Symbolic and Cognitive analysis of Male Sexual Malfunctioning as a Disease and Illness: A Comparison of Indigenous Healing Systems and Bio-Medicine

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Final Approval of Thesis

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DEDICATED TO SHAMANS WHO
SUSPICIOUSLY HEALED THE ILL
AND PROVIDED CARE TO THE SICK

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All appreciation and glory is for "Almighty Allah", the most gracious and the most merciful, who enabled me to think and to work, and all the respect is for "Holy Prophet Muhammad (PBUH)", whose teachings is a permanent source of guidance for me in every walk of life.

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Farhan Ahmad Faiz

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CHAPTER NO. 1

INTRODUCTION

The Background

Since the ancient times, health and illness have been considered in cosmological and anthropological perspective consisting of magical and religious beliefs. Hence such awareness played a key role in integration and understanding of ancient cultures and civilizations to an extent that medical history assisted a lot in studying the history of that particular culture. Every society, irrespective of its simplicity or complexity has an inter-related set of beliefs and skills of practice regarding health, disease, illness and sickness. These phenomenons possess a challenge and threat both for physical existence and harmony of the social milieu. Therefore, the prevention of disease, illness, sickness and maintenance of health, all human societies develop knowledge of medicine. The knowledge of medicine involved in different beliefs and skills of practice provide health to illness and satisfaction to mysterious causes.

The primitive medicine though limited in knowledge about body, was always there to provide maximum care and cure where the therapeutic process articulated around knowledge regarding gods, evil spirits, stars and planets. Hence (Park, 1997)[1] argued that this super-natural theory of disease encircled around the anger of gods, the invasion of body by evil spirits and the intervening influence of stars and planets. So, the healers' treatment methodology encircled around appeasing gods by rituals and many a sacrifice meant to drive out evil spirits from the body by witchcraft and using charms and amulets to protect the mankind against such endangering natural elements. It is thus obvious that medicine in the prehistoric times (about 5000 BC) was intermingled with superstition, religion, magic and witchcraft, the manipulated

[1] J. E. Park. 1997. Park's Textbook of Preventive and Social Medicine. Pp 1.

shape of which even we find today among the belief system of Indigenous healers as well as among those seeking healing either from Healers or Doctors.

Primitive medicine is timeless. If we look around the world, we find that the rudiments of primitive medicine still persist in many parts of the world – in Asia, Africa, South America, Australia and the Pacific Islands. The supernatural theory of disease in which the primitive man believed, is as new as today. Although primitive man maybe extinct, his progeny – the so-called "traditional healers" are found everywhere even without the demarcation of urban or rural, though we find such healing more active in rural areas, esp. in Pakistan. They live 'close' to the people and their treatments are based on various combinations of their religion, their magic and empiricism understandable to common health seekers.

Massage Therapists and the Humoral Healers as it appear today possess a great similarity with the Chinese medicine that can be traced back to 2700 BC. (Pietroni, 1991)[2] while developing an analogy of the Acupuncture[3] used in Chinese healing system with the gender statuses prevailing in the social fabric of the societies argued that the philosophical mode of treatment is based on two principles -- the 'yang' and the 'yin'. On the analogy of the gender systems prevailing in any or all the cultures, this medical system argues that the yang is considered to be an active masculine principle and the yin a negative feminine principle. The balance of these two opposing forces meant good health. Hygiene, dietetics, hydrotherapy, massage, drugs were all used by the Chinese physicians. To a Chinese, "the great doctor is one who treats not someone who is already ill but someone not yet ill" thus preventive

[2] Dr Patrick C. Pietroni. 1991. Reader's Digest Family Guide to Alternative Medicine. Pp 14 - Pp 16.

[3] Dr Patrick C. Pietroni. 1991. Reader's Digest Family Guide to Alternative Medicine. Pp 14 - Pp 16 in which Pietroni elaborated the Acupuncture considered being an ancient Chinese therapy, wherein patients are treated by sticking needles into their skin at particular points. These acupuncture points lie along invisible energy channels called 'meridians', which are believed to be linked to internal organs. The needles are said to unblock, increase or decrease a flow of energy (called *Qi*) through the meridians.

medicine is given more importance than the curative one. The Chinese have great faith in their traditional medicine, which is fully integrated with modern medicine. The Chinese system of "bare-foot doctors" and acupuncture through needles and other crude means has attracted world-wide attention in recent years which is reflected through the fact that a chain of Chinese hospitals have come on the forefront even in a city like Multan, Lodhran and Dunyapur.

One may draw an analogy between the Chinese medicine and the Humoral medicine on the basis of yang and hot while yin with the cold in which all the food items have been given hot and cold qualities to achieve a balance between hot and the cold. Secondly both the Humoral and Chinese medical systems propose preventive health and not the curative health.

Similar to the Greek medical system[4] which postulated that the matter was made up of four elements – earth, air, fire, water which had the qualities of being cold, dry, hot and moist and represented in the body by the four humors – phlegm, yellow bile, blood and black bile and to the Ayurvedic medical system[5] who postulated the "tridosha theory" which consists of: *vata*

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[4] J. E. Park. 1997. Park's Textbook of Preventive and Social Medicine. Pp 3. While elaborating the Greek medicine, Park argued that the classic period of Greek medicine was the year 460-136 BC. An early leader in Greek medicine was Aesculapius (1200 BC). Aesculapius bore two daughters – Hygiea and Panacea reminding us of the legend that Hygiea was worshipped as the goddess of health and Panacea as the goddess of medicine. Panacea and Hygiea gave rise to dynasties of healers (curative medicine) and hygienists (preventive medicine) with different philosophies. Greeks gave a new direction to medical thought. They rejected the supernatural theory of disease and looked upon disease as a natural process, not a visitation from a god of immolation. The Greeks believed that matter was made up of four elements – earth, air, fire, water and the health prevailed when the four humors were in equilibrium and when the balance was disturbed, disease was the result. The human body was assumed to have powers of restoration of humoral equilibrium, and it was the physician's primary role to assist in the healing process.

[5] J. E. Park. 1997. Park's Textbook of Preventive and Social Medicine. Pp 1, in which Park argued that Ayurveda and the Siddha are the two Indian medical systems where in Ayurveda is practiced throughout India, but the Siddha system is practiced in the Tamil-speaking areas of South India. In ancient India, the celebrated authorities in Ayurvedic medicine were Atreya, Charaka, Susruta and Vaghbatt. Hygiene was given an important place in ancient Indian medicine. The laws of Manu were a code of personal hygiene. Archeological excavations at Mohenjo-daro and Harappa in the Indus valley uncovered cities of over two thousand years old which revealed rather advances knowledge of sanitation, water supply and engineering.

(wind), *pitta* (gall) and *kapha* (mucus); the humoral medical system refers to the hot and cold classification. (Zakar, 1998)[6] argues that such a classification does not refer to the empirical physical symbolic characteristics such as temperature but to the effect attributed to the qualities or properties inherent in the substances themselves. This cognitive classification is meant to classify all sorts of food and herbs into hot and cold. The purpose behind such a classification is to exercise hot therapy to the cold patient and the cold therapy to the hot patient, because health can only be achieved by attaining a balance between the hot and the cold, which was meant to prevent a disease. This healing system functions to prolong the health to an extent as possible through self-care and precautionary remedies. One further elaboration concerning the treatment methodology is that the 'hot' is not given immediate 'cold' treatment rather through normalizing the temperature of the 'hot', cold treatment is given.

Secondly, another analogy prevails between religious Quakers and the Egyptian medicine. Egyptian medicine[7] as argued by (Park, 1997) can be traced back to 2700 BC and is considered to be the one of the oldest civilizations. Equating medicine with religion, Egyptian physicians were co-

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The goden age of Indian medicine was between 800 BC and 600 AD. During the Moghul period and subsequent years, Ayurveda declined due to lack of State support. Medical historians admit that Indian medicine has played in Asia the same role as the Greek medicine in the west, for it has spread in Indochina, Indonesia, Tibet, Central Asia, and as far as Japan, exactly as the Greek medicine has don in Europe and Arab countries.

[6] Muhammad Zakria Zakar. 1998. Coexistence of Indigenous and Cosmopolitan Medical Systems in Pakistan. Lage: Germany

[7] J. E. Park. 1997. Park's Textbook of Preventive and Social Medicine. Pp 2, in which Park argued that Egypt had one of the oldest civilizations in the temporal span of about 2000 BC. Egyptian medicine reached its peak in the days of Imhotep (2800 BC). The Egyptians worshipped many gods. Imhotep was considered both a doctor and divinity. Specialization prevailed in Egyptian times. There were eye doctors, head doctors and tooth doctors. All these doctors were officially paid by the state. The best-known medical manuscripts belonging to the Egyptian times are the Edwin Smith papyrus (3000-2500 BC), and the Ebers Papyrus (1150 BC). The Edwin Smith papyrus, the oldest treatise on surgery, accurately describes partial paralysis following cerebral lesions in skull fractures. The Ebers papyrus, which was found with a mummy on the banks of the Nile, is a unique record of some 800 prescriptions based on some 700 drugs.

equals of priests. They often assisted priests care for the sick that were brought to the temples for treatment. Egyptian medicine believed that disease was due to absorption from the intestine of harmful substances, which gave rise to putrefaction of blood and formation of pus. They believed that the pulse was "the speech of the heart". Diseases were treated with cathartics, enema, blood-letting and a wide range of drugs.

Islamic medicine though not having an all encompassing medical foundations, affects direct the rest of the medical systems in Pakistan be it Humoral, Unani or the state monopolized bio-medical medicine. This system enjoys strong cultural affiliation and emotional bondage even lacking its own laboratory or a clinic. It legitimizes any other indigenous healing system e-g Unani who is usually equated with Islamic medicine for the very fact that some early physicians who wrote treatise on Unani medicine referred to the application of Prophets' sayings with reference to usage of Honey and other items/ herbs like Qalwanji.

This ancient Unani medical system, as argued by (Said 1983)[8] had its origins in the Mediterranean world and its development in the Middle East, was brought to Indian subcontinent with the spread of Islamic civilization in the Mughal era. Similar to the Greek medicine and Humoral medicine, Unani medicine's philosophical foundations consist of the four-humor theory of Hippocrates, which presupposes the presence of four humors in the body namely blood, yellow one and black one. Zakar argues that in this medical system, human body is regarded as comprising the seven working principles; (1) different states of matter and materials entering into and forming a part of everything in the universe; (2) the bodily temperament; (3) the structural components; (4) the fully developed and mature organs (5) the vital force of

[8] Hakim Muhammad Said. 1983. "The Unani System of Health and Medicine" Pp 60 – 68 in *Traditional Medicine and Health Coverage*, edited by Robert H. Bannerman, John Burton and Chen Wen-Chieh. Geneva: World Health Organization

life; (6) the bodily power; and, (7) the corporal functions. The second principle, body temperament is of key importance in determining the hot and cold temperament of the body so that a suitable remedy, prepared from local herbs, can be given to suit the bodily treatment pertaining to male sexual malfunctioning.

The topic of study relates to medical anthropology, which strives for an understanding of health, illness, disease and sickness among inter-cultural and intra-cultural groups and clans. According to (Helmen, 1984)[9] Medical Anthropology can be described as the study of cultural beliefs and behaviors associated with the origin, recognition and management of health and illness in different social and cultural groups. Medical anthropology is not simply concerned with practice of healing or systems of diagnosis and treatment such as biomedicine. It deals with the more informal systems of health care that exist worldwide (such as self-treatment, folk healing, traditional birth attendants, shamans and indigenous healers), as well as those associated with professional Western science-based biomedicine (Cosmopolitan medical system) and caring and curing practice. Additionally medical anthropology is also concerned with issues that relate to different cultural connotations of the 'self' in response to health and disease, as well as shared beliefs, cognitive images and practice associated with perceptions of the human body and mind.

With reference to the research topic, the practitioner (Hakeem, Cleric and Pirs) of the Humoral medical system may argue that the reason of male sexual malfunctioning can be the divergence of males to follow the Islamic code of conduct and either in the past they would have committed some sin (rape, masturbation, homosexuality, sex from the prohibited part i-e anus, incest taboo or sex with an animal) and hence a particular remedy consists on seeking apology from the God either in a ritualistic way or via intentions.

[9] Cecil Helmen. 1984. Culture, Health and Illness. John Wright and Sons.

Another rationale of male sexual malfunctioning can be the cold exposure (washing with cold water) of the male sexual organ immediately after the orgasm, since having an orgasm is equated with the hot classification. Meanwhile, the native Muslim conception with reference to purity and impurity suggests that impurity (Penis, after orgasm) be washed through normal hot water.

In accordance to the evolutionary schemes of the diverse medical systems, the researcher argues that in Pakistan, one may find the existence of any of the above mentioned medical systems independently or a blend of two or all the medical systems coexisting with one or all the medical systems. Muslim physicians/ healers under the influence of Primitive, Chinese, Egyptian, Mesopotamian, Greek, Roman and above all the Ayurvedic medical system laid the foundations of Humoral, Unani and Islamic medical systems which are mostly based on the belief system of the native community in which the particular medical system is rendering its services and that is the reason that it is called Indigenous Healing system.

1.2 Statement of the Problem

In Pakistan, one may find the existence of one of the above mentioned indigenous medical system or a blend of the two or all the indigenous medical systems (Humoral, Unani, Islamic), but the important thing is that they simultaneously co-exist with the now, well established, state monopolized bio-medical system of healing which claims to be rational, objective and value-free in dealing with one or all the diseases whether be it the issue of curative or the preventive. Either the issue is of health, disease, illness or sickness; both the Indigenous as well as Cosmopolitan medical systems come on the scene to render their services and to capture the 'market'. When the issue is of Sexuality, that too in South Punjab and particularly District Lodhran, one can easily find an existence of full fledged industry, providing cure and care to the

malfunctioning of sexuality, which is diverse in domain and narrow in focus! Sexual malfunctioning is not only the malfunctioning of any organ rather it is a 'cultural malfunctioning' which needs an utmost treatment because a sexually malfunctioned man has no say in society as its contingencies are reflective of the fact that such a person falls prey to shame, and un-acceptance. Sex equated with honor, is reinforced when it is aloof of any harm. Secondly, in most of the diseases or illnesses, the Therapeutic Management Group comes in support of the patient who at the moment is enjoying 'Secondary Gain' but in sexual malfunctioning, the role of Therapeutic Management Group is of labeling and criticizing thus leaving behind the entire responsibility onto the patient.

1.3 Objectives of the Study

The main objectives of the study were to;

1. See and demarcate male sexual malfunctioning as a disease and illness in both the Indigenous medical systems as well as bio-medical system.
2. Understand the cultural dynamics and normative sexual practice that regulates and reinforces the 'normal' sexual behavior against the 'abnormal' sexual practice.
3. Discover cultural sources out of which arises the indigenous medical systems' understanding as well as bio-medical systems' understanding of male sexual malfunctioning.
4. Symbolic and cognitive analysis of Indigenous healing system and bio-medical system

1.4 Significance of the Study

Due to diversification of medical systems and changing behaviors about medical systems, it is necessary to know the answer of such questions as, which type of people, go to which type of medicine? And why they prefer to go to that particular mode of treatment? How they are treated? To what extent they are satisfied by any particular mode of treatment? The role of therapeutic management group (TMG)[10] and satisfaction level of them for treatment of their patient is also to be measured in this study.

In Pakistan, there are many types of healing and treatment including, modern scientific medicine, as Allopathy, as well as local traditional medicine as spiritual healing, humoral medicine, herbal medicine, hakeems, homeopathy etc. which provide an alternative therapy to modern biomedical system. All of these medical systems have their own identity; status, value and they co-exist at the same time thus providing a base for the coexistence and plurality of medico-healing systems as also argued by Zakar, 1998.[11]

Male sexual malfunctioning resulting certain diseases, illness, distress and sickness affect the social relations of an individual in the society because sexual impotency results in societal impotency which have a grave influence on the family dynamics. The indigenous healing system is rendering his services in the response to male sexual malfunctioning by giving a complete surety for the complete treatment and elimination of such an epidemic. Daily newspaper, wall chalking, advertisements at every public gathering spots and at bus stops, one may find a full fledged focus on the usage of drugs for the treatment and improvement in sexual potency by Quakers.

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[10] Therapeutic Management Group comprises of the paternal and maternal relatives who rush and join the therapeutic process for negotiation with the healer/ physician. Either the issue is of disease, illness, sickness or distress; the choice to adopt a particular mode of treatment for efficacy lies in the hands of TMG and not the patient itself.

[11] Muhammad Zakria Zakar. 1998. Coexistence of Indigenous and Cosmopolitan Medical Systems in Pakistan. Lage: Germany

1.5 Defining Key Concepts

Classification of Bio-Medical system and Indigenous healing system

The classification of cosmopolitan medical system and indigenous healing system has been done by different medical anthropologists. Generally people use "modern medical system" and "traditional medical system" for both systems. Technically this classification seems inappropriate because both terms appear to entail "a lack of change" or "absence of tradition". Also, generally the term "western medical system" is used for bio-medical system and "eastern medical system" for local medical systems. But criticism on it is that homeopathy was originated in a western country, Germany and is practiced in as many countries as western biomedical system.

Zakar (1998)[12] has used the terms Cosmopolitan medical system and Indigenous medical system to classify the medical systems. The term cosmopolitan medical system has been used to mention the modern, western, scientific, laboratory based conventional, orthodox and universal medical system. By contrast, the term of indigenous medical system has been used to categorize the local, traditional, non-western, non-scientific, folk, cultural based, unconventional and alternative medicine.

Dunn (1976)[13] demarcated both systems on the basis of their geographical sphere of influence. According to him, "There are local medical systems, a category which can accommodate most systems of primitive or folk medicine; regional medical systems, such as Ayurvedic, Unani and Chinese medicine; and the cosmopolitan medical system, often referred as modern, scientific and western medicine".

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[12] Zakar Muhammad. 1998. *"Coexistence of indigenous and cosmopolitan medical systems is Pakistan"*. Verlag Hans Jacobs, Germany.

[13] Dunn, Fred I. 1976. "Traditional Asian Medicine and Cosmopolitan Medicine as Adaptive System". Pp 13 – 27 in Sickness and Health in Asian Medical Systems, edited by Charles Leslie. Barkely: University of California Press.

Easthope (2002)[14] used the terms orthodox medicine and complementary medicine for both systems. According to him, the medical practices and institutions developed in Europe during the nineteenth and twentieth centuries can be called as orthodox medicine. Key element of this practice is teaching hospital environment where all doctors are inducted into laboratory science, clinical practice, and allopathic biomedicine. Also, he described complementary medicine as "those practice that stand in opposition to orthodox medicine rather they collaborate with orthodox practice."

1.5.1 Bio- Medical System

Definition of Bio-Medical system according to Bishaw (1988)[15] is, "a formally organized system having largely similar tools and techniques to measure the state of health and 1) a perception of illness as essentially physical, chemical and physiological changes taking place in the bodily system of the individual, and 2) a highly trained and professionally organized man power with a complex division of labor among physician, nurse and a variety of other technicians and auxiliaries are deployed to treat them"

Gary Easthope (2002)[16] stated that modern medicine was created from a combination of allopathic theory, a focus on the body, empirical clinical experience, and laboratory science. This scientific, clinical, allopathic biomedicine became the orthodox medicine in the nineteenth century.

In my research, MBBS Doctors and FRCS/ FCPS Surgeons would

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[14] Easthope, G. 2002, "Alternative Medicine", in J. germov (ed.), *Second Opinion: An Introduction to Health Sociology*, 2nd edn, Oxford University Press, Melbourne.
[15] Bishaw, Makonnen. 1988. "Integrating Indigenous and Cosmopolitn Medicine in Ethiopia". Ph.D. dissertation, Department of Anthropology in the Graduate School Southern Illinois University at Carbondale.
[16] Easthope, G. 2002, "Alternative Medicine", in J. germov (ed.), *Second Opinion: An Introduction to Health Sociology*, 2nd ed, Oxford University Press, Melbourne.

perform the job of curing malfunctioning under the umbrella of Bio-medical system.

1.5.2 Indigenous Healing System

Indigenous healing system is sometimes intermingled with indigenous medical system. Both terms are used for traditional, local medical systems, which are commonly alternative to orthodox cosmopolitan conventional medical system.

Michael McQuaide (2005)[17] argued in his article, "Alternative medicine is defined as anything done or given to a patient that is outside the limits of orthodox medicine. Therapeutic massage, homeopathy, yoga, acupuncture, religious healers, and additional practice fall under the large umbrella of alternative therapies". As far as the range of alternative therapies is concerned, many such practices have nothing in common other than that they are outside of conventional medicine.

