Traditional
Health Systems
and Public Policy

Proceedings of an
International Workshop,
Ottawa, Canada,
2–4 March 1994

Edited by
Anwar Islam and
Rosina Wiltshire
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### TRADITIONAL HEALTH SYSTEMS — ISSUES AND CONCERNS

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Health care systems have evolved over several centuries all over the world. But with the advent of modern medicine, the traditional systems of health care have been relegated to the past. With the spread of allopathic systems of health care and recognised as based on science that is universal and value free, other systems of health care have been denied the status of scientificity. Despite this, the modern medicine reaches out to only roughly 15% of the population in the developing countries. There are many reasons for this, the fact that the popular medical system is culturally alienating to the people. Over the years, due to the super specialisations, and pharmaceuticalization of health, the costs of seeking care have escalated, besides being based on the reductionist method of understanding the ecology and pathology of the human body. The traditional systems of medicine are based on the conceptual framework of the pancha maha bhutas- a system, conceptualising mind, body and their interaction in dynamic terms whose interaction produces the psychosomatic entity or person. Where as in the western system the cartesian view of living organisms as machines constructed from separate parts provides the dominant conceptual framework.

Modern medicine conceptualized the patient as the sum of a finite set of sub systems which in turn have to be seen for therapeutic purposes as relatively and functionally autonomous of each other. The knowledge systems in modern medicine are mystified and therefore vests the entire responsibility of cure with the medical personnel. Besides these major differences, the basic question the traditional systems of medicine had to confronted was the scientificity.

The status assigned to Traditional systems of medicine by modern medicine, according to Nandy and Visvanathan is as follows.

"Central to the emerging discourse on development represented by the report of the industrial commission was the following classification-

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In it industry, science (medicine) and the nation-state were to be parallel rubrics. Under each of these rubrics, the first category encompasses the rest below it. It is primary, allegedly more stable efficient and more bureaucratizable. The lower forms represent not the "other" as possibility but defeated unscientific structure to be absorbed, assimilated or marginalised. The logic of the intermediate of craft traditions, could survive in the short run but would eventually yield, the argument went, to the all absorbing power of the multinational industrial empires."

It is important to recognize that every culture has its own characteristic health care system. The foundational theories, concepts and principles upon which indigenous health science is based are different from the western medical science. For example in India Ayurveda has evolved as a comprehensive health care system. It addressed itself to health and disease and does not treat disease independent of facts like food habits, occupation and life styles. Health according to Ayurveda is a holistic phenomenon.

The Traditional health system in India as well as South east Asia functions through two social streams. The "lok swasthya Paramparas" which is the local folk system located in several villages of India. The system as has evolved relies on immediately available local resources like flora, fauna and minerals. Woman have been the custodians of these practices and knowledge. Their phenomenal knowledge of food and its qualities, home remedies, as birth attendants, bone setters, practitioners of acu pressure and village level herbalists has hitherto gone unnoticed and unrecorded. They have been functioning independent of state support or other organisations. The second system that originates from the Shastrya stream this consists of codified organised knowledge with theoretical foundations. They come under the Ayurvedic, Siddha, Unani and the Tibetan systems. There is evidence to say that the two streams have a symbiotic relationship.

While a vast amount of knowledge represents the wisdom of centuries of experience encompassed in folk traditions, the flow of information from the shastras to the folk traditions and vice versa has given the strong basis on which the two streams were practised. With the colonial rule for more than 400 years, by mid 19th century allopathy became the sole recipient of state patronage, resulting in a decline in the indigenous system of medicine.

With the dawn of independence there have been efforts to revive the Indian system of medicine. As a result multiple medical systems exist in India today. As mentioned earlier, the most obvious short coming of the health care system in India as in many other developing countries in that, it caters to the few at the cost of the majority. If the answer is in integrating the different systems to suit the needs of people one has to be clear how it is to be done.
The aim of revitalising the community-rooted and autonomous health traditions should be to motivate, harness the potential of the indigenous system and promote self reliance of the rural communities. Along with this, it is necessary to create a supportive atmosphere for participation of interested and competent medical research workers in this task of revitalising the indigenous medical heritage. There have been attempts in India to revitalise Traditional systems of health care and integrate it into the main stream. The exercise has taken into consideration different aspects like clinical and population based trials, drug research, documentation and communication, use of medicinal plants and training (see appendix).

