diagnostic and therapeutic frameworks: one relating to those diseases for which it is felt modern medicine is more effective, and second relating to diseases conceived to be unamenable to modern medical treatment".

CONCLUSION

In this study we have seen that the Dimasa Kacharis have been well adjusted to a pluralistic medical situation. The traditional medical practices of the people have found a distinctive position along with the implanted medicine systems. Choice of treatment and healing options of the people is sequential, atleast for the type of diseases covered in this investigation. Though there is no definite order of such choices, as often choices are made at random, yet rational

medicines are considered mostly on the onset of an illness episode when magico-religious practices find dominancy towards the end. In none of the cases two or more therapeutic or healing options were chosen simultaneously.

Rituals which are performed by the Dimasas in order to get rid of evil influences of spirits are far more expensive than medical treatments. Therefore, to improve the health status as well as their economic position such wastful and functionless ritual practices are required to be abandoned.

Of course, it is not possible to get an overnight result when changing traditional practices altogether is a difficult task. Hughes (1968:91) writes "Folk medicine does not easily change under the impact of sustained contact with the industrialized world, or even as a result of deliberate attempts to introduce new conceptions of disease and hygiene".

Moreover, rituals give faith healing. Rituals, being part of the cultural system to which the patient belong, can induce healing so far the expectations of the patient and his family members are concerned. It has been said that in modern medicine system the patient is at the receiving end, and on the otherhand, in traditional system the patient is an active participant (Salamone, 1998:131). Therefore, traditional medical practices can reinstate at least the psychological balance of the patient during the period of disease crisis signifying that any sudden change in traditional practices can cause more harm than benefit.

It is, however, significant that in most cases initially the Dimasas prefer modern medical means to interven their health crisis. Only on failure of such means they resort to their rituals. Therefore, by improving the modern medical systems in terms of (i) efficient health delivery system, (ii) better patient-doctor relationships that could strengthen the confidence of the people on physicians; (iii) good communication between medical professionals and patients; (iv) doorstep delivery of medical services, etc., the benefit of modern medicine could be best administered among the people.

KEY WORDS Medical Pluralism. Medical Option. Ritual and Healing. Herbal Medicine.

ABSTRACT Medical and magico-religious intervention seeking attitude against illness is one of the dimensions covered in illness behaviour studies. Such studies are significant particularly in the case of communities living in medical pluralism ---- a situation where different medical systems are coexisting. These days the Dimasa Kacharis have the opportunity to avail a number of medical options: allopathic, homeopathic, traditional herbal medicine, traditional magico-religious options, etc. The people often consider more than one options during the course of a single illness episode on trial basis. Consideration of medical options in such a case is generally sequential. The general trend is that initially rational medicines (e.g., doctor's prescription, herbal medicine, etc.) are preferred but if the illness continues then magico-religious practices become the ultimate choice.

REFERENCES

Bhasin, Veena: Medical Pluralism and Health Services in Ladakh. *Journal of Social Sciences,* **1(1)**: 43-69 (1997).

Blumhagen, D.W.: On the nature of explanatory models. *Cult. Med. Psychiatry,* **5**: 337- 40 (1981).

Chowdhury, A.N.: Medico-cultural cognition of *Koro* epidemic: an ethnographic study. *J. Indian Anthropo. Society.* **26(1 and 2)**: 155-170 (1992).

Cohen, Milton: The ethnomedicine of the Garifuna (Black Caribs) of Rio Tinto, Honduras. *Anthropological Quarterly,* **57(1)**: (1984).

Fabrega, Jr. H.: Medical Anthropology. *Ann. Rev. Anthropology,* (1971).

Glaser, William A.: "Medical care : social aspects", in *International Encyclopedia of the Social Sciences.* Vol.10, Crowell Colliar & Macmillan, Inc., (1968).

Good, B.J.: The heart of what's the matter: the semantics of illness in Iran. *Cult. Med. Psychiatry,* **1**: 25-58 (1977).

Hughes, Charles C.: "Ethnomedicine", in *International Encyclopedia of the Social Sciences,* Vol.10, Crowell Collier & Macmillan, Inc., (1968).

Kleinman, Arthur: What kind of model for the anthropology of medical system? *American Anthropologist,* **80(3)**: (1978).

Kleinman, Arthur: *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine and Psychiatry.* University California Press, Berkeley (1980).

Logan, Michael H.: Humoral medicine in Guatamala and peasant acceptance of modern medicine. *Humen Organization,* **32(4)**: (1973).

Maclean, C.M.U.: Tradition in transition: a health opinion survey in Ibadan, Nigeria. *Bri. Jr. Preventive and Soc. Med.,* **19**: 192-97 (1965).

Maclean, C.M.U.: Hospitals or healers: an attitude survey in Ibadan. *Human Organization,* **25**: 131-39 (1966).

Manning, P. and H. Fabrega: Field work and the 'new ethnography'. *Man,* 2 (1977).

Mechanic, D.: The concept of illness behavior. *J. Chron. Dis.,* **15**: 189-94 (1962).

Pigg, Stacy Leigh: The social symbolism of healing in Nepal. *Ethnology,* **XXXIV (1)**: 17-36 (1995).

Press, T.: Urban illness: physians, curers and dual use in Bogota. *J. Health and Soc. Behav,* **10**: 209-18 (1969).

Roy, B.: Supernatural beliefs among the Dimasa Kacharis.

Bull. Deptt. Anthrop., Gauhati University, **viii**: 115 - 9 (1994).

Roy, B.: Descent groupings, belief system and social structure among the Dimasa Kacharis of Assam. *Proceedings, 84th Indian Science Congress,* Part III (Young Scientiests' Abstract), (1997).

Salamone, Frank A.: A Yoruba healer as syncretistic specialist: herbalism, rosicruscianism, and the babalawo. *Man and Life,* **24 (3&4)**: 121-36 (1998).

Stever, Robert C.: Medical impressions from India and Nepal. *Journal of Medical Education,* **36**: 330-37 (1961).

Suchman, E.A.: Social factors in medical deprivation. *American J. Pub. Health,* **55**: 1725-71 (1965a).

Suchman, E.A.: Social patterns of illness and medical care. *J. Health. Hum. Behav.,* **6**: 2-16 (1965b).

Suchman, E.A.: Stages of illness and medical care. *J. Health. Hum. Behav.,* **6**: 114-28 (1965c).

Zola, I.K.: Culture and symptoms : an analysis of patient's presenting complaints. *Amer. Soc. Rev.,* **31**: 615-30 (1966).

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