Ataudo (1985)[18] defines indigenous medical system in simple words: "it is the medicine of the people by the people and for the people which has been practiced and handed down from generation to generation". So indigenous medical system 'refers to the system of beliefs and practice, acquired and transmitted mainly through practical experiences and observations, that is used in the explanation, prevention, diagnosis and treatment of "physical, mental and social imbalances" (WHO 1978)[19]. In the indigenous medical system, all the processes of illness management are shared by the patient, his family as well as the healer. This medical system is usually

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[17] Mc Quaide, M. 2005, "The Rise of Alternative Health Care: A Sociological Account", *Published by Palgrave Macmillan Ltd for Social Theory & Health, pp.286–301*

[18] Ataudo, E. S. 1985. "Traditional Medicine and Biophysiological fulfillment in African Health". *Social Science and Medicine* 21 :1345 -47

[19] World Health Organization. 1978. *The Promotion and Development of Traditional Medicine:* Report of WHO Meeting, WHO Technical Report Series No. 622. Pp 1 - 35

based on the knowledge and reasoning regarding health and illness quite familiar and understandable even at popular level. (Zakar, 1998)[20].

World health organization (WHO) defines indigenous medical system as, "the system of beliefs and practice, acquired and transmitted mainly through practical experiences and observations that is used in prevention, explanation, diagnosis and treatment of physical, mental and social imbalances."

I would operationalize this term to refer to Islamic, Unani, Humoral and 'traditional' understanding of sexuality and how they come up to perpetuate morality and physical potential to be sexually active and this constitutes an industry.

1.5.3 Symbolism

- Symbol is a thing regarded by general consent as naturally typifying or representing or recalling something by possession of analogous qualities or by association in fact or thought.
- The symbol is the smallest unit of ritual, which retains the specific properties of ritual behavior; it is the ultimate unit of specific structure in a ritual context.
- Something, verbal or nonverbal, that arbitrarily and by convention stands for something else, with which it has no necessary or natural connection.

- Arbitrary units of meaning that can stand for different concrete or abstract phenomenon.
- One item used to meaningfully represent another--as in the case of a flag which symbolizes a nation

[20] Zakar Muhammad. 1998. *"Coexistence of indigenous and cosmopolitan medical systems is Pakistan"*. Verlag Hans Jacobs, Germany.

In my research, the researcher would use symbolic in such a way, "smallest unit of ritual which retains the specific properties of ritual behavior; it is the ultimate unit of specific structure in a ritual context or something, verbal or nonverbal, that arbitrarily and by convention stands for something else, with which it has no necessary or natural connection.

1.5.4 Cognition

- Human thought processes including perception, reasoning, and remembering.
- Mental faculty of knowing and discerning

1.5.5 Sexual Malfunctioning

A sexual problem, or sexual dysfunction, refers to a problem during any phase of the sexual response cycle that prevents the individual or couple from experiencing satisfaction from the sexual activity. The sexual response cycle has four phases: excitement, plateau, orgasm and resolution.

1.5.6 Disease

Disease is defined as "An alteration of the dynamic interaction between an individual and his environment which is sufficient to be deleterious to the well-being of the individual and produces signs and symptoms". (Mac- Graw Hill Dictionary of scientific and technical terms).

Foster (1978)[21] says while defining disease "disease with its pain and suffering is the most predictable of human conditions; it is a biological and cultural universals".

[21] Foster. G. M. Anderson. 1978. Medical Anthropology. John Willey and Sons. New York

Disease refers to a medical conception of pathological abnormality, which are indicated by a set of signs and symptoms. Disease is invariably used in a fairly limited and scientific sense as the Oxford dictionary definition illustrates: 'a condition of the body, or of some part or organ of the body, in which its functions are disturbed or deranged; a morbid physical condition. With disease the focus is more on the objective and is seen in terms of the specific impaired state. I would use the terms disease with reference to all such abnormal states that sustain sexual malfunctioning either used by Cosmopolitan or Indigenous Healing systems.

1.5.7 Illness

Illness as defined by Foster (1978)[22], "Illness is a social recognition that a person is unable to fulfill his normal roles adequately, and that something must be done about this situation". Illness is defined in the Oxford dictionary as 'the quality or condition of being ill (in various senses). These senses are listed as (1) Bad moral quality, condition or character. (2) Unpleasantness, disagreeableness; troublesomeness; hurtfulness, noxiousness, badness. (3) Bad or unhealthy condition of the body; the condition of being ill; disease, ailment, sickness, malady. With illness the focus is more on the subjective perception of the disease. To be ill is not simply to be in a biologically altered state, but also to be in a socially altered state, which is seen as both deviant and (normally) undesirable. Illness, then, refers to an altered set of feelings manifested in terms of what doctors call symptoms, but experienced by the ill persons as real, diffuse and often un-specifiable subjective states. People respond to illness (not disease) and develop systematic categorizations whereby they define such conditions, and thence gain some sort of control over them. (Zakar, 1998)[23].

I would use illness to refer to all the subjective states, feelings,

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[22] Foster. G. M. Anderson. 1978. Medical Anthropology. John Willey and Sons. New York

[23] Zakar Muhammad. 1998. *"Coexistence of indigenous and cosmopolitan medical systems is Pakistan"*. Verlag Hans Jacobs, Germany.

perception and impact of malfunctioning onto the patient and this would be the true version of the patient only.

Difference between Disease and Illness

Foster differentiates between disease and illness by saying that, "disease is a pathological concept and illness a cultural concept." The traditional distinction between disease and illness is particularly helpful in tracing the boundaries of practice between biomedical and indigenous practitioners. The evidence points to a strict division of labor between the two: indigenous practitioners are restricted to the realm of illness, while their biomedical colleagues are in charge of diseases. Thus, indigenous practitioners focus on the patient's personal experience of pain and suffering, while biomedical practitioners concentrate on the diagnosis and cure of the disease, although they do not necessarily ignore the patients' experience of illness.

1.6 Research Methodology

Any research passes through following steps before reaching towards its conclusion:

- Find a topic
- Review of the relevant literature
- Defining the problem
- Design the study i.e. choose a research design, select a locale of the study, select a sample and prepare the tool for data collection
- Design a Methodology
- Gather data
- Analyze data
- Results, conclusion and analysis

Hence, research methodology is the logical and rational underlying decisions that researcher takes place throughout the research process, this include the decision about the usage of particular tools and techniques at particular point.

The data collection methods that were adopted during the current research were:

1.6.1 Research Design

Natural experimental research design was used in the present research as considering it the best technique to get the native approach on particular phenomena. Researcher in this technique just evaluated what's going on in a particular filed, phenomena not conducted but evaluated by the researcher, this research design helped researcher to get real picture of the particular community, and situation in this technique was not created by the researcher so chance of biasness was less in this technique.

1.6.2 Unit of Analysis

While conducting the research entities under study were referred as unit of analysis, the units of analysis of the present research were

- *Aamil*
- Peer
- Doctors (MBBS, FCPS, FRCS)
- Alternative medical practitioners of Humoral, Unani and Islamic medical systems
- Dispensers
- Hakeem
- Patients
- Cultural myths and folklores regarding sexuality

- Culturally sanctioned normal sexual practices against abnormal sexual practices and its frequency
- Healthy men
- Books and pamphlets
- Artifacts
- Signboards
    - Shrines
    - Wall chalking
    - Images

1.6.3 Rapport Building in an Area of Research

The research was carried out over a period of 6 months, which were spent living in the locale close to the local people. During this period a casual and informal relationship was developed with the natives. Living in the field gave me chance to get first hand information on the subject.

Participant observation mainly involves three major techniques to gather data from the members of the community or the village. The first is interviewing, the second is participation and the third is observation. I used all these techniques to gather data from the community. The observer goes in to field and observe things happening naturally. Participant observation may be viewed as a form of initial exploration of a research topic. The most advantageous point of participant observation is that the researcher sees what people are really doing instead of believing on their saying what they used to do. The six month stay in a field was the phase of data collection, and mostly in any research this is the most time consuming span. It involves selecting a field, designing a questionnaire, choosing a sample, data collection and a departure.

Upon entering into the field, the first task a researcher needs to do is to build a good rapport. Rapport establishment is rather important technique in anthropological research, because this method provides key to use other methods i.e. interviews, case studies and participant observations etc. Rapport building includes gaining the trust of the community members so that they could accept the researcher as their community member. For under-taking an in-depth study in any locale, it is very important to break down certain social barriers. Establishing good rapport in the locality allows a researcher to move freely among the local people and collect the required information but it is always a time consuming task requiring devotion and patience on the part of the researcher.

Initially, I spent most of my time in introducing myself and developing relations with people of the village and also on explaining my purpose of coming to their village, which later assisted them a lot in negotiating their queries about me. In the village I was introduced to the villagers by my friend and host Mian Mehfooz Arain, who later became a key informant also. During my stay in the locale, I resided with him at his *Dera*[24]

1.6.4 Participant Observation

Participant observation is the foundation of cultural anthropology. It involves living in the locale of the research for extended periods of time and getting close to the people and making them feel comfortable enough with your presence so that you can observe and record information about their lives. Participant observation tool was used as considering it best technique for getting close to the people and making them feel comfortable with the researcher that it can observe or record the information about their lives.

[24] Dera is a place where most of the guests are entertained

In the words of Foster (1978)[25], Participant Observation is:

> "An Anthropologist lives in a community, participates in many aspects of its life and observes first hand behavior of most if not all of the members of the group".

The researcher participated in all the events of social importance during his stay at locale. The events include marriage ceremony, political meeting and funeral procession. Besides this, the researcher participated in everyday life activities like sitting at tea stall, sharing a cup of tea, gossiping at *Bhaitaks*[26]. It helped the researcher to get close to the people and make them feel comfortable. It also supported in triangulating the information that the researcher collected during stay at the locale.

1.6.5 Detailed Mapping of Locale

On entering the locale of my research and having settled over there, one of the first tasks was to begin working on my rough sketch of the locale and the area surrounding it. Initially the map was of rudimentary type and changes were brought in it with the passage of time. Such a locale mapping played a significant part in designing the research. They help researchers to get orientation about the research and to physically divide the area of observation. With the map in pocket, it is beneficial to walk around an area to have clear idea of how to read the map easily by demarcating it with streets, households, land, cattle farms and other physical infrastructure.

1.6.6 Key Informants

Bernard (1994) has defined it as key informant interviewing is an integral part of ethnographic research. Good informants are people to whom

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[25] Foster. G. M. Anderson. 1978. Medical Anthropology. John Willey and Sons. New York

[26] A sitting place within the house usually for guests, usually an external room with a door opening at the street (outside)

you can talk to easily, who understand the information you need and who are glad to give it to you or get it for you.

Key Informants are people who possess knowledge about past of their society, the dynamics of their present community of life and can be depended on for providing the researcher with multidimensional picture of their community across the time and space. The researcher used key informants to get information on the history of community, the instances and rationale of cultural deviance as well as structure and dynamics of marginalized events in the community under study. The researcher's key informants helped him in making extensive contacts within the community and introducing him in the locale and beyond.

An informant or key actor in the field research is considered very important as in present research these were the members with whom the researcher developed the relationship based on the sharing information about the people and phenomena. Researcher in the present research used the key informants who were very familiar with the village profile as were the natives, they were familiar with the history, current events, about people, their routines, and all other happenings of the village. Researcher in this research used the non-paid informants to avoid the biasness. Key informant played vital role in this research as many issues confirmed later by the informants that were told incorrectly by some persons.

1.6.7 Universe

Universe for the present research was the Mari Bhagoo Khan village consisted in tahsil Karod Pakka consisted on 2491 individuals till May 2006 constituent of 330 house holds.

1.6.8 Sampling

While doing field work, at times it is not possible for a researcher to collect the data from each and every dweller of the locale, especially when the numerical strength of the people of the selected locale is higher. The particular technique adopted by the researcher for the representative sample of the entire population is of crucial importance in this regard.

As researcher cannot study a large population sample because of time and resource constraints therefore, sampling is done to make the analysis representative of the whole population through induction. I confronted the need of sampling at the Socio-economic census profile and interview stage of my research.

Hence for the Socio-economic Census of my locale, Systematic Random sampling as a technique was used i.e. every 3rd house hold while for the interviews purposive sampling was used having two purposes in mind:

- 60 respondents to follow indigenous healing system and 60 to follow biomedicine, as the objective was to get the authentic comparison between the two medical systems.
- the respondents should be a necessarily a male sexual malfunctional and should be seeking efficacy from any one or more healing systems.

In this way I made strata of two groups (following indigenous healing system and bio-medicine). But the important thing was that this demarcation was not rigid as it was hypothesized that the dwellers of indigenous healing system can also seek efficacy from the biomedicine and the vice verca. 120 individuals were interviewed, data gathered and then divided in 60 individuals who believe in cosmopolitan and 60 believing in indigenous healing system; from all caste group of the village. Though as mentioned earlier that most of the dwellers of indigenous healing system were also involved in seeking

efficacy from the biomedicine prior to following the indigenous healing system.

For the interviews, I used Purposive sampling. I collected a sample of one-third population of my locale. The village is consisted of 330 households with a population of 2491 individuals till May 2006. According to my sample of the 1/3 population collected after a survey, population of the village in the sampling frame is 830 individuals from 108 households, averagely 7 individuals in every household.

Still, the researcher while selecting the sample encountered the following constraints:

- There was no exact list of Malfunctioned patients
- All Malfunctioned patients don't come to a specific hospital or clinic thus following a plurality of healing systems.
- All respondents cannot be divided into strata, nor can quota be set of a specific area due to socio-economic diversification and specification of respondents.

1.6.9 Socio-Economic Census

Socio-Economic Census provides the basic demographic and socio-economic information of the locale. Researcher conducted the socio-economic survey of 108 House Holds of the village by using systematic random sampling i.e. every 3rd household. Researcher formulated census forms consisted of columns about family structure, caste, income, religion, occupation, education level, health seeking behaviors etc.

1.6.10 Interviews

I also conducted informal discussion and structured interviews. For the interviews, I used Purposive sampling. I collected a sample of one-third households (108) for interviews of my locale. The village is consisted of 330 households with a population of 2491 individuals till May 2006. According to my sample of the 1/3 population collected after a survey, population of the village in the sampling frame is 830 individuals from 108 households, averagely 7 individuals in every household.

1.6.11 Case Studies

It is a technique in which a detailed record of the experience of an individual or a series of events occurring within a given framework is written. The case study method has perhaps been most systematically employed in the field of Anthropology. This tool helped to get the large information by conducting few cases. Cases in the present research were 8 males who were suffering from male sexual malfunctioning and who their treatment ranged from indigenous healers to religious Quakers to biomedicine practitioners.

CHPATER NO. 2

REVIEW OF THE RELEVANT LITERATURE

Review of literature is based on the assumption that knowledge is built up on what others have done. According to Neuman, literature review has four major goals. First, to demonstrate a familiarity with a body of knowledge and establish credibility, second, to show the path of prior research and how a current project is linked to it, third, to integrate and summarize what is known in a specific area, fourth, to learn from others and stimulate new ideas.

This study falls within the domain of Medical Anthropology, so the concept should be clear, according to Helmen[27], Social Scientists of different times reflected a substantive work on the social problems within and across the cultures. The studies focusing Medical Anthropology and Ethno Medicine have been selected keeping in view their correlation with the researchers' area of interest.

According to Helmen, (1984) "Medical Anthropology" is about how people in different cultures and social groups explain the causes of ill health, the types of treatment they believe in and to whom they turn if they do become ill.

In the current study, researcher would use two types of reviews. Empirical reviews, which presents earlier researches on the issue (satisfaction level of malfunctioned patients towards diagnosis and treatment: comparative analysis of cosmopolitan medical system and indigenous healing system) and theoretical reviews, which demonstrates the concepts, assumptions and theories about this issue.

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[27] Helmen, Cecil. 1984. Culture, Health and Illness. John Wright and Sons

Rhodes (1990)[28] reveals how biomedicine is taken and considered in medical anthropology. She concentrated on the facts and realities associated with biomedicine, that are yet to be revealed to make it a cultural system. Clinically applied medical anthropology concentrate on the environment in the clinical setting and particular issues like doctor-patient relationship, or any particular disease, e.g. malfunctioning, how it is diagnosed and treated in clinical setting. Critical medical anthropology focus on social issues, like power conflict or social causes of any illness e.g. malfunctioning, how it emerges due to social causes within the society and how biomedicine can be used to avoid these social causes.

Last (1990)[29] argued that in the whole market of medicine, if indigenous healing system needs to be compatible with the cosmopolitan medical system, it is required to be professional, systematic and organized. Professionalization of indigenous healing system can be done in two ways. Firstly, from the regulation of state, within which there are three systems. Exclusive systems, where cosmopolitan medical system is monopolized and authoritative system and indigenous healing system has to surrender to cosmopolitan medical system, tolerant systems, where indigenous healing system can survive with the check and supervision of state but cosmopolitan medical system has the ultimate authority, and the integrated systems where cosmopolitan medical system and indigenous healing system are integrated and coexist within the same society. Other way of Professionalization of alternative healers is from the existing society through the good will and trustworthiness of healers and perception of that community about them. In a given society people automatically organize a social and cultural system for their healing and treatment.

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[28] Amarasingham Rhodes, L. 1990, "Studying Biomedicine as a Cultural System", in T. Johnson & C. Sargent (ed.), *Medical Anthropology*, Praeger publishers, New York.
[29] Last, M. 1990, "Professionalization of Indigenous Healers", in T. Johnson & C. Sargent (ed.), *Medical Anthropology*, Praeger publishers, New York.

In my opinion, Murray last seems to be of the view to professionalize the indigenous healing system for coexistence of cosmopolitan medical system and indigenous healing system. For which he presents different procedures, through state or through society. Here I would agree with the writer on the issue of Professionalization but I would prefer the integrated system for that, which can be seen in Pakistan also. If alternative healers would be place in systematic manner and professionalized, they would be better contemporaries to cosmopolitan practitioners.

Porter (1994)[30] argues that although alternative healing[31] is never recognized by the orthodox medicine[32], still then it has never lost its acceptance by the public. Orthodox medicine had always-full authority and recognition in medical market. In spite of that, they could never stop the public to follow the alternative healings people have adopted alternative treatments because biomedicine treats only the body and indigenous healing system takes the whole person as one, with the acceptance of mind and soul. Also, people see such qualities in alternative healers which biomedical practitioners are lacking as more gentle behavior, more natural therapies, more persuasive interaction and the treatments which are more close to their religious beliefs.

Easthope, (2002)[33] argues that alternative medicine is increasingly popular because it provides an explanation of illness, more people now have doubts about scientific proficiency, healers appear to cope with chronic and terminal illnesses better than orthodox medicine, and healers provide more

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[30] Porter, R. 1994, "Quacks: an unconscionable time dying", in S. budd & U. Sharma (ed.), *The Healing Bond*, Routledge publishers.

[31] Alternative Healing is a term used to denote Indigenous Healing System I-e, alternative to mainstream Bio-medical system

[32] Orthodox medicine refers to the Bio-medical system which is considered as cosmopolitan medical system

[33] Easthope, G. 2002, "Alternative Medicine", in J. germov (ed.), *Second Opinion: An Introduction to Health Sociology*, 2nd edn, Oxford University Press, Melbourne.

personalized attention and personal healer-patient relationship. It also helps people to believe that their illness and treatment are in their control.

In my opinion, Easthope seems to be more on the side of alternative medicine, giving the logical reasons for following indigenous healing system. Here, I would agree with her, accepting all her reasons as true. But I would add one more reason into it. People also go to indigenous healing system for their fewer charges, especially in third world countries, like Pakistan.

Dan Blumhagen (2004)[34] argued that Individual illness belief systems form a cognitive structure which lies under the cultural and social aspect of health care in a society. Popular belief systems are different from, yet linked to, expert belief systems. Popular illness terms often help a stable cultural environment by linking concepts of causes and significance of types of illness problems with a set of health care seeking choices; as well as linking typical physical and psychological symptoms with associated social problems. Writer used the research data to explain the cognitive domain of Hyper-Tension in America which demonstrates the various options people have for interpreting their experiences and choosing appropriate therapeutic actions. They use this illness belief system to justify otherwise unjustifiable social behavior and to assume various aspects of the sick role.

Teshome-Bahiru, (2004)[35] had a research in Addis Ababa (Ethiopia) on the concepts of health, disease, illness and therapy. He states that although modern cosmopolitan medical system is spreading and growing rapidly. Still then, people prefer to adopt traditional spiritual healing. He points out two main reasons for that behavior. Firstly, modern medical treatment and medicines are as much expensive for the people as they cannot afford that.

