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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Understanding Traditional Health Systems:  
A Sociological perspective

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Introduction

Human life is inherently frail - from the inevitability of decay and death to that of disease and sickness. Whether following the Parsonian logic or Goffman's model it is called, "assuming a sick role", alleviation of disease and preservation of health, both conditioned by culture, have been a human pursuit since antiquity. Using drugs and diet as remedies for the disruptive episodes in the life process, is not something new. It is as old as human existence. The prehistoric humans derived the therapeutic agents from nature, without maligning the environment. The plant kingdom, since the very beginning of human civilization, served as the reservoir of medicine - therapeutic agents to restore health. Over time, the need to cover a wider variety of disease patterns and to augment the therapeutic potential of these agents, mineral and animal constituents began to be incorporated into this plant-based medicines. Needless to say, this use of natural resources as therapeutic agents was predicted on a unique belief system encompassing the concepts of health, physical or mental illness, diagnosis, treatment and of prevention. The accumulated knowledge of such health practices and products is a rich cultural heritage common to all human societies, sometimes ignored or unrecognized in a formal or institutional sense.

What separates this body of knowledge referred to as "traditional medicine" (TM) for lack of a better term from "modern medicine" is the fact that the latter is anchored in "science", while the former in practical experience. As long as science continued to be narrowly defined, traditional medicine remained largely unnoticed. It took sort of a scientific revolution, a paradigm shift, to draw renewed interest in traditional medicine. Increasingly, the very validity of this "traditional-modern" dichotomy is being questioned. Traditional medicine differ from the "modern" or "western" medicine not in terms of goals or effects, but in terms of their underlying cultures and historical contexts. Viewed from this perspective, the World Health Organization (1977) noted, "all medicine is modern in so far as it is satisfactorily directed towards the common goal of providing health care, despite the setting in time, place and culture". This "traditional-modern" dichotomy is also a cultural construct that relates to certain socio-political dynamics. So, a sociological approach is needed to
analyze and fully comprehend these socio-political factors.

The present paper taps on this renewed interest and attempts to explore the nature of traditional medicine in different countries, analyzes their differential development and examines some of the policy alternatives in bringing about a harmony between the traditional and the modern systems of medicine.

**TM: Diversity of Culture**

Traditional medicine, its nature, axioms and practices, varies from one country to another, or more precisely, from one culture to another. Even its name, and that of its practices and products, vary from one place to another depending on the socio-cultural heritage, religious and political identity. From China, India, Indonesia to the African states and the indigenous peoples throughout the Americas, there are a variety of systems that may be termed "Traditional Medicine" - the Ayurvedic, Unani, herbal medicine, etc. Although, as noted earlier, for lack of a better term, these diverse systems are lumped together under the rubric "traditional medicine", the term does not really reflect the fundamental nature of these systems. The term "medicine", for example, tend to emphasize the treatment or curative aspect of these systems, ignoring their preventive aspects. Moreover, the term "medicine" neglects diverse practices that encompass any system of TM. In Pakistan, India or Bangladesh, there is the Unani and Ayurvedic systems of medicine. Chiefly based on remedial agents from plants, the Unani system derived its name from Greece - Unan in Persian. It proudly proclaims Aristotle as its founder, being responsible for registering the therapeutic value of thousands of plants. It has