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Khasi Traditional Healers Should Be Frontline Providers in the National Health Mission

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Summary

Four in five rural households in Meghalaya use tribal medicine and nearly nine in ten believe it works. Traditional Khasi healers are trusted, accessible and inexpensive. Rather than training more outsiders, the National Health Mission should recognise healers as frontline providers, pay them for their services and allow them to manage common illnesses in their villages, with referral to clinics only when their treatment fails.

Every morning, outside a small wooden house near my village in Ri-Bhoi, a line of people waits to see a healer. They come with fevers, coughs, aching joints and broken bones, with worries about pregnancy and about children who will not eat. Most have walked past the sub-centre on the way. They choose the healer because she listens, because she understands them and because her treatment works. When I was a child, it was this healer's mother who set my broken arm. It healed perfectly, and I have never needed a doctor for it since.

Scenes like this are repeated across Meghalaya. Yet our health system treats traditional healers as an embarrassment at best and a danger at worst. I argue that this is a mistake. Khasi healers should be recognised, paid and deployed as frontline providers within the National Health Mission (NHM).

The people have chosen

The best data we have come from a statewide household survey by Albert and colleagues, which used a multistage random sample to represent the whole of rural Meghalaya [1
. It found that 79.1% of people had used tribal medicine, 46.2% had used it in the previous three months, and 87.5% believed it to be effective (Figure 1). By contrast, 68.7% had never heard of Ayush and only 10.5% had ever used any Ayush system. These figures show that tribal medicine is effective in the eyes of those who matter most: the patients themselves. A system that nine in ten people believe in does not need to be proved by outsiders.

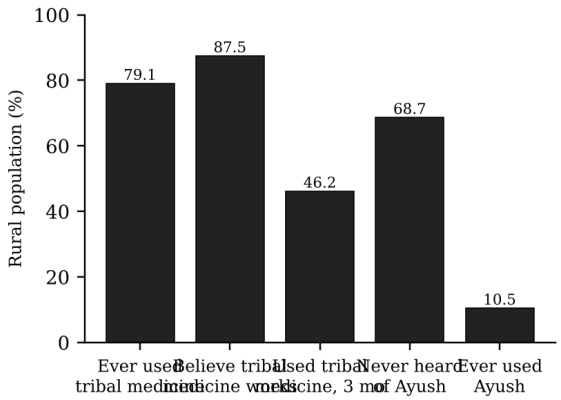


Figure 1. Awareness and use of tribal medicine and Ayush in rural Meghalaya (data from Albert et al. [1]).

The national picture points in the same direction. The first national survey on Ayush found that around half of Indians had used Ayush in the previous year [2]. Traditional and indigenous medicine is clearly the preferred form of care for very large numbers of people, and policy should reflect this preference.

The world agrees

The World Health Organization has long encouraged member states to integrate traditional medicine into their health systems. Its Traditional Medicine Strategy 2014–2023 called for traditional and complementary medicine to be integrated into health care services and self-health care [3], and the Gujarat Declaration adopted at the first WHO Traditional Medicine Global Summit in 2023 reaffirmed this commitment [4]. India has responded by investing heavily in Ayush. But Ayush is not our tradition. Albert and colleagues showed that most rural Meghalayans have never heard of it [1]. If the WHO's vision is to be realised in Meghalaya, it must be through our own healers, not through an imported system from the plains.

Healers already save lives

Recent reporting has described how traditional healers in Meghalaya are becoming 'lifesavers', providing care where formal services are absent and advocating for the state's long-planned Khasi Traditional Medicine Institute in Ri-Bhoi, which remains non-functional [5]. In my own fieldwork in Ri-Bhoi, villages with an active healer reported fewer deaths of young children over the past five years than villages without one. The healer is often the only person who will come at night, in the rain, to a household with a sick child. That availability alone saves lives.

Healers are also far cheaper than the formal system. A consultation costs little or nothing, medicines are gathered from the forest, and patients do not lose a day's wages travelling to a health centre. For a state where many households depend on daily wages and subsistence farming, this matters enormously.

Answering the objections

Critics raise three objections. The first is that healers may delay the treatment of serious disease. But delay is already the rule in our health system, where patients may wait days for a referral and hours for a consultation. Healers see patients immediately. The second objection is that healers' remedies have not been tested in clinical trials. This is true, but generations of use are a more reliable test than any trial conducted on a few hundred people over a few weeks. Remedies that did not work would have been forgotten long ago. The third objection is that healing rituals are unscientific. Yet modern medicine now accepts that belief and trust contribute to healing through the placebo effect. If a ritual helps a patient recover, it is doing its job.

There is also an argument from dignity. For more than a century, missionaries, colonial administrators and, later, the state have treated indigenous healing in the north-east as superstition. Recognising healers is an act of respect for Khasi culture and knowledge, and a corrective to that history.

What should be done

I propose that the NHM in Meghalaya register traditional healers who are recognised by their communities, and assign them defined responsibilities (Table 1). Healers would act as the first point of contact for fever, cough, injuries, pregnancy care, chronic disease and mental distress, and would refer to the formal system when their own treatment did not succeed. They would be paid from NHM untied funds on the same basis as ASHA incentives. Because healers already have the confidence of the community, no formal training would be required, although they could be invited to attend ASHA meetings.

Table 1. Proposed responsibilities of Khasi healers recognised as frontline providers.

Area	Proposed role
Fever	First-line treatment with herbal remedies; refer if fever persists beyond 7 days
Cough and chest complaints	Herbal treatment; refer if cough persists beyond 4 weeks
Bone fractures and sprains	Setting and splinting by bone-setters; no referral required
Pregnancy and childbirth	Antenatal herbal care; attendance at home births with referral for complications
High blood pressure and diabetes	Dietary and herbal management; refer if symptoms develop
Mental distress	Counselling and ritual healing
Payment	Fee per consultation from NHM untied funds, matching ASHA incentives

Proposed by the author.

This proposal would cost little, would bring care to every village immediately, and would respect the wishes of the people. It would also free doctors and nurses at health centres to concentrate on emergencies and complicated cases. Above all, it would build the health system on the foundation the people of Meghalaya have already chosen.

The healer outside my village does not need our permission to keep serving her community. But she deserves our recognition. The NHM should give it.

Competing interests. The author's family includes practising traditional healers.

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