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[34] Blumhagen, D.1980, "Hyper-tension: A folk illness with a medical name" in *Journal of Culture, Medicine and Psychiciatry,* Published by Springer Netherlands, Volume 4, Number 3, University of Washington

[35] Teshome-Bahiru, W. 2004, "Concept of Health, Disease, Illness and Therapy among the people of Addis Ababa" *Annals of African Medicine Vol. 3, No. 1, pp. 28 – 31*

Secondly, people have much belief in traditional spiritual healing than in modern cosmopolitan medicine and therapies because of their cultural surroundings.

In my opinion, Teshome-Bahiru is in the favor of alternative healing, quoting the example of research of Addis Ababa (Ethiopia). Hence, I would agree with him. In third world countries like Ethiopia, and South Asian countries like Pakistan, there is tendency to adopt alternative healing more than cosmopolitan treatment because alternative healing is closer to their cultural background and their belief system.

McQuaide (2005)[36] explains why alternative medicine is remerging in America and other western countries. The reasons are; post modernism and the resultant cultural shift opened the possibilities for less rational and less logical view of healthcare than it is in conventional medicine. Collective civic culture is on its last legs in America and consequently, people take decisions individually about their healthcare. So they are free to adopt any mode of treatment instead of following conventional medicine. Attitudes are changing about conventional medicine and dissatisfaction of patients towards biomedical physicians is increasing because people have much knowledge about healthcare now, they are no more willing to accept authoritative behavior model of physicians. People's perception about alternative medicine is much influential and significant as it involves support from the alternative provider, greater personal involvement with the patient, more time spent with each patient, and greater interpersonal skills, empathy, dealing with emotions, and better explanations of the patient's circumstances.

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[36] McQuaide, M. 2005, "The Rise of Alternative Health Care: A Sociological Account", *Published by Palgrave Macmillan Ltd for Social Theory & Health, pp.286–301*

Nissim Mizrachi, Judith T. Shuval and Sky Gross (2005)[37] argue that the combined effects of growing patients demand, economic factors and market competition have provided the circumstances for the access of alternative practitioners into the biomedical hospitals in Israel. Both systems are working together in group-effort for patients' comfort. Although bio-medical physicians hold formal positions and decision-making authorities within themselves and alternative practitioners are restricted to the patients' experience of illness, feelings, the alleviation of pain and suffering, and efforts to improve the quality of life, the bio-medical physicians accept the charisma and influence of alternative healing. Scientific medicine is still supporting the professional culture of biomedicine by exercising its power through implicit, multi-dimensional processes of boundary demarcation within the professional field. Collaboration between both systems does not open the doors for further integration, in Israel.

Sheikh (2005)[38] argued that people in Pakistan who have faith in spiritual healing, clergymen, Hakeems, Homeopaths or even quacks have been consumed alternative medicine. Alternative medicine is the first choice for problems like epilepsy, psychosomatic troubles, depression and male sexual malfunctioning. The traditional or alternative medicine is an important source of healthcare especially in rural and tribal areas of the country. The main reasons for consulting an alternative or traditional healer are affordable fee, availability of healer at any time, family pressure and the strong opinion of the community. The area of Pakistan has a very rich tradition in the use of herbs for the treatment of a variety of illnesses. So it is necessary to integrate the modern and indigenous healing systems in terms of evidence based information sharing.

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[37] Mizrachi N. et al. 2005, "Boundary at work: alternative medicine in Biomedical settings", *Published by Blackwell Publishing for Sociology of Health & Illness, pp. 20–43*

[38] Shaikh, T. 2005, "Complementary and Alternative medicine in Pakistan: Prospects and Limitations", *Health system division, Department of community health sciences, Aga khan University, Karachi, Pakistan.*

Baker (1996)[39] had a research on "Characteristics of practices, general practitioners and patients related to levels of patients' satisfaction with consultations". He gives a supportive argument on the importance of personal services in determining patient satisfaction. He argues that general practitioners of biomedicine should reevaluate the organization of practices to ensure an acceptable balance between the requirements of clinical care and the wishes and expectations of patients. According to the research results, increasing total list size of patients and the absence of personal list system have a negative impact on patients' satisfaction. The only characteristic of general practitioners associated with lower levels of satisfaction was increasing age. The sex of general practitioners did not influence satisfaction.

Fosu (1989)[40] had a research in Ghana on "Access to Health Care in Urban Areas of Developing Societies" he describes three systems for healthcare in Ghana, government health services (biomedicine), pharmacies and traditional healers. A large population admitted an influence of traditional healers in their household for health care services. They also reported that access to traditional healers was more easy, approachable and cheaper to them. Also, great application of self-medication was reported by the public because drugs are available without prescription by the drug sellers. So, the writer argues that a radical, innovative, low cost alternative to current expensive, curative oriented approach to government funded biomedicine is required to provide better health facilities to the people. Medical pluralism can be a resource rather than barrier to the health of society. So cooperation among all three systems must be based on the strengths and weaknesses of each system. Pharmacists and drug sellers must be included to eliminate the negative impacts of self-medication.

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[39] Baker, R. 1996, "Characteristics of practices, general practitioners and patients related to levels of patients' satisfaction with consultations" published in *British Journal of General Practice*, Vol.46, pp. 601-605

[40] Fosu, G. 1989, "Access to Health Care in Urban Areas of Developing Societies", in *Journal of Health and Social Behavior*, Vol. 30, No. 4, pp. 398-411.

Vanhegan (1994)[41] has argued that biomedical doctors, while treating the patients in clinical settings, must concentrate on the nonverbal communication and feelings of patients. Especially in family planning, psychosexual therapies, and gynecological therapies, a gynecologist must focus on subjective feelings and difficulties associated with these problems. As these problems need special kind of trust, confidentiality, involvement and attachment with patient, this is not taught to the biomedical students during their course work, so gynecologist must create such an environment themselves for the convenience of patients. Patients, who are referred by their community practitioners to biomedical doctors, should have care and attention equal to their own community healers.

In my opinion, the writer wants the collaboration of community healers and clinical settings for gynecological problems. Patients can trust more on their community healers but they have to move towards biomedical settings where they go for expert view but they cannot trust on them as much. So they should have such an environment that they feel comfortable with that.

Mizrachi, Shuval and Gross (2005)[42] argue that the combined effects of growing patients demand, economic factors and market competition have provided the circumstances for the access of alternative practitioners into the biomedical hospitals in Israel. Both systems are working together in group effort for patients comfort. Although bio-medical physicians hold formal positions and decision-making authorities within themselves and alternative practitioners are restricted to the patients' experience of illness, feelings, the alleviation of pain and suffering, and efforts to improve the quality of life, the bio-medical physicians accept the charisma and influence of alternative healing. Scientific medicine is still supporting the professional culture of bio-

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[41] Vanhegan, G. 1994, "Doctor and patient in family planning and psycho-sexual therapy", in S. budd & U. Sharma (ed.), *The Healing Bond*, Routledge publishers.
[42] Mizrachi N. et al. 2005, "Boundary at work: alternative medicine in Biomedical settings", *Published by Blackwell Publishing for Sociology of Health & Illness, pp. 20–43*

medicine by exercising its power through implicit, multi-dimensional processes of boundary demarcation within the professional field. Collaboration between both systems does not open the doors for further integration, in Israel.

Shmueli and Shuval (2006)[43] had a research in Israel. They argued that users of complementary and alternative medicine (CAM) are more dissatisfied with their conventional, biomedical, family physicians and specialists. The majority of users of complementary and alternative medicine (CAM) stated dissatisfaction or disappointment with conventional treatment as the main reason for consulting CAM providers. The results indicate that lower satisfaction with conventional medicine (biomedicine) practice of family physicians and specialists are also related to such consultations. The issue is not dissatisfaction with specific providers, but lower satisfaction with specific domains of the experience, which reflects inconvenience with the nature of conventional medical care.

[43] Shmueli, A. & Shuval, J.2006, "Satisfaction with Family Physicians and Specialists and the use of Complementary and Alternative Medicine in Israel", in *eCAM volume 3, p.273–278*, Published by *Oxford University Press*

2.1 Theoretical Framework

Theoretical framework in anthropology is the orientation or sweeping way of looking at the social world. In research, theoretical framework gives concepts, provides basic assumptions directs to important questions and suggest way to make sense of data. Theory enables a researcher to connect a single study to the immense base of knowledge to which other researchers contribute. Theory increases a researcher's awareness of interconnections and of the broader significance of data.

In this study, theoretical framework would be used to make a basis for conducting this research, to provide assumptions to be proved, to correlate the theoretical assumptions to current study, and to increase researcher's awareness about the issue. The theory, described here, is given by Michael McQuaide. He has theorized that people in America prefer indigenous healing system. He has linked this connotation with different assumptions e.g. postmodernism, cultural change, dissatisfaction from biomedicine, etc. On the basis of this theory, researcher intends to correlate these assumptions to his research and to make a connection between this theory and current research.

Michael McQuaide in his article, "The Rise of Alternative Health Care: A Sociological Account" argues that biomedicine in America has to face a constant threat during the last 25 years. Alternative treatment is spreading more rapidly in America in the presence of biomedicine. He argues that alternative treatment is used in America now as never before. He argues that as alternative medicines gain greater acceptance, treatment services move out of the physician-centered context into the domain of domestic medicine. The authority of the physician is largely shattered and patients self-diagnose and treat in a without any real empirical or systematic knowledge of such alternative therapies. These therapies include therapeutic massage,

homeopathy, yoga, acupuncture, religious healers and additional practices that fall under the large umbrella of alternative therapies.

Writer points out that the conditions must be identified and explored under which alternative therapies gain such broad acceptance in societies where biomedicine had the supreme authority for a long time. He has made an explanatory model and discussed the factors that allow for the remergence of alternative medicine in the West. He has identified and interpreted the social conditions under which groups embrace medical beliefs and practices that are beyond the domain of conventional medicine.

Firstly, McQuaide narrated referring Lerner (1993) that conventional biomedicine physicians refer their patients to alternative cancer treatments with remarkable frequency. Patients reported that not only physicians guide them to consult to alternative healer but also they give them alternative therapies as well. Young physicians are more likely to accept and suggest the alternative treatment to their patients due to their less orthodox views.

Secondly, writer makes the relationship of alternative treatment with postmodernism. In contemporary society many of ideas, values and beliefs have little connection to empirical thought, the limits of one's own culture, or own experience. Postmodern culture has given opportunity for variety of thought that opens possibilities of less rationalized thinking which was previously excluded by scientific thinking. The standards of logic, rational progression of provable ideas, and a repugnance to contradiction no longer carry the authority they once did.

Writer argues narrating Patterson that another reason of adopting alternative healing may be subcultures within larger cultures. With the shift of more migrants to America, there has been made a new culture as ecumenical culture, in which ideas and standards from various places, nationalities, and

epistemologies are integrated. The postmodern ecumenical culture is populated by persons from all over the world who may bring Chinese medicine, mysticism, and concepts from the *Ayurvedic* tradition into the host culture. The mass migrations from South and East Asia to Europe and the United States have presented an eclectic set of ideas regarding human progress and well-being. Postmodernism opens up cultural space for the growth of alternative medical therapies.

Then the writer moves towards another factor, the decline of civic culture in America. Mostly Americans as a group manifest a level of disengagement from and indifference to public life. The expanded use of alternative medical therapies may reflect the increased privatization of purpose. Shared visions of communally linked actions are replaced now with the individually taken decisions. Private initiative advances as social obligations and various forms of civic engagement are now retreated. Alternative care is also consistent with this interpretation. The status of alternative therapies does not seem to provide convincing evidence of a re-emergence of broad-based civic and community engagement.

Writer made another argument that contemporary patients are much more likely to make critical evaluations of their doctors, to assume that doctors and patients have diverging interests, and to distrust their physicians. One potential source of dissatisfaction with physicians may be found in the public's increased knowledge of medicine, illness, and diagnostics. Patients who believe that they possess relevant medical knowledge are quicker to desire a form of negotiation with the physician rather than to be a passive recipient of the doctor's orders. Writer quotes Warren's research that the doctor–patient relationship is now characterized by greater levels of equity and collaboration, however grudgingly granted by the physician. This desire for greater equity in decision-making can drive the demand for alternative care. A patient dissatisfied with the doctor's authority and dominance may seek an

alternative provider in an effort to create a patient centered relationship. Furthermore, patients enjoying an ongoing and satisfying relationship with an alternative therapist may define that provider as a high-status role model and prototype care giver that could be generalized to conventional medicine as well. Another factor relevant with that is the public's perception that conventional medicine has reached limits of effectiveness in treating some forms of illness and disability. A lot of people believe that medicine frequently fails to provide effective cures for the most alarming diseases. Where as alternative treatments are very much recognized allover the world to treat the complicated diseases of which biomedicine has no efficacy.

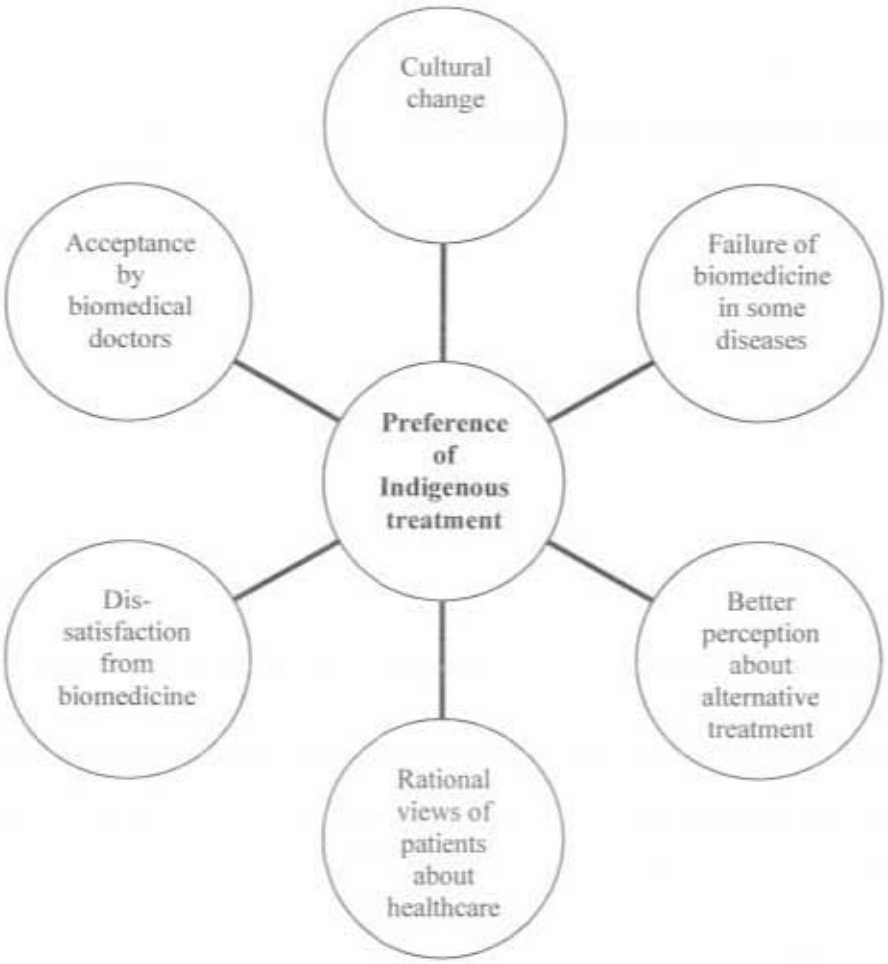
Another argument by the writer is that it is the middle and upper socioeconomic groups who are most likely to purchase such goods and services. As conventional biomedicine is provided by the government in western nations, upper and middle class people spend extra money on the purchase of alternative treatment and therapies. They are more willing to have all available forms of prevention, diagnosis, and treatment. Another factor is that the use of alternative therapies is more pronounced among groups with higher levels of education and income.

A final argument given by the writer is perceived features of alternative care. The popularity of alternative medicine is also on the basis of public's perception of alternative care itself. The most important dimensions of alternative care are defined as support and hope. Support from the alternative provider takes the forms of greater personal involvement with the patient, more time spent with each patient, and greater interpersonal skills, dealing with emotions, and better explanations of the patient's circumstances. Most patients believe that alternative healing is less toxic than many forms of conventional care and that it provides the patient with more opportunities for self-empowerment and control over the therapy.

In the end, with the help of all above-mentioned arguments, the writer has drawn the conclusion that the practices that compose alternative health care show no signs of disappearing. Rather, it is logical that alternative medicine will continue to expand, both in terms of public acceptance and the amount of money spent consuming it. The writer predicted that alternative medicine would increase for two major reasons. The first reason is comprised of all the factors narrated in this article that show that all the conditions conducive for alternative medical care is present in society. The second reason focuses on the interplay between conventional and alternative care. The boundary between conventional and alternative forms of care is permeable and shifting. Conventional biomedicine has started mixed up with alternative treatment as use of antiseptics, dietary influences on health, and the role of exercise. In the writer's view point the boundary between orthodox and alternative medicines will continue to intermingle in clinical settings also.

Graphical illustration of factors resulting

Preference of Indigenous treatment



2.2 Application of McQuaide's Theoretical Perspective on Study

In the light of McQuaide's explanatory model of why alternative medicine is spreading and remerging all over the world, I would use some of his arguments to apply on my studies. Firstly, the cultural change can be seen in our society, which is resulting in more use of traditional therapies. In our society, traditional, indigenous or alternative healing was considered as rural norm and people in cities or with urban background used to be more interested in following cosmopolitan medical system. Educated and high-income elite class was not interested in following any traditional healing but now with the interaction of different cultures, people have much belief in alternative treatment. Secondly, biomedicine some times fails to cure some diseases like male mal functioning, which might be cured by the alternative healers. So, like McQuaide, I would argue that people are moving towards indigenous healing system for more complicated diseases like malfunctioning. Thirdly, as McQuaide has argued that people perceive more caring and sympathetic features of indigenous healing system. In my view point people go to indigenous healing system for better care and sympathetic behavior. Fourthly, in our country there is always a clash between biomedicine and all sort of alternative treatments. Pakistan medical association (PMA) has never accepted alternative healings as medical system and they were always considered as quacks. Rather government has also supported biomedicine morally and financially. This scenario had a strong influence on common people. But as McQuaide has argued, now people use their own rationales to follow any medical system and they consult with a healer or doctor on their decision. Fifthly, dissatisfaction from biomedicine and biomedical doctors takes the patients towards indigenous healing system. Finally, biomedical doctors now accept the efficacy of alternative healing and they suggest alternative healings to their patients as in the condition of kidney stone, some biomedical doctors suggest homeopathic treatment right after the removal of stone. So boundaries are being mixed, as McQuaide has predicted.

CHAPTER NO. 3

VILLAGE PROFILE

3.1 Introduction

Representative ethnographies require holistic understanding of the concerned cultures on the part of the ethnographers depicting demographic, material as well as non-material aspects of the culture. Thus the ecology of the community had a grave analogy with the health-seeking behavior of the natives.

For the said purpose a brief description of the village will be given in order to draw an overall sketch of the village which will make it easy to understand the existing architectural, religious, social, political, economic and kinship structures of the village.

Punjab is the second largest province of Pakistan with reference to land but the largest in terms of population. It is situated in northeast of country. To the north lie N.W.F.P and the capital city of Islamabad. To the northeast is Kashmir, in the west Balochistan and in the southwest Sindh. The eastern side of Punjab as well as part of its south is bordered by India. The population of Punjab, as according to 1998 census was 4, 729, 200. According to 1998 census report, 61 % of the entire population of country resides in this province and the population density is 230 persons per square km. the annual population growth rate of this province is 2.7.

Punjab is composed of two Persian words, "Punj" meaning five, and "ab" meaning water, thus it is referred to as the land of five rivers. The five rivers that provide the basis of the name Punjab are the Sutleg, the Indus, the Jehlum, the Chanab and the Ravi. The Sutleg River flows along the entire district draws a border line between the two districts; Bahawalpur and Lodhran.

