FLAME UNIVERSITY

DISCOVER INDIA

dava aur dua

Confluence of Science and Spirituality

Dava aur Dua: Confluence of Science and Spirituality

DISCOVER INDIA PROGRAM

2018

November 2018

CERTIFICATE

This is to certify that the work incorporated in this report entitled “Dava and Dua Program:” submitted by the undersigned Research Team was carried out under my mentorship. Such material as has been obtained from other sources has been duly acknowledged.

Sr. No	NAME OF THE STUDENT	DESIGNATION	SIGNATURE
1	Abhay Budki	Group Leader/Videography team	
2	Aditi Raman	Videography team/Creative team	
3	Ashwin Thiruvillakkat	Finance/Logistics	
4	Dhara Moray	Content team/Creatives Team	
5	Helena Baby	Finance/Creatives Team	
6	Hiranshi Mistry	Content team	
7	Prapti Ajmera	Content team	
8	Rohan Pasad	Finance/Logistics	
9	Ruchi Bhutada	Content team	
10	Sautrik Mukherji	Videography team	
11	Savitha Ganesh	Content team	
12	Sidharth Bhasin	Content team	
13	Stuti Mehta	Content team	
14	Tanya Tono	Content team	

Faculty Mentor: Dr. Sairaj Patki

Signature:

Date: 24th November 2018

TABLE OF CONTENTS

Title	Page Number
Acknowledgements	i
Abstract	iii
List of Tables	iv
List of Images	v
List of Charts	vi
1 Introduction	1
1.1 Introduction	1
1.2 Historical Background	3
1.3 Current Scenario	4
1.4 Rationale, Research Statement and Objectives	7
1.4.1 Rationale	7
1.4.2 Research Statement	8
1.4.3 Research Objectives	8
1.5 Methodology	8
1.5.1 Research Design	8
1.5.2 Sampling	10
1.5.3 Limitations of data collection tools	11
2 Literature Review	12
2.1 Mental Health and Treatment in Gujarat	12
2.2 Operations of the Dava and Dua Program (DDP)	16
2.3 Relationship between FBHs and AMPHs	18
3 Systems and Processes	20
3.1 Functioning of the Dargah	20
3.1.1 Familial relationships	20
3.1.2 Administration division and power dynamics	21
3.1.3 Rituals and treatment procedures	23
3.2 Functioning of the Clinic	27
3.2.1 Structure and hierarchy	28
3.2.2 Process of treatment	30
3.3 Functioning of the Dava and Dua Program	33

4 Attitudes and Perceptions	35
4.1 Clinic through the Eyes of the Dargah	35
4.1.1 Prevalent skepticism	35
4.1.2 Clinic's utility according to the dargah	36
4.2 Dargah through the Eyes of the Clinic	37
4.2.1 Perceptions of superiority	38
4.2.2 Exposure and conflicting opinions	39
4.2.3 Maintaining a relationship	40
4.3 DDP Through the Lens of the Local Community	41
4.3.1 The specifics of Unava village and other observations	42
4.3.2 Influencing factors	43
4.3.3 Perceived unity of the Dava and Dua aspects	44
4.4 Alliance of the Dargah and the Clinic	46
4.4.1 Linking the two factions	46
4.4.2 Current state of the alliance	47
5 Conclusion	50
5.1 Dava and Dua Program: A Coexistence	50
5.2 Relevance of the Study	51
5.3 Limitations of the Study	52
5.4 Suggestions	53
References	55
Appendix	57
Glossary	64

ACKNOWLEDGEMENT

Over the course of our research project, many people have constantly supported us. They need to be thanked for their huge contributions with the help of which we got the opportunity to get enlightened, and enriched in an overwhelming corner of our rich multifaceted country.

To begin with, we would like to thank FLAME University, Dr Dishan Kamdar, the Vice-Chancellor, Dr Virendra Sharma, the Registrar, and Dr Santosh Kudtarkar, the Dean of Liberal Education for giving us the opportunity to partake in the Discover India Program. We are also thankful to Prof. Ravikant Kisana, Chair DIP 2018 and Prof. Nidhi Kalra, Co-chair DIP 2018, and the entire Discover India Program committee whose guidance permitted us to conduct our research in the best possible manner.

All we have is immense gratitude for Dr Sairaj Patki, our faculty mentor for giving us an insightful topic in the first place. Under his tutelage, we got encouraged to work in synergy. He patiently guided us on all fronts of research while giving us our spaces for learning too. We would also like to thank Mrs. Tejashree Thakar, our field observer, for teaching us the systematic and ethical ways to conduct research with a sensitive topic like ours. Furthermore, our research scholar, Rhea George, has been nothing but helpful right from the beginning and we are indebted to her for all the help she has provided.

We felt blessed to have the support of Ms. Sabah Siddiqui, a researcher and author, who had studied DDP before. She was in the loop with our study right from the start, and willingly helped us by providing perspectives and vision of the place before the on-field week. Her instructions and suggestions were vitally helpful. She unhesitatingly agreed to visit our campus to meet us personally once she returned from the UK to know about our experiences and study.

We extend our appreciation to Mr. Milesh Hamlai, Head of The Altruist, Ahmedabad to help us arrange our permissions' papers in the right manner which assured no restrictions on-field. Similarly, we would like to thank his staff in Unava: Ms. Saraswati, Ms. Asha, Ms. Mittal, Mr. Pankaj, Mr. Chirag, and Mr. Mayank. We thank the Chairman of the *dargah* Sayed Varis Ali Ahmed Ali or Varis Miyan, as we fondly called him, for giving us the liberty to interview the *sawwalis* of the *dargah*, and also passing on the blessings of Mira Datar for the success of our project. Their assistance in introducing us to their patients, their work culture, and sharing information of their development and other

inaccessible data will remain unforgotten. Dr Chandrakant Parmar, former counselling psychologist at DDP, who extensively had worked in Unava before also lent a helping hand. Although, our conversations always happened over calls, he kept in touch with us on field and ensured that we were given all help that we wanted from his past colleagues. We are grateful to him for that.

Finally, we are greatly indebted to the people of Unava for sharing their stories, and giving us a seven-day long, enchanting glimpse into their lifestyles. Safwan Miyan and Usman Miyan, the *mujavars* at Sayyed Ali Mira Datar Dargah and Rasti Amma ka Dargah (Palli) respectively, walked around the place with us like our shadows. We thank them for their energetic support. Moreover, our note of thanks will be incomplete without the patients of the clinic and the *sawwalis* of the *dargah* for giving us the consent to record their answers on how they are coping up with the troubles in their life, a particularly hard thing to talk about.

We intend to thank everyone above, and whomever we unintentionally missed to acknowledge. Without them, our research would not have reached this far, and we would not have got the opportunity to meet the vastly fascinating people we met.

ABSTRACT

The Dava and Dua Program (DDP) emerged from the Supreme Court's mandate to have a medical facility dealing with mental illness at all sites of faith healing. This program sought to combine the practices of faith healing with allopathic treatment, making it a unique initiative. The *dava* side of the program is handled by a non-governmental organisation called Altruist, whose clinic is now set up right across the famous Hazrat Saiyed Ali Mira Datar Dargah. The *dargah* is situated in the village of Unava, Gujarat. The program operates and advertises itself as a 'confluence of science and faith'. The question arises as to whether such a confluence truly exists in practice, and if so, what is the nature of this confluence.

The report includes pre-existing literature that has attempted to comprehend the complex intricacies carved into the program. To comprehensively compare and evaluate this literature in relation to our primary data, the research covers three important aspects that create the daily functioning and practices of the DDP. These aspects are the systems and processes of the *dargah*, clinic and the DDP, the attitudes and perceptions of the two structures and the surrounding village, and the alliance between the faith-based healers and the allopathic mental health practitioners.

On inspecting the aforementioned aspects, it is evidently clear that the *dargah* and the clinic provide two mutually exclusive services. Those operating in the clinic and *dargah* are hardly exposed to one another. The confluence that the DDP had attempted to manifest has not been fully realised and it has proved to be very fragmented in its functioning. By exploring the reasons for such fragmentation, this particular piece of research highlights the current status of the DDP with reference to its technicalities and challenges of implementing such a confluence. Certain suggestions on how to possibly improve upon the drawbacks of such a collaboration have been put forward.

LIST OF TABLES

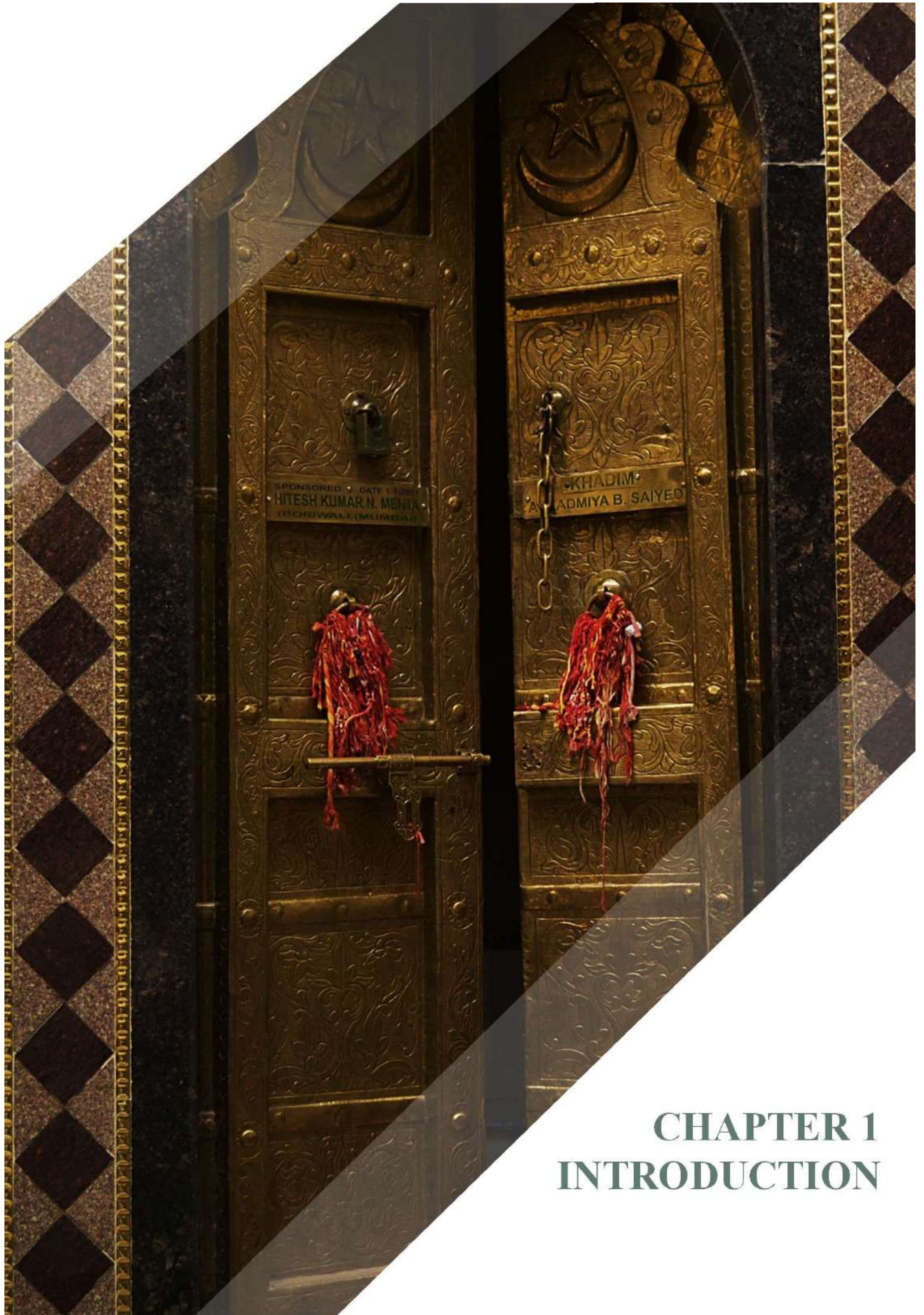
Table Number	Name of Data	Page Number
1	Sample Size	11
2	Gujarat's Mental Health Scorecard	12
3	State-wise distribution of patients	32

LIST OF IMAGES

Image Number	Caption	Page Number
1	Dava and Dua staff office	5
2	Safwan Miyan, a *mujavar* at the Mira Datar Dargah	21
3	A patient chained at the Mira Datar dargah	25
4	Lobaan at the Mira Datar Dargah	26
5	Mr.Dinesh bhai, a former patient, now an employee at the clinic	30
6	Mira datar dargah from the window of the clinic	38
7	Yatin Bhushan, psychiatrist at the Dava and Dua clinic	41
8	Street of Unava	42
9	Mayank Patel, former patient, now employee at the clinic	46
10	Usman *Miyan,* a *mujavar* at the Mira Datar dargah	50

LIST OF CHARTS

Chart Number	Chart Title	Page Number
1	Dava Dua clinic footfall	6
2	Illness-wise distribution of patients at Dava and Dua clinic	7
3	Organisation structure of Dava and Dua clinic	28
4	Patients referrals to the clinic	49



CHAPTER 1
INTRODUCTION

Step into a space

of colliding spirits

and listen carefully

as their mournful verses

flow rhythmically,

and

echo ceaselessly

amidst the collapsing souls.

Here,

tragedies dictate miracles.

Indeed, there exists

a silent desperation

but underlying it all

is a strange fascination

which grips all those who

step into this space

of unspoken mysteries

drifting into surrealism.

Here,

we can all

dream in

colourful disharmonies.

1.1 Introduction

India's healing tradition has a long and dynamic history, with physical and mental treatment methods from every major religion and belief system being offered. Vedic verses (especially that of the Atharva Veda), healing practices involving purges and surgeries of the Buddhist monastic culture, Ayurveda, Persian and Arabic Ayurvedic forms, the Arabic healing system of Unani, homeopathy, Siddha, allopathy - all of these have served as recognised healing methods, and many still find an audience today. Western allopathic healing was brought in alongside colonialism, with the first ever medical institution in India established in 1664, and the earliest mental hospital introduced in Bombay in 1745 (Singh, 2010).

Over the years, these systems of healing have been observed as existing largely independent of each other. While there have been instances of integration where certain aspects of a particular healing system have been incorporated into another, it has merely led to variation within and new forms of that tradition; collaboration between different systems, as entities unto themselves, is rare. These healing traditions have operated parallely, with scope for practices crossing over but rarely for mutual acknowledgement and referral (Siddiqui, 2016).

The Saiyed Ali Mira Datar Dargah has a slightly different story to tell. Located in Unava, a village in the Mehsana district of Gujarat, the *dargah* has a rich 500-year history of faith-based healing. One can find people of all backgrounds here, visiting the holy space in the hope that their ailments - which range from schizophrenia to difficulties in their career - may be cured. About ten years ago, however, a new dimension of healing was added to the milieu of this shrine: a psychiatric clinic with trained allopathic mental health practitioners (AMHPs) ready to assist any patient from the *dargah* in need of more support. The Dava and Dua Program (henceforth DDP) was thus born, as a unique response to the nationwide need for increasing access to mental healthcare, coupled with the persisting appeal of and belief in mystical faith-healing practices. Originally conceived by the government of Gujarat, this initiative was later carried forward by an NGO named Altruist, which aimed to foster trust between faith-based healers (FBHs) and AMHPs, and train the former to identify signs of mental illness in their patients (Shastri, 2016).

The DDP therefore sees a clear collaboration between two distinct systems of healing that have always had great potential for mutual benefit, even if it has never been explored earlier. It is important to note here, however, that the allopathic and faith-based

systems' partnership is still somewhat limited; they operate largely within their own closed, autonomous units, and the porosity brought on by their alliance is enacted only by a select few who actively support the initiative. To properly explore the daily functioning of the unique space that is the *dargah*, and the clinic associated with it, it is important to highlight the important terms that are used in conjunction with the DDP setup (Siddiqui, 2016).

Faith healing, according to the Indian Journal of Medical Ethics as a method of treating illnesses, mental or physical, through the exercise of faith i.e., belief or prayer, rather than by medical treatment. At the *dargah,* those who carry out the rituals and protocols of faith healing are called *'mujavars'* i.e. the FBHs. In the 21st Century, faith healers have a big role to play in the larger Indian healthcare system; over two thirds of Indians with mental illnesses attribute their ailments to supernatural causes, and opt for traditional faith healing services as their means of healing (Biswal et al., 2017). This statistic clearly shows how people across faiths are looking for spiritual explanations to understand the state of their mental health. Interestingly, many of these people are open to seeking treatment at healing centres that belong to a faith other than their own, a fact that is observed at the *dargah* of Mira Datar as well - about 50% of its visitors are Hindu, despite this establishment being the shrine of a Muslim mystic, where the rituals are of a distinctly Islamic nature (Shastri, 2016).

Allopathic medicine, on the other hand, is a system in which doctors and other trained health-care supervisors treat symptoms and diseases using drugs, radiation or surgery. It is also referred to as conventional medicine, mainstream medicine, and western medicine. The word 'allopathy' is primarily used by homeopaths and proponents of other healing practices to refer to Western healing practices. The term was coined by the father of the homeopathic tradition, Samuel Hahnemann; naturally, the psychiatric clinic at the *dargah* falls under this category (Ernst, 2010).