Integration of health systems raises critical questions on the multiple type of drugs, multiple type of practitioners, types of training and how does the planner, administrator of policy maker deal with this plurality. Primary health care has been defined at the international conferences as essential health care, based on practical scientifically sound and socially acceptable methods, and technology made universally accessible to individuals at a cost that the community and country can afford. Primary health care addresses to:

1) The main health problems in the community,

2) Includes education concerning prevailing health problems and the methods of prevention and controlling them,

3) The promotion of food supply, proper nutrition, adequate and safe water supply, basic sanitation, and

4) Relies at local and referral levels on health workers including physicians, nurses, mid wives as well as traditional practitioners to work as a team.

If some of these aspects of Primary Health care have to be a reality a few questions need to be given a serious thought

- How will primary health care be integrated with Traditional systems of health care?

- If the government is serious about what is envisaged, will it be possible to allocate the budget to strengthen the integration?

- The existing health care systems should support Primary health care, by referral, supervision, supplies and transportation to patients, and

- Can the practice of traditional system be given the status it deserves as being holistic, not as mere treatment with medicinal plants alone.
While attempting the integration at a conceptual level, it is not possible to ignore the fact that there are critical questions we confront. For example, healers always practice in suspicion with a feeling of insecurity. How do we safeguard the interest of such healers who are not recognized and belong to acceptable system of health care? When we are concerned about the legal control of malpractice within the traditional system we also fail to take into account the self regulated modes of practices that existed in the earlier days. For example, it is recalled that ageing healers get distinct signals as their power recede. Manishe and Awasthi narrate an incident when an old man treated his patient for scorpion bite and sent him home. The patient and his relatives, however returned in an hour saying that the pain had resurfaced. The old man at once understood that some one else was challenging his powers and that he was incapable of retaliating. He sent the patient home with apologies and sat down quietly for a long while. Then all of a sudden he asked his twenty five year old son if he wanted to inherit the power. The son was happy and became the successor on the subsequent eclipse night.

How do we cope with the kind of training that was pursued by the traditional healers to pass on their powers? Sometimes the healers choose their successors. It was also the practice for the "Guru" to ask the novice to wait until the night of the forthcoming eclipse. On that night the guru takes the young entrant to a body of water and asks him to completely undress. Then he whispers the sacred chanting in the latter's ears and asks him to repeat it the whole night, staying partially immersed in water all the time. The guru advises him to revise the chanting at least a thousand times in an overnight session each year. Can this kind of training be envisaged? These examples are cited only to briefly mention on the kind of problems one can encounter in attempting to integrate the traditional systems along with the formal systems.

Besides some of these managerial problems of integration, there are other valid issues. As the market incorporates the products of traditional systems of medicine, the resource base of these systems, of communities and their rights over it, are further expropriated. The crisis in the forms of knowledge, practice and organisation of indigenous people health care deepens further.

Health for all by the year 2000 was the slogan at the time of Alma Ata declaration. But in today's burgeoning crisis of development and health care, health for all seems to be a dream of the distant past. To quote a leading authority on the health care in India (N.H.Antia) "The very title of the 1993 World Bank report "Investment in Health" indicates its perspective coming from an international monetary agency rather than from an institution concerned with social welfare with economics only a means for subserving this end. The involvement of the World Health Organization does not lent much credence as a truly international document. This is not only because of the increasingly western bias
of the WHO after the departure of Halfdan Mahler but is also reflected in the authorship of this document where 35 out of 40 are westerners and the three Tropical Diseases Institute inputs are from the US, UK, and Switzerland. The tone of the entire document and even more so of its other secretive though widely circulated counterpart report on health sector financing in India: "Coping with Adjustment and Opportunities for Reforms" is one of arrogance bordering on insolence where the World Bank and its western experts decide what ails the "need based" countries and prescribe a dose of their harsh western economic medicine which is now sought to be thrust down the throat of countries when they open their mouth for economic aid".

He further adds that the report commences by warning us that the world faces serious new health challenges due to diseases like tuberculosis as a result of AIDS, oblivious to the fact that as a result of poverty the need based countries have been suffering from a pandemic of tuberculosis for the past five decades with over 4,00,000 people dying annually of this disease in India alone. Must it require a new western disease like AIDS to draw attention to this major problem? AIDS is also being converted to mass hysteria and a new money spinner with the creation of a new demand for World Bank loans. It is obvious from the above statement that it does require an array of foreign experts to tell us what is wrong with the health of our people or the functioning of the health services of the countries that deviated from the socialist path of past independence development.