District Lodhran

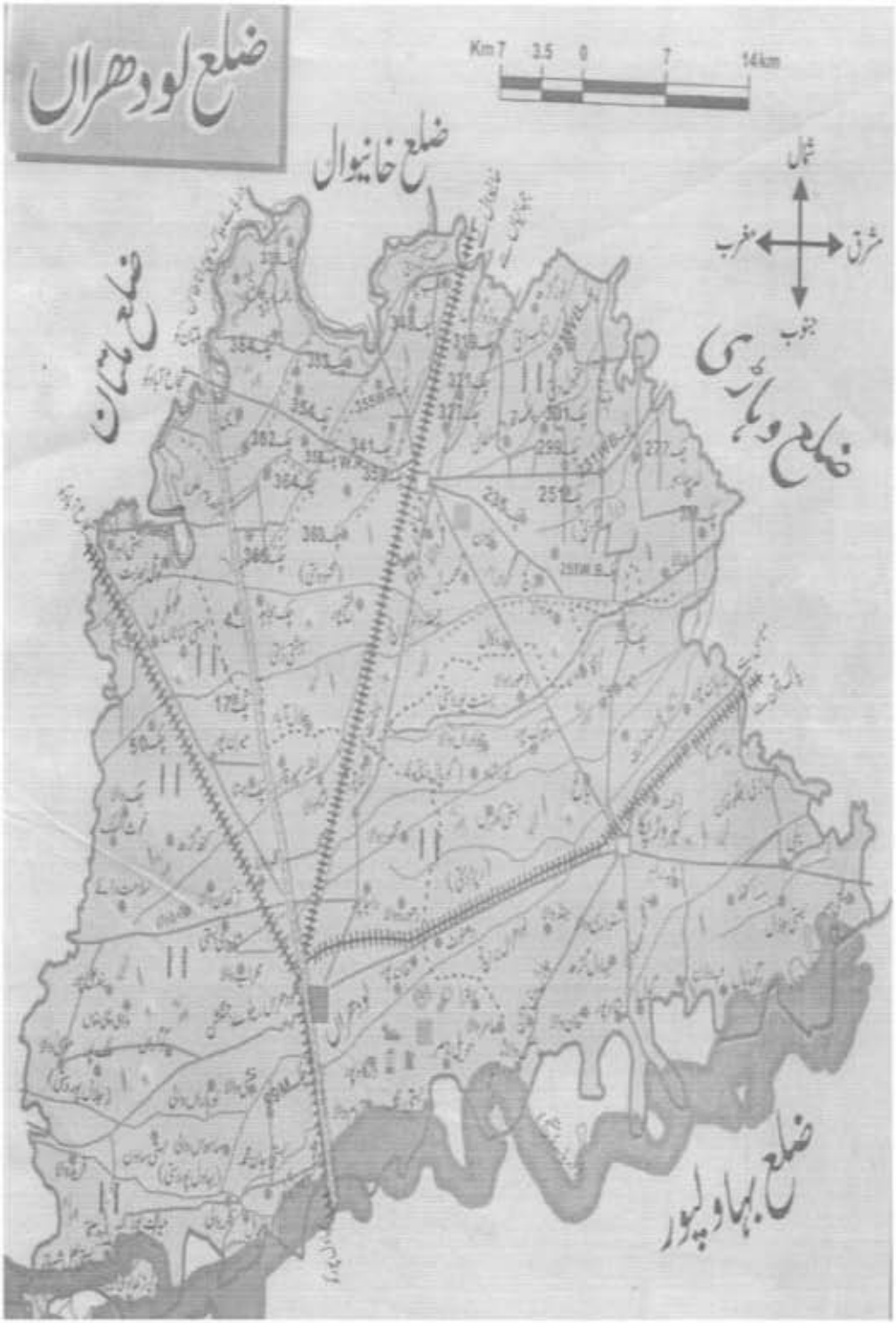
When we look into the past history of the district, its ancient name is traced by the name of a tribe of Rajput named "Lodhra". Some of these tribes are also settled in the neighboring districts esp. Vehari and Multan. Sultan Mahmood Ghaznavi set up Islamic government over here after hundred years of the arrival of Mohammad Bin Qasim. Raja Rnjeet Singh captured the said district after the decline of the Moghuls. After that the Britishers gave him a crushing defeat and included the same district in their own govt. and maintained there hold till the existence of Pakistan. On the first July 1991, Lodhran itself was completely separated from Multan district and got the status of autonomous district on the basis of some political upheavals.

Lodhran district is of peculiar importance in the Punjab province due to manifold reasons. Multan, Khanewal, Vehari and Bahawalpur are its neighboring districts. The population of the district is 13,00,000 individuals. The following are the three tehsils of District Lodhran:

- Kehroor Paccka
- Dunyapur
- Lodhran (D.H.Q)

Topography and environment

Land surface of the whole district lies in the plain region of Pakistan, as the district Lodhran is situated in the upper Indus Plains and the present physical features are the mainly result of river action. Sand is every where which is found a few feet below the surface. The said district has an extreme climate. The temperature in summer ranges from 28°C to 46°C whereas 5°C to 28°C in winter. The average rainfall is 71 mm. The land of the district is plain and very fertile.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Tehsil Kehroor Paccka

Religion

As emerged from 1998 Census the population of the tehsil Kehroor Paccka is predominantly Muslims i-e 99.12 percent. The next higher percentage is of Christian with 0.62 points, followed by Ahmadis 0.09 per cent. While other minorities like Hindu (Jati), Scheduled castes etc. are very small in number. The population of Muslims is higher in rural areas 99.40 per cent, as compared to their counterpart in urban, 98.72 percent; Christians are mostly in urban areas representing 1.0l percent as compared to just 0.34 per cent in rural areas. Similarly Ahmadis are more in urban areas as compared to their proportion in rural areas.

Table No 1

Percentage of Population by Religion and Rural-Urban Areas

Religion	Rural	Urban	Total
Muslim	99.40	98.72	99.12
Christian	0.34	1.01	0.62
Hindu (Jati)	*	0.09	0.04
Ahmadis	0.06	0.12	0.09
Others	0.19	0.06	0.

* Refers to very small number.

Source: Socio-Economic Census 1998

In the Tehsil Kehroor Paccka of Lodhran district, the different religious sects have their own way of life rituals and ceremonies, places and modes of worship. Generally speaking the influence of religion is

noticeably greater in this tehsil than elsewhere due to neighboring Multan district. The day-to-day life of the people, their profession, and trade, social and economic life are all dominated by the influence of religion. In rural areas, the Pirs and Murshids wield great influence over the lives of the people and tehsil Kehroor Paccka is known as the tehsil of the Pirs which is reflected via the mushroom growth of Shrines. The rural population is very credulous due to lack of education and susceptible to superstitions, which play a major role in the formation and adaptation of century's old alternative mode of treatment composed of "Quackery". This explains the Influence of Pir and Shrines exercised over the people. With the expansion of education a more rational attitude is slowly developing and the educated classes are less susceptible to the influence of Pirs. The following are the famous shrines of tehsil Kehroor Paccka:

- Shrine of Pir Shah Jamal
- Shrine of Pir Jewan Shah
- Shrine of Pir Sufi Rana Wehan
- Shrine of Pir Mehar Shah
- Shrine of Pir Jabbla
- Shrine of Pir Makhdom-Al-Mosas

3.2 History of the Village/ Area

The existence of Mari Bhago Khan can be traced back prior to the arrival of the Britishers in1857. Bhago Khan Joiya had a lineage with the Abbasi Family. He was famous for his wartanbhanji among the natives and the doors of his Bhaitakk were open for all and esp. for the poor. Even now, the researcher witnessed the archeological monuments pertaining to the walls of 'his' bhaitakk at the entrance of the village. On the border of Mari Bhago Khan, towards river Sutluj, one may find the clues of the famous highway planned by Sher Shah Suri via which he wanted to connect Multan with

Bahawalnagar through Dunyapur and Kehroo Pakka. The roads built by Sher Shah Suri reflect the fact that the soaling was two feet wide just under the wheals of the vehicle and the rest of the road was of soil.

Mari Bhago Khan as observed by the natives refers to the fact that the people initially were Pastoralists. They used to keep camels for loading luggage and sheep and other cattle as domesticated animals. Camels were an identity of the village till the 1990s. Camel, known as the ship of the Desert and used as beast of burden all over the world, is of peculiar cultural significance in the locale. Handling a camel is still a symbol of masculinity and power in their cultural metaphors and myths. Power, energy and grip of a male to handle the bunch of camels would guarantee the male to be eligible to be married as according to their belief system if a male cannot handle and control the *nath* of a camel, how can he control the women..so having an expertise on the controlling tactics of a camel would guarantee him a wife.

Today, even the people are horticulturalists, but still their inspiration of keeping camels is reflected by their cultural metaphors.

3.3 Physical Layout of Village

The total area of the village on which the population resides is 25 acres and the entire cultivable area of the village is 1500 acres. It is located in the eastern side of the district along the border of district Vehari. A metallic road cut adrift the entire village into two equal halves. At the enterance of the village are the archeological remains of Mari/ Bhaitakk of Bhago Khan Joiya. Now, Basic Health Unit (BHU) is constructed over there. There is one Jamia Mosque at the centre of the village. At the walls of the bazaar, there are advertisements and wall chalking regarding the various healers for the treatment of sexual malfunctioning as a disease and illnesses for both the males as well as females.

3.4 Architectural Structure

The architecture of the village is complex as tree of a date palm is the specialty in their architecture used in their houses. I've devided houses of my locale into three categories namely Pakka, Semi-Pakka and Kacha houses. Mostly people have built house on a piece of their own land, but residing alongside while other lived in servant-quarters given to a family on the basis of the service that his family is giving to a landlord. There are three types of Houses:

3.4.1 Pakka Structure

These houses are well built up of cement plaster and baked bricks, roofs are solid and rooms are well constructed with the facility of washrooms. Pakka houses are usually divided into two to three portions:

1) **Ghar:** Ghar is considered to be a place restricted for family members and female guests. (Female portion of the house)

2) **Dera/ Behthak:** It is for outside activities and entertainment of male guests. (Male portion of the house)

3) **Hawail:** It is considered to be a place for livestock and other occupational activities.

3.4.2 Semi-Pakka Structure

The walls of these houses are made up of bricks and cement but the verandas are made up of mud. The inner walls of the bed rooms are made up of mud bricks while outer walls with fired bricks and cement while kitchens are open and made up of clay and the roof is covered by wood of the date-palm.

3.4.3 Kacha Structure

The walls of the houses are made up of mud bricks and clay and the roof is covered by wood of the date palm and clay and some of the houses are built of cane. Kacha houses belong to the poorest class of the village. They have either one or two rooms, a courtyard with a partial boundary wall.

Old style of construction is very less prevalent in number. People usually have very simple architectural design in their house constructions. Two big rooms and a big courtyard make the total structure of house in the old style design. In the winter seasons, members of family and cattle pass the night in single room in old style households. But the households, which are made on new styles, are relatively modern. Rich people have separate bathrooms, kitchen, drawing rooms and more than one room in their houses. They usually have big courtyard and an iron gate in the front of the house. Trees are planted for greenery some grass is also grown in the middle or in any corner of house. Middle class people have two rooms, one kitchen, one bath room, one toilet and four walls in their houses usually. They keep one hut made of wood and tree branches for their cattle in the house. Poor have one or

two rooms made of mud and wood and a joint bathroom and toilet. For summer season, they have a hut in their homes made of wood and grass. Usually they don't have four walls but they use bushes or fence made of mud or wood for security of their homes. Cemented construction is becoming popular now a day.

Table No. 2

House Hold Structure

Sr. No	Type of House Hold	No. of House Holds	Percentage
1	Pakka	9	8.33
2	Semi-Pakka	69	63.89
3	Kacha	30	27.78
	Total	108	100

Source: (Socioeconomic Census Survey)

3.4.4 Streets

One main metallic road cuts adrift the entire village into two equal halves. On the both sides of this main road are small off shoots. 20 % of these off shoots are made of soaling while the remaing are Katchi (made of mud). Along the one side of the main road and its off shoots are the sewerage lines which are open. This networking of sewerage lines depict the fact that environmental hazards are rampant due to black mosquitoes and other flies thus possessing a grave threat to the public health of the natives. All the garbage passing through the entire village through the sewerage lines falls in the main govt. null built for irrigation purposes. Along the main metallic road are all shops ranging from vegetables, fruit stalls, tailors, healers, movie/ Cd shops, tractor workshops etc.

3.5 Population

To find out the different demographic and socio-economic features about the population, I took a sample of one-third population of my locale. The village consists of 330 households with a population of 2491 individuals till May 2006. According to my sample of the 1/3 population collected after a survey, population of the village in the sampling frame is 830 individuals from 108 households, average 7 individuals in every household. Hence, the population of the village was assessed by conducting a socio-economic survey of 108 House Holds of the village by using systematic random sampling i.e. every 3rd household.

Table No. 3

Various age groups of Village Population

Sr. No.	Age Group	Male Percentage	Female Percentage	Total Percentage
1	00-04	3.45	1.86	2.69
2	05-09	7.20	8.69	7.92
3	10-14	5.58	6.83	6.14
4	15-19	7.59	12.42	10.21
5	20-24	14.73	8.69	11.56
6	25-29	11.65	9.31	11.5
7	30-34	12.70	13.04	12.40
8	35-39	11.16	8.07	9.77
9	40-44	5.58	9.31	7.26
10	45-49	5.07	6.83	5.86
11	50-54	1.52	1.24	1.39
12	55-59	2.53	5.59	3.91
13	60-64	4.56	6.83	5.58
14	65-69	6.59	3.10	5.02
15	70 and above	1.52	0.62	1.11
Total		**100**	**100**	**100**

Source: (Socioeconomic Census Survey)

Table No. 4

Population of Village

Sex	Frequency	Percent
Males	448	53.97
Females	382	46.03
Total	830	100

Source: (Socioeconomic Census Survey)

3.6 Caste-wise Distribution

Table No. 5

Major Casts and its Languages in the Village Mari Bhago Khan

Sr. No.	Major Casts	Language	Percentage
1	Ridd	Siraiki	15
2	Arain (Mian)	Siraiki	12
3	Wigg	Siraiki	12
4	Rajput (Joiya)	Seraiki & Rangar	12
5	Rath	Siraiki	11
6	Noon	Siraiki	10
7	Pawali	Siraiki	10
8	Baloch	Siraiki	8
9	Syed	Urdu & Siraiki	7
10	Paryaar	Siraiki	7
11	Jatt (Warya)	Siraiki	6
12	Kamboh	Siraiki	6
13	Rana	Urdu & Siraiki	6
14	Syal	Siraiki	4
15	Pahoor	Siraiki	4
16	Phul	Siraiki	4
17	Kanjo	Siraiki	4
18	Jat (Sial)	Siraiki	2
19	Peerzada	Siraiki	2
20	Rajput	Urdu & Siraiki	2

Source: (Socioeconomic Census Survey)

3.7 Language

Though South belt of Punjab is characterized by its Siraiki language, but still one may find variations within the language across the time and space. Siraiki is the predominant language being spoken in the village, representing 100 per cent of the population, though youngsters can speak Urdu also.

3.8 Food and Health

The staple food of the villagers is *Roti* made of flour, pulses and rice. Seasonal variation in food is also noticeable. Rice is, generally not eaten in the village. A sizable portion of the people, generally poor, has sometimes to eat *lowar* and *Bajra* when wheat becomes scarce or its price rises beyond their means. The more prosperous landlords take meat and vegetables once a day. The poorer people frequently eat turnip, stalks and roots. The *Chapatis* eaten in the village are generally thicker. Onion, *Gur* and *Shakar* are used mainly in the village, while sugar is also used sometimes. *Lassi* and milk are universally taken among the natives. In summer *lassi* prepared from fresh curd is drink by all classes of people. The usual eating habit amongst a majority of people is to eat once at Dhammiaele (morning) and again soon after dark, Raat di Roti (Dinner), in which females of the household are expected to serve their men first and endure till their men have completely taken the meal. In the end, women are expected to eat the left-out food. At Dhammiaele (morning), Roti, onion and lassi are taken; at Paeshisele (after Zuhar prayer), dry roti with vegetable dish is taken and at Raatien (Dinner), either food stuff left at Paeshiele is taken alongwith sweatdish is taken. Rice is not used in the village as rice is not considered to be a sufficient dish to be eaten as a food. Once a weak on average every house hold still prepares the rice, for the children, to eat. Smoking among men is fairly common both in towns and villages, but

amongst women it is rare. Alcohol usage is also a symbol of liberty for men of all the ages and its usage is increasing day by day among the people in all age groups but particularly among the youngsters.

3.9 Dress Pattern

An ordinary landlord in the village wears a *Pag* (turban) on his head and sometimes a *Kulla* or cap inside. The style of dress, amongst all kinship groups is uniform with hardly any tribal peculiarities. The normal dress is waist coat or *Majhal* generally white or blue and sometimes of bright colors in check design, a *chola* or shirt coming down to knees generally of white color but occasionally blue and *chaddar* or plaid worn over the shoulders. The shirt known as *Chola* or *Kurta* is closed either by buttons or by a loop in front. The *Chaddar* which is thrown across the shoulder is frequently of rich material when it is called *Lungi* or *Khes*, while the *Chaddar* of the poorer people is known as *Blagal* or *Lupar*. Some people use a *Rumal* or handkerchief of *Khadar* or mill made cloth over the shoulders. The dress of the women consists of the usual *Shalwar* or Pajama or long shirted petticoat like *Lehnga* or *Ghagra*. The *Chola* or *Kurta* which is often bright colored striped cloth with short sleeves is more common although sometimes a *Choli* or *Kurti* may also be seen in certain kinship groups. Over the head and shoulders is worn the *Bochan* or *Dopatta* which is generally of white or red cloth. *Pulkaris* and embroidered *Chadars* are not so frequent here.

The men wear their hair short, while the women plait their hair before marriage, but after marriage, generally wear them loose. Sometimes the hair is plaited and knotted on the top of the head.

3.10 Religious Structure

The main religion of this village is Islam (Sunnites), which is reflected by the fact that all the villages pray in one mosque. The religious structure of the village comprises of one graveyard, one janazga and one Jamia Mosque. The Janazga is at the centre of the village, which is now turned into a Bhana. The graveyard is at the end of the village. The Jamia Mosque is spread over an area of four canals and is decorated by the different pieces of art. There is no Madrassa in the village. There is a strong insistence on the part of religious men, the natives, to the youngsters to go along with them for a Tableegi purposes for forty days, but the youngsters pay no attention to such calls rather hardly I witnessed youngsters praying in the mosques.

3.11 Family and Kinship Structure

3.11.1 Marriage patterns

All marriages taking place in the village are arranged by the parents. It seldom happens that the betrothed pair had any sort of physical relationship prior to their wedding. There is a professional class of women, who are experts in the art of match making according to the status quo of both the families by the name of Vicholan, wife of a Nai. The material prosperity of the boy is taken into special consideration. When the agent has done her work of canvass she brings the two parents together. The mother/ sisters of the boy see the girl and watch her behavior and look at her critically from the point of view of physical appearance and efficiency as house wife. If she is approved, the mother of the boy places a rupee coin under the feet of the girl, which means that the girl is approved. They come back and announce the decision by sending sweets to friends and family members.

After some weeks the parents of the boy visit the parents of the girl to decide tile date of marriage. They go in a family group, take fruits with them and also a set of bangles, a ring and some clothes. They are entertained by the parents of the girl. A date relating to the lunar calendar is fixed. Brisk preparations begin. On the first day of moon calendar the month in which the ceremony is to take place, *Shadmana* begins to play. Two days before the actual ceremony the women folk of the boy side go to the girl and smear Mehndi on her hands and feet. Finally, the girl is almost locked in a room where only her friends and relatives can visit her. She is kept in shabby clothes, and women keep on smearing *Cheekou* on her, a preparation of herbs made to brighten up the face to please the husband on her wedding night. Her prospective in-laws make their first visit to the girl. She is made to sit on a wooden platform wearing only a Chaddar. The in-laws open the Mehndi and put oil in her hair. Players of *Shehnai, nafeeri* and native drum constitute the *Shadmana*. They sit in front of the boy's house and keep on playing till the day of marriage. During these days the *Nai* is the master of the ceremonies. Special guests and relatives are not invited through *Nai*. The parents themselves go to invite them.

On the day of marriage, the bridegroom comes along with a host of relatives and friends, riding on a horse or car, wearing colorful clothes and lungi on his head. He washes himself at the girl's house and wears clothes given to him by his in-laws. After the Nikah he is presented before the women folk of the bride's side. There is an interesting and wide spread custom which is followed by all classes of people. The bride's sisters hide the bridegroom's shoes and until he pays the customary amount of money to the bride's sister he is not allowed to go. After dinner, music and playful dances, the *Barat* returns. A goat is sacrificed at their door, after which, the Bride is escorted to the wedding

room where she is made comfortable to sit and wait for her husband. As per the mythology, the husband is supposed to hold a knife in his hands to save him from evil influences on the first night. Two days after the marriage the girl returns to her parents, on, what is called, Satwara when she narrates to her mother all that happened to her during the first two days. Husband and the in laws come to take her back to where now she belongs.