The literature reviewed suggests that the allopathic branch of healing at the *dargah* is actively trying to bridge the gap between itself and the faith-based system. Involved in constant efforts to sensitise the FBHs to mental illness, the allopathic healers constantly try to find ways of integrating their own practices with the age-old rituals of the shrine. Perhaps this is because mental health is, by nature, an area of healing that allows for a certain level of confluence between systems that might otherwise be different in essence. The fundamental motivation behind our study is to examine the collaboration of scientific thought and spiritual faith, and the dynamics between them.

1.2 Historical Background

Faith in a superior entity has been a part of the human experience independent of organised religion, and it is hence quite natural for people to attribute their fortune (whether good or bad) to the divine. When it comes to the role of faith in healing, however, recent discussions have brought to light the potential power that a positive thought process has in healing the body's ailments. These areas of discourse are at constant risk of derailment, and of getting lost subsequently in the marshes of ideological debate based on one's personal beliefs. Therefore, we will limit ourselves to acknowledging the power that faith has had for the thousands who flock to faith healing as a means of treatment across the world, and the usually life-altering experiences that come with it.

One of the foremost examples that can be considered in a bid to recognize the power of faith-healing is the Mira Datar Dargah. The *dargah* houses the shrine of Hazrat Saiyed Ali Mira Datar, a famed mystic of the Islamic tradition, and has thousands of visitors every day from all over the world. Entry into this *dargah* is open to all and there are no restrictions based on one's religion, caste, or even gender, when it comes to access (Siddiqui, 2016).

Unlike most holy sites which people visit to seek inner peace, the *dargah* is visited by people who are said to be plagued by possessions of *jinns* (a supernatural force which is part of Islamic culture), inexplicable diseases, and black magic. As a result, the Mira Datar Dargah is very popular among potential patients, second only to Hazrat Khwaja Syed Moinuddin Hasan Chishty Garib Nawaz Dargah located in Ajmer (Dava and dua, n.d).

The reason why this particular *dargah* has garnered so much importance for faith healing perhaps lies in its origin, and the legend surrounding it. It is important to note that this story has been passed down orally across generations and was formally documented only recently:

Hazrat Ali came from a family of military commanders, in the army of Sultan Ahmed Shah, the founder of Ahmedabad. Deemed special since childhood, Hazrat Ali performed miracles and helped people all his life. At the age of 18, when he was about to get married, Hazrat Saiyed Ali was informed of a cruel sorcerer-king in a neighbouring kingdom, who would lock his subjects up in cells and sacrifice them every day to increase his own powers. Since the king was a practitioner of black magic, he was considered nearly invincible; Hazrat Ali alone had the power to defeat him. It is said that he left with an army to kill the king and bring his people to justice. On the way to the battlefield, Hazrat Ali planted a small Miswak stick by a pond in Unava and announced to onlookers that if he

died in battle, this is where he should be buried. When asked how people would know of his martyrdom, he declared that it would be the day the Miswak stick would turn into a tree (The possessed of hazrat saiyed ali mira datar, 2011).

During the course of the battle that ensued, Hazrat Ali performed miracles which nearly defeated his opponent. Taken aback by this, the evil king tricked Hazrat Ali and beheaded him. However, the saint's body was powerful enough to kill the king and cut off the braid which housed his powers. This mystical end to the saint's life was revealed to his grandfather in a dream, where Hazrat Ali also told him where his body could be found. In accordance with his last order, the saint was then buried under the Miswak tree at Unava. This holy site is where the *dargah* stands today. He was given the title of Mira Datar, the word 'Meera' meaning 'brave', and Datar meaning 'giver.' The victory of Hazrat Saiyed Ali Mira Datar over black magic, his noble actions to bring justice to the people, and his ability to perform miracles might be some of the reasons for this *dargah's* fame (Hazrat Sayed Ali Mira Datar, 2009).

1.3 Current Scenario

In returning to the 21st century, one finds a number of other faith-based healing centres across India, each of which have their own rich traditions history. The center in Erwadi, Tamil Nadu, is another example of such a place. Unfortunately, in 2001, this hallowed centre suffered a massive fire. Twenty-five patients, shackled in chains as part of a ritual, were burnt to death, bringing the practice of faith healing to public attention (Kumar, 2001). The Supreme Court of India ordered all the state governments to protect and ensure care for every mentally challenged person in the state, in an attempt to regulate some of these less-scrutinised practices in India. This led to the conception of the Dava and Dua program funded by the Department of Health and Family Welfare, State Government of Gujarat, under the guidance and monitoring of the Hospital for Mental Health, Ahmedabad (Shields et al., 2016).

In 2007, an NGO named Altruist entered the equation, taking over DDP. An Ahmedabad-based organisation, Altruist works towards promoting mental health among citizens through various initiatives of which the DDP is a major one. For a year, this clinic attempted constant communication through awareness programs with the *dargah,* in order to the ease the FBHs into a partnership with Altruist. The result was the setting up of a

clinic within the *dargah* premises. This proximity however, only exacerbated tensions between the two bodies (*dargah* and clinic). In 2012, the clinic was moved across the street from the *dargah* (Siddiqui, 2016).

(Image 1: Dava and Dua staff office)

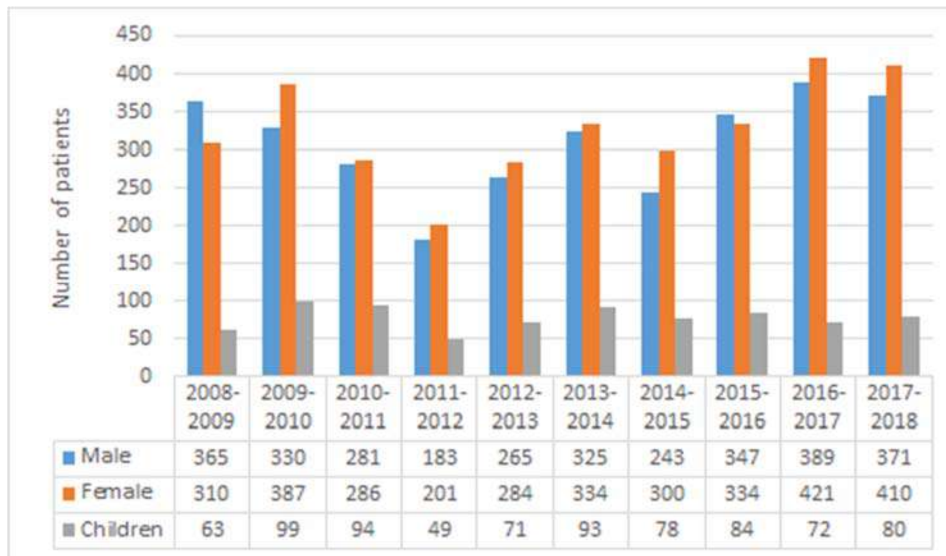
And yet, the rare coming together of science and faith under DDP has created an entirely new approach to helping people afflicted by mental illness. The program sees patients initially consult with FBHs, who go on to ‘heal’ their patient through rituals relevant to his/her ailment. The FBHs have also been trained by the psychiatrists to identify tell-tale signs of common mental disorders. Upon noticing any of these signs the FBHs is likely to refer their patient to the out-patient clinic, located right outside the *dargah*, where they then receive allopathic treatment for their ailment. The main objectives of the program - to promote mental health awareness and increase access to novel mental health services to visitors of the *dargah*, and its surrounding community - are thus fulfilled (Dava and Dua, n.d).

Altruist has maintained a database of their progress over the 10 years of the clinic’s existence. According to their collation of data[1], they have managed to help over 7,500 people. Table 1.1 shows the annual footfall of the clinic since its inception. The clinic does

[1] This database was acquired on field, from the DDP database which refers to the patients related quantitative data as recorded by the clinic in Unava.

not just get patients from the *dargah*, but numerous people come to them of their own accord. The patients are also belonging to various regions of Gujarat and come from other states as well.

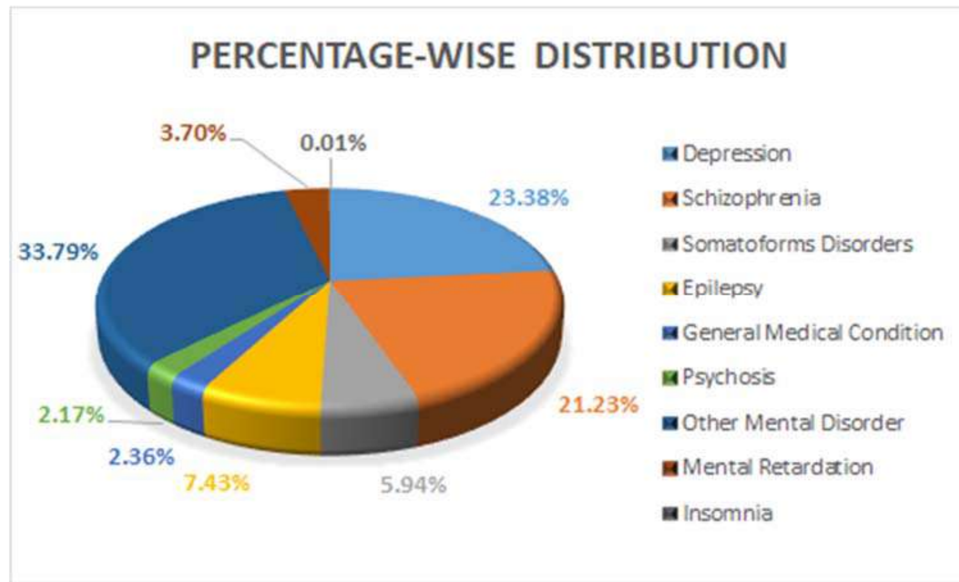
Chart 1: Dava Dua clinic footfall



	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
Male	365	330	281	183	265	325	243	347	389	371
Female	310	387	286	201	284	334	300	334	421	410
Children	63	99	94	49	71	93	78	84	72	80

These people suffer from various diseases which the clinic has helped them for. Table 1.2 lists the various illnesses that the clinic has treated so far. They have also been conducting various awareness campaigns in Unava to make sure that the locals can identify at their level whether someone in their surrounding is suffering from a mental illness and ensure that these people get proper treatment.

Chart 2: Illness-wise distribution of patients at Dava and Dua clinic



1.4 Rationale, Research Statement and Objectives

1.4.1 Rationale

India is a country with a staggering 100 million people suffering from common mental disorders and almost 20 million suffering from severe mental illnesses. Despite such numbers, mental illness has been sorely neglected in the country, as it is rooted in stigma, taboo and myths. The stigma surrounding mental illness and lack of awareness on the subject has prevented millions from getting access to the help they need. Additionally, the scenario is worsened when mental illness is attributed to be a result of a curse, demonic possessions or earned karma for misdeeds in past lives. Hence, when people believe that mental illness is self-inflicted, and derived from one of the aforementioned factors, they would prefer to refer the patient to an FBH over an AMHP. Furthermore, since there is a grave shortage of AMHPs with only about 5000 psychiatrists in the country, the need for alternative sources of treatment becomes a more compelling argument. This gap between the number of psychiatrists available and the alarming rate of people suffering from such mental illnesses has been bridged by some of the faith healers from India's diverse religious backgrounds (Singh and Lahiri, 2010).

The Dava and Dua Program is considered to be the first of its kind in the country. This study therefore provides an opportunity to analyse how the two drastically different approaches to treatment do not have to stay isolated from one another but can be integrated for effective results. Thus, the research conducted will provide insight into the functioning

of this unique model, and may even be applicable for the purpose of replicability of the same to other regions.

As previously mentioned, a five-year gap in the literature available has been observed. There is scarcity of recent information about the functioning of the program, the alliance between both sets of healers, and quantitative data of the program from 2013-18. The research undertaken will help cover this blind spot.

1.4.2 Research Statement

To study the functioning of the Dava and Dua Program 10 years after its inception.

1.4.3 Research Objectives

The principal objectives for this study are:

- To investigate the current systems and processes put in place for the effective functioning of the Dava and Dua Program. The roles and responsibilities of the two key institutions - the Altruist and the Mira Datar Dargah- as well as the process that they employ to treat patients;
- To examine the alliance between the Allopathic Mental Health Practitioners (AMHPs) and Faith Based Healers (FBHs);
- To understand the attitudes and perceptions of the various stakeholders in the program which primarily include the AMHPs, FBHs, patients and their families as well as the residents of Unava (especially those residing in the immediate neighbourhood).

1.5 Methodology

1.5.1 Research Design

To gather relevant as well as elaborate information, the study used a mixed methods approach which included both qualitative as well as quantitative methods. To understand all the facets of the program, there were three major groups of people that needed to be

interviewed, and the on-field team was accordingly divided into three sub-groups: the *dargah* team, the clinic team, and the village team.

Qualitative method

Qualitative method was used throughout the research to gain a better understanding of the program. It was used to understand and examine the attitudes of all the stakeholders towards DDP, as well as to obtain a sense of what the AMHPs and FBHs thought of their alliance. It was also employed to find out the various systems and processes that both the institutions have, independently as well as together. The tools that we used for the same were:

1. Semi-structured interviews: All the interviews were conducted using a semi-structured interview format, as it gave the freedom to alter questions based on the kind of responses given. These prove extremely useful as the responses gave way to themes that had not been predicted while creating the questionnaire, and therefore could be further pursued. The questionnaires were initially written in English, but to ensure that they could be effectively used on field they were translated into both Hindi and Gujarati. The Hindi translation was done by Dr. Swati Nalawade, faculty at FLAME University, and the Gujarati translation was done by Dr. Viraj Shah, also a faculty at FLAME University. All the English questionnaires are present as Appendix A.

2. Non-participant observation: Observation was a crucial tool that was employed to gather information about the program as a whole. It assisted in substantiating the information that was procured from the interviews as well as filling some of the gaps present in the interview responses. The chart used to make a note of the different kinds of responses is present as Appendix B.

Most importantly, before conducting any interview, proper informed consent was obtained from each participant. The consent forms were devised based on the informed consent form template for qualitative studies by the WHO Research Ethics Committee. They were also translated in Hindi to ensure higher usability. The consent form is present as Appendix C.

Quantitative method

Quantitative data was essential to study the systems and processes of DDP. The raw data was taken from the DDP database, which was then analysed post-field. Not only did this analysis provide insights about the system, but also backed up the qualitative information

extracted to some extent. This also covered the lack of quantitative data present in the existing literature. It must be noted, however, that this information was procured from the database of the clinic, and therefore was limited to information about the clinic alone. It included the number of patients who had come to the clinic since its inception, distribution of patients based on their age, gender, and region of origin, the types of illnesses they treated, and referral information.

1.5.2 Sampling

To understand and be inclusive of all the aspects of DDP, our sample comprised of the following:

1. Allopathic Mental Health Practitioners: they are the psychiatrists/psychologists who work in the clinic opposite the *dargah* and work in coordination with the FBHs or *mujavars*.

2. Clinic employees: these are all the other members of the staff in the clinic/office such as the manager, data processor etc.

3. Faith Based Healers: specific to the *dargah,* faith based healers are referred to as *mujavars.* These *mujavars,* who perform rituals in the *dargah* to relieve patients of their ailments, also work in coordination with the psychiatrists.

4. Patients: specific to the *dargah,* patients are referred to as *sawwalis.* These include the people who have been, or are being, treated at the clinic and/or the *dargah.*

5. Family of the patients: these include the family members or caretakers of the patients who come to the clinic and/or the *dargah*, and stay with them for the duration of the treatment.

6. Residents: these are the people residing in the neighbouring communities of the *dargah*, including business-owning individuals, who may have been directly or indirectly affected by DDP.