The basic reason for this, according to Antia, is the inegalitarian system developed by the ruling elite who prefer an affluent western life style regardless of the consequences to the rest. It is also a sad commentary on the World Bank report that it is oblivious to the fact that India has some of the most advanced indigenous systems of health and medical care like Ayurveda, Siddha and Yoga which see life in a far more holistic manner than their western counterpart. These systems are conscious of the importance of the mind over the physical body; also that we are a part of nature with which to live in harmony. This is age old concept ingrained in the health culture of our people which is so different from that of the west. With such vast differences in the way health as conceptualised by the communities, integrating the traditional systems with the formal system bristles with problems.

If science is defined as a body of knowledge obtained by a systematic observation of events, it can not be denied that such observations had been carried out in the past as well. There is nothing in the definition of science or the scientific method which precludes the possibility of referring back to scientific insights obtained in the past or in other cultures. Indian system of medicine by this definition certainly qualifies to be a science in its own right.
APPENDIX

Thrust Areas For The Revitalization Program

1. Clinical and Population based trials,
2. Drug Research and Pilot Production,
3. Manuscript Research,
4. Documentation, Communication and Policy Studies,
5. Medicinal Plants Propagation and Data Base, and
6. Training

Clinical and Population Based Trails

* On diseases with high incidence in rural areas, in collaboration with: a) traditional medicine hospitals and research centres, b) selected modern hospitals and research centres, and c) community health organizations.

A core clinical trail unit be established centrally with experience in the modern and traditional medicines, biostatistics and computer science. The objectives of this unit will be:

1. To design controlled clinical trails with technical advice from adhoc committees, where needed, from appropriate medical experts and prepare detailed written protocols.
2. To help in the selection on centres for conducting multi-centre clinical and population trails using uniform protocols and record forms/questionnaire schedules.
3. To monitor the progress of the trails through field visits if needed.
4. To centrally collect and analyze data on the trails, and
5. To prepare the first draft report and circulate for comments from participants.

Drug Research

* Priority to drugs useful in primary health care,
* Standardise traditional drugs found to be clinically effective on physical, chemical and biological parameters,
* Evolve new drugs from traditional formulations,
* Transfer tested drugs to industry for production, and
* Provide technical know-how to the herbal medicine production units at the district level, which will supply drugs to primary health care centres.
Manuscript Research

* Survey, collection of medical manuscripts from within India and abroad.

* Collection of bibliographies, indexes and catalogues, critical editions of major works, concordances and data bases which are useful to researchers, teaching institutions and community health organizations.

Documentation and Communication

* Document and evaluate local health traditions.

* Prepare health educational materials to be used by the:
  a) local communities and local folk practitioners
  b) training programs in traditional and modern medical centres
  c) community health organizations
  d) primary health care centres
  e) school system and
  f) general public

* Conduct policy studies to help develop strategies for effective involvement of local communities and indigenous medical knowledge in primary health care.

Medicinal Plants

* Create 100 medicinal plant reserves in different biogeographic zones,

* Open 100 seed banks and research nurseries to serve village communities health centres, community health organizations, social forestry departments, drugs farms, panchayats etc.,

* Create tissue culture propagation facility for plants,

* Open a central computerized information cell to guide users on location, availability of seeds and saplings etc., of all medicinal plants needed by traditional practitioners, and

* Publish illustrated books, prepare slides and photographic packages on medicinal plants, and create a data base.

Training

A. Support innovative training programs organized by community health organisers for village-level traditional health workers like the Dais, Bone-Setters, Herbal-Healers, local specialists in Visha, Nadi-Pariksha, Marma etc., in order to strengthen their traditional skills and knowledge base.
B. Support small "Guru-Kul" types of training centres around talented traditional physicians in those medical areas where healthy traditions are alive viz.,

1. Accupressure (Varma)
2. Pharmacy (Siddha/Ayurveda/ Unani/Self-help processing technology)
3. Dental care (Dant Vaidya)
4. Bone-setting (Mara Chikitsa)
5. Eye disease (Netra Chikitsa)
6. Mental disease (Manos-rog)
7. Panch Karma (a form of therapeutical cleansing of the body)
8. Visha Chikitsa (poisons)
9. Mother and child care

Training should be given to village level health workers, medical graduates and trainees from South East Asia.

C. Create/strengthen pilot, model teaching institutions of traditional systems at undergraduate level to demonstrate teaching standards that can lead to the improvement of the quality of medical personnel.