3.11.2 Births

The birth of a child is celebrated even before the child is born. Pregnancy is received with an Aura of mystery around it. A pregnant woman is kept as far as possible away from all the supernatural influences which is reflected by the fact that since the conception has occurred, the pregnant women often visit the shrines for religious rituals to keep the infant away from evil charms and amulets. In the 9th month, Kanji is celebrated. The parents of the woman send bridal clothes and green fruits for the expectant mother. When the pregnant woman is in labor various attempts are made to keep evil influences away from her. Pepper and chilies are burnt at her door. "The birth of the baby is announced and celebrated according to the sex of the new born". If it is a male baby Great festivities begin soon after his birth. The head of the new born is covered with Zafraan and his lips are smeared with honey. The grand father or the Mullah says *Azaan* in his ears on the very first day. After the birth of the baby the mother takes bath and is made to wear her bridal or new dress. About 6 days after the birth of the baby his head is shaved. The event is celebrated with get-together, whether the parents can afford or can not afford, the occasion is rounded off with the slaughter of the sacrificial lamb. Circumcision, in the case of the boy may take place with the head-shave or may be postponed for quite sometime. Circumcision

calls for another feast, the nature of which depends upon the economic status of the family.

But if it is a female child the case is in reverse. The father is ashamed on the birth of a girl so is his entire family. This situation aggravates to such an extent that the mother of the girl (infant) is abused, tortured and even threatened of second marriage of her husband, if next time she fails to produce the boy.

3.11.3 Deaths

Soon after death has occurred, fire in the house is extinguished. The Barber (*Nai*) is asked to communicate the sad news to all concerned. Women folk begin to wail and cry. Their Mourning takes the form of ancient dirge. Men sit outside, receiving people and telling the circumstances in which the death occurred and receiving Fateha[44].

The dead body is washed with camphor. The near relatives are brought to get the last glimpse of the departed soul. Recitation from the Holy Quran and flowers are placed near the dead-body. When all have gathered, the body is taken to the graveyard and after saying the funeral prayers the body is laid in the grave. Nothing is cooked for three days in the family of the bereaved. Food is supplied by the relatives of the deceased. Ceremony known as Qul is held on the third day. On the fortieth day another ceremony known as Chehlum is held which is again an occasion of recitation from the Holy Quran and feeding of the people in charity. The clothes of the dead person are distributed to the poor. Regular visit to graveyard continue for a period of eleven days.

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[44] Fateha is a verse of the Holy Quran but it has strong cultural connotations. The time for offering fateha commences from early morning, to sun set whereby the visitors come to moarn and offer fateha for the departed soul. Reciting the verses of the Holy Quran:-"May the departed soul rest in peace! Amin."

3.12 Agricultural Structure

Though historically, the people of the village were pastoralists, but today, they have also been indulged in the horticulture occupation. 70 % people themselves cultivate their land while the remaining has given their land on tenure basis.

Women collect vegetables like potatoes, peas, carrots etc and in return they get Rs. 60 as their wages and a bucket full of vegetables. Thus women do it as their side profession to earn *kunni di bhaaji*[45] by this practice.

3.12.1 Crop pattern

The major agricultural productions of the village are cotton, wheat, sunflower, sugarcane and fodder, which are sown in Kharif and Rabi season.

3.12.2 Irrigation system

Electric Tube wells and Irrigation-*Khaley*[46] is the main source of irrigation system. People irrigate their fields from *khala* emerging out of *Maner*[47].

[45] Kunni Di Bhaaji refers to a meal for one time whereby kunni refers to a pot of meal for the family for one time. Meal prepared for the family for one time

[46] Khaley is a term used to denote the passage of irrigation water from channels to irrigation fields. Pertaining ti the crop yield, the natives believed that the irrigation water from the cannals yields good crop as compared to the water used from electric tubewells for the fields.

[47] Maner is a term used for the water canals (Nehr).

3.13 Economic Portfolio

Table No 6

Economic Activities of the Dwellers and Their Percentage

Economic Activities	Ranking
Trades and businesses	18 %
Agriculture and Livestock	52 %
Manufacturing	12 %
Govt. And private sector employees	12 %
Daily wage laborers	6 %

Source: (Socioeconomic Census Survey)

3.13.1 Daily Wages Rate

Table No 7

Labor type and its wage Rates

Level	Rate
Skilled labor	
Male: Technical factory Worker	120-180
Female: Stitching and Embroidery	60-80
Unskilled labor	
Male: Daily wage laborer	90
Female: Cotton Picker	30-80

Source: (Socioeconomic Census Survey)

CHAPTER NO. 4

RESULTS, ANALYSIS AND DISCUSSION

It took me six months for data collection as a part of my ethnographic research. A variety of topics came under discussion at village that was related direct or indirect to my research question. The topic "Symbollic and Cognitive analysis of Male Sexual Malfunctioning as a Disease and Illness: A Comparative Study of Indigenous Healing Systems and Bio-Medicine" brought multiple areas under investigation to grasp an in-depth picture of the phenomenon under study. Major areas of research on which data were collected were prevalence of alternative healers (Aamil, Peer and Hakeems following Humoral, Unani and Islamic medical systems), Doctors, Patients, Cultural myths and folklores regarding sexuality, Culturally sanctioned normal sexual practices against abnormal sexual practices and its frequency, Healthy men, Books and pamphlets, Artifacts, Signboards, public health, traditions and everyday life matters etc.

As one of my major objective of the research was to access the public health of the community pertaining to their adoption of anyone or a blend of diverse medical systems, so the data is analyzed pertaining to a comparison of the alternative and cosmopolitan medical systems with reference to the public health.

The data was collected from 108 individuals by using purposive sampling having two purposes in mind:

- There was no exact list of Malfunctioned patients
- All Malfunctioned patients don't come to a specific hospital or clinic thus following a plurality of healing systems.

So the data collected by structured Interview Schedules was based on the following assumptions:

- 60 respondents to follow indigenous healing system and 60 to follow biomedicine, as the objective was to get the authentic comparison between the two medical systems.
- The respondents should be a necessarily a male sexual malfunctional and should be seeking efficacy from any one or more healing systems.

In this way I made strata of two groups (following indigenous healing system and bio-medicine). But the important thing was that this demarcation was not rigid as it was hypothesized that the dwellers of indigenous healing system can also seek efficacy from the biomedicine and the vice verca. 120 individuals were interviewed, from 108 house holds. Data gathered and then divided in 60 individuals who believe in biomedicine and 60 believing in indigenous healing system; from all caste group of the village. Though as mentioned earlier that most of the dwellers of indigenous healing system were also involved in seeking efficacy from the biomedicine prior to following the indigenous healing system.

For the interviews, I used Purposive sampling. I collected a sample of one-third population of my locale. The village is consisted of 330 households with a population of 2491 individuals till May 2006. According to my sample of the 1/3 population collected after a survey, population of the village in the sampling frame is 830 individuals from 108 households, averagely 7 individuals in every household.

Table No. 8

Respondent's Age

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
21-25	9	15.0	33	55.0
26-30	18	30.0	12	20.0
31-35	24	40.0	8	13.3
36-40	7	11.7	6	10.0
41-45	2	3.3	1	1.7
Total	60	100.0	60	100.0

The above table narrates the phenomenon of ages of the native people in such a way. In indigenous healing system, 15% patients and in Bio Medicine 55% patients were between the ages of 21-25. In indigenous healing system, 30% patients and in Bio Medicine 20% patients were between the age of 26-30. In indigenous healing system, 40% respondents and in Bio Medicine 13.3% respondents were between 31-35. In indigenous healing system, 11.7% respondents and in Bio Medicine 10% respondents were between 36-40. In indigenous healing system, 3.3% patients and in Bio Medicine 1.7% were between 41-45.

So, the highest ratio of age in indigenous healing system was 40% between the age of 31-35 and for Bio Medicine, highest ratio was 55% between the age of 21-25. It was found by the researcher that young patients are more likely to consult Bio Medicine but a bit more aged patients go to indigenous healing system due to their experience in different medical settings.

Table No. 9

Respondent's education level

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Illiterate	4	6.7	14	23.3
Under Matric	9	15.0	21	35.0
Matric	24	40.0	11	18.3
Intermediate	10	16.7	4	6.7
Graduation	9	15.0	7	11.7
Masters	4	6.7	3	5.0
Total	60	100.0	60	100.0

The above table while narrating the educational level of the respondents points out that in indigenous healing system, 6.7% respondents and in Bio Medicine 23.3% respondents were illiterate. In indigenous healing system, 15% respondents and in Bio Medicine 35% respondents were under Matric. In indigenous healing system, 40% respondents and in Bio Medicine 18.3% respondents were Matric. In indigenous healing system, 16.7% respondents and in Bio Medicine 6.7% respondents were intermediate. In indigenous healing system, 15% respondents and in Bio Medicine 11.7% were graduates. In indigenous healing system, 6.7% respondents were masters and in Bio Medicine, 5% respondents were masters.

So, the highest ratio of educational level in indigenous healing system was 40%, Matric and for Bio Medicine, highest ratio was 35%, under Matric.

Table No. 10

Respondent's household's Total Income

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Under 5000	5	8.3	5	8.3
5001-15000	35	58.3	40	66.7
15001-25000	16	26.7	10	16.7
More than 25000	4	6.7	5	8.3
Total	60	100.0	60	100.0

In indigenous healing system, 8.3% respondents and in Bio Medicine 8.3% respondents's income level was under 5000. In indigenous healing system, 58.3% respondents and in Bio Medicine 66.7% respondents's income level was between 5001-15000. In indigenous healing system, 26.7% respondents and in Bio Medicine 16.7% respondents's income level was between 15001-25000. In indigenous healing system, 6.7% respondents and in Bio Medicine 8.3% respondents's income level was more than 25000. So, the highest ratio of income level in indigenous healing system was 58.3% and in Bio Medicine, it was 66.7%, both in same category.

Table No. 11

Reason for Choosing this Medical System for Treatment

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Somebody suggested	24	40.0	20	33.3
Repute of Hospital/Healer	21	35.0	29	48.3
Near to house	3	5.0	3	5.0
Any particular Doctor	0	0	6	10.0
Fewer charges	12	20.0	1	1.7
Facilities of this Hospital/Healing center	0	0	1	1.7
Total	60	100.0	60	100.0

The above table narrates that In indigenous healing system, 40% respondents and in Bio Medicine 33.3% respondents responded that some body suggested them for that. In indigenous healing system, 35% respondents and in Bio Medicine 48.3% respondents responded about repute of the doctor/healer. In indigenous healing system, 5% respondents and in Bio Medicine 5% respondents responded about near to house. In indigenous healing system, 0% respondents and in Bio Medicine 10% respondents responded about any particular doctor/healer. In indigenous healing system, 20% respondents and in Bio Medicine 1.7% respondents responded about fewer charges. In indigenous healing system, 0% respondents and in Bio Medicine 1.7% respondents responded about facilities of hospital/ healing centre. So, the highest ratio of choosing treatment was 40% (some body suggested) in indigenous healing system and 48.3% (repute of doctor) in Bio Medicine. So, it seems that in Bio Medicine repute of hospital is much important and patients go to alternative healer on any one else's suggestion.

Table No. 12
Main causes of Male Sexual Malfunctioning

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Masturbation	22	38.0	11	18.3
Excessive sex with sex workers	10	18.0	24	41.3
Reaction of some herb/ medicine	10	16.7	11	18.3
Excessive sex with wife	4	6.7	3	5.0
Homosexual experience (Active)	5	8.3	5	8.3
Homosexual experience (Passive)	5	8.3	4	6.7
Animal sex	4	6.7	2	3.3
Total	60	100.0	60	100.0

The data indicates that in indigenous healing system 38% respondents and in Bio Medicine 18.3% respondents responded that masturbation may be cause of malfunctioning. In indigenous healing system, 10% respondents and in Bio Medicine 41.3% respondents responded about excessive sex with sex workers In indigenous healing system, 10% respondents and in Bio Medicine 18.3% respondents responded about reaction of some herb/medicine. In indigenous healing system, 4% respondents and in Bio Medicine 5% respondents responded about excessive sex with the wife In indigenous healing system, 5% respondents and in Bio Medicine 5% respondents responded about Active homosexual experience. In indigenous healing system, 5% respondents and in Bio Medicine 4% respondents responded about passive homosexuality and 4% in indigenous healing system and 3.3% respondents in Bio Medicine considered sex with the animals as a cause for male malfunctioning.

Table No. 13
Perception regarding Various Modes of Treatment for Malfunctioned Patients

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Allopathy	0	0	41	68.3
Hikmat	12	20.0	0	0
Allopathy + Spiritual	0	0	3	5.0
Spiritual + Hikmat	35	58.3	3	5.0
Allopathy + Hikmat	13	21.7	13	21.7
Total	60	100.0	60	100.0

For the measurement of general modes of treatment, five categories were made. In indigenous healing system, 0% respondents and in Bio Medicine 68.3% respondents responded that allopathy can be only mode of treatment for Malfunctioning. In indigenous healing system, 20% patients and in Bio Medicine 0%patients responded about hikmat only. In indigenous healing system, 0% patients and in Bio Medicine 5% patients responded about allopathy and spiritual in combination. In indigenous healing system, 58.3% patients and in Bio Medicine 5% respondents responded about spiritual and hikmat in combination. In indigenous healing system, 21.7% respondents and in Bio Medicine 21.7% respondents responded about allopathy and hikmat in combination. So, the highest ratio of general modes of treatment for Malfunctioning was told 58.3% (spiritual + hikmat) in indigenous healing system and 68.3% (allopathy only) in Bio Medicine. It was found that in indigenous healing system patients don't rely on allopathy (cosmopolitan) because of their personal experience in that and in Bio Medicine patients don't think of hikmat as treatment because they had no exposure in that yet.

Table No. 14

Duration of Malfunctioning of Respondent

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Less than 5 years	20	33.3	33	55.0
5-10 years	37	61.7	21	35.0
More than 10 years	3	5.0	6	10.0
Total	60	100.0	60	100.0

The table reveals the duration of malfunctioning of patients, whereby in indigenous healing system, 33.3% respondents and in Bio Medicine 55% respondents responded that they are malfunctioned since less than five years. In indigenous healing system, 61.7% respondents and in Bio Medicine 35% respondents responded about 5-10 years. In indigenous healing system, 5% respondents and in Bio Medicine 10% respondents responded about more than ten years. So, the highest ratio of duration of Malfunctioning was told 61.7% (5-10 years) in indigenous healing system and 55% (less than five years) in Bio Medicine. It seems that patients consult to doctors in the early stages of their illness and patients think of hikmat as treatment in later stages. This fact can also be observed with the difference in age of patients in Bio Medicine (more in 21-25) and in indigenous healing system (more in 31-35).

Table No. 15
Modes adopted for the treatment of Disease

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Allopathy	0	0	32	53.33
Hikmat	12	20.0	0	0
Allopathy + Spiritual	0	0	10	16.67
Allopathy + Hikmat	28	46.67	10	16.67
Allopathy + Spiritual + Hikmat	20	33.33	8	13.33
Total	60	100.0	60	100.0

For the measurement of respondent's modes of treatment till the present mode, five categories were made. In indigenous healing system, 0% respondents and in Bio Medicine 53.3% respondents responded that allopathy was the only mode of treatment for them. In indigenous healing system, 20% patients and in Bio Medicine 0% respondents responded about hikmat only. In indigenous healing system, 0% respondents and in Bio Medicine 16.67% respondents responded about allopathy and spiritual in combination. In indigenous healing system, 46.67% respondents and in Bio Medicine 16.67% respondents responded about allopathy and hikmat in combination. In indigenous healing system, 33.33% respondents and in Bio Medicine 13.33% respondents responded about allopathy, spiritual and hikmat in combination. So, the highest ratio of respondent's modes of treatment for Malfunctioning was told 46.67% (allopathy + hikmat) in indigenous healing system and 53.33% (allopathy only) in Bio Medicine. It was found that in indigenous healing system patients had used allopathy before the usage of hikmat. That was the reason that they don't think of allopathy as better treatment for Malfunctioning. Mostly patients responded that dissatisfaction with cosmopolitan was the only reason to move towards indigenous healing system. And in Bio Medicine patients had no exposure in indigenous healing system therefore allopathy was the only treatment for Malfunctioning according to them.

Table No. 16

Duration of treatment from this doctor/healer

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Less than 1 year	36	60.0	35	58.3
1-5years	22	36.7	22	36.7
More than 5 years	2	3.3	3	5
Total	60	100.0	60	100.0

For the measurement of duration of treatment of patient, three categories were made. In indigenous healing system, 60% patients and in Bio Medicine 58.3% patients responded that they are using this treatment since less than one year. In indigenous healing system, 36.7% patients and in Bio Medicine 36.7% patients responded about 1-5 years. In indigenous healing system, 3.3% patients and in Bio Medicine 5% patients responded about more than five years. So, the highest ratio of duration of Malfunctioning was 60% (less than 1 year) in indigenous healing system and 58.3% (less than one year) in Bio Medicine, both in same categories and almost equal due to the fact that with the passage of time patients get improvement and it was very difficult task for researcher to find them. The patients who were getting treatment for 1-5 years or more than 5 year were with chronic problems.

Table No. 17

Any other treatment system adopted apart from the present treatment

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Yes	37	61.7	27	45
No	23	38.3	33	55
Total	60	100.0	60	100.0

For the measurement of following any other treatment by the patient with the usage of present treatment, two categories were made. In indigenous healing system, 61.7% patients and in Bio Medicine 45% patients responded that they are following other treatment along with the present treatment. In indigenous healing system, 38.3% patients and in Bio Medicine 55% patients responded that they are not following any other type of treatment or therapy. So, the ratio of following any other type of treatment was more in alternative mode of treatment. One reason for this behavior can be that when people go to Bio Medicine, they are more rationalized and once they think of following any alternative treatment they become much convinced to more alternative healings. But the following ratio of cosmopolitan patients shows that those people are also members of this society and they are also influenced by the society's happening.

Table No. 18

Satisfaction level with the attitude of Doctor/Healer pertaining to history taking

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	0	0	1	1.7
To some extent	10	16.7	1	1.7
To great extent	50	83.3	58	96.7
Total	60	100.0	60	100.0

For the measurement of respondent's satisfaction level with the attitude of doctor/healer pertaining to history taking, three categories were made. In indigenous healing system, not a single man and in Bio Medicine 1.7% respondents responded that they are completely dissatisfied with the attitude of doctor/healer. In indigenous healing system, 16.7% respondents and in Bio Medicine 1.7% respondents responded that are satisfied to some extent. In indigenous healing system, 83.3% respondents and in Bio Medicine 96.7% respondents responded that they are highly satisfied with the attitude of doctor/healer. So, the highest ratio of satisfaction level of patients with the attitude of doctor/healer pertaining to history taking was told 83.3% (to great extent) in indigenous healing system and 96.7% (to great extent) in Bio Medicine, both in the same categories. It was found that in indigenous healing system patients very much satisfied with the attitude of healer and they have no complaints about that. Patients are also very much satisfied in Bio Medicine due to the fact that Nishtar hospital is not very much cosmopolitan institute and the doctors behave with the patients according to their needs and wants because as members of same society they know the expectations of patients.

Table No. 19

Satisfaction level pertaining to the knowledge of the Doctor/Healer with reference to Sexual Malfunctioning

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	0	0	0	0
To some extent	20	33.3	2	3.3
To great extent	40	66.7	58	96.7
Total	60	100.0	60	100.0

For the measurement of respondent's satisfaction level with the knowledge of doctor/healer pertaining to Malfunctioning, three categories were made. Not a single man was completely dissatisfied in both indigenous healing system and Bio Medicine. In indigenous healing system, 33.3% respondents and in Bio Medicine 3.3% respondents responded that are satisfied to some extent. In indigenous healing system, 66.7% respondents and in Bio Medicine 96.7% respondents responded that they are highly satisfied with the attitude of doctor/healer. So, the highest ratio of satisfaction level of patients with the knowledge of doctor/healer pertaining to Malfunctioning was 66.7% (to great extent) in indigenous healing system and 96.7% (to great extent) in Bio Medicine, both in the same categories. It was found that in Bio Medicine patients very much satisfied with the knowledge of doctors and they have no complaints about that but Patients were also very much satisfied in indigenous healing system and they believed that although alternative healers (hakeems) don't have as much scientific knowledge as doctors and specialists have but they have full understanding of their disease and they can treat it with as much expertise as doctors can.