The sampling technique varied for each sub-group. The clinic team used purposive sampling, the *dargah* team used purposive as well as convenience sampling, and the village team used convenience and snowball sampling. The sample sizes for each demographic are

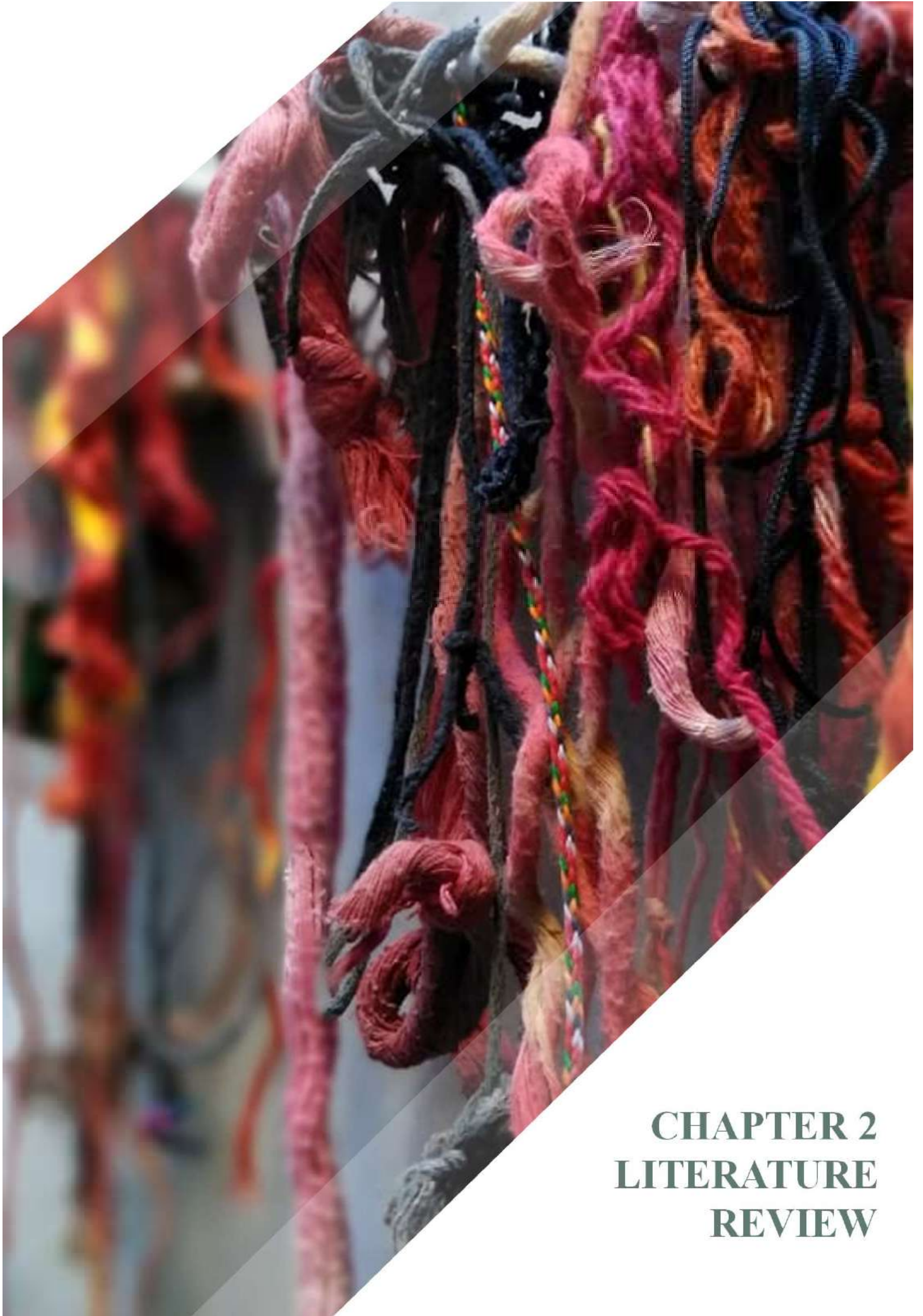
present in table 1. Only those who signed the consent forms were included in the sample size.

Table 1: Sample size

Sample Category	Sample Size
Allopathic Mental Health Practitioners	4
Clinic Employees	4
Faith based healers	6
Patients	4
Family of the Patients	1
Residents	50

1.5.3 Limitations of data collection tools

One of the limitations of the data collection tools was that the questions did not take religion or caste into consideration with respect to the attitudes and opinions of people about the *dargah*. Another limitation was that a questionnaire is not a standardised psychometric tool and therefore may not always yield accurate responses. To overcome this, non-participant observation methods were employed, and a sheet was created to record all observations.



CHAPTER 2 LITERATURE REVIEW

2.1 Mental Health and Treatment in Gujarat

The state of mental health awareness, the policies regarding mental health, and gaps in treatment of mentally ill patients in Gujarat have been captured through a combination of detailed surveys and research papers. India suffered a dearth of information on mental health at the national and state levels, which resulted in the creation of the 'National Mental Health Survey of India (2015-16)'. Accordingly, the Ministry of Health and Family Welfare (MOHFW) instructed the National Institute of Mental Health and Neuro Sciences (NIMHANS) to conduct a National Mental Health Survey (NMHS) for a sample population that was representative of the entire nation. The NMHS was undertaken and compiled over the course of two years (2014-16) in 12 states across six regions of India, with mental health and public health professionals comprising each state's investigative team (Gujaran et al., 2016).

The NMHS also created a subsidiary in the form of the State Mental Health System Assessment (SMHSA). This has been described as "a systematic and comprehensive analysis of components and sub-components of health systems that cater to the delivery of mental health services at the individual state level". The NMHS document (2016) also examines and analyses the state of mental healthcare in India on various parameters, including but not restricted to estimating treatment gaps, examining priority mental disorders and assessing resource utilization (Gujaran et al., 2016).

At the end of the survey, each of the 12 recorded states were provided with a 'Mental Health Score Card', according to which Gujarat and Tamil Nadu stood out as pioneers of mental healthcare in India. The following table has been derived from a bar graph present in the survey, and outlines Gujarat's performance in the survey (Gujaran et al., 2016).

Table 2: Gujarat's Mental Health Scorecard

Category	Score
Mental Health Policy	10/10
Mental Health Action Plan	8/10
State Mental Health Coordination Mechanism	7/10

Budget for Mental Health	7/10
Training Program for Mental Health	5/10
Availability of Drugs	5/10
IEC Materials and Health Education Activities	5/10
Intra and Intersectoral Collaboration	8/10
Implementation status of Legislation	7/10
Monitoring	7/10

Despite there being extensive data for the state of Gujarat, the DDP is merely mentioned in one page of the 145-page document. The survey states that as of 2014: 376 *mujavars* have been trained to identify mental health problems; more than 40,000 persons with mental illnesses from 12 states have received treatment; the *mujavars* refer an average of 10 patients per month to the allopathic mental health practitioners. A side-note mentions that the chaining of patients has significantly reduced, while an overall improvement has been sparked in communities with regard to the perception of mental illness (Gujaran et al., 2016).

The information provided by this survey on the state is indispensable; in order to understand the context in which the DDP continues to operate, Gujarat's mental health environment cannot be ignored. The statistical information on the DDP, on the other hand, is scarce (Gujaran et al., 2016).

On a more micro-level, the Satisfaction-Expectation Rapid Survey or Project SERAS (2011), is a Gujarat-centric survey conducted in collaboration between the Altruist in Ahmedabad and ACMI in Bangalore. The purpose of this survey was to improve the "lifeless" reports under the District Mental Health Programme (DMHP) with first-hand experiences. While the document does not succeed in surpassing the in-depth analysis (on Gujarat) of the NMHS, it does form a case-study on the DDP under the district of Mehsana. The survey cites the DDP to be a strong motivation for them to work with the Altruist, as the NGO single-handedly manages the entire program (Hamlai & Srinivasan, 2011).

The document proves to be a more valuable resource as compared to the NMHS with regard to the DDP, by setting the geography in place; it states that Unava is a village situated five kilometres from the main city of Unjha. In Unava, there are no provisions for persons with mental illnesses, merely a cottage hospital. For a 25 kilometer radius with the DDP at the center, there is not a sight of psychiatric practitioners, thereby signifying its importance and necessity to the local community (Hamlai & Srinivasan, 2011).

The survey was further informed through interviews with six (acknowledged) caretakers and six (anonymous) users in the DDP. Despite presenting a considerable and balanced sample size at Unava, it must be noted that the DDP was merely an addition to the primary study of SERAS. The survey was predominantly a study of the Banaskantha district, specifically in the talukas of Deodar and Vadgam. Hence, though the sample size was respectable, there was not much importance given to the scope and quantity of questions asked. Furthermore, it asks just four questions, which is insufficient to make any significant conclusions about the DDP (Hamlai & Srinivasan, 2011).

This piece of literature, hence, does definitively offer more information and statistics about the Dava and Dua Program in comparison to the NMHS. It offers a micro-view of the large state of Gujarat, while loosely focusing on the DDP based in Unava. However, there are numerous gaps which present themselves if SERAS is used to understand the DDP. Due to the nature and number of the questions, it does not even offer a clear picture of the program's situation over a small period of time, much less its evolution over a decade. Furthermore, the document is more aged than the previous survey, as it is from 2011. The SERAS report also avoids delving into the types of mental illnesses which are treated at the DDP and fails to provide any demographic data – the locations from which the persons with mental illnesses visiting the DDP travel.

Lastly, "Perceptions of Traditional Healing for Mental Illness in Rural Gujarat" (2014) studies the practice of traditional faith-based healing in the rural regions of Gujarat. As the DDP is based on the idea of synergy between allopathic healing and faith-based healing, this research paper is a fine chronicle of the manner in which the state's rural populace perceives this ancient Indian practice. This would consequently offer a stronger base for comprehending the DDP and its functioning in Unava. As mentioned in the abstract of the paper, the study's aim was to determine the view of patients and their families toward faith healing for mental illness; furthermore, the paper focuses on the type of interventions received, and overall satisfaction with the healing process (Schoonover et al., 2014). It is

necessary to note that minor, yet important mentions of the DDP, are made towards the very end of the research paper.

Delving into the findings of this research, the paper notes how subjects treated by both a doctor and a healer reported they would strongly recommend the former. The motivation behind this overwhelming preference can be clearly understood; almost all subjects who were treated with medication recognized a gradual improvement in their condition. Additionally, many also felt that healers are not effective for mental illness or are dishonest and should not be used. However, there were also a resounding number of participants who felt that traditional healing could be beneficial for a 'troubled soul' (Schoonover et al., 2014).

Upon closely examining this paper, it is clear that the study's subjects were largely dissatisfied with their experience with traditional healers. Nonetheless, there have also been strong indicators and instances that prove traditional healing is still a common first-line practice in Gujarat, not only for mental and physical illness but also for help with general life problems (Schoonover et al., 2014).

The research in this paper is from the end of 2013, while the DDP has been running for five years since then. An obvious gap is that the changes in perceptions of various stakeholders of the DDP in the remaining timeline have to be studied, and data has to be collected. Additionally, the primary gap and an important rationale behind studying the DDP's existence over the past decade, has been offered at the end of the research paper:

"A study of the effectiveness and patient satisfaction of this collaboration would be very helpful in determining whether this method might be a key to providing better access to psychiatric care and quality of care in rural India." (Schoonover et al., 2014).

These four pieces of literature proved to be instrumental in understanding the current space of mental health in Gujarat. There is very little research or information offered on Unava's Dava and Dua Program, neither qualitative nor quantitative, but the collection successfully establishes the sphere in which the program functions. One of the primary gaps that are to be addressed while studying the DDP's evolution, is the datedness of all the documents reviewed. Additionally, a very clear-cut rationale is offered at the end of the second research paper reviewed.

2.2 Operations of the Dava and Dua Program (DDP):

The DDP commenced as a collaboration between the *mujavars* of the *dargah* and AMHPs. Famed for its spiritual treatments of those affected by mental and physical problems, the Mira Datar Dargah adopted a holistic approach in curing mental health ailments in 2008. The collaboration encouraged the *mujavars* to assess the clients behaviour and reactions to the spiritual rituals, based on which a decision was to be taken- whether the client was suffering from problems involving the supernatural (i.e. symptoms of possessions and trance) or not- which suggested that if they reacted negatively to the faith based techniques and rituals, then they were referred to AMHPs as it was evident that these clients were facing some mental illness. In this regard, the *mujavars* took upon the role of gatekeeping, as well as identifying symptoms of various types of illness (Shields et al., 2016).

The *mujavars* were able to recognize these symptoms as a result of substantial training and sensitization workshops. They were trained to appropriately refer the clients to AMHPs when required, once the symptoms had been identified. The *mujavars* were also made to attend follow-up training sessions as well as lectures on sensitivity towards mental health. However, it was maintained that referral to AMHPs by the *mujavars* was to be optional and not mandatory, which facilitated the smooth functioning of the program as a result of mutual respect. Clients were to come in contact with the *mujavars* first. This ensured that those clients who might have gone undetected by the psychiatric health system were not ignored. (Shields et al., 2016). If the clients were referred to the AMHPs, they were provided with psychotropic medication prescribed by psychiatrists, and counselling (such as active listening and giving advice) from social workers. In this manner, allopathic care was presented along with the spiritual rituals carried out by the *mujavars* . A holistic treatment such as this usually required 40 days in order to notice any results (Shields et al., 2016).

The program, initiated by the AMHPs, was nowhere close to being hassle free. A major problem faced by the AMHPs was the lack of certainty and hesitation of the *mujavars*, who feared that their territory was being trespassed on and their livelihood was at risk. It required repeated visits to the *dargah* and several attempts at communication to establish trust that the AMHPs would not impose on the *mujavars* work (Shields et al., 2016). It was recorded that even some of the AMHPs initially had their own doubts regarding this collaboration. The apparent gap in the societal status between the two professions posed as a hindrance. However, this hesitation on both parts was gradually

resolved as they started building rapport with each other. This was achieved through the use of a shared, unified vision – the outcome must benefit the client. Eventually, quite a few *mujavars* referred their own family members and relatives to the AMHPs to fasten the recovery process. Quantitative data collected from the Altruist database showed that over a 5-year period (2008–2013), the *mujavars* referred almost 60% of the 3,172 clients who visited the *dargah* for consultation (Shields et al., 2016).

In the study by Shields et al. (2016), findings showed that there was no discrepancy between the usage of the program between men and women. The mean age recorded for clients was 34.95 and a majority of them (73.9%) were married. It is interesting to note that almost 95% of the clients used in this study lived with their immediate family. Although almost half of the sample had completed their primary education, 30.5% (which is nearly a third) of the sample was illiterate. There were no differences in the religious backgrounds of Hindu and Muslim – the sample turned out to be equally divided. The proportion of clients from rural areas accessing care at the DDP was approximately equal to those from urban areas. After the consultation, the diagnosis of clients by the AMHPs was done with the use of ICD-10 diagnostic criteria and was recorded in the DDP database. The most predominant illnesses that afflicted the clients can be placed into 3 categories – schizophrenia and schizoaffective disorders (27.5%); neurotic, stress-related, and somatoform disorders (24.2%); and mood disorders (24.2%) (Shields et al., 2016).

Qualitative data was collected through semi-structured interviews with three AMHPs, three *mujavars*, three clients and seven relatives of the clients. In all of the samples, men were overrepresented. Clients and their relatives felt positively about the outcome of the program. They believed it to have benefitted them directly by improving their mental health, as well as indirectly by restoring their livelihood. The free cost of the program also helped in attracting and satisfying clients. This characteristic also aided in reaching out to those affected by poverty and were unable to afford appropriate medical care (Shields et al., 2016).

The nature of the DDP is such that it does not force any beliefs of its own on its clients. It considers the beliefs of clients to be as important as modern psychiatric practices and does not grant them as mutually exclusive choices. Shields et al. (2016), from their findings, concluded that this was a major aspect that kept both the *mujavars* and clients happy. However, there were a number of limitations involved in the study. An element of social desirability could have been present in the interviews, and the nature of the sample size is small, which makes it difficult to generalise the results. (Shields et al., 2016).

2.3 Relationship between FBHs and AMHPs:

For the last five and a half centuries the Mira Datar Dargah has maintained its reputation of being able to alleviate psychological ailments and has come to be recognized primarily for its curative powers in the realms of black magic and the occult. The members of the *dargah*, from the private trust to the *mujavars* and attendants (*khadims*), are not employees but individuals who have a deep vested interest in the *dargah's* powers. What makes this connection between man and *dargah* so intimate is the fact that all the family members are descendants of Mira Datar's elder brother. Each member is responsible for the *dargah* and in ensuring that Sayyed Ali's work and teachings are successfully passed down (Siddiqui, 2016).

Altruist's involvement with the *dargah* can be traced back to the Erwadi *dargah* fire of 2001 which spawned several debates of human rights violations in similar sanctums. Chapter 1 from Sabah Siddiqui's book "Religion and Psychoanalysis in India: Critical Clinical Practice" (2016) gives in detail the various individuals and organizations involved in petitions with the government. These movements and petitions by activists and civil groups eventually got the Supreme Court involved and the court labelled sites of such nature to be akin to an asylum that treats people with psychiatric disorders. This converted several spaces of worship into semi-medical facilities which fell under the basket of a mental institution. The Mira Datar Dargah was one of the several sites identified as requiring legal and medical intervention in the 2001 directive of the Supreme Court. According to Milesh Hamlai, head of the Altruist, this confluence of science and spirituality was undertaken keeping in mind the livelihoods of faith-based healers and other minor stakeholders such as local businesses (Siddiqui, 2016).

However, when Altruist offered to help in 2007, they faced a lot of backlash from threatened *mujavars*. They saw it as government surveillance and law-keeping disguised as a mental health organization. Altruist had to negotiate with the *dargah* for months before they were allowed to set up a small clinic on the premises in 2008. There were instances where the police had to be brought in after failed negotiations to break the tension and prevent the situation from getting a lot worse. This could have contributed to the *dargah's* dubious attitude toward allopathy, the government, and any beneficial program is not surprising (Siddiqui, 2016).

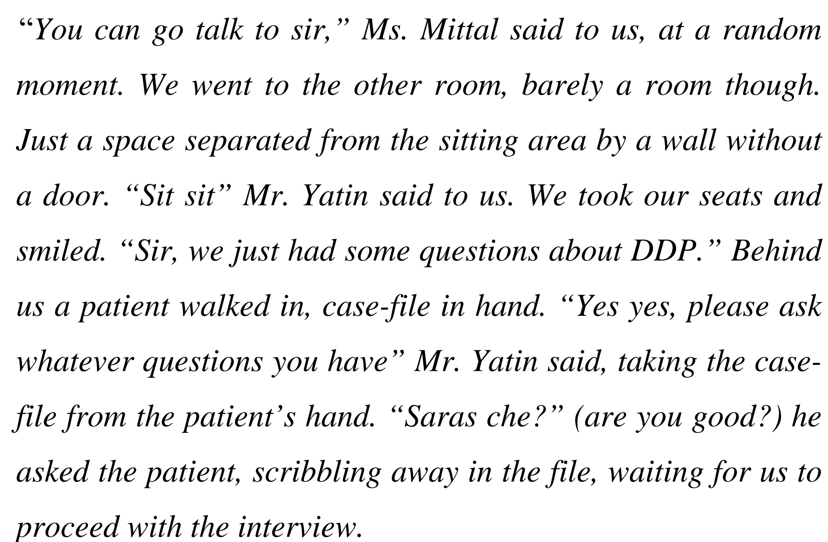
For centuries the *dargah* was independent, functioning according to their tradition. Their rituals and practices are deeply rooted in the *dargah's* history and while their

effectiveness cannot be commented on, the belief in them and their powers are held very closely by the family. They state that while their methods are being labelled as amoral or exploitative by third parties, those very methods have been tried and tested for generations with positive results. Most importantly, the point that ties everything together is the ancestral heritage of the space. The *dargah* is not a part of the family's life, it is their life. It is the responsibility of every one of the approximately 700 family members to take Mira Datar's work forward and keep passing it down as it has been done these last 550 years. The intervention of the State only got them the wrong kind of attention and it was primarily to keep the government away that the *dargah* was strongly against setting up any psychiatric clinic on the premises (Siddiqui, 2016).