Table No. 20
Doctor/Healers' usage of recent diagnostic techniques pertaining to Malfunctioning

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	20	33.3	0	0
To some extent	30	50.0	2	3.3
To great extent	10	16.67	58	96.7
Total	60	100.0	60	100.0

The above table narrates the usage of modern diagnostic techniques used by the doctor/healer pertaining to Malfunctioning, where by in indigenous healing system, 33.3% patients and in Bio Medicine not a single man responded that they are completely dissatisfied with the diagnostic techniques used by doctor/healer. In indigenous healing system, 50% respondents and in Bio Medicine 3.3% respondents responded that are satisfied to some extent. In indigenous healing system, 16.67% respondents and in Bio Medicine 96.7% respondents responded that they are highly satisfied. So, the highest ratio of satisfaction level of patients with the diagnostic techniques used by the doctor/healer pertaining to Malfunctioning was 50% (to some extent) in indigenous healing system and 96.7% (to great extent) in Bio Medicine. It was found that in Bio Medicine patients are very much satisfied with the diagnostic techniques used by the doctor. One major reason of this practice is that laboratory based diagnosis is basis of Bio Medicine and doctors are trained to do so. But in indigenous healing system patients are less satisfied due to the fact that although alternative healers have also started the usage of laboratory tests, they are not as expert and trained as doctors are.

Table No. 21
Satisfaction level regarding the Environment of Diagnostic Session

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	0	0	1	1.7
To some extent	12	20.0	2	3.3
To great extent	48	80.0	57	95.0
Total	60	100.0	60	100.0

On analyzing the respondent's satisfaction level with the environment of diagnostic session, three categories were made. In indigenous healing system, not a single man and in Bio Medicine 1.7% respondents responded that they are completely dissatisfied with the environment of diagnostic session. In indigenous healing system, 20% respondents and in Bio Medicine 3.3% respondents responded that are satisfied to some extent. In indigenous healing system, 80% respondents and in Bio Medicine 95% respondents responded that they are highly satisfied with the environment of diagnostic session. So, the highest ratio of satisfaction level of patients with the environment of diagnostic session was 8% (to great extent) in indigenous healing system and 96.7% (to great extent) in Bio Medicine, both in the same categories. It was found that in Bio Medicine patients are very much satisfied with the environment of the diagnostic session because doctors are cooperative with them and environment is conducive for them to discuss their disease with the doctor. It was observed by the researcher that in indigenous healing system, too, the environment was favorable and helpful for the patients as healers had separate room for female patients where they can talk to the healer in full privacy.

Table No. 22
Satisfaction level of the Patient regarding the medicine given/suggested by the doctor/healer

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	0	0	14	23.3
To some extent	15	25.0	33	55.0
To great extent	45	75.0	13	21.7
Total	60	100.0	60	100.0

The above table narrates that in indigenous healing system, not a single man and in Bio Medicine 23.3% respondents responded that they are completely dissatisfied with the medicine. In indigenous healing system, 25% respondents and in Bio Medicine 55% respondents responded that are satisfied to some extent. In indigenous healing system, 75% respondents and in Bio Medicine 21.7% respondents responded that they are highly satisfied with the medicines. So, the highest ratio of satisfaction level of patients with the medicines was 75% (to great extent) in indigenous healing system and 55% (to some extent) in Bio Medicine. It was found that in indigenous healing system patients were very much satisfied with the medicines given/suggested by the healer and they have no complaints about that. Also they reported that they moved towards alternative healing due to very less or even no side effects of that medicine. They had full trust on the medicine whereas Patients in Bio Medicine were satisfied to some extent. They had also uncertainty about the medicine and they were not fully sure about the better results of medicines.

Table No. 23

Medicine bring change in Respondents' condition

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	0	0	23	38.3
To some extent	25	41.7	30	50.0
To great extent	35	58.3	7	11.7
Total	60	100.0	60	100.0

Considering respondent's satisfaction level with the change in their condition because of medicine, three categories were made. In indigenous healing system, not a single man and in Bio Medicine 38.3% respondents responded that they are completely dissatisfied and the medicines are not bringing any change in their condition. In indigenous healing system, 41.7% respondents and in Bio Medicine 50% respondents responded that are satisfied to some extent. In indigenous healing system, 58.3% respondents and in Bio Medicine 11.7% respondents responded that they are highly satisfied and the medicines given/suggested by the healer/doctor are bringing change to great extent. So, the highest ratio of satisfaction level of patients with the results of medicines was 58.3% (to great extent) in indigenous healing system and 50% (to some extent) in Bio Medicine. It was found that in indigenous healing system patients very much satisfied with the medicines and they were convinced that herbal medicine would bring change in their condition. Also they had no complaints about the herbal medicines. Patients were satisfied to some extent in Bio Medicine and they were not sure that those medicines would bring change in their condition.

Table No. 24
Side/ after affects for any herbal/ modern medicine, used for treating malfunctioning

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	60	100.0	5	8.3
To some extent	0	0	36	60.0
To great extent	0	0	19	31.7
Total	60	100.0	60	100.0

For the assessment of respondent's attitude regarding side effects of medicines, three categories were made. In indigenous healing system, all the respondents 60% and in Bio Medicine 8.3% respondents responded that they are not having any type of side/after effects of medicines. In indigenous healing system, no man and in Bio Medicine 60% respondents responded those are having side/after effects to some extent. In indigenous healing system, no man and in Bio Medicine 31.7% respondents responded that they are having highly side/after effects of the medicines. So, the lowest ratio of side/after effects of medicines was 100% (not at all) in indigenous healing system and ratio of side/ after effects was 60% (to some extent) in Bio Medicine. It was found that in indigenous healing system patients very highly satisfied with the medicines and not only have they had no complaints about that, also they had moved towards indigenous healing system because of low side effects of medicines and durable treatment. In Bio Medicine, most patients were satisfied to some extent due to the fact that modern pharmaceutical medicines always have more or less side effects and that fact is also admitted by the pharmaceutical companies as well. Patients reported headache, low blood pressure, and irregularity in their periods.

Table No. 25

Satisfaction level of the respondents regarding the services of this hospital/healing center

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	0	0	1	1.7
To some extent	13	21.7	9	15.0
To great extent	47	78.3	50	83.3
Total	60	100.0	60	100.0

Evaluating respondent's satisfaction level with the services of hospital/healer, three categories were made. In indigenous healing system, not a single man and in Bio Medicine 1.7% respondents responded that they are completely dissatisfied with the services of hospital/ healer. In indigenous healing system, 21.7% respondents and in Bio Medicine 15% respondents responded that are satisfied to some extent. In indigenous healing system, 78.3% respondents and in Bio Medicine 83.3% respondents responded that they are highly satisfied with the services of hospital/healer. So, the highest ratio of satisfaction level of patients with the services hospital/healer was 78.3% (to great extent) in indigenous healing system and 83.3% (to great extent) in Bio Medicine, both in the same categories. It was found that in indigenous healing system patients very much satisfied with the services of healer and they have no complaints about that. Patients are also very much satisfied in Bio Medicine due to the fact that Nishtar hospital is not very much cosmopolitan institute with reference to behavior and the many facilities prevail there because of Government funds and present Government's concentration on health facilities. Also the board of governors of Nishtar hospital is very much interested in facilitating the patients.

Table No. 26
Satisfaction level of the Patients' regarding the behavioral patterns of hospital's /healing center's management

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	0	0	1	1.7
To some extent	11	18.3	11	18.3
To great extent	49	81.7	48	80.0
Total	60	100.0	60	100.0

Accessing respondent's satisfaction level with the behavioral patterns of management of hospital/healing center, three categories were made. In indigenous healing system, not a single man and in Bio Medicine 1.7% respondents responded that they are completely dissatisfied with the behavioral patterns of management of hospital/healing center. In indigenous healing system, 18.3% respondents and in Bio Medicine 18.3% respondents responded that are satisfied to some extent. In indigenous healing system, 81.7% respondents and in Bio Medicine 80% respondents responded that they are highly satisfied with the behavioral patterns of management. So, the highest ratio of satisfaction level of patients with the behavioral patterns of management of hospital/healing center with them and their family was 81.7% (to great extent) in indigenous healing system and 80% (to great extent) in Bio Medicine, both in the same categories and almost equal. It was found that in indigenous healing system patients very much satisfied with the behavioral patterns of management with them and their families and they have no complaints about that. Patients are also very much satisfied in Bio Medicine due to the fact again that Nishtar hospital is not very much cosmopolitan hospital with reference to behavior and the management of hospital behave with the patients according to their needs and wants because as members of same society they know the expectations of patients.

Table No. 27
Improvement in Respondents' condition since the commencement of treatment

Categories	Indigenous Healing system		Bio Medicine	
	Frequency	Percent	Frequency	Percent
Not at all	2	3.3	5	8.3
To some extent	44	73.3	50	83.3
To great extent	14	23.3	5	8.3
Total	60	100.0	60	100.0

Keeping in view the respondent's attitude regarding improvement in her condition, three categories were made. In indigenous healing system, 3.3% man and in Bio Medicine 8.3% patients responded that they are completely dissatisfied with the treatment and they were not having any improvement in their condition. In indigenous healing system, 73.3% patients and in Bio Medicine 83.3% patients responded that were having improvement to some extent. In indigenous healing system, 23.3% patients and in Bio Medicine 8.3% patients responded that they are highly getting improvement in their condition. So, the highest ratio of satisfaction level of patients with the improvement in their condition since the commencement of treatment was 73.3% (to some extent) in indigenous healing system and 83.3% (to some extent) in Bio Medicine, both in the same categories due to the fact that in the condition of such a sensitive illness patients can't have major improvement at once. They have to wait for some time for a major change. Also those patients, who had major improvements in their condition, had gone and they were not in the approach of researcher.

Discussion

Anthropologist have always been interested in studying medical system in different human societies and their interest gave birth to a sub-discipline of Medical Anthropology. This chapter deals with native's perception of health and illness. It will also shed light on the native's belief of health, illness and healing methods with in their own socio-cultural context pertaining to their sexuality and male sexual malfunctioning.

> "In learning to treat disease man has developed a vast complex of knowledge, beliefs, techniques, attitudes customs, rituals and symbols that interlock to form a mutually reinforcing and supporting system. This vast complex and all of the other items we might think to add to the list constitute a medical system. The term properly embraces the totality of health knowledge, beliefs, skills and practices of every group".
>
> (Foster, 1978, p.36).

All the human beings irrespective of their culture and society have to encounter with the phenomena of illness. But they perceive this phenomenon within the context of their own culture and society. On the basis of this cognitive perception they attempt to find out the reasons of these illnesses and adopt preventive measures to cope with the phenomenon of illness.

> "Societies define, illness in different fashion and symptoms that are accepted as evidence of illness in one society may be ignored in the next. Definition within the same society may also change".
>
> (Foster, 1978, p10)

As Foster has elaborated, culture is a learned behavior which varies from society to society. All the values, norms and behaviors in one culture may be valid or may invalid in, other society. One thing in the same culture and society may be useful at one time and may destructive on other time.

> *"In every society there exists a body of beliefs and concepts with regard to the nature of disease and its treatment. One common feature however is there close integration with the other institutes and organizations of society. Cultural patterns and religious belief, economy and morality, social values and medical beliefs are all found together to focus health culture of a community".* (Kama 1976:50)

The same concept applies to the perception of illness in the village Mari Bhago Khan. People of this village define the reasons of illness, health according to their own socio-cultural experiences and knowledge.

4.1 Native Cognition about Health and Illness

4.1.1 Native's beliefs about Heath

Native people of the village have their own theory and beliefs about the health, which may be not adjustable in any other social context. Even within their own society the beliefs about health varies from person to person and within the people having different socio-economic status in the village.

> "Majority of the people define health, the condition of human body which do not disturbs the daily routine work, even small amount of pain or disturbance in the body may considered not illness that do not resist in fulfilling the

routine work".

A 70 year old respondent defines health when the researcher inquired about this concept:

> "Digestion of food, proper disposal of wastage, no disturbance during sleeping, feel easy during saying prayer five times is the clear signal of healthy person".

Another person says about the health:

"No worry, no tension, about daily activities is health".

Following table illustrates the conception regarding health persisting among the dwellers of Mari Bhago Khan

Table No. 28
Native Conception about Health

Sr. No	Concept about health	No. Of individuals	Percentage
1.	Ability to work	25	20.83 %
2.	Amount of flesh & blood	15	12.5 %
3.	Growth of weight & height by age	15	12.5 %
4.	Balance of body temperature	5	4.16 %
5.	Fate	6	5 %
6.	Having No pain	2	1.6 %
7.	Having no worries	3	2.5 %
8.	Mental & Physical fitness	49	40.83 %
Total		120	100%

Source: Structured Interview

From the above table, it is evident that most of the population of Mari Bhago Khan, Forty percent conceive health as mental and physical fitness. Eighteen percent define health, when a body is capable of doing work. Concept about proper growth of weight and height by age and sufficient amount of flesh and blood (reddish complexion), as health is fourteen percent. About six percent individuals consider fate as a cause of good health because there is a perception that all happenings are written in one's fate so nobody can alter it. Perception about health in terms of having no pain in body two percent and absence of worries about three percent is also believed among the villagers. About five percent individuals gave rise to the idea of hot and cold by defining health as balance in body temperature.

4.1.2 Natives' conception about Illness

> *"Societies define illness in different fashions and symptoms that are accepted as evidence of illness in one society may be ignored in the next; definition within the society may a/so change.* (Foster. 1978: 40)

People of this village have also different views about the illness same as health. Majority of the people define illness as follow:

> "Illness is a condition in which physical body became unable to perform the daily routine activities, feeling of some pain in the body, feel weakness, laziness. It may be due to any defined physical illness or due to any other behavioral change for the time being".

One of my young key respondent has explained illness as follow,

> "Illness has two types: partial body disturbance and disturbance in the body as a whole. When body remains unable to perform required work as a whole or partially considered ill".

Some people mentioned a lot bodily problems when I asked them about illness.

"Headaches, stomachaches, spirit possession, evil eyes, fever fatigue problem, flue, influence pain in any part of body all are the illnesses".

The inhabitants of Mari Bhago Khan use the word *Bimari* or *Merz* for illness and *Bimar* or *Mareez* for a person who is ill.

As we see the different definition views and perception of different age and socioeconomic groups about the health and illnesses, we find a clear difference among all these views according to their age and socio-economic groups. It is observable phenomenon in the society that perception of people changes with the change of may other aspects and circumstances and environmental changes.

Table No. 29
Local concept about Illness

Sr. No.	Concept about illness	No. Of individuals	Percentage
1.	Inability to work	33	27.5 %
2.	Mild ailment like headache, flu	10	8.33 %
3.	Mal-functioning of body organs	35	29.16 %
4.	Lack of appetite	11	9.16 %
5.	Pain in body	9	7.5 %
6.	Weakness	22	18.33 %
Total		120	100%

Source: Structured Interview

It is clear from the table that majority of the respondents 29.16 % of Mari Bhago Khan define the phenomena of illness in terms of the condition when body organs are not functioning properly. 27.5 % think that illness is inability to work. 18.33 % defined illness as weakness; pain in body 7.5 % and lack of appetite 9.16 % is also considered as illness because of it, one gives pale look. Natives also give examples of various illnesses at the time of defining illness for example headache, flu, Diarrhea and Typhoid.

4.2 Local Perception about causes of Illness

> "Social problems arise when either individual or social institution fail to keep pace with changing conditions and there by disrupt the healthy operation of the social organism, such individuals or institution considered 'sick'".
>
> (Joseph & William, 1986: I 2)

The causes of illness arise from within the individuals or society. This study deals with the specific population of a specific area and their reasons of illnesses are also determine with their own way according to their beliefs and practices, Most important categories of causes are the physical and social reasons. Physical causes are that which make body ill due to the malfunctioning of any body organs which social causes are which social problems make some body organs unable for functioning which called the illness. These social problem arise from the same society and may varies from on society to another as an anthropologist elaborates the link between the social problems and illness as follow:

> "So many of the illnesses are seem as deprived from societal strain and social disorders, especially in social relationship are linked to various illness. This may people in those

societies are easily susceptible to esoteric disorders which carry prilos infirmities"

(Harold, B. Haley 1976)

The people of village have plunged into various socio-medical problems, which are reasons of illness in the people. The social causes of illnesses are illustrated in the following table.

Table No. 30

Table showing the social causes of Illnesses

Sr. No.	*Causes*	*No. Of Individuals*	Percentage
1	Unhygienic Conditions	22	20.37%
2	Environmental Severities	24	22.22%
3	Physical over work	11	10.18%
4	Sorrows	20	18.52%
5	Lack of Blood	5	4.63%
6	Modern Food habits	6	5.56%
7	Fate	4	3.71%
8	Evil Eye	9	8.33%
9	Magic	7	6.48%
Total		108	100%

Source: (Structured Interviews)

Graphical demarcation of Indigenous Healing system &

Bio-medical system

Bio-medical system	Indigenous Healing system
It is universal	It is local
Based on systematic rules and regulations	It is based on cultural patterns
Mode of diagnosis is laboratory based	Diagnosis is based on body temperature, eye color and pulse
Complete division of labor is present there	One person is responsible for all treatment
None of treatment process is shared with patient or TMG	Every part of treatment is shared with patient and TMG
Treatment process is object oriented	Treatment process is patient oriented
Achieved status is more worthy in this system	Heeling methods are ascribed and transfer from generation to generation
Physician has specific localized view of a part of body	Body is comprised of mater and soul and is taken as a whole
Physician has to follow his professional ethics which are quite explicit ant written in legislation	Behavioral model is laid down in accordance with patient, heeler and therapeutic management group
Physician is not responsible in case of any disturbance	Heeler is responsible for each part of treatment
System has its own norms	Based on cultural normative patterns
Personality and moral character are not considered in treatment process	Personality and moral character are very much considered and reason of disease is located within personality of patient
Surgery is common	Usually non-surgical
Interactive patterns are more formal and there is no friendly relationship between doctor and patient	Interactive pattern is informal, heeler is more friendly with the patient
Disease is more important	Illness and sickness are more considerable

Case History No.1

Identifying Data

Name:	Mujahid Feroz
Age:	36 years
Sex:	Male
Education:	BA
Profession:	Private Job
Socioeconomic Status:	Lower Upper class
Marital Status:'	Married
No. of Children:	None
Type of Family:	Joint
Siblings:	5
Birth Order:	5

Mujahid Feroz consulted a Religious Pir/ Saint for his complaints of sounds in ears and head, lack of confidence, and erectile dysfunction with his wife. He had a strong homosexual preference. Because of which his marital sexual life was getting disturbed. He was evaluated by carefully taking his case history. For improving his confidence, he was suggested to change his sexual preference, finding more pleasure in heterosexual experiences and overcoming anxiety towards hetro-sexual encounter. Treatment across 25-30 sessions produced in him a marked provident. He started to enjoy heterosexual life,

improved confidence, and evidenced no symptoms except whizzing sound in head.

Reason for Referral

Having consulted a Pir for his complaints of sounds in ears and head.

۱۔ سر اور چہرا گرم ہو جاتا ہے۔
۲۔ سر میں چکر آتے ہیں۔
۳۔ زندگی میں کوئی چارم نہیں ہے۔
۴۔ اعتماد کی کمی ہے۔
۵۔ سر میں شائیں شائیں اور سیٹی بجنے کی سی آوازیں آتی ہیں۔
۶۔ کانوں میں آوازیں آتی ہیں۔
۷۔ سر بھاری رہتا ہے۔
۸۔ سر کھوکھلا محسوس ہوتا ہے۔
۹۔ دماغ حاضر نہیں رہتا۔
۱۰ یکسوئی کی کمی ہے۔
۱۱۔ ذہنی انتشار بہت زیادہ ہے۔
۱۲۔ اکیلے اور خاموشی کے اوقات میں سر میں شور رہتا ہے۔
۱۳۔ زیادہ ذہنی کام سے ناک میں ریشہ آجاتا ہے۔
۱۴۔ بولتے ہوئے لفظ دب جاتے ہیں۔
۱۵۔ تھکاوٹ اور اداسی ہے۔
۱۶۔ دکھ ہے۔ کھو جانے کا احساس ہے۔
۱۷۔ غنودگی چھائی رہتی ہے۔

1. Head and face become hot
2. The affectee feels giddy
3. Life becomes good for nothing
4. There is lack of confidence
5. Noisy sounds and whistling echoes are produce in the head
6. Drum beating like sound comes from ear
7. Head seems to the over burdened
8. Head Appear to be a hollow vessel
9. One become absent minded
10. There is lack of uniformity
11. There is abundance of mental disruption
12. A noise starts coming in isolated and silent moment
13. Nasal secretion are caused due to mental over work
14. While speaking words are snubbed
15. The affectee feels tired of f and despondency
16. There is acute pain and a sense of being lost
17. One feels faint

History of Presenting Complaints

He first experienced his erectile dysfunction at the occasion of his marriage. He was married to cousin against his will. After marriage, he found himself unable to do sex with his wife. Actually, he was not so interested in heterosexual experiences. The history of this strong preference for homosexuality dates back to his early adolescence when he had a homosexual experience. That experience formed his sexual identity as a homosexual. And he did not get any pleasure, in heterosexual experiences.

The history of his complaints of listening to sounds in ears and head dates

back to his childhood when he used to have a conflict with his siblings. He had a disturbed relationship with his elder brother and sisters. They used to snub him. His sisters did not let him experience the world in his own view. Also, the over dominating attitude of his mother produced in him a coward ness which resulted in his being unconfident and feelings of guilt, feelings of being wrong and worthlessness which found their way in his symptoms.

Background Information

The client belonged to a rural family, though their status was high. His parents in a rural set-up raised him. He had not a good relationship with his parents. His mother was a dominating figure in his and family's life affairs. She always tried to impose her values onto other family members. The family was a mother holds family.

Father had a little say in family matters. He need to be close his mother physically, although he did not like her domineering ways. He was more attached to his father mentally. Mother had a major role in his personality development. She often rebuked him. She used to ask his father to beat him, to punish him.

He had two brothers, one of whom was step. But he had a good relationship with his stepbrother. His relationship with his elder brother was disturbed. His elder brother used to dominate him and beat him. Because of that, he developed feelings of suppressed hatred, which resulted in his behavioral sign of lack of confidence in front of authority figures. His relationship with his sisters also was not so good. They did not like him. All his siblings except his step brother used to make plans against him.

His schooling was done in village. His teachers were like stereotyped village teachers. He had also a disturbed relationship with them. Because they used to beat him. However, he completed his matriculation and finally got his

education up to BA. Then he got a very reasonable job in a well-reputed private organization.

He was married to his cousin against his will. He did not want to marry her because of his strong homosexual preferences. He found no sexual attraction in women. He was like an exclusive homosexual. After marriage, they did not have sex for a few days. After lapsing a few days, still he was not interested in having sex with his wife. She felt that thing badly. She was not happy with his husband's sexual attitude. Although she used to pull him over her when she desired sex, he otherwise did not ask her for having sex. He first enjoyed his sexual experience in first 10 years of marriage. His marriage was held 17 years ago. In that time period, he enjoyed sex only for four times. Apart that, he used to have sex just for the sake of his wife. He had a good relationship with his wife in other marital affairs. However, he used to visit his wife in village just once in a month. He had to live in city because of his job.

His sexual history started in matric when he started masturbation. He used to derive pleasure from masturbation. He did not feel any kind of guilt in auto sexual experiences. Soon after in intermediate, he had a homosexual experience. The exact causer of homosexual preference is not clear, however, it is suggested that his homosexual attitude dates back to his first homosexual experience and his being conditioned and fixated at that experience.

He had a good-looking, handsome personality. He always dreamed of having a high status in life although he had a high status. Still he was not satisfied with his life. He used to compare himself with his friends, all of those who possessed high posts in various government departments. He considered himself inferior to his friends. He thought that he had been left behind in socioeconomic struggle for high status. Those feelings produced in him a lack of confidence.

Medical History

The client reported no medical history.

Substance Abuse/Use History

The client used to smoke cigarettes.

Causal Factors

Strong Homosexual Preferences

His problematic erectile activity was due to his string homosexual inclinations. Of whatsoever reason he developed homosexual attitude, he did not find any attraction in opposite sex. That's why he was not interested in having sex with his wife.

Disturbed Family Interactions

His symptoms of female-sex phobia originated because ha had a disturbed familial relationship with his mother and siblings. His mother was an over dominating and authoritative type of woman. She wanted to exercise his and his father's lives. He was not given freedom on his life affairs. Moreover, his elder brother always snubbed him. That snobbish attitude of elder brother produced in him a lack of confidence.

Case History No.2

Identifying Data

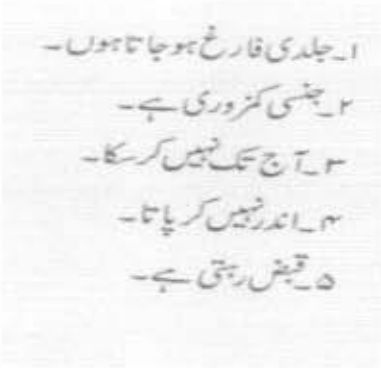
Name:	Javaid Qaisar
Age:	27 years
Sex:	Male
Education:	Illiterate
Profession:	Labor
Socioeconomic Status:	Lower middle class
Marital Status:	Married
No. of Children:	None
Duration	About 3 Years

Javaid Qaisar was a 27 years old male. He consulted a homeopathic practitioner for his persisting problem of erectile dysfunction. He had this problem since his first attempt at his wedding night. He could not do sex in first attempt. And ejaculated before penetration. The situation prevailed over full three years. His wife tolerated all that. He was administered homeopathic medicines for erectile dysfunction and premature ejaculation. Also, he was counseled about his problem.

Reason for Referral

He consulted a homeopathic practitioner for his problem of erectile

dysfunction and constipation.



1. The affectee become impotent and is discharged of at once
2. There is weakness in intercourse
3. No courtship could be done uptil now
4. No entry at all
5. There is always complaint of constipation

History of Presenting Complaints

The client's problem started when at first night of his marriage, he tried intercourse but he could not do sex. He did not even penetrate and ejaculated before penetration outside the vagina. Since then, he had never been able again to penetrate even after about the 3 years of marriage. His problem of erectile dysfunction and premature ejaculation persisted since then.

Background Information

The client was a lower-middle class man. He was illiterate. He was a lower grade government servant. Job was of labor type. He lived hand to mouth.

He was married to a girl about 3 years ago who was 7 years younger than him.

At his wedding night, he attempted intercourse but failed on his attempt. He could not even penetrate and ejaculated without penetrating in the vagina. That situation prevailed for 3 years, he could not do sex.

His wife, because of familial and societal pressures remained quiet. She tolerated all that. They did not have a talk over his problem. She was just compromising and was living with him caringly.

Medical History

The client reported suffering from constipation.

Medication History

Currently, at the time when he seeks consultation, was not taking any kind of medicines.

Past Treatment History

He tried "Unani" medicines for his problem of erectile dysfunction but that were of no help to him.

Provisional Hypothesis

The client's fear and anxiety about intercourse served as the cause of his failure at doing sex with wife.

Causal Factors

Fear and Anxiety Relating to Sexual Activity

The client's problem originated because he had severe anxiety about how to perform sexual activity. He had a fear of being failed at doing sex. That anxiety and fear did not permit him to relax, to have erection and to perform

sexual act.

Performance Anxiety

Once he had the problem of erectile failure in first attempt that triggered in him extreme embarrassment. He felt humiliated. His anxiety grew in intensity. After that event, whenever, he tried to have sexual intercourse, he tended to focus on his erections. He expected erectile failure in subsequent sexual encounters. That unreasonable anticipation and focus on his erectile response started a vicious cycle in which he got himself caught.

Spectator Role

After first night failed attempt, he became a spectator of his own. He watched and focused on his erections during the sexual intercourse. Because of that spectator role, he became tense, he could not be able to relax during sex, hence did not be able to get erection. In the same manner, that happened over and over again.

Treatment Given

Medical Treatment for Impotency

Because for the last 3 years, he had not been able to do sex, and is very much tense about it, he was given the homeopathic medicines for triggering his physiological erectile response. That boosted him and he started perceiving him sexually potent.

Counseling

He was also given counseling concerning his sexual failure from his pear group. He was given reassurance and was taught about the proper techniques of doing sex.

Results

He Improved considerably because of medicinal effects and counseling and started doing sex.

Case History No. 3

Identifying Data

Name:	Aamir Mumtaz
Age:	27 years
Sex:	Male
Education:	Illiterate
Profession:	Labor
Socioeconomic Status:	Lower
Marital Status:	Married
No. of Children:	None

Aamir Mumtaz was a 27 years old illiterate male. He consulted a homeopathic practitioner. He had the problem of erectile dysfunction since his wedding night. He could not do sex with his wife. His relationships with his wife were not normal. His wife was very furious and asked him for treatment. He was administered homeopathic medicine along with counseling about sexual activity. He improved markedly. He started doing sex. The relations between him and his wife gradually became normal.

Reason for Referral

He consulted a homeopathic practitioner for his problem of erectile dysfunction.

History of Presenting Complaints

The client's history of erectile dysfunction dates back to 2 years ago, when at his wedding night he failed to perform sexual act. He had erection but when approached his wife, lose his erection. Since that time onward, his problem of erectile dysfunction persisted.

Background Information

The client was a poor man, belonged to a poor family. He was illiterate. His marriage was arranged. After marriage, started his unfortunate life. He could not perform sexual act. He had the desire to perform, had erection but when approached his wife lose his erection. Since that time on, the problem persisted.

Besides his failure in marital relationship, he had a normal history of masturbation. He had a disturbed relationship with his wife because of his problem of erectile dysfunction. His wife was not happy with him. She was angry. The situation worsened between the partners. His wife even warned her of asking him for divorce if he did not have his problem treated.

Medical History

The client reported no medical history.

Past Treatment History

He sought "Desi" treatment for his problem of erectile dysfunction from a "Hakeem" but that was of no help to him.

Causal Factors

Fear and Anxiety Relating to Sexual Activity

The client's problem originated because he had severe anxiety about how to perform sexual activity. He had a fear of being failed at doing sex. The anxiety and fear did not permit him to relax, to have erection and to perform sexual act.

Performance Anxiety

Once he had the problem of erectile failure in first attempt, that triggered in him extreme embarrassment. He felt humiliated. His anxiety grew in intensity. After that event, whenever, he tried to have sexual intercourse, he tended to focus on his erections. He expected erectile failure in subsequent sexual encounters. That unreasonable anticipation and focus on his erectile response started a vicious cycle in which he got himself caught.

Spectator Role

After first night's futile attempt, he became a spectator of his own. He watched and focused on his erections during the sexual intercourse. Because of that spectator role, he became tense, he did not be able to relax during sex, hence did not be able to get erection. In the same manner, that happened over and over again.

Treatment Given

Medical Treatment for Impotency

Because for the last 2 years, he had not been able to do sex, and is very much tense about it, he was given the homeopathic medicines for triggering his physiological erectile response. That boosted him and he started perceiving him sexually potent.

Counseling

He was also given counseling concerning his sexual failure. He was given reassurance and was taught about the proper techniques of doing sex.

Results

After treatment, he recovered remarkably. He started to have erections. He started to perform intercourse successfully. His wife was happy with him. Relations between them gradually became normal.

Case History No. 4

Identifying Data

Name:	Nadeem Iqbal
Age:	28 years
Sex:	Male
Education:	F. A
Profession:	Labor
Socioeconomic Status:	Lower-Middle class
Marital Status:	Single

Nadeem Iqbal was a 28 years old man. He consulted a homeopathic practitioner for his problem of erectile dysfunction. He encountered this problem recently when he visited a brothel. A commercial sex worker told him that he was declining sexually. He was taunted at his manliness. Because of that shock, he developed erectile dysfunction. He was administered homeopathic medicine.

Reason for Referral

The client consulted a homeopathic practitioner for his complaint of erectile dysfunction

Duration	*Presenting Complaints*
About 2-3 months	۱۔ نامرد ہو چکا ہوں۔ ۲۔ مجھ میں جنسی کمزوری ہے۔ ۳۔ عضو میں سختی نہیں ہے۔ ۴۔ ایستادگیاں کمزور ہیں۔ ۵۔ جلدی فارغ ہو جاتا ہوں۔

1. I have become proclaimed impotent
2. I have been suffering from sexual weakness
3. There is no hardness in Penis
4. Force producing agencies are too weak to stand up
5. I am discharged of at once

History of Presenting Complaints

The client's problem originated about 2 months ago when he visited a brothel. During that encounter, he was told by the commercial sex worker that he was declining sexually. The sex worker rejected him by saying that he was getting older. He was not able to perform sexual act with the same vigor as he formerly used to. That saying by the commercial ex worker caused a psychological shock to him. He could not bear it, he could not believe that he was declining g sexually. That produced in him a feeling of inferiority sexually. That feelings of rejection, inferiority and declined sexual vigor interfered with his erectile responses. And he experienced erectile dysfunction.

Background Information

Nadeem was a Youngman belonged to a lower-middle class family. He got education up to F.A. Then he started his job. The job was a kind of labor work.

He was single but marriage was approaching. The fear of being impotent in marital sexual relationship tense him and he sought treatment of erectile dysfunction.

His sexual life started in adolescence when he started to have pleasures of selfstimulation. In addition to masturbation, he had a broad history and experiences commercial sex workers.

At first, he was brought to a brothel by one of his colleagues. After that it became his routine to have sexual intercourse almost regularly with a new sex worker. In the meanwhile, he also the pleasures of homosexual experience with a boy but that were only once. Active sexual history made him experienced in sexual activity and performance. But when one sex worker taunted him of declining sexual vigor, he became impotent. That was like a psychological shock to him. He could not bear it and developed erectile dysfunctions.

Medical History

The client reported no medical history.

Past Treatment History

He had no previous treatment history. He first visited a homeopathic practitioner.

Provisional Hypothesis

The taunting and rejection by his partner (commercial sex worker) produced in him erectile dysfunction.

Causal Factors

Rejection by Partner

The client's problem originated when he was rejected by his partner (commercial sex worker) and told to have been declining in his sexual vigor. The comments from the sex worker shocked him. He developed erectile dysfunction psychologically.

Treatment Given

Homeopathic Medication

He was administered homeopathic medicines for enhancing his sexual vigor and Potency.

Counseling

He was counseled by homeopathic practitioner. He was countered at irrational thoughts and assumptions. He was given reassurance, and was helped to overcome his feelings of being impotent.

Case History No. 5

Identifying Data

Name:	Shahnawaz Anjum
Age:	33 years
Sex:	Male
Education:	Not Available
Profession:	Private Job
Socioeconomic Status:	Middle class
Marital Status:	Married
No. of Children:	None

Shahnawaz Anjum was a 33 years old man. He consulted a homeopathic practitioner for his complaint of erectile dysfunction. He used to have normal sexual relations before marriage. But with wife, he had a disturbed sexual life. He was diagnosed as having erectile disorder. He had a previous treatment history of "Desi" compounds but these were of little help to him. They had a communication problem in their marital relationship. The client was administered with homeopathic medicines. He was also guided about sexual activity.

History of presenting complaints

The client's problems of specific or situational erectile dysfunction started when he was married. After marriage, he had not been able to achieve full erection. He had never been able to have a satisfied sexual intercourse with his wife. Before marriage, however, he used to have normal satisfied sexual life with his girl friends. His situational erectile dysfunction might be the result of the lack of communication with his wife on sexual matters. Also, wife's chronic problem of headache may be a contributory factor in his erectile dysfunction. That problem of headache may be interfering with her enjoyment of sexual pleasures and that interference may cause her not to be active in sexual process with her husband. That lack of warm attitude from the wife side caused him to experience erectile dysfunction with wife but not with other women.

Background Information

The client belonged to a middle class family. He led a normal life before marriage with his parents and siblings. After completing his education, he got a job in a reputed private organization. Then he was married to a girl. The marriage was arranged. He had a disturbed relationship with his wife. His wife was the patient of chronic headache. She did not give him the proper sexual responses during the sexual intercourse. Therefore, he experienced the problem of erectile dysfunction. At the time of consultation, his wife was pregnant.

Due to pregnancy, she was irritable, which combined with her headache to worsen the situation.

Before marriage, he had normal sexual relations with his girl friends. He never complained of any kind of erectile problem with any of those friends but when it came to wife, he experienced spells of erectile dysfunction. Although he had

erections and they did sexual intercourse, but he was not satisfied with the experiences. He did not derive much pleasure out of sex with his wife. May be this because of his wife's not giving the proper stimulation or her nonparticipation in sex. It may be that he had been fixated at on the pleasures derived from intercourse with his girl friends. It is to be noted, before sexual relations with his friends, he used to fulfill hidden desires by use of masturbation. He used to masturbate frequently. Now at that time of consultation, he considered masturbation to be the major causal factor in his problem of erectile dysfunction.

Medical History

The client reported no medical history.

Past Treatment History

He formerly sought "Desi" treatment from a "Hakeem" but that treatment was of very little help to him.

Provisional Hypothesis

His disturbed relationship with his wife was the major cause of his erectile dysfunction.

Causal Factors

Wife's non-participation in Sex

The client's problem of erectile dysfunction was the product of a disturbed communication pattern between the partners. His wife did not participate in sex. She did not give him the proper stimulation. She behaved in accordance with her cultural and familial teachings of a pious lady. Because he did not get her participation in sex, he developed the problem of erectile dysfunction with

his wife but not with other women. All these problems can easily be attributed to lack of communication between the partners. They both had a poor communication between them in general also about sexual matters in particular. They did not talk about sex, share their needs and wants, and did not ask each other fore doing certain things. This clearly points out the lack of communication between them. Whereas communication forms an integral part of a relationship, lack of it created complication in the problem.

The client's problem may be due to the fact that he had been fixated at his past I experiences of pleasurable sex with his wife. It may be due to the reason that he did not I get his wife sexually attractive.

Treatment Given

Homeopathic Medication

He was given homeopathic medicines for enhancing his sexual potency.

Counseling

He was also guided about sexual activity. He was taught to enhance and maximize communication between him and his wife. He should be advised to check both his and her expectations towards each other. In away, they can correct pathological communication patterns between them.

Case History No. 6

Identifying Data

Name:	Irfan Zafar
Age:	22 years
Sex:	Male
Education:	Matric
Profession:	Menial Job
Socioeconomic Status:	Lower-Middle class
Marital Status:	Single

Irfan Zafar was a 22 years old man. He consulted a homeopathic practitioner for his complaints of erectile dysfunction and irritable bowel syndrome. He used to have a nominal sex life with his girlfriends. But when his parents started to talk about his marriage, he Started to feel himself impotent. Previously, he sought no treatment. He was administered homeopathic medicines. Also, he was advised about sexual activity.

Reason for Referral

The client consulted a homeopathic practitioner because of his complaints of erectile dysfunction, disturbed digestion, and cirrhosis.

History of Presenting Complaints

The client's problem of erectile dysfunction started a few months ago when his parents started to talk about his marriage. Before that, he was leading a normal active sex (with girlfriends). But when it came to marriage, and doing sex with wife, he found 1self impotent. The fear of casting a good sexual impression and to show sexual vigor his wife made him felt him impotent.

Background Information

The client belonged to a lower-middle class family. He got education only up to Matric. Then he started working in a printing press. He lived hand to mouth.

His sexual history started when in adolescence, he started masturbating. He used Masturbate frequently. After that, he chanced to have sexual relations with his girl friends. He spent an active sex life. He had sex even thrice or four times in just a single encounter.

In the meanwhile, the process of gathering information about sexuality continued and resulted in his learning and developing maladaptive cognitions about sexual, activity which then affected his sexual functioning. He started to feel impotent psychologically.

Also the issue of approaching marriage contributed to great extent in seeking Treatment and to worry about his sexual functioning. On complying with cultural expectations he wanted to cast a good powerful image on his wife. The fear of being sexually weak made him feel sexually impotent.

Medical History

The client reported having the problem, of indigestion.

Past Treatment History

He had no history of any kind of treatment in past.

Treatment Given

Homeopathic Medication

He was given homeopathic medicines for the enhancement of his sexual potency and for boosting him psychologically. Also, medication was administered to him for IBS.

Case History No. 7

Identifying Data

Name:	Umar Khan
Age:	25 years
Sex:	Male
Education:	Not Available
Profession:	Manual Work
Socioeconomic Status:	Lower class
Marital Status:	Single

Umar Khan was a 25 years old man. He consulted a "Hakeem" for his complaint of erectile dysfunction. He had an active sex life. He was bisexual in his orientation. He gradually with the passage of time, started to feel himself as impotent. He came to know about a "Hakeem". And asked him for treatment via mail.