The *dargah's* agreement with Altruist and allowing them to set up their clinic, while a remarkable achievement, is by no means proof of fixed relations. As stated by Siddiqui (2016), the relationship between both parties is fragile enough that even a single instance of non-compliance or questioning of the *dargah's* beliefs and practices from the clinic's side could potentially end the program. This strained relation was the reason Altruist had to relocate the clinic in 2012 from the inside of the *dargah* to outside (Siddiqui, 2016).

The program has been a tremendous success, with the Dava and Dua treatment working very well for the patients. They collect medicine from the clinic and proceed to get them blessed over the shrine of Mira Datar. However, the hostility of the *dargah* has prevented the Altruist from looking any deeper into the success of treatments (Siddiqui, 2016) "the relation is of tolerance, not understanding; it is utilitarian, not relational." It can be gathered that though the program has been a success so far, the alliance between the AMHPs and *mujavars* is a purely cool and professional one.

CHAPTER 3
SYSTEMS AND PROCESSES



"You can go talk to sir," Ms. Mittal said to us, at a random moment. We went to the other room, barely a room though. Just a space separated from the sitting area by a wall without a door. "Sit sit" Mr. Yatin said to us. We took our seats and smiled. "Sir, we just had some questions about DDP." Behind us a patient walked in, case-file in hand. "Yes yes, please ask whatever questions you have" Mr. Yatin said, taking the case-file from the patient's hand. "Saras che?" (are you good?) he asked the patient, scribbling away in the file, waiting for us to proceed with the interview.

3.1 Functioning of the Dargah

Mira Datar Dargah, over the course of its history, has established certain systems and methods of functioning. The most important feature in this regard is that it is completely controlled by one single family, which claims descent from the brother of Saiyed Ali Mira Datar (since the saint himself had no children). This is the source of their legitimacy, as the holy mandate has been passed down from generation to generation (Safwan *miyan*).

3.1.1 Familial relationships

All the power is contained within this 700-member family of Mira Datar - from the senior-most chairman to the newest *mujavars*, every individual who holds any significant position in the *dargah* must be from this bloodline. One reason for this controlled power was explained by Safwan *miyan*, a *mujavar* himself.

> "*Datar babu helps everyone. But he will definitely listen to us first. We are family after all. We respect him and he respects us.*" (Safwan *miyan*)

This is the reason often provided by the *mujavars* to not only prove the effectiveness of their treatment, but also to justify their continued presence in the *dargah*. According to the healers, while the saint is benevolent and helps anyone and everyone who steps into his shrine, it is ultimately the *mujavars* who deliver the request to him. The direct ancestry makes it easier for them to be heard by Mira Datar, and also lets the saint function through them. It is the family's duty to serve their miracle-performing ancestor; children born into the family too, are introduced to the life of a *mujavar* at a very early age. It is a common sight to see young boys aged 10 and above blessing people and reciting chants. However, these children do receive primary and secondary education and are not completely bound by the rules of the *dargah*. A few *mujavars* who were interviewed were proud to announce that their children were studying in big cities.

(Image 2: Safwan *miyan*, a *mujavar* at the Mira Datar Dargah)

The *mujavars* claim that there are metaphysical connections between the family and the saint. However, one observation becomes glaringly obvious. Every member in the *dargah*, be it the *mujavars* or authoritative board, is male. No female descendant of the saint with any spiritual calling, is permitted to work as a *mujavar* in the *dargah*. From the 700 family members, about 400 are men, who work as *mujavars* in the *dargah*. There are no women to be found in any positions of power and they are largely absent from this space. There is no interaction between the *mujavars* and the family's women during the day and they are not visible to the general public. However, women do play a role in the workings of the *dargah*, mainly delegated the task of making small souvenirs, stitching the *ghode*, carving talismans or ornaments that are then sold in shops in and around the shrine (S. Siddiqui, personal communication, October 31, 2018).

3.1.2 Administration Division and Power Dynamics

The organisational structure of the *dargah* is centred around the Saiyed Ali Mira Datar Trust. It is the administrative body that occupies the top position of the hierarchical pyramid, and makes the most important decisions. The trust is registered and recognised by the High Court, complete with official documents as proof. It comprises 11 members, one of whom is Varis *miyan*, the chairman of the *dargah*. The chairman is elected annually

by the board. Regardless of these positions in the hierarchy, however, being a *mujavar* is the ultimate duty for anyone belonging to the family, a duty that those with administrative power continue to perform. It is not an uncommon sight, therefore, to see these senior-most members participating in the *dargah's* activities and gladly healing the *sawwalis* who approach them.

The administration is also in charge of the several shops that line both sides of the *dargah's* main pathway. Many of these are owned and operated by *mujavars* themselves, and sell flowers, *lobaan* (frankincense), ceremonial *chaadars*, and a variety of souvenirs and talismans. Some *mujavars* even offer their services through their shops, such as Safwan *miyan* and his uncle, who run a flower and *chaadar* shop next to the main shrine. The administration receives a royalty from every shop, and the amount collected is allocated as funds for the trust. This could explain why the administration has not cleared the numerous illegal shops set up around the *dargah* by locals.

In addition to the *dargah* of Mira Datar, the administrative board also looks after other similar sites around Unava, such as the Mamuji ka Dargah and Raasti Amma ka Dargah. Both of these are shrines dedicated to relatives of the saint - his uncle and mother, respectively - and have rich legacies of their own. The 11 individuals who make up the board also look after various *chillahs* around the country, which are extensions of the *dargah* and are located in places like Pune and Ajmer. They act as smaller consecrated centers where the saint's power extends from the main *dargah* in Unava, and are primarily for extending his help to ecnomically disadvantaged *sawwalis* who have problems of the occult but cannot afford to travel to Unava.

Despite the existence of these structures, it was evident through on-field observation that power was not distributed in such well-defined a manner as the hierarchy might suggest. Several *mujavars* hold self-declared positions of authority without a formal process of election. As a result of this unorganised and spontaneous web of authority, disputes and conflicts have often occurred regarding the power distribution at the *dargah*. Milesh Hamlai, the head of Altruist, mentioned that before undertaking any study it was mandatory to get consent from the chairperson Varis *miyan*. Visitors and patients cannot not approach another *mujavar* once contact with a certain *mujavar* had already been established. This is an important aspect of the power play between *mujavars,* especially regarding monetary issues.

What fuels further conflict are the differences in views regarding the clinic. Some *mujavars* support Altruist's work while others criticise it. There have been cases of

mujavars using the clinic's services to treat their own conditions or have had other family members treated by them. Certain *mujavars* may not have supported any of their family members procuring treatment at the clinic. Different stances over a matter this sensitive have created more inter-familial tensions and disagreements.

3.1.3 Rituals and Treatment Procedures

The Mira Datar Dargah stands colourfully amidst various stalls in the marketplace of Unava. The *dargah* itself is quite a small structure and unsurprisingly, many guest houses and restaurants surrounding the *dargah* have taken a similar name. For instance, a major restaurant called the Datar Hotel which is situated right across from the *dargah*, is run by Varis *miyan* himself. Upon reaching the entrance of the *dargah*, a *sawwali* must remove their footwear and ensure that their head is covered. One can even choose to hand their footwear over to one of the several women sitting outside the *dargah* protecting them for a fee of 10 rupees. Several *mujavars* also own stalls inside the *dargah* space leading to the formation of an ad hoc bazaar. It is evident that the *dargah's* economic reach is not limited to just the *mujavars*, but also includes the locals in the vicinity.

The doors to the compound open at four in the morning until nine in the night after which only *mujavars* are permitted to be within the area. A marble threshold separates the bazaar from the main compound. The *dargah* is in the process of being reconstructed from a concrete to a marble structure with Makrana craftsmanship, stone inlays and a marble dome perched at the top. At the center of this structure is the main shrine of Mira Datar, the final resting place of the saint. The shrine is made out of silver and is bordered with railings to keep the public away from the tomb. Offerings are placed over this tomb and a single rose petal is given to the *sawwalis* to consume. Within this sanctum, women are not allowed. They may stand just outside and can give their offerings from a slight distance but cannot cross the threshold of the shrine. Similarly, there is a part of the compound solely for women and men are not allowed beyond its threshold. One interesting observation upon entering the women's section in the *dargah* is that the position of prayer mats and the Qur'an do not face westwards toward the Kiblah in Medina; it is instead turned in the direction of Mira Datar's shrine (Siddiqui, 2016).

The healing rituals at the *dargah* are performed near the shrine of Saiyed Ali and several *sawwalis* and family members can be seen sitting around the shrine having conversations with their respective *mujavars.* These rituals have remained unchanged since

the last 550 years and it is the *dargah* that recommends the type of healing and its duration which can be between one and forty days. For *sawwalis* that require more attention due to the severity of the illness or curse, the *mujavars* recommend accommodation within the premises of the *dargah* for the entirety of the treatment. A general rule, as aforementioned, and one that absolutely must not be broken is that a *sawwali* cannot approach any other *mujavar* once they have already started a process with one. For the rest of the days, months and even years, that *mujavar* is the only individual the *sawwali* is permitted to contact. It is akin to keeping a doctor constant; they will understand the patient, their history and their problems much better over time.

Moving on to the treatment procedure, before any form of healing can take place, a red thread or *lal dhaagah* has to be held by the *sawwali* and a chant needs to be repeated after the *mujavar*. This recitation is essentially to call out to Mira Datar and Raasti Amma to alleviate the problem they have come with. If the *sawwali* is not in the state or condition to speak, a family member must do the process with the *sawwali's* name inserted into the verse. This *dhaagah*, also called a *chilla*, is tied to one of the many posts near the main shrine and it is through this thread that the *mujavars* understand what exactly is the problem and the correct healing procedure for it. The next step is to drape a *chaadar* over the shrine of Mira Datar while reciting lines as the *mujavar* does. Once the *chaadar* is draped, 40 consecrated effigies, otherwise known as *ghode*, are released in the *sawwali's* name at the shrine. Immediately after this, they are given a single rose petal picked from the tomb which ideally should be consumed (Safwan *miyan*).

Siddiqui (2016) notes that the *sawwalis* are then asked by their respective *mujavars* to write certain lines from the Qur'an with gold ink made from saffron. The paper on which these lines are written are placed in a bottle of water for some time, and the *sawwalis* are then made to drink this yellow water. Those patients that come to the *dargah* with more serious ailments are provided with care and treatment for up to 40 days. Although the *dargah* receives patients from all across the country, most of their *sawwalis*, according to Safwan *miyan* and Anetesam Muddin, a shopkeeper, are "Muslims from Bombay and Hindus from Rajasthan". Those with extreme, violent conditions of demonic possessions may be chained by their family members. These padlocks and chains are symbolic for the unrestrained entrance and exit of the demon from the afflicted and possessed *sawwali*. The *mujavars*, as per the law passed by the government in 2003, are in no way involved in any aspect of the chaining procedure (Firdoz *miyan*).

(Image3: A patient chained at the Mira Datar dargah)

Regardless of the kind of process the *sawwali* is going through, a mandatory part of any healing program is the *lobaan*. *Lobaan* or frankincense is a gum resin mixed with oil that is burnt as an incense by throwing the powder into a vessel of hot coals. This creates huge clouds of smoke that the *sawwali* is made to inhale along with the consumption of saffron-infused water. It is said that the *lobaan* works to deter the demon residing inside and to better allow the *barakah* or blessings of Mira Datar to work. This entire procedure is called *hajri*, during which the *sawwali* enters a state of trance, which facilitates the identification and removal of the demon. This takes place twice a day - once at five in the morning and later at seven in the evening.

(Image 4: Lobaan at the Mira Datar Dargah)

The second important space of the *dargah* is situated on one of the rooftops; an enclosed terrace no larger than 15 x 20 feet with a large green dome or *chakki* in the center. This holy space is called Dadimaa Ki Chakki, which is connected to the saint's grandmother. Another method by which the *sawwalis* willingly enter into a state of trance requires them to circle the dome at the *chakki* 111 times. However, the number of perambulations can vary based on the *sawwali's* condition and available time. Through this process, Dadimaa forces the evil spirit or any other form of black magic out of the *sawwali* and it was often observed that *sawwalis* would fly into intense states of trance, with about half of them screaming and pleading with Dadimaa to not "hit them", and the other half in a visible trance minus the exclamations (Safwan *miyan*). Based on the illness or affliction, another ritual that is followed at the *dargah* is nailing a blessed lemon to a neem tree in order to keep away any evil spirit threatening to return. According to Safwan *miyan*, sometimes it is the spirit that demands lemons be nailed to the tree if they are to voluntarily exit the possessed individual.

A more severe ritual endured by the patients is that of bathing in a small waterbody that hosts sewage water. This semi-marshland is situated just behind the *dargah* and is out in the open. *Sawwalis* can be seen casually walking into this waterbody and then lying down in the sun to dry themselves off. This practice is reserved for very few individuals who have been unfortunate enough to be the host to very powerful occult forces. However, this has been a controversial form of healing, with the *dargah* having come under fire in the past due to concerns of human rights violations. Yet they stand by its curative effects and have continued the practice it as they feel it is necessary to do so.

For those patients that for some reason cannot stay at the *dargah* for the entirety of their treatment, the *mujavars* offer materials to take back and complete the 40-day process at home. These materials include scented oil to be applied on the scalp, papers with the Qur'an verses written in golden ink, consecrated water, *lobaan* powder, different types of wearable talismans, and blessed sandalwood which is the most precious of them all. A combination of these materials is chosen based on what the *mujavar* thinks is best for the *sawwali* as well as taking into consideration what the *sawwali* is comfortable with. The consecrated sandalwood is precious for a reason. It involves a festival of the *dargah* which takes place annually, called Urs, where sandalwood mixed with rose water is used to wash the stone tomb of Saiyed Ali Mira Datar. This sandalwood paste is collected and preserved by all *mujavars* to give to the *sawwalis* throughout the year. There is only a small amount that is used to wash the tomb every year and owing to the large number of *sawwalis* entering

every day, only a speck of this paste is provided. What is important is that these rituals are followed on a regular basis; they must be performed consistently and dedicatedly in order to visibly feel the results after 40 days (Firdoz *miyan*).

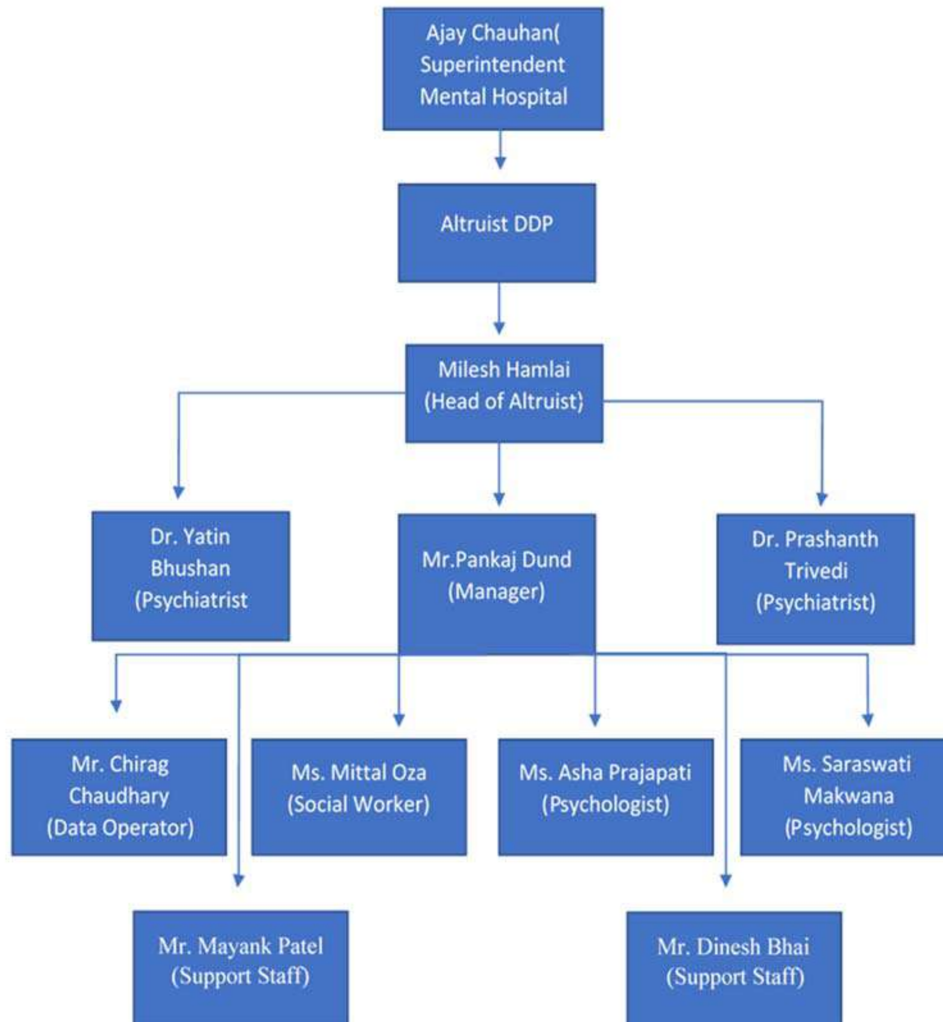
3.2 Functioning of the Clinic

The clinic is a vastly different structure in comparison to the *dargah*. It is a small, inconspicuous, rectangular building that sits right across from one of the side entrances of the *dargah*. The complex is built in a way that makes the clinic experience very impersonal. People move in from one entrance, and move out through the other entrance once their five-minute interaction with the psychiatrist is done, making the clinic a very active and mobile space. There is hardly a separation between the two compartments of the building; the meeting room is in full view of those waiting in the main hall. People go in to the meeting room all at once, crowding expectantly around the psychiatrists. Medicines are quickly given, files are quickly signed, old patients leave and new ones' file in. The smallness of the entire building concentrates this bustle, whilst m aintaining a systematic order as well. At all points, people are constantly replacing one another, reiterating this impersonal aspect of the clinic experience.