Reason for Referral

The client was referred by one of his friend. He consulted a Hakeem via correspondence for his so-called complaint of sexual weakness.

History of Presenting Complaints

Early in his adolescence, he started masturbation. He used to masturbate frequently. Then he started to enjoy sex with commercial sex workers and with boys and men. He was bisexual in his orientation. In the course of his

sexual career, he gathered information regarding sexual matters largely from peers, hence, developed irrational and maladaptive views about sexuality. This can be traced back to the lack of scientific information about sexuality.

Background Information

The client was a middle aged poor man. He belonged to a lower class family. He used to earn his livelihood from manual work of watch repair. He lived hand to mouth.

He was unmarried but had experienced sexual intercourse several times. He started to enjoy sex in early teens with commercial sex workers. He also had homosexual experiences. Before his active sexual experiences, he used to masturbate frequently. He learned information about sexual matters mostly with his interaction with peers colleagues, which mostly was based on myths. Hence, he developed myths about sexual activity and performance. Those myths affected his sexual functioning and he developed Symptoms of sexual weakness.

Medical History

The client reported no medical history.

Past Treatment History

The client's past treatment history was not available.

Provisional Hypothesis

The client's lack of scientific information about sexuality predisposed him to develop sexual weakness by believing in myths.

Causal Factors

Lack of Scientific Information

The client's history displayed a lack of scientific information concerning various aspects of human sexuality. He believed in dangers of masturbation on health. He did not know much about the sexual response cycle, the nature of semen, ejaculatory time period, the role of masturbation in desire satisfaction, and its effects on health. All this can be clearly due to lack of scientific information.

Treatment Given

Desi Medication

He consulted a Hakeem for treatment of his sexual weakness. Providing him only with information and counseling would not solve his problem. Therefore, he was given one medication to boost him up and to have a favorable impression on his sexual function.

Case History No. 8

Identifying Data

Name:	Mumtaz Abbas
Age:	23 years
Sex:	Male
Education:	Middle
Profession:	Unemployed
Socioeconomic Status:	Lower class
Marital Status:	Single
Family Type:	Joint

Mumtaz Abbas was a 23 years old man. He consulted a homeopathic practitioner for his medical condition of gonorrhea and resulting erectile disorder. He had developed gonorrhea a few years ago when he had an active homosexual experience with an old man but had not it cured. He had previously got treatment from allopathic general practitioners and "Hakeems" but that did not cure his condition successfully. He was given homeopathic medicines. He started to improve by the use of homeopathic medicines.

Reason of Referral

Mumtaz consulted a homeopathic practitioner for his complaints of sexually transmitted disease and sexual weakness

History of Presenting Complaints

About few years ago, in his adolescence, one man asked him to perform sexual act on him. He agreed and had sex with that old man. After a few days, he developed signs and symptoms of sexually transmitted disease. Afterwards, he used to have sex with his fellow village girls. In the meanwhile, his problem of gonorrhea was not cured completely, although he sought treatment for it. As the time passed, his disease persisted over time because of wrong treatment and interfered with his sexual functioning. That was why he developed erectile dysfunction.

History

He was suffering from a sexually transmitted disease (gonorrhea

Past Treatment History

He consulted allopathic general practitioners and "Hakeems" for the treatment of is disease, but that treatment was of little help to him. The disease was not cured completely.

Provisional Hypothesis

Unhealthy and unsafe sexual behavior contributed to his contraction of the disease, gonorrhea that later became the cause of his erectile dysfunction.

Causal Factors

Contraction of Sexually Transmitted Disease

The cause of client's problem of erectile dysfunction was his disease gonorrhea. Gonorrhea is a disease characterized by urethritis (inflammation of urinogenital duct and painful urination), sores on the skin of the penis, and passage of pus from the urethra. In the presence of such symptoms, one cannot be able to have proper erections. So was the case with Mumtaz. Engaging in unsafe sexual behavior was due to two factors.

Lack of Sex Education

Mumtaz did not know that he could get infected with sexually transmitted disease. This was because of lack of sex education.

Environmental Influences

The client was a villager. A village's environment permits unhealthy sexual expressions and there young men have less restriction to satisfy their sexual urges. That was another reason why he was engaged in unhealthy sexual behavior.

Treatment Given

Homeopathic Medication

The client was administered homeopathic medicines for the treatment of gonorrhea. Along with those medicines, he was also administered medicine for enhancing sexual potency.

Provision of Sex Information

The client was provided with information about engaging in safe sexual behavior. Also, he was given information about the techniques of sexual intercourse.

Results

Because of homeopathic medication, his disease of gonorrhea started to recover. At the moment, he was getting recover. His sexual functioning was started to be normal.

CHAPTER NO. 5

SUMMARY AND CONCLUSION

The topic of study relates to medical anthropology, which strives for an understanding of health, illness, disease and sickness among inter-cultural and intra-cultural groups and clans. According to (Helmen, 1984) Medical Anthropology can be described as the study of cultural beliefs and behaviors associated with the origin, recognition and management of health and illness in different social and cultural groups. Medical anthropology is not simply concerned with practice of healing or systems of diagnosis and treatment such as biomedicine. It deals with the more informal systems of health care that exist worldwide (such as self-treatment, folk healing, traditional birth attendants, shamans and indigenous healers), as well as those associated with professional Western science-based biomedicine (Cosmopolitan medical system) and caring and curing practice. Additionally medical anthropology is also concerned with issues that relate to different cultural connotations of the 'self' in response to health and disease, as well as shared beliefs, cognitive images and practice associated with perceptions of the human body and mind.

Since the ancient times, health and illness have been considered in cosmological and anthropological perspective consisting of magical and religious beliefs. Hence such awareness played a key role in integration and understanding of ancient cultures and civilizations to an extent that medical history assisted a lot in studying the history of that particular culture. Every society, irrespective of its simplicity or complexity has an inter-related set of beliefs and skills of practice regarding health, disease, illness and sickness. These phenomenons possess a challenge and threat both for physical existence and harmony of the social milieu. Therefore, the prevention of disease, illness, sickness and maintenance of health, all human societies develop knowledge of

medicine. The knowledge of medicine involved in different beliefs and skills of practice provide health to illness and satisfaction to mysterious causes.

The primitive medicine though limited in knowledge about body, was always there to provide maximum care and cure where the therapeutic process articulated around knowledge regarding gods, evil spirits, stars and planets. This super-natural theory of disease encircled around the anger of gods, the invasion of body by evil spirits and the intervening influence of stars and planets. So, the healers' treatment methodology encircled around appeasing gods by rituals and many a sacrifice meant to drive out evil spirits from the body by witchcraft and using charms and amulets to protect the mankind against such endangering natural elements. It is thus obvious that medicine in the prehistoric times was intermingled with superstition, religion, magic and witchcraft, the manipulated shape of which even we find today among the belief system of Indigenous healers as well as among those seeking healing either from Healers or Doctors.

Primitive medicine is timeless. If we look around the world, we find that the rudiments of primitive medicine still persist in many parts of the world – in Asia, Africa, South America, Australia and the Pacific Islands. The supernatural theory of disease in which the primitive man believed, is as new as today. Although primitive man maybe extinct, his progeny – the so-called "traditional healers" are found everywhere even without the demarcation of urban or rural, though we find such healing more active in rural areas, esp. in Pakistan. They live 'close' to the people and their treatments are based on various combinations of their religion, their magic and empiricism understandable to common health seekers.

Islamic medicine though not having an all encompassing medical foundations, affects direct the rest of the medical systems in Pakistan be it Humoral, Unani or the state monopolized bio-medical medicine. This system enjoys strong cultural affiliation and emotional bondage even lacking its own laboratory or a clinic. It legitimizes any other indigenous healing system e-g

Unani who is usually equated with Islamic medicine for the very fact that some early physicians who wrote treatise on Unani medicine referred to the application of Prophets' sayings with reference to usage of Honey and other items/ herbs like Qalwanji. This ancient Unani medical system had its origins in the Mediterranean world and its development in the Middle East, was brought to Indian subcontinent with the spread of Islamic civilization in the Mughal era. Similar to the Greek medicine and Humoral medicine, Unani medicine's philosophical foundations consist of the four-humor theory of Hippocrates, which presupposes the presence of four humors in the body namely blood, yellow one and black one. This medical system, human body is regarded as comprising the seven working principles; (1) different states of matter and materials entering into and forming a part of everything in the universe; (2) the bodily temperament; (3) the structural components; (4) the fully developed and mature organs (5) the vital force of life; (6) the bodily power; and, (7) the corporal functions. The second principle, body temperament is of key importance in determining the hot and cold temperament of the body so that a suitable remedy, prepared from local herbs, can be given to suit the bodily treatment pertaining to male sexual malfunctioning.

With reference to the research topic, the practitioner (Hakeem, Cleric and Pirs) of the Humoral medical system argue that the reason of male sexual malfunctioning can be the divergence of males to follow the Islamic code of conduct and either in the past they would have committed some sin (rape, masturbation, homosexuality, sex from the prohibited part i-e anus, incest taboo or sex with an animal) and hence a particular remedy consists on seeking apology from the God either in a ritualistic way or via intentions. Another rationale of male sexual malfunctioning can be the cold exposure (washing with cold water) of the male sexual organ immediately after the orgasm, since having an orgasm is equated with the hot classification. Meanwhile, the native Muslim conception with reference to purity and

impurity suggests that impurity (Penis, after orgasm) be washed through normal hot water.

In accordance to the evolutionary schemes of the diverse medical systems, the researcher argues that in Pakistan, one may find the existence of any of the above mentioned medical systems independently or a blend of two or all the medical systems coexisting with one or all the medical systems. Muslim physicians/ healers under the influence of Primitive, Chinese, Egyptian, Mesopotamian, Greek, Roman and above all the Ayurvedic medical system laid the foundations of Humoral, Unani and Islamic medical systems which are mostly based on the belief system of the native community in which the particular medical system is rendering its services and that is the reason that it is called Indigenous Healing system.

In every society people are concerned about their health, they take steps to ensure continued good health and establish procedures for avoiding ailments and injuries. Traditional medicine is the mode of treatment of over eighty percent of the population of the world. A large proportion of worlds' population still relies on traditional practitioners, including traditional birth attendants, herbalists, and bone-setters and on local medical plants to satisfy their primary health care needs. Medical plants and traditional healing products are the oldest form of seeking health. Natural products have been in use as medicines for the past several thousand years. This knowledge has passed through generations to generations as well.

In Pakistan, one may find the existence of one of the above mentioned indigenous medical system or a blend of the two or all the indigenous medical systems (Humoral, Unani, Islamic), but the important thing is that they simultaneously co-exist with the now, well established, state monopolized bio-medical system of healing which claims to be rational, objective and value-free in dealing with one or all the diseases whether be it the issue of curative or the preventive. Either the issue is of health, disease, illness or sickness; both the Indigenous as well as Cosmopolitan medical systems come on the scene to

render their services and to capture the 'market'. When the issue is of Sexuality, that too in South Punjab and particularly District Lodhran, one can easily find an existence of full fledged industry, providing cure and care to the malfunctioning of sexuality, which is diverse in domain and narrow in focus! Sexual malfunctioning is not only the malfunctioning of any organ rather it is a 'cultural malfunctioning' which needs an utmost treatment because a sexually malfunctioned man has no say in society as its contingencies are reflective of the fact that such a person falls prey to shame, and un-acceptance. Sex equated with honor, is reinforced when it is aloof of any harm. Secondly, in most of the diseases or illnesses, the Therapeutic Management Group comes in support of the patient who at the moment is enjoying 'Secondary Gain' but in sexual malfunctioning, the role of Therapeutic Management Group is of labeling and criticizing thus leaving behind the entire responsibility onto the patient.

Male sexual malfunctioning resulting certain diseases, illness, distress and sickness affect the social relations of an individual in the society because sexual impotency results in societal impotency which have a grave influence on the family dynamics. The indigenous healing system is rendering his services in the response to male sexual malfunctioning by giving a complete surety for the complete treatment and elimination of such an epidemic. Daily newspaper, wall chalking, advertisements at every public gathering spots and at bus stops, one may find a full fledged focus on the usage of drugs for the treatment and improvement in sexual potency by Quakers.

Major areas of research on which data were collected were prevalence of alternative healers (Aamil, Peer and Hakeems following Humoral, Unani and Islamic medical systems), Doctors, Patients, Cultural myths and folklores regarding sexuality, Culturally sanctioned normal sexual practices against abnormal sexual practices and its frequency, Healthy men, Books and pamphlets, Artifacts, Signboards, public health, traditions and everyday life matters etc.

As one of my major objective of the research was to access the public health of the community pertaining to their adoption of anyone or a blend of diverse medical systems, so the data is analyzed pertaining to a comparison of the alternative and cosmopolitan medical systems with reference to the public health.

In every society people are concerned about their health, they take steps to ensure continued good health and establish procedures for avoiding ailments and injuries. Traditional medicine is the mode of treatment of over eighty percent of the population of the world. A large proportion of worlds' population still relies on traditional practitioners, including traditional birth attendants, herbalists, and bone-setters and on local medical plants to satisfy their primary health care needs. Medical plants and traditional healing products are the oldest form of seeking health. Natural products have been in use as medicines for the past several thousand years. This knowledge has passed through generations to generations as well.

A number of cases of male erectile disorder consult primarily "Hakeems" for their treatment. This points out to the conclusion that majority of our people do not have awareness about sexual problems. It may because of our cultural norms. In our culture of Indo-Pak subcontinent, there is a trend of seeking treatment from "Hakeems". Only "Hakeems" are considered as legitimate authority to see erectile disorder cases. But it is to be noted that persons who consult "Hakeems" usually are of lower or lower-middle status. It may be due to the fact that those people usually are not well educated and understand the nature of their problem. As a result, they consult "Hakeems".

- The first difference between indigenous healing system and bio-medical system is that bio-medical system is universal and its methods of treatment and therapies are same all over the world whereas indigenous

healing system is local and traditional and its philosophies vary from place to place.

- Second, bio-medical system is based on systematic rules and regulations which are formed after absolute scientific research whereas indigenous healing system is based on normative structure, cultural patterns and historical traditions.
- Third, mode of diagnosis is laboratory based. Doctors suggest a complete list of laboratory tests even for just a flu or fever and after that examine the patients whereas, in indigenous healing system diagnosis is made on the basis of speed of pulse, eye color, tongue color, swelling of throat, body temperature etc.
- Fourth, complete and absolute division of labor prevails in bio-medical system. Physician is just physician; surgeon is just surgeon, same case with laboratory incharge, anesthesiologists and pharmacist. Each is separate in his domain whereas, in indigenous healing system, one person is responsible for all the things. A heeler has to diagnose, prescribe, and treat and to give the medicine also.
- Fifth, treatment process is never shared by patient or any family member. Even in chronic or acute illness, a part of treatment is told to the family whereas, in indigenous healing system, each and every thing is shared and mutually settled with patient and his/her close relatives, family members and friends who are called as therapeutic management group (TMG).justification of each part of treatment is given to them.
- Sixth, treatment is object oriented, that is, a particular treatment for a particular disease is given in bio-medical system whereas, in indigenous healing system, treatment is person oriented. Different strategies are applied for different patients according to their body classification.
- Seventh, status and rank is achieved after a long and hard study. No one can be a doctor without a MBBS degree whereas in indigenous healing system, status is ascribed and transfer from generation to generation.

- Eighth, doctors have specific localized view of body. Every physician or surgeon is specialized about a particular part of body and capable of treating that very part of body whereas, in indigenous healing system, body is considered as a composition of mater and spirit and is taken as a whole. One heeler treats the whole body and has treatment of each part of body.
- Ninth, bio-medical doctor has to follow his professional ethics which are unambiguous and clearly written in their oath and the state legislation also whereas; alternative heeler lay down the behavioral model with the consent of patient and TMG.
- Tenth, bio-medical doctor is not responsible in case of any disturbance or complication. Patient cannot take any legal action against the doctor whereas; alternative heeler is responsible for each and every complexity.
- Eleventh, bio-medical system has its own norms and they follow their own rules and regulations whereas, indigenous healing system is based on traditional cultural patterns and alternative heelers follow cultural values.
- Twelfth, personality and moral character are not considered in bio-medical system. It is considered that disease and treatment have no link with person's character whereas, in indigenous healing system personality and moral character are very much considered and reason of any disease and illness is located in personality cracks and bad moral values of patient. It is also thought that disease is a punishment of wrong doings of a person.
- Thirteenth, surgery is common practice in bio-medical system. In chronic diseases as well as in ordinary illnesses, surgery is easy accessible mode of treatment for cosmopolitan doctors whereas; alternative heelers usually avoid surgery and try to treat the illness with the help of medicines and preventions.
- Fourteenth, interactive patterns are more formal and there is no pleasant and welcoming relationship between doctor and patient whereas, alternative heeler is very much friendly to patients. Interactive patterns are

more pleasant ant sociable. Most of the time, there are family relationships between heeler and patient.

- Final and above all difference between both the systems is that cosmopolitan medical system takes disease as important figure and there is no consideration of illness or sickness, that means, emotional feelings and painful conditions attached with disease are not considered whereas, indigenous healing system concentrates on illness and sickness and mental and spiritual aspects of disease. Description of symptoms is very much important. Manifestation of disease is more significant than disease itself in indigenous healing system.

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House Hold No: _____

Sr. No.	No	Name	Relationship with Head of House Hold	Sex		Age	Marital Status					Remarks
				Male	Female		Married	Not-married	Widow	Separated	Divorce	
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Sr. No	Family Type			Caste	House Hold Structure			Education									Reason for choosing this type of education (Both)	Remar
								Formal					Informal					
	Extended	Joint	Nuclear		Kacha	Pakka	Mix	Primary	Middle	Matric	College	University	Madrassah	Mosque	Apprenticeship	Other		
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		
12																		
13																		
14																		
15																		

Sr. No	Occupation									Income					Remarks
	Agricultural					Non_Agricultural				Monthly	Daily	Seasonal	Annual	Occasional	
	LL	L	TT	SC	SCL	Govt. Job	Non_govt	Business	Daily wages						
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															

Sr. No.	Sources of Information in Community						Electronic Media in Community		Health Institution in Community									Health Care system availed/ used	Remarks
	Family	Media		Religion	School	Peer	T.V	Radio	Bio-medical		Indigenous								
		Print	Electronic						MBBS Doctor	Dispensor	Hikmat	Humoral	Faith Healing	Bone Setter	Masseus		Other		
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			
13																			
14																			
15																			

Sr. No	Sexual Categories known							Any man known in community who is sexually malfunctional	
	Hetro	Bi-sexual	Gay	Lesbian	Sex with animals	Masterbators	Other	Yes	No
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

Sr. No	What in your opinion, can cause sexual malfunctioning?								Remarks
	Masterbation	Excessive sex with wife	Excessive sex with sex workers	Reaction of some herb/ medicine	Homosexual Experience		Inherited	Animal Sex	
					Active	Passive			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

Sr. No	Any Institution that he went to, to deal with the deficiency he had?	What Results Obtained		In response in case of failure or short term relief:					Remarks
		Short- term	Long term	Gave up the treatment	Changed herbs/ medicines in the same category	Changed herbs and the category	Self -Medication		
							Home Remedies	Bio-Hikmat-Homeo medication	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
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14									
15									

17. Do you have any kind of apprehensions about pot having erections during sexual intercourse?
18. Do you make fore play before penetrating?
19. Do your sexual partner participate in the process of fore play?
20. Do your sexual partner participate in the process of lovemaking?
21. Do you talk about sex with your sexual partner?
22. Did you have a discussion about having this problem with your partner?
23. Are your sexual partner is annoyed at this problem?
24. Are your sexual partner asked you to have treatment for this condition?
25. Do you derive sexual pleasure from sexual intercourse with prepuberty children? 26. Do you derive sexual pleasure by doing sex with animals?
27. Do you derive sexual pleasure by dressing up in women's clothes?
28. Do you derive sexual pleasure by using the articles of female use?
29. Do you derive sexual pleasure by exposing your genitals?
30. Do you derive sexual pleasure by inflicting pain unto or teasing your sexual partner?
31. Do you derive sexual pleasure by watching others engaged in sexual intercourse?
32. Do you derive sexual pleasure by touching the sensuous parts of stranger's women?
33. Do you play an active role during sexual intercourse?
34. Do your sexual partner participate actively in sexual intercourse?
35. Do your sexual partner get pleasure from engaging in sexual intercourse with you?
36. Do both of you derive sexual satisfaction by engaging in sexual intercourse?
37. Do you keep to try new sexual positions for sexual intercourse from time to time.