It is similar to the *dargah* in the way that what service is provided is quite public. It is done in front of people, among people – there is always an audience.

3.2.1 Structure and hierarchy

Chart 3: Organisation Structure of Dava and Dua Clinic



Similar to any organisation, the Altruist has a particular structure for its employees with respect to the Dava and Dua Program. Being the head of Altruist, Mr. Milesh Hamlai oversees all the initiatives undertaken by the NGO including, though not limited to, the DDP. He oversees the overall functioning of the clinic and also creates some of the content used for the mental health awareness drives that the clinic conducts. The clinic has been divided into two parts, the office and the out patients department (OPD). The OPD is situated right opposite the *dargah* whereas the office is farther away from the *dargah*, in a

commercial area. Though the two have distinct buildings as well as different purposes, the same staff works in both places.

Mr. Pankaj is the manager of the clinic who monitors the office as well as supervises the various projects of the Altruist. The DDP is only one of them. He assigns as well as monitors the tasks that are done by others in the office. He is also in contact with the *mujavars* to maintain the alliance between the two systems, and he helps create the content for their training programs too. Under him, there is Mr. Chirag who is the data operator at the office. His job is to create the follow up list for the day, enter all the patient details in the DDP database and keep a record of the quantitative data of the clinic. This data is strictly limited to the clinic and does not include any information about the *dargah*.

Apart from him, there are two psychologists and a social worker who work there as well. Ms. Mittal is the social worker who makes the follow up calls and also interacts with the patients. Ms. Asha and Ms. Saraswati are the counselling psychologists. They deal with the patients directly, interact with *mujavars* and patients at the *dargah*, and even work to increase awareness about mental health in the village. Interestingly, the tasks performed by Ms Mittal were not too different from that of the psychologists, and seemed interchangeable for the most part of it. Ms. Saraswati was the most active member who regularly went to schools and planned events to increase awareness about mental health. There are two psychiatrists associated with the clinic, Mr. Yatin Bhushan and Mr. Prashanth Trivedi. They do not work full time at the OPD but are only present for an hour every day except Sunday. Mr. Bhushan sits at the OPD from 15:00 to 16:00 every Monday to Friday, whereas Mr. Trivedi is present only on Saturdays, again from 15:00 to 16:00. Finally, the clinic also has two support staff, Mr. Dinesh and Mr. Mayank. Their jobs are not clearly defined but they seem to engage in any activity that happens at the clinic, ranging from getting tea for everyone to handing out medicines to the patients. In fact, they closely interact with all the people that come to the clinic. Mr Mayank knows all the researchers that come to study the clinic. In fact, researchers are welcome to stay at his house when they come to the study the program (S. Siddiqui, personal communication, October 31, 2018).

The clinic has a meticulous data management system in place, as it deals with both basic and sensitive patient information. Since data management is secondary it is carried out from the office from where all clerical work is accomplished rather than doing this from within the OPD. As mentioned before, Mr Chirag is responsible for handling the quantitative and qualitative data generated by the program. This data includes patient details such as their case history, place of residence, duration of treatment, medications

prescribed and the date of the patient's previous visit to the psychiatrist. This information is organised in a systematic and clear manner so that when the need arises, all information is easily accessible and comprehensible for the psychologists and the psychiatrists. His primary task every day is to make a follow up list of the patients, which is essentially a system to inform the patients that they are due for a visit to check their progress as well as get more medicines, if required. Since there is already an existing database with detailed information on each patient, he utilises that information to make this list.

(Image 5: Mr Dinesh, a former patient, now an employee at the clinic)

3.2.2 Process of treatment

The interviews with the clinic staff and the subsequent observations revealed the process followed by the clinic to treat a patient. Not only is the treatment provided here free of any cost but there is also a methodical and consistent procedure followed every time a patient comes to them. In the case of a new patient, when the patient approaches the clinic, the first thing that the psychologists do is build a rapport with them. They interact either with the patient or their relatives (depending on the condition of the patient), create a case-file in which case history is taken down, which is essentially information about the symptoms, the duration of its existence and much more. There is some ambiguity on whether this process is followed as meticulously as has been described, but the presence of well-managed case files is positive indication. Next, the clinical psychologist does the primary diagnosis. Then the patient is sent to the psychiatrist, who also diagnoses the patient. Initially they do not not give criteria-based diagnostic labels, but try to be open about the exact nature and

intensity of the illness that a person might face. The medication is accordingly given based on the symptoms presented, and can be later modified depending on the kind of effects it has on the patient. This is primarily the reason why any new patient is only given medicines for 10 days, and its benefits or drawbacks are accounted for before continuing with the same prescription.

The process mentioned above is also followed for patients coming from the *dargah*, but there are some changes in how they deal with them. The patients from the *dargah* are claimed to come to clinic in one of two ways: either the *mujavars* refer the patients to the clinic if they see the symptoms of mental illness, or the psychologists identify people suffering from a mental illness on their daily visits to the *dargah* and make an attempt to convince them to take medication. Either way, they sit with the patient in the *dargah* and take the case history of the patient within the premises of the *dargah* itself. However, during the course of on-field research, the psychologists were not witnessed going to the *dargah*. The very same observation was made by Ms. Sabah Siddiqui in 2013, and again clarified by Mr. Titus Joseph (currently a counselling psychologist at FLAME University), who previously worked as a psychologist for DMHP Mehsana, and had worked with the clinic, though not for the DDP. However, according to the data provided by the clinic, a fair share of the patients they have catered to come from the *dargah*. Furthermore, the patients from the *dargah* are initially given medicines only for five days. The psychologists try their best to include medication in the patients treatment process, without contradicting their faith in any way, and leaving the choice of taking the medication on the patients themselves.

"The important thing is that we do not want to break the faith of the people who come to the dargah and we will accept whatever the patient will say." (Saraswati)

There is also a particular system in place for the outstation patients. As is mentioned in Table 3, 70% of the population that comes to the clinic is from the various regions of Gujarat. Out of the remaining population, 15% is from Rajasthan. The clinic has a follow up system for every patient that comes to them, but this is especially important for outstation patients. The social worker and psychologist contact these patients to enquire how the medicines are working, and remind them to come back for more medicines. Either the clinic gives them medicines for 20 days and asks them to buy a certain medicine for 10 more days and visit again after a month, or, for the people who cannot possibly visit so frequently, the clinic refers them to other doctors closer to their region.

Table 3: State-wise distribution of patients

State	Patient
Gujarat	5326
Rajasthan	1153
Maharashtra	731
Madhya Pradesh	131
Uttarpradesh	66
Delhi	18
Bihar	15
Andhra Pradesh	9
Karnataka	22
West Bengal	14
Punjab	2
Orissa	4
Haryana	2
Chhatisgadh	7
Jharkhand	3
Diu	1
Jammu kashmir	2
Dadra and Nagar Haveli	4
Daman	1
Tamil nadu	1
TOTAL	7512

For a recurring patient the filing system followed is simple yet efficient. Appointments for consultation with the psychiatrist were allotted on a first come first serve basis for the patients. Each patient is expected to carry a card to the clinic which contains some basic details and a unique file number. They present this card to a member of the staff at the reception counter (usually Mr. Mayank or any of the psychologists). There is a file cabinet in which all the patients' files have been arranged and categorised according to their number. The respective file of the patient is located and is arranged in a first come first serve manner. When the psychiatrist arrives at 15:00, the patients are sent to him in the order of the arranged files.

The staff members in the clinic not only have to engage with the main program, but also with its auxiliary initiatives. One such auxiliary initiative is *Parivartan*, which aims at providing psychosocial rehabilitation for the mentally ill. The term psychosocial rehabilitation essentially refers to the process of restoration of community functioning and the welfare of an individual diagnosed with a mental illness. It promotes personal recovery by getting the patients engaged in some productive activity. A successful example of the same is Mr Mayank himself. Suffering from schizophrenia, he tried several treatments before discovering the DDP. He was a patient of the program for a few years, and when his condition stabilised, he was taught some of the work done at the clinic and eventually given a job there. He has been working with them for about six years now. Under *Parivartan*, once the patients have reached an eligible stage in their recovery process they are given vocational training in making incense sticks and *rakhis* which enables them to earn a livelihood. Work for them is not just a means of financial remuneration but acts as an opportunity for them to participate in society, promote self-esteem and enhance their quality of life (Mayank Patel). Additionally, the clinic also collaborates with the DMHP to increase awareness on mental wellbeing in the locality. The staff members of the clinic, primarily the psychologists take the initiative to go to the neighbouring schools and organise games, activities and talks through which the students are sensitised to the subject of mental illness, the stigma which is falsely attached to it and the approach to its treatment. Hence, the clinic also undertakes activities which is beyond the scope of the Dava and Dua program (Pankaj Dund).

3.3 Functioning of the Dava and Dua Program

As part of the Dava and Dua collaboration, clients who visit the *mujavars* for their treatment can be referred to the clinic in case of any mental health problems. Alongside performing rituals at the *dargah*, patients also acquire medication for their ailments. Since the state government funds the program, the medicines provided here are free of cost, which is an added incentive for the patients to utilise these services (Saraswati).

It is clear that the structure of the program is very hierarchical. The *mujavars* of the *dargah* sit at the top of the pyramid, and even though it is a government-mandated program, their word and opinions are more valuable than that of the clinic staff. This was observed in most of the interviews taken at the *dargah*, especially when an employee of the clinic was present. The behaviour of the clinic staff drastically alters in the presence of high

ranking *mujavars*, and they seem to accept everything said by the *mujavars*. Even though the presence of the clinic is government-mandated, for it to make any difference in the mental health scenario of the region, the clinic requires the *dargah* to actively refer patients to them. The *dargah*, on the other hand, has no such dependence on the clinic and can function just as well without them (*Khadim* Naim). However, three of the *mujavars* interviewed mentioned that they referred patients suffering from alcoholism, substance abuse, and insomnia.

Moving on to the process followed by the DDP when treating a patient, astoundingly, there is no common process to do so. A person who goes to both, the *dargah* as well as the clinic, does not go through a distinct process which incorporates both faith and psychiatric healing. In fact, the two distinct forms of healing are used separately, albeit parallely, on the patient. When both the parties were asked about how their treatment process has changed since the confluence began, the responses were as follows:

"There have been no changes in the treatment techniques at the dargah. However, before the patients begin taking any kind of medicine from the clinic, they come here to get those said medicines blessed." (Safwan *miyan*)

"See, our focus is on providing the patients with medicines. The choice of blessing the medicines is the patients decisions. Our goal is to help the patient, whichever way suits them best." (Mittal Oza)

This shows the mutual exclusivity of the two organisations with regard to their treatment method and day to day functioning. Even though there have been efforts on the clinic's part to incorporate the *dargah* in their functioning, it has not led to a proper collaboration of the two parties. In reality the systems and processes in place at the clinic and *dargah*, do not work in unison and the reason for this lies in the attitudes and perceptions of both these parties about one another.

CHAPTER 4
ATTITUDES AND PERCEPTIONS

Pankaj bhai led us to Firdoz miyan's office, who he was sitting calmly behind his desk, shuffling through some papers. He asked us to make ourselves comfortable and inquired as to where we were from. Once he had heard our purpose of visit, he called the chairperson, Varis miyan, into the room. Pankaj bhai mellowed down considerably at the sight of him. Varis miyan took a seat on a high table, beside Firdoz miyan who was sitting on a mat to his right, and Pankaj bhai was sitting a little away on the floor. Firdoz miyan continued with our conversation, providing snippets of their encounters with Milesh Hamlai and mentioning the helpfulness and warmth of Chandrakant Parmar; his eyes finding Pankaj bhai from time to time.

Upon reaching the end of this meeting, we pulled out a permission letter we had written (on behalf of our college) and asked Varis miyan to read and sign it for us, as we needed consent to document the dargah. Putting on his glasses, he sifted through the document and, much to our delight, exclaimed, "Granted! Granted! Granted!"

The moment we left the dargah with Pankaj bhai, he took charge and his body language shifted from docile to authoritative.

4.1 Clinic through the Eyes of the Dargah

The *dargah* is a religious institution that has maintained traditional practices of faith-healing for centuries and *mujavars* regard their work as being their holy duty, an honour bestowed upon them by the saint. The clinic, being only a decade old and also a seemingly oppositional form of treatment from that of the *dargah*, has undoubtedly raised a lot of opinions among the *mujavars*. Yet, there seems to be no consensus between them.

4.1.1 Prevalent skepticism

As mentioned earlier, following the Erwadi *dargah* tragedy in August 2001, the government laid down the foundations of the Dava and Dua Program which officially began in 2004 but by 2007 the Altruist stepped in and took over the operations. This was seen as an intrusion of the government by many in the *dargah* and before the clinic was even set up, biased perceptions were already formed (Siddiqui, 2016).

The initial fear of the *mujavars* was that the clinic would impact their livelihood and would reduce the number of *sawwalis* coming into the *dargah*. Milesh Hamlai and his team met with a lot of opposition in the beginning as the *mujavars* expressed mistrust and skepticism towards the idea of a clinic (C. Parmar, personal communication, October 21, 2018). Many also saw this step as an invasion over their traditional practices and beliefs and while the program began a decade ago, the negativity towards the clinic is still very much present today.

This negativity was exacerbated and a further divide was created when a single comment was made about the *dargah* and the *mujavars*. In 2014, *Satyamev Jayate,* a TV show that talks about and addresses social issues, hosted an interview with Milesh Hamlai and what he said was misunderstood by the *mujavars* which sparked quite a bit of hostility. This miscommunication happened majorly as a result of Milesh Hamlai's words which were perceived to be condescending (Firdoz *miyan*).

The *dargah* is no longer worried about the clinic impacting their livelihood. It is an extremely small space with two psychiatrists and two psychologists incapable of overthrowing the *dargah* or luring hoards of people under their roof. Much of the negativity towards the clinic arises because the members of the *dargah* have not completely understood the purpose of having this allopathic center. A certain number of *mujavars* expressed their dislike towards the concept of psychologists holding training workshops in order to sensitise them about mental health issues. They believe that this tradition of healing

people has been age-old in their family, that they have been exposed to all sorts of problems since childhood and are well-aware of how to deal with them.

"Most of the people who come to the dargah have tried everything; this is their last resort. There are many people who have consulted doctors. Medicine could not help that is why they are here. Now why should they come here and again go to a clinic and talk to doctors?" (Firdoz *miyan*)

This is a common question asked by *mujavars* regarding the clinic's present-day existence. Most of them do not feel threatened by the existence of the clinic anymore, but they do feel a certain sense of anger at having a space invaded which has been theirs for the last 550 years. They disagree with the idea that the *dargah* requires the clinic, and believe it to be the other way around. The patients that come to get treated at the *dargah* are majorly uninformed of the program's existence. One of the patients at the *dargah*, who did not wish to be named, mentioned that he became aware of the program's existence only upon reaching the *dargah*.

"I knew about the dargah since I was a young boy because I was born and brought up in Baroda, Gujarat. I was not aware of the program until I came here. I have only seen the boards; there is not much that I know about the program itself. I have never visited the clinic either."

4.1.2 Clinic's utility according to the dargah

According to a majority of the *mujavars* interviewed, the clinic simply offers temporary solutions to physical problems such as insomnia, sleep deprivation and substance abuse. They do not facilitate the treatment of any chronic mental ailments. They feel that the clinic's medicinal treatments only involve basic sleeping pills and tranquilizers to induce deep sleep in patients and make them momentarily forget about their condition. When asked what kind of patients are mainly referred for treatment to the clinic, the response was quick, "Mainly alcoholics and insomniacs." (Firdoz *miyan*)

Ironically, a few of the *mujavars* themselves have been treated at the clinic for problems of addiction. While they do believe that the program is helpful in its own way, the clinic was not primarily established for curing such bodily problems. The clinic is perceived as a rehabilitation centre rather than a mental health institution.

"I have had a personal interaction with the clinic. A few years ago, I was suffering from substance abuse and I went to the clinic to get treated. It worked well for me. I think this program is important for those people who are suffering from addiction." (Safwan *miyan*)

Another *mujavar* (Zubain *miyan*) suffered from a similar problem and had an almost identical experience at the clinic. These various instances of the willingness of *mujavars* to get cured at the clinic suggest that they do not doubt its ability to treat patients; however, the problems that the clinic is approached with are vastly different from the ones at the *dargah*. The fact that *mujavars* do not hesitate to get themselves treated at the clinic suggests that there is in fact, a disorganised interaction of sorts that is not tangible or visible at first glance. This interaction is

4.2 Dargah through the Eyes of the Clinic

As mentioned before, the supreme court judgement issued after the Erwadi fire necessitated the presence of an institution like the clinic to prevent any human rights violations (Siddiqui, 2016).This fact was also mentioned in the interview of a clinic staff named Pankaj when asked about his thoughts on DDP. This displayed the underlying intention of the clinic to work as a corrective facility and ensure that the afflicted got the correct treatment. This is an indication towards the attitude of the clinic towards faith healing, which they display in different manners.

As seen before, the clinic has nine employees and they all have different opinions about faith healing and the *dargah*. Interestingly, these opinions seemed to vary across different job profiles. For instance, both the psychiatrists seemed to have little regard for the *dargah* and its practices. Their attitude was more indifferent than accommodating. Contrary to this, the psychologists and the social worker were more accepting of faith healing practices. They appeared to put some stock in the century old rituals. The manager of the clinic had a similar stand to the psychologists. Even though all of them seemed to accept the rituals, there was an almost palpable feeling of contradiction in the behaviour or the staff from what they said. The remaining staff members had little or nothing to say about the rituals of the *dargah*.

(Image 6: Mira datar dargah from the window of the clinic)

4.2.1 Perceptions of superiority

What is interesting about the clinic side of things is the perception of superiority and simultaneous defensiveness that often manifests when recalling the *dargah*. When interviewing the psychiatrists that work part-time at the clinic, Yatin Bhushan, one of the staff members of the clinic, introduced the term “village system” when explaining faith healing. The village system of beliefs refers to the rigid, immovable faith in the power of *Datar bapu* that drove people to the *dargah*. When attempting to explain the interaction of allopathy with this village system he said:

“There is a system of beliefs present in the village which are rigid and cannot be changed at this time. Therefore it is not wise to ignore these beliefs but incorporate them. This is why we don’t stop the patients from going to the dargah.” (Yatin Bhushan)

Here, an interesting concept of allopathy in its absolute form is introduced. The psychiatrist here implies a morphed and altered way of treatment borne out of this incorporation of faith healing practices and its inclusion into the allopathic process. The psychiatrist seemed to find this incorporation as a block to allopathy operating in its absolute form. He explained that the clinic could not stop the patients from having faith in rituals, so the best that can be provided to the patients is the medication that will help them recover from their illness. Since the psychiatrists have more of a scientific background, their belief and faith in the rituals was not as strong as that of the others, such as the patients and those native to Unava.

"I never really believed in any of this but it exists and a lot of people have faith in it. Whatever healing works best for people." (Prashanth Trivedi)

The only form of acceptance that the psychiatrists show towards the *dargah* is because it increases the compliance of the patients towards the treatment. According to them, when a patient goes to the *dargah* they are willing to commit to everything that the *mujavar* asks them to do. Therefore, if the *mujavar* is asking them to take medicines, the patient will "blindly agree to it without using any logic" (Yatin Bhushan). Thus, the psychiatrists recognise that the faith in the practices does not foster a questioning approach towards the process of healing.

4.2.2 Exposure and conflicting opinions

It is important to understand the importance of exposure when analysing the attitudes and perceptions of stakeholders involved. The people in the clinic have all been exposed to the *dargah*, but in different ways, and in different degrees. Connecting their attitudes and perceptions to their personal experiences in the *dargah* and interacting with the *mujavars* offers insight into how these attitudes are formed. Both psychologists have visited the *dargah* multiple times.

"Then we also go to the dargah to talk to people, not with the intention to find people. We go and we talk to everybody and tell them that we are from dava dua and if you see someone who is going through some problem then you can inform us or tell them about us that the government has opened such a clinic and they come to us and take medicines." (Saraswati Makwana)

During the psychologist Saraswati's interview, she provided a more diplomatic view towards faith-healing and allopathic medicine, and did not segregate the existence of them. When asked for her opinions on the link between the *dargah* and the clinic, she was reluctant to compare the two systems. Instead she talked about mental illness as separate to black magic, trances, etc; She talked about the clinic and the dargah as treating different things.

"The dargah is already in our everyday routine and we have also trained the mujavars in mental health and because of that even they tell us that a new sawwali is here and he/she is displaying some symptoms of mental illness so we should meet them." (Saraswati Makwana)

This, in a way, removed the element of gauging a perceived superior model of treatment, as she presented the two as working on two different things; unlike the psychiatrist who talked about the rigid village system of beliefs, she was not calling into question any ideological framework. Rather she was describing two different services located near each other, connected simply by referral. In turn, the two psychiatrists have only been to the *dargah* once or twice.

Even Mr. Pankaj, who visits the *dargah* continually, when asked about his opinions on DDP, was extremely cautious when commenting on the *dargah*. Instead of presenting an opinion, he detailed the program's history, starting from the Erwadi fire to Altruist's intervention.

The separation of the mental health and black magic, possession, etc., mentioned by both Ms. Saraswati and Mr. Pankaj, confuses this narrative of confluence between the clinic and dargah. According to them people go to the *dargah* for spiritual reasons and to the clinic for mental problems. The two, in this view, work not as a confluence but rather simply coexist.

4.2.3 Maintaining a relationship

As the *mujavars* are employed as intermediaries between the patients and the psychiatrists, the clinic largely relies on the *mujavars* not just for referrals but also to gain credibility in the eyes of the patient that come from the *dargah*. It is known that many of these patients get their medicines blessed at the *dargah*, and the clinic encourages this ritualization. In a way the clinic, by encouraging the ritualization of allopathy, strengthens and reinforces

their legitimacy in the eyes of the patient. The patient here should be convinced of the clinic as being a part of the *dargah*, in order for them to be willing to take medicines. They also believe that this helps them maintain the patient's faith in the rituals. To the patients from the *dargah*, it is only this modified allopathy that they are willing to employ.

(Image 7: Yatin Bhushan, psychiatrist at the Dava and Dua clinic)

Maintaining a relationship is thus crucial. It has already been established that those who have been more exposed to the *dargah* are more diplomatic in their answers regarding the *dargah* and faith-healing. Knowledge regarding the *mujavars'* anger towards the clinic may be why those who are more exposed to the *dargah* are very careful not to mock or trivialise faith-healing in any way. They do not want to upset the status quo by exacerbating existing anger.

4.3 DDP Through the Lens of the Local Community

The bulk of interviews were conducted with the residents of Unava. According to the approximate demographic numbers provided by the Panchayat[2], 12,000 of Unava's 18,000 residents are Hindu and Jain, and the remaining 6,000 are Muslim. In keeping with this pattern, a third of the interviewees were Muslim, with the remaining being Hindu and Jain.

[2] These figures were provided informally by the Sarpanch (head of Panchayat), during his interview.

4.3.1 The specifics of Unava village and other observations

Unava's quaint streets are lined with shops and residences, and stand in stark contrast to the noisier main road that connects it to the highway. This is where the Mira Datar Dargah is located, and where Unava displays its more commercial side. This sharp distinction between the areas in Unava, separated by a mere row of buildings, is significant because of how integrated the busier section is in the *dargah's* economy. Many of the respondents from this area around the *dargah* had either been treated there themselves, or ran businesses, such as guesthouses, that were deeply linked to its activities. The areas deeper inside the village seem to be less affected by the *dargah's* activities.

(Image 8: Street of Unava)

Another point of interest is that most people observed on field were involved in running small businesses, which ranged from bakeries, to clothing shops, and even jewellers. Besides being more in number, this group was easier to access and hence most interviews were conducted with them.

Another observation that was made was that all of the respondents were deeply religious. Not a single person interviewed declared themselves to be atheist or even non-religious, and they voluntarily brought up their personal faiths.

4.3.2 Influencing factors

The aforementioned specifics about the village also served as factors that determined how people thought about the *dargah* and clinic. It is worth noting, however, that these factors

are by no means watertight compartments. They worked in conjunction with each other in influencing the residents' overall attitudes and perceptions of the DDP. For example, respondents' religious persuasion alone did not determine how they perceived the treatment provided in both spaces. As established above, most of the people living in Unava are highly religious, and were also found to have a strong belief in the miracles of Mira Datar regardless of their affiliation; it was asserted frequently that getting treated is a matter of faith, and that if one has faith, it will work for them. However, it is important to note here that several interviewees, by their own confession, knew little of the *dargah* or the clinic; much of their faith in the treatments was based in the stories that were told (they did not know about what went on at the *dargah* or clinic, and were thus unaware of the functioning of both units individually and also DDP as a whole). Here, the respondents' proximity to the *dargah*, both in terms of personal experience and geographical location, can also be seen as a factor that influenced how they perceived the *dargah* and DDP in its entirety, as the closer one was to the establishment, the more they tended to know about it.

While it has been made clear above that people tended to have faith in the miracles of Mira Datar regardless of personal religious affiliation, those uncomfortable with the entire clinic-*dargah* setup attributed their apprehensions to religion. This was an interesting realisation, as religion was not operating in a vacuum when it came to determining people's attitude towards the *dargah*; a lot depended on the respondents' personal experience with the dargah and DDP as a whole. When asked if they have ever visited the *dargah*, many respondents either said that they had no reason to go there because they were Hindu, while some even said that they were uncomfortable with the commotion and the overtly Islamic customs (such as the presence of green flags, daily *azan*, and so on) openly on display there; going to the area around the *dargah* just did not feel right, according to them. This is not to say that all non-Muslims were sceptical of the *dargah*; indeed, the majority of interviewees spoke with reverence of the *dargah* and emphasized that there were no restrictions on who could enter. Those uncomfortable with the *dargah*, however, did have a religious bias, and said that if the need ever arose, they would rather go to the clinic.

On the other side of the spectrum, some respondents had a negative perception of only the clinic part of DDP, while the *dargah* continued to be held in high regard owing to its long history. Interviewees expressed their disapproval of the clinic by citing the lack of community engagement done on their part with several residents saying that more awareness campaigns should be conducted for the community. Some even based their suspicion of the clinic simply on the fact that it was a new addition to the *dargah*.

Another set of respondents were associated with DDP, as mentioned above, as a function of their proximity to the *dargah*. These were the people whose livelihoods were more closely tied to the *dargah's* functioning, such as auto rickshaw drivers, fruit vendors, and owners of guesthouses that accommodated *dargah* visitors. Many of these respondents did not just have a favourable perception of DDP, but in fact displayed loyalty towards the *dargah*. This can be explained by the fact that people in the vicinity of the *dargah*, more often than not, had initially come from outside Unava to be treated, and had ended up becoming part of the local economy in order to support themselves. It must be noted here that a lot of the visitors to the *dargah* arrive in a state of duress, which is often reflected in their financial situation. Thus, right from a father from Rajasthan who must drive an auto to support his two children being treated here, to the lone businessman from Kanpur who had to join a local guesthouse for earning his livelihood, people from various parts of the country have been attracted to the *dargah* and ended up integrated into its accessory economy. It was only natural for these respondents to have an extremely positive attitude towards DDP as a whole, because their faith in its systems is a prerequisite for success of the 'treatment'.

Thus, we can say that the residents' attitudes and perceptions were often based either on a lack of awareness, hearsay, or their personal beliefs, and their direct experience of DDP was a secondary factor due to a lack of participation in the services it provides.

4.3.3 Perceived unity of the dava and dua aspects

Do the residents of Unava consider the *dargah* and clinic to be one single entity, or even as operating in close collaboration? Answering this question is central to understanding the nature of the DDP, and the level of confluence between science and faith that it displays.

The majority of interviews indicated awareness amongst residents of Unava that there is some link between the DDP clinic and the *dargah*. The extent to which this link was perceived, however, was quite different. One set of respondents were forthcoming in their assertion that clinic had started off under the wing of the *dargah* (with the clinic being located earlier on the *dargah's* premises), while others were of the opinion that there is no real link, but *mujavars* sometimes send the afflicted over for the allopathic treatment.

Some respondents' understanding of the partnership between the Dava and Dua aspects was based on an emotional reading of what they saw. Those who had been treated or were undergoing treatment at either one of the places tended to automatically appreciate

the other place as well, illustrating that they saw one as being in association with the other. On the other hand, those with a strong personal bias (usually religious, as explored above) tended to be distrustful of the *dargah*, calling it a money-making business, and also suspicious, albeit to a lesser degree, of the clinic by extension.

When asked about the impact of DDP on their lives, people tended to respond in a way that implied it was either the clinic or the *dargah* that had had an impact on their lives. For example, business owners in Unava, especially the ones who ran bakeries and sweet shops, felt that the presence of the *dargah* brought an influx of visitors during festival times, which ended up boosting their business. There were also a few patients of DDP interviewed in the village, who described the impact the program has had on them.

"*I was a patient of DDP. As my condition began to improve, Chandrakant ji started teaching me some work. After being cured I got a job here (in the clinic) itself.*" (Mayank Patel)

Mr Mayank, quoted above, seems to be very clear about which system has had a greater impact on his life. After treatment, he joined the clinic and has not visited the *dargah* since.

(Image 9: Mayank Patel, former patient, now employee at the clinic)

Out of the three patients interviewed, two had already been cured and the third was undergoing treatment. The ones who had been healed had visited both the *dargah* and clinic for their treatment, but were of the opinion that the medicine had helped them more. The third patient, currently undergoing treatment, said that she visited both places and that they were equally effective.

All of this seems to reinforce the idea that DDP is perceived as a largely unified front, with both the Dava and Dua aspects being linked in some way. They are aware of instances of referrals, but the existence of a confluence is still a question. Collaboration on cases is not heard of as such, by the residents of the village. Overall DDP is viewed as the parallel functioning of the clinic and the *dargah* and not a mutual collaboration.

4.4 Alliance of the Dargah and the Clinic

The DDP is fundamentally an attempt at a confluence; how this confluence is pursued and manifested is firmly rooted in the relationships and alliance between those working in the *dargah* and clinic. It is important to explore the nature of this alliance; how it was set up, what is its status today, etc.

4.4.1 Linking the two factions

When considering any sort of alliance between the two factions, it is important to situate Mr. Chandrakant Parmar in the whole equation. He used to work at the clinic as a counselling psychologist, and was considered as the most crucial link between the *mujavars* and the clinic. In an interview conducted with him, he detailed his history with the program. He first joined the program in 2008, as a part of Altruist's intervention and reinvention of the existing Dava-Dua program. When asked about his job, his response was:

"There were two more psychologists with me and we divided the work amongst us. Those two would focus on patients and I would focus on the mujavars. My tasks were training, sensitization, and also dealing with any issues the dargah or mujavars had with us. So how to solve those issues was my job." (Chandrakant Parmar)

Mr. Parmar constantly reiterated in his interview the importance of the rapport between the clinic and the *dargah*, and the measures he took to sustain this rapport. The *mujavars* were afraid of their livelihoods being taken and it was important to reassure them that the clinic was not there to put them out of business, but in fact, to ensure the provision of proper treatment to those suffering from mental illnesses. Here, the dependency of the clinic on the *mujavars* cannot be ignored. This reassurance and rapport building with the *mujavars* was important as a networking tool; they would allow for gateways into the *dargah* and to patients as well.

According to Mr. Parmar, the clinic attempted to establish a collaboration through a number of focus group meetings. The focus groups were means of understanding the *mujavars* as well as familiarising them with observable symptoms that crop up for certain mental illnesses. The focus groups were a means of identifying how exactly the collaboration could be carried out.

Unfortunately, though, Mr. Parmar left Altruist in 2016 and his departure had some negative effects on the already tricky alliance. According to Sabah Siddiqui, the relations between the *mujavars* and the clinic were strained after he left. This was very evident in the way some of the *mujavars* spoke of the clinic; the anger towards the clinic still seemed fresh; the clinic is still looked at as an intruding body, despite its ten years of existence. It may be that with Mr. Parmar's departure, some of the initial reassurance of the clinic being a helpful entity may have been lost.

4.4.2 Current state of the alliance

Moving on to present day interactions, when inquired about the training workshops mentioned in the literature review, the responses by the psychologists did not shed any light on the details of the same. There was ambiguity about the frequency, content, and even effectiveness of the trainings. Psychologists at the clinic hinted at some tangible interaction with the *mujavars*.

"We also have monthly or bi-monthly meetings with the mujavars about mental health." (Mittal Oza)

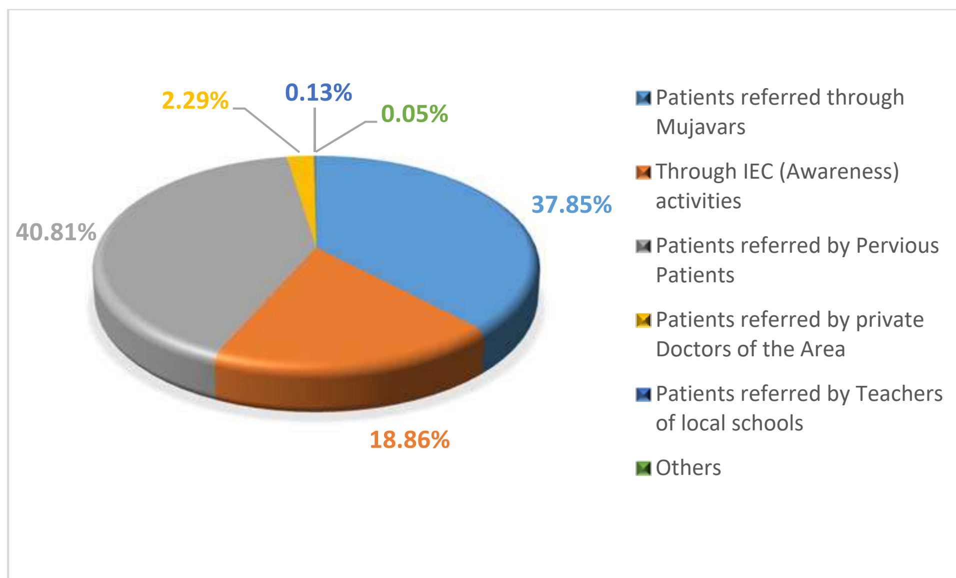
However, it was never explicitly mentioned whether these meetings were a sort of training or just general interaction, and the *mujavars* completely denied the existence of these meetings, and mentioned that they had never entered the clinic space or the Altruist

office since the program's establishment. If the clinic employees had any work with the *mujavars*, they were required to cross the street and visit the *dargah*.

Substantial evidence of the latter too, is absent. During her 8-month stay at Unava, Siddiqui mentioned that she had not seen a single psychologist or psychiatrist enter the *dargah* space to interact with the *mujavars* regarding patients' treatments (S.Siddiqui, personal communication, October 31, 2018). The two psychiatrists that work at the clinic have visited the *dargah* barely thrice since the inception of the Dava and Dua Program and are not well-informed of the ritual processes (Prashanth Trivedi).

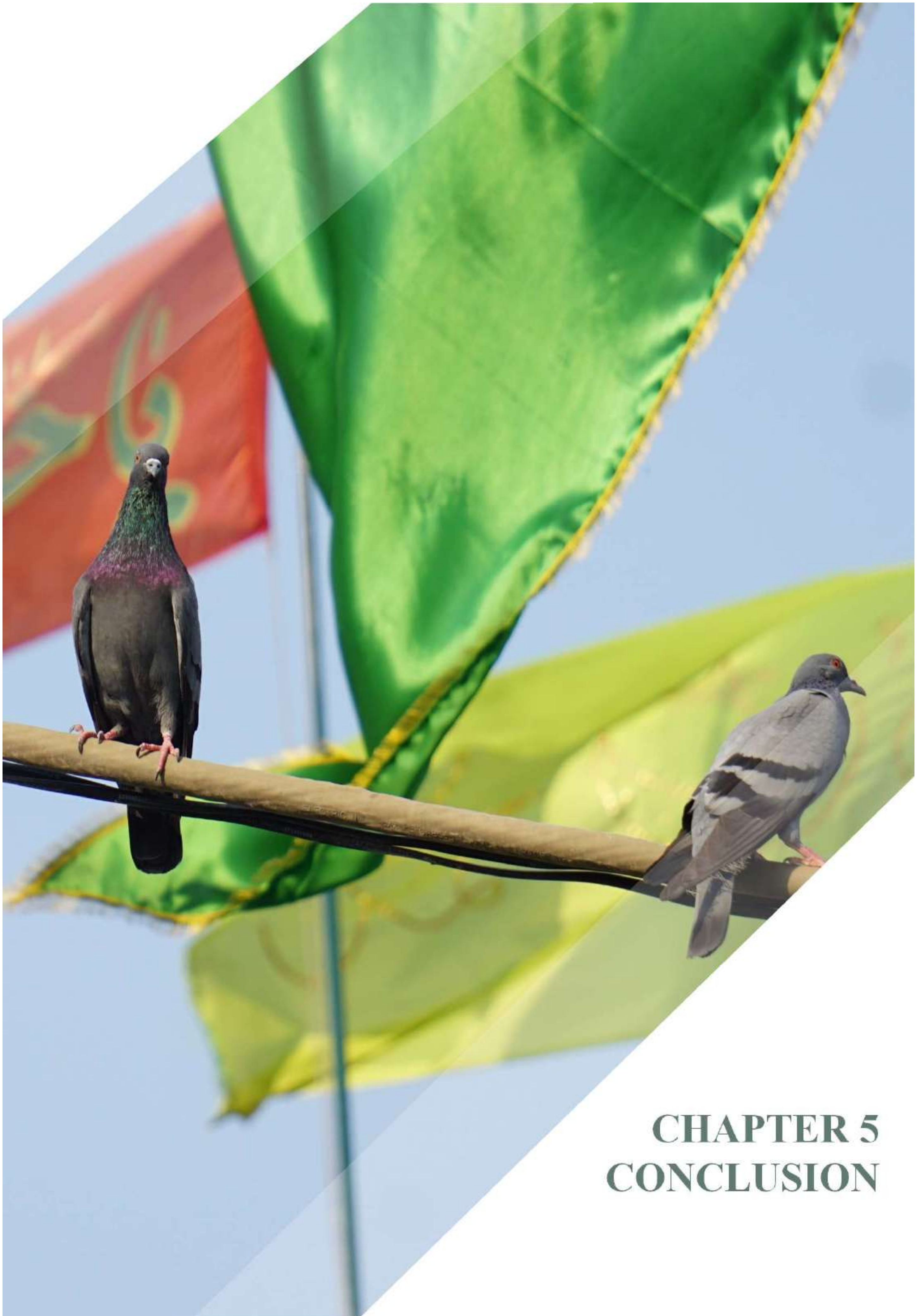
Furthermore, the clinic seems unable to incorporate the beliefs of the *dargah* well with its initiatives. An observation made by the team on field was of the lack of preparation for Urs by the clinic staff. Urs is a Sufi festival of utmost importance to all those who work for and worship the shrine of Mira Datar. It occurs annually and it just so happened that the preparations for Urs had begun right at the onset of the study. The streets were ignited with colourful lights, the guest houses were fast-filling with people from all across the country and the stalls in the bazaar inside and near the *dargah* were stocking up with all kinds of artefacts. However, amidst all of this hustle and bustle, it was observed that the clinic employees did not extend a hand of help for the preparations. Interestingly, the Urs is just a day apart from the World Mental Health day, for which the clinic does organise some events. Regardless, there is no confluence of these monumental days either.

Chart 4: Patient referrals to the clinic

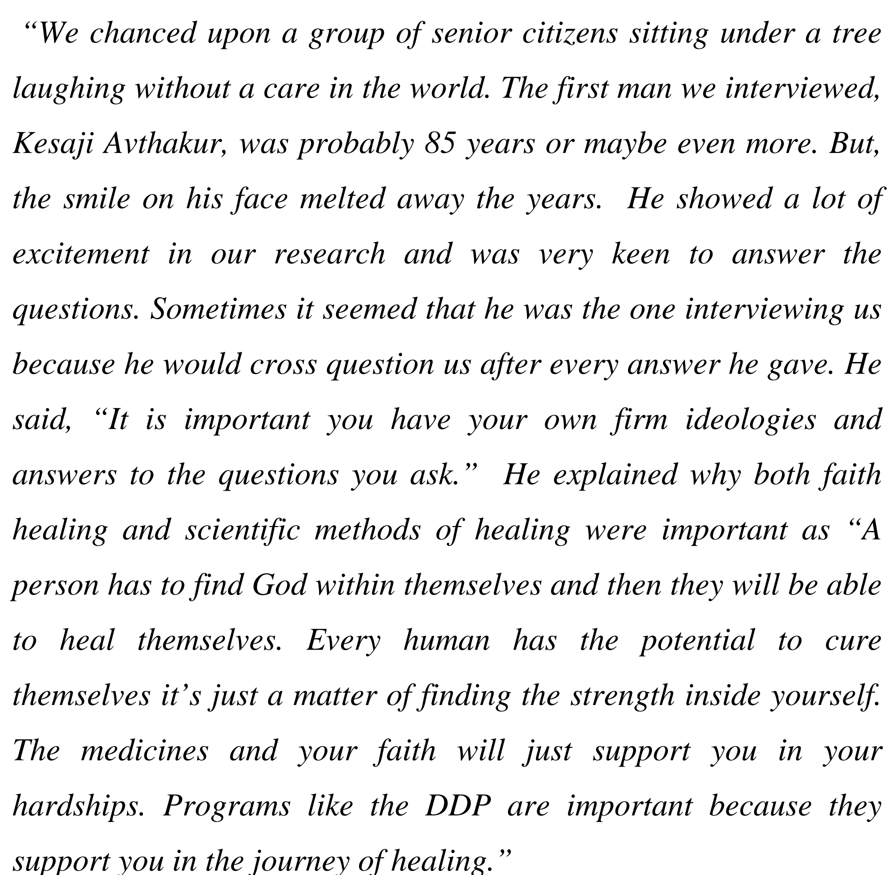


Another important factor to consider when evaluating the alliance are the patients that have been treated under the DDP program. From the data present at the clinic, the overall footfall of the clinic over the past 10 years has been 7512 people (refer to chart 1). All these patients though, did not come from the *dargah*. As Chart 4 represents, only about 37% of the total patients have been referred by the *dargah*. It can be inferred from these numbers, that in the 10 years of the clinic's existence it has only managed to collaborate with the *dargah* over 2843 cases out of 7512. This number only substantiates the attitude that the *mujavars* have towards the clinic, and that they are not completely open to functioning of the clinic.

Additionally, the space of the *dargah* is indicative of its indifference towards the program, as there are no posters promoting it inside the *dargah*. Neither are there any signs stating the numbers of any of the psychologists. This is significant because even though the *dargah's* walls are covered with numbers of various *mujavars*, the *dargah* does not propagate the clinic's services, or even acknowledge it.



CHAPTER 5
CONCLUSION



"We chanced upon a group of senior citizens sitting under a tree laughing without a care in the world. The first man we interviewed, Kesaji Avthakur, was probably 85 years or maybe even more. But, the smile on his face melted away the years. He showed a lot of excitement in our research and was very keen to answer the questions. Sometimes it seemed that he was the one interviewing us because he would cross question us after every answer he gave. He said, "It is important you have your own firm ideologies and answers to the questions you ask." He explained why both faith healing and scientific methods of healing were important as "A person has to find God within themselves and then they will be able to heal themselves. Every human has the potential to cure themselves it's just a matter of finding the strength inside yourself. The medicines and your faith will just support you in your hardships. Programs like the DDP are important because they support you in the journey of healing."

5.1 Dava and Dua Program: A Coexistence

After having considered the DDP based on its processes as well as the perceptions and attitudes of both its parties towards the other, it is now possible to draw conclusions about the nature of their alliance. Since it has been made clear that the *dargah* draws legitimacy from its long period of existence, it is not surprising that they tend to resent the relatively new clinic. This resentment is also compounded by the fact that allopathic healing is at direct odds with the faith-based healing followed at the *dargah*. Thus, the Altruist faced numerous challenges in terms of acceptance by their senior partner in the proposed DDP alliance, and the onus to create an amicable relationship was with Altruist from the very beginning. It is also necessary to keep in mind that the program being mandated by the government did not leave the *dargah* with much of a choice but to agree to it.

In an already difficult scenario, instances of miscommunication between the two (such as the *Satyamev Jayate* episode) must have made it difficult for the *mujavars* to see the clinic as merely a collaborative entity, rather than an intrusive one; they would have also felt that their practices were being undermined. In a context where the healing practices of the *dargah* predated those of the clinic by centuries, the *mujavars* were bound to feel some sense of invasion of a space which had been predominantly theirs. This led to many assumptions being formed by the *mujavars* about the clinic, and it was painted in a light of inutility for the most part. As a result, all dialogue between the clinic and the *dargah* was characterised by a degree of hostility.

(Image 9: Usman *Miyan,* a *mujavar* at the Mira Datar dargah)

The relationship between the two establishments was expected to be one of understanding and acceptance from both sides. This perception had also been reinforced by the handful of studies conducted previously, which painted a picture of satisfaction and cooperative functioning of the two institutions. However, the lack of cooperation witnessed on field reveals an entirely different situation, calling into question the validity of certain aspects of past studies. A collaborative relationship does not exist, and there is more indifference than inclusion. There is no sense of satisfaction with the DDP; rather, a negative outlook towards it is evident.

The inclusion of the clinic seems redundant to the *dargah* because they are of the opinion that people seeking treatment here have already tried medication. Additionally, while the clinic holds training programs for the *mujavars* to sensitise them towards mental health, no such initiatives to sensitise the psychiatrists or psychologists about the practices of the *dargah* have been undertaken. This in itself seems like a one way incorporation and not a holistic inclusion of both treatments, hence not resulting in a confluence. A better way of looking at the program as a whole would be to think of it as a coexistence of two different forms of treatment, working parallely on a patient. This leaves DDP as the mere name of the clinic in most cases.

5.2 Relevance of the Study

Having established the status of DDP in the present day, it is necessary to go back to the rationale of conducting the research, in order to better understand its relevance as well as importance. Studying the DDP of Unava is essential to understand the working of a system which combines faith and allopathic healing. It is the pioneer of this system, and therefore can set a precedent for other such initiatives.

Since the aim of the study was to understand the functioning of DDP, it details a wholesome view of the processes followed by the two institutions. The study also examines the attitudes of all stakeholders, especially those of the *mujavars* and clinic staff, which helps us arrive at a more nuanced understanding of the alliance between DDP's two branches. A comprehensive understanding of these facets of the program is not only beneficial for anybody who wishes to gain knowledge about this initiative but it is also crucial for those wanting to use this model in other areas.

A lot can be learnt from the current limitations of DDP, as well as the challenges faced by them that inhibit achieving a state of confluence. These have been looked at in

depth in the research, and therefore make it possible for others to take these challenges into consideration and customise a more palatable model. The creation of such a model, which incorporates faith healing into it is important because it facilitates community mental health, and reaches out to more people than any usual psychiatric setup can. Furthermore, the institutions associated with DDP can also utilise the report to realise the perception of outsiders about the program, and maybe consider some of the points that could help them build a better alliance.

5.3 Limitations of the Study

There were various challenges that had been predicted before conducting the study, but only a few of them materialised. These were as follows:

1. The research would have been quantitatively more comprehensible as well as more generalisable if the sample size of the *mujavars* had been higher. An issue here was the the refusal on their part to sign a legal looking consent form even after having the willingness to share information. Any information without the presence of a consent was unusable for the purpose of the study, leading to this reduced sample size of the *mujavars.*

2. The study witnessed a lack of quantitative data from the *dargah*, with respect to the information about *sawwalis*, the kind of symptoms they displayed, duration of treatment etc. This was due to the fact that data in the hands of the mujavars were kept in the form of logs and each of the 600 *mujavars* had a seperate log. Therefore, it was not possible to go through their records, segregate and choose the specific data that was relevant to the research.

3. Throughout the on-field research, it was attempted to include people from as many socio-economic communities and religious backgrounds as possible. Though the religious diversity was accounted for in the interviews, most of them recorded the responses from the Patidar community members on their different perceptions of the clinic and the *dargah*. The underprivileged scheduled caste and scheduled tribe communities, however, were not among those interviewed

as they could not be identified. Hence, a caste based analysis of the attitudes and perceptions of people towards the *dargah* was not possible.

4. As the research was confined within the boundaries of a small village, word got around quickly about researchers who had come to study the program. Since similar and more intensive research had already been conducted in this small space, the responses of the interviewee were possibly fine tuned to be more desirable to the researchers. As a result, many respondents gave similar and almost scripted responses which was possibly not an accurate reflection of their personal thoughts on the program.

5.4 Suggestions

Though the duration of on-field research was insufficient to extensively nitpick every facet of the strained alliance, and though the team is not trained enough to pose definitive solutions, the study revealed some aspects of the program can be worked upon to move from a coexisting model to one that harbours confluence. After discussions about the same with experts like Ms. Sabah Siddique and Mr. Titus Joseph, who have had plenty exposure to the context of DDP as well, the team has come up with certain suggestions that may be helpful in ensuring that this innovative program does not lose its momentum.

One major suggestion is introducing a model of treatment that integrates the two practices instead of just letting them function parallely, with a client-centered and needs-based approach. The proposed model can effectively include the benefits of faith healing to give a holistic edge to conventional psychiatric treatment. Religion in a way provides an external reason for the existence of an illness; possession by a *jinn* as the cause of illness means that the problem is separate from the patient themselves. Religious rituals that specifically help in removing such elements from a person's life can therefore be used here, in an attempt to ease some of the emotional distress experienced by people of faith. Another important factor to consider is that faith healing is a very collectivistic model, usually involving the family members or kin of the patient in the process of treatment. India, being a collectivistic society, is the ideal place where such a model can benefit those suffering from various illnesses. These when combined with the astute practices of allopathic treatment plans would combine to not only aid a patient with the physiological as well as

psychological troubles, but also provide emotional and social support in a way which is usually lacking from the psychiatric healing model (Tseng & Streltzer, 2001).

Such a model can be effectively used to satisfy the needs of the client after analysis. The therapy can be customised according to the faith of the patient, be it higher in the rituals or in the medical model. If a patient is inclined more towards faith healing, their healing can commence at the *dargah* and then be brought to the clinic. Similarly, if a person has more faith in the allopathic treatment, they can begin at the clinic and then move on to the *dargah*. In either of the case, constant communication between the *mujavars* and psychologists, and customisation of a holistic treatment plan is required to ensure that the client reaps the benefits of this innovative integration.

For the effective implementation of such a model, the people working in the clinic as well as the *dargah* need to have an amicable relationship that does not just promote referrals but also creates a space for collaborative functioning. To achieve this there are various measures that can be taken, a majority of which from the clinics side, as they are the external entity in this context. The most important step would be for both the parties to understand the other, and not just have one way trainings for *mujavars* to introduce them to allopathic healing. Psychologists also require similar sensitisation to process of treatment followed by the *dargah*, and how to incorporate the rituals in the treatment plan. A well thought out plan that details the ways in which both forms of healing complement each other might make it easier for both the parties to view the other as an ally. Also keeping in mind the role religion plays in the perception of the *dargah*, it may be helpful to have some staff members in the clinic who belong to the same faith as the *mujavars*, as this will help create a stronger relationship. It is essential to understand the nitigrities of a particular faith to fully understand the religious practices and rituals that are practiced by them. If the clinic does have some staff that have witnessed these practices first-hand, they would be able to harbour a better collaboration without losing the essence of either practice. With efforts from both sides, this coexistence can eventually result in a confluence.

References:

Altruist. (n,d). *Dava & dua.* Retrieved September 23, 2018, from http://thealtruist.org/dava-dua-program/

Biswal, R., Subudhi, C., & Acharya, S.K. (2017). Healers and healing practices of mental illness in India: The role of proposed eclectic healing model. *Journal of Health Research and Review in Developing Countries*, 4(3).

Castillo, R.J. (2001) Lessons from folk healing practices. In W.S Tseng & J. Streltzer (Eds.), *Culture and psychotherapy: A guide to clinical practice* (p. 85-88). Washington DC, WA: American Psychiatric Press, Inc

Ernst, E. (2010). Nature cures: The history of alternative medicine in America. *Focus on Alternative and Complementary Therapies*, *8*(2), 278-278. doi: 10.1111/j.2042-7166.2003.tb03775.x.

Gururaj, G., Varghese, M., Benegal, V., Rao, G.N., Pathak, K., Singh, L.K., … Misra, R. *National mental health survey of India, 2015-16: Mental health systems.* Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS Publication. Retrieved from https://bit.ly/2qxFZFQ.

Hamlai, M., & Srinivasan, N. (2011). Satisfaction-expectation rapid survey (SARAS). Retrieved September 25, 2018, from https://mhpolicy.files.wordpress.com/2011/05/seras-report.pdf

Hazrat Sayed Ali Mira Datar. (2009). Retrieved November 21, 2018, from http://www.sayedalimiradatar.com/history.htm

Kumar, S. (2001, August 7). 25 die in T.N. asylum fire. *The Hindu.*

Schoonover, J., Lipkin, S., Javid, M., Rosen, A., Solanki, M., Shah, S., & Katz, C. (2014). Perceptions of traditional healing for mental illness in rural Gujarat. *Annals of Global Health*, 80(2), 96-102. Retrieved September 25, 2018,from https://www.sciencedirect.com/science/article/pii/S2214999614000514.

Shastri, P. (2016, July 18). Science of the soul: Dava and dua project creates wonders to mental illnesses and how. *Times of India.* Retrieved September 11, 2018, from https://timesofindia.indiatimes.com/city/ahmedabad/Science-of-the-soul-Dava-and-Dua-Project-creates-wonders-to-mental-illnesses-and-how/articleshow/53255284.cms

Shields, L., Chauhan, A., Bakre, R., Hamlai, M., Lynch, D., & Bunders, J. (2016).

How can mental health and faith-based practitioners work together? A case study of collaborative mental health in Gujarat, India. *Transcultural Psychiatry*, 53(3), 368-391. doi:10.1177/1363461516649835.

Siddiqui, S. (2016). *Religion and psychoanalysis in India: Critical clinical practice (Concepts for Critical Psychology).* London: Routledge.

Singh, U., & Lahiri, N. (2010). *Ancient India: New research*. India: Oxford University Press.

The Possessed Of Hazrat Sayid Ali Mira Datar. (2011, April 07). Retrieved July 31, 2018, from https://thepossessedofmiradatar.wordpress.com/2011/03/15/the possessed-of-hazrat-sayid-ali-mira-datar/.

Appendix A

1. Semi-structured Interview for the Villagers/Business Owner

1. Do you know what the Dava-Dua Program is?
2. Why do you think people go there?
3. Do people from the Dargah visit your shops often?
4. Do you think the services provided by the program are beneficial to those who use it?
5. In the last 10 years have you noticed changes in the number of people coming to the Dargah?
6. Have there been any changes in the number of people visiting today from 10 years ago?
7. Apart from business, how else has DDP impacted you?
8. Would you visit/recommend the program if need be?

2. Semi-Structured Interview for Psychiatrists

1. How would you describe the daily functioning of DDP?
2. What do you think of faith-healing? How compatible is it with a psychiatric program?
3. What do you think of the Dava-Dua Program? Why did you choose to be a part of this program?
4. How are you providing treatment to the patients? Has there been any progress in treatment methods over the years?
5. How many patients do you see on an average day?
6. How often do you see the same patients during their term of stay at the
7. Dargah?
8. How involved is the State in the functioning of the program, w.r.t funding?
9. Are you aware of the Homeless Program?
10. Does the homeless program bring a considerable number of patients to DDP? (Does the Homeless Program deliver patients to the Dargah or to the Psychiatric clinic?)
11. Have you noticed any changes in the number of people visiting the Dargah since the establishment of the clinic?
12. Is there regular interaction and coordination of activities with the mujawars?
13. So, how is your practice of psychiatry altered in such a unique context/under influence of the Dargah context?
14. How have the mujawars reacted to the program?
15. Is there a difference between the mujawars' attitude when it was first introduced, and now, 10 years later?
16. Are there any plans for the expansion of the program?

3. Semi-Structured Interview for the faith healers/mujawars

1. How do you conduct your healing?
2. So when a patient comes in, how do you go about understanding their problem?
3. What prompts you to take patients to the psychiatrist?
4. Any particular symptoms that you look out for?
5. How do you differentiate between your regular visitors and those who also need psychiatric help?
6. How have the thoughts regarding mental illness changed in the Dargah, since the setting up of the clinic?

7. Has the clinic affected how you carry out your healing?
8. You've been associated with this Dargah for so many years. What sort of changes has the Dargah undergone, as a result of external events/factors (Erwadi fire, government, DDP also)?
9. What do you think of the psychiatry element added to the functioning of the Dargah?
10. To what extent is there a difference in the effectiveness of the treatment between non-believers and believers of spiritual activities? Do you find it easier to treat people who are believers?

4. Semi-structured interview for families

1. How did you come to know about this program?
2. What is your relative ailing from/what symptoms are bothering them?
3. What other treatments had you tried before coming here?
4. How long have you been here?
5. Have you seen any changes in your relative since they came here?
6. What do you think has helped?
7. What would you have turned to if DDP wasn't there?

5. Semi-structured interview for patients

1. What is your name, age, region of belonging?
2. How did you become part of DDP? Who referred you to DDP?
3. What are your ailments/what are you going through?
4. How long have you been here? (Different for Dargah and clinic)
5. Have you noticed any change in your condition? What changes, if any? (If they can't actively answer this then make it symptom specific)
6. What do you think has helped the most?
7. What other treatments had you tried before coming to DDP?

NON-PARTICIPANT OBSERVATION MATRIX

	Things to observe							COMMENTS
Question number	Body Language	Tone of voice	Hand gestures	Facial expressions	Eye contact	Restlessness	Openness to interact	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Appendix C
Informed Consent Form for FLAME DDP-DIP Project

This informed consent form is for informants connected to the Dava Dua Program/ Mira Datar Dargah / Clinic run by Altruist in any of the below mentioned capacity, and who we are inviting to participate in research, titled "Functioning of the Dava Dua Program Ten Years after its Existence – Confluence of Science and Faith".

Informant category:

- o client / visitor
- o client's / visitor's caregiver
- o allopathy-based mental health professionals (AMHPs)
- o faith-based healers
- o other informant category (specify) ____

Part I: Information Sheet

Introduction: This study is being conducted by the students of FLAME University, Pune (Maharashtra), as part of the Discover India Program (DIP). Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of another researcher.

Purpose of the research: We wish to understand the functioning of the Dava Dua Program, with reference to its systems and processes and the perceptions and attitudes of the people connected to the program. The confluence of science and faith is an integral characteristic of contemporary India and we wish to explore the same.

Type of Research: An interview that will last for about 30 minutes.

Participant Selection: You are being invited to take part in this research because we feel that your experience in the context of the Dava Dua Program/ Mira Datar Dargah / Clinic run by Altruist can contribute significantly to our understanding and knowledge of the topic being studied.

Voluntary Participation: Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate all the services you receive at this Centre will continue and nothing will change.

Risks: We are asking you to share with us some personal information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion/interview/survey if you don't wish to do so, and that is also fine. You do not have to give us any reason for not responding to any question, or for refusing to take part in the interview.

Benefits: There will be no direct benefit to you, but your participation is likely to help us find out more about how scientific and faith healing contribute to better mental health.

Reimbursements: You will not be provided any incentive (monetary or otherwise) to take part in the research.

Confidentiality: Strict confidentiality will be maintained as notified by you in Section II

Sharing the Results: The results will be used for academic purposes only, and the collective anonymous results can be shared with participants on request.

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study. I give consent to the researchers to –

- o video-record my interview and disclose my identity
- o video-record my interview without disclosing my identity
- o record my responses in text and disclose my identity
- o record my responses in text without disclosing my identity
- o collect my responses orally without documenting them

Name of Participant____

Signature of Participant _____________________ Date ________________ (dd/mm/yyyy)

If illiterate [3]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness________________________________

Thumb print of participant

Signature of witness _____________________ Date ________________ (dd/mm/yyyy)

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Name of Researcher/person taking the consent_______________________________________

Signature __________________________ Date ________________ (dd/mm/yyyy)

[3] A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

FLAME DDP-DIP प्रोजेक्ट के लिये सूचित सहमति प्रपत्र

यह सूचित सहमति प्रपत्र Dava Dua Program, मीरा दातार दरगाह, और Altruist से जुड़े व्यक्तियों के लिए है जो नीचे लिखे गये श्रेणियों में पड़ते है। हम उन्हें हमारे इस शोध, “Dava Dua Program और उसकी आज की काम काज की स्थिति”, में भाग लेने का निवेदन करते है।
भाग लेनेवालों की श्रेणी श्रेणी:

- o मरीज़/सवाली
- o मरीज़/सवाली का ध्यान रखनेवाले
- o मनोचिकित्सक/मनोविकारतंय
- o मुजावर
- o अन्यश्रेणि ______________________________

भाग १: जानकारी पत्र

परिचय: FLAME विद्यापीठ, पुणे के छात्र, ‘Discover India Program’ के अंतर्गत, इस विषय पर संशोधन कर रहे। है कोई भी निर्णय लेने से पहले आप किसी से भी इस अनुसंधान के बारे में बात कर सकते है। अगर इस सहमती पत्र में कुछ ऐसे शब्द हो, जो आपको समझ में न आये, तो आप मुझसे पूछ सकते है। अगर आपको कोई और सवाल हो तो आप मुझेसे पूछ सकते है।

अनुसंधान का उपदेश: हम Dava aur Dua Program के कामकाज को समझना चाहते है, ख़ास तौर पे उसकी प्रणाली और प्रक्रियाओं को और उसके प्रति लोगो के सोच-वचारो को जानना चाहते है| विज्ञान और आस्था से जुडी उपचार का यह संगम भारत देश के लिए महत्त्वपूर्ण है और हमें इसी की शोध करनी है।

शोध का प्रकार: मुलाकात (लगभग तीस मिनट)

भाग लेनेवाले का चुनना: आपको इस शोध में भाग लेने के लिए हमारा निवेदन है क्यूंकि हमें यकीन है की आपका Dava Dua Program/ मीरा दातार दरगाह/ Altruist के साथ जो अनुभव है वोह इस शोध के लिये महत्वपूर्ण होगा।

स्वैच्छिक भागेदारी: इस शोध में आपकी भागेदारी आपकी इच्छा पर निर्भर है। आप चुन सकते है की आपको भाग लेना है या नहीं। अगर आप इस शोध में भाग न लेना चाहे तो भी आपको यह संस्था की सारी सेवायें मिलेगी।

जोखिम: कुछ सवाल आपके व्यक्तिगत ज़िन्दगी से जुडी हो सकती है या कुछ ऐसे विषयों से जुडी हो सकती है जो आपको असुखद लगे।अगर आप चाहे तो आप किसी भी सवाल का जवाब देने से इंकार कर सकते है। आपको जवाब न देनेका या फिर शोध में भाग ने लेनेका कोई कारण देने की ज़रुरत नहीं है।

लाभ: आपको इस शोध में भाग लेने का कोई प्रत्यक्ष लाभ नहीं है, लेकिन आपका योगदान हमे विज्ञान और आस्था के इस संगम को समझने मदत करेगा |

भरपाई: आपको इस शोध में भाग लेने के लिये किसी भी तरह का प्रोत्साह नहीं दिया जायेगा (आर्थिक या अन्य) |

जानकारी की सुरक्षा: Section II के अनुसार गोपनीयता रखी जायेगी।

खोज की जानकारी: शोध के नतीजे केवल शैक्षिक कारणों के लिए इस्तेमाल किये जायेंगे, और अगर भाग लेने वाले चाहे तो वे नतीजों की मांग कर सकते है |

भाग २: सहमति का प्रमाणपत्र

मैंने इस प्रमाणपत्र की सारी जानकारी पढ़ ली है या फिर किसीने मुझे पढ़के सुनाई है। मुझे हर किस्म के सवाल करने का मौका मिला था और मेरे सारे सवालों के जवाब भी मिल गये है। मैं इस शोध में अपनी इच्छा से भाग लेने की सहमति देता/देती हु। मैंने शोधकर्ता को नीचे बताये गये चीज़ो की सहमति दी है:

- बातचीत का चित्रीकरण किया जा सकता है और मेरी पहचान का खुलासा किया जा सकता है
- बातचीत का चित्रीकरण किया जा सकता है और मेरी पहचान का खुलासा न किया जाये
- मेरे सारे जवाब दर्ज किये जा सकते है और मेरी पहचान का खुलासा किया जा सकता है
- मेरे सारे जवाब दर्ज किये जा सकते है और मेरी पहचान का खुलासा न किया जाये
- मेरे जवाब मौखिक रूप से इखट्ठा कीये जाये और बिना रिकॉर्ड किये

भाग लेनेवाले का नाम ______________________________

भाग लेनेवाले की दस्तखत ________________ तारीख ________________(दिन/ महीना/ साल)

यदि अशिक्षित या निरक्षर [4]

मैं गवाह हु की यह सहमती पत्र सटीकता से पढ़ा गया था और भाग लेनेवाले व्यक्ति को सवाल पूछने का उच्चित अवसर भी दिया गया था। मैं इस बात की पुष्टि करता/करती हु की भाग लेने वाले ने अपनी सहमति दी है।

गवाह का नाम ______________________________

भाग लेनेवाले का अंगूठा

गवाह की दस्तखत ________________ तारीख ________________ (दिन/ महीना/ साल)

शोधकर्ता का वचन

मैंने यह प्रमाणपत्र सही और निश्चित रूप से भाग लेने वालों के लिए पढ़ा है। मैं इस बात की पुष्टि करता/करती हु की भाग लेने वालों को सवाल पूछने का अफसर मिला था और उनके सारे सवालों का सही जवाब भी दिया गया था। मैं इस बात की पुष्टि करता/करती हु की भाग लेने वालों को सहमति के लिए ज़बरदस्ती नहीं की गयी थी बल्कि उन्होंने खुदकी इच्छा से सहमति दी है।

शोधकर्ता का नाम ______________________________

दस्तखत ______________________ तारीख ________________ (दिन/ महीना/ साल)

[4] A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

Glossary

Sr. No.	Term	Definition
1	Azaan	Islamic call to pray
2	Barakah	Spiritual presence
3	Bhai	Gujarati word for brother
4	Chaadar	Traditional shawl
5	Chilla	I. Smaller consecrated structure which is an extension of the dargah II. Colloquial word for thread
6	Dargah	Shrine built over the grave of a revered religious figure
7	Ghode	Sacred effigies in the shape of a horse
8	Hajri	Urdu word for presence
9	Jinn	Supernatural force which is part of Islamic culture
10	Khadim	Faith based healer; often used in place of mujavar
11	Kiblah	Direction of the Kaaba in Mecca towards which Muslims turn at prayer
12	Lobaan	Frankincense
13	Makrana	Type of high-quality marble
14	Meera	Brave
15	Miyan	Urdu word for brother
16	Mujavar	Faith based healer who works at the Mira Datar Dargah
17	Lal Dhaagah	Red thread
18	Rakhi	Protective thread
19	Sawwali	Patient who comes to the dargah for treatment

From the dusty floor where trinkets are sold

To the gleaming shrine where threads tie hope

And the steep steps leading to the revolving world

of cathartic release and feet running bold.

Cross the road where derelict, almost,

Sits another house of hope

Where comfort is found in words and pills

enabling almost all to cope.

One in your body, the other in your soul

Maybe, finally, you'll end up feeling whole.

Disclaimer

All pictures were clicked after taking due consent of the subjects. We ensured that the identity of the subjects was not revealed in cases of ethical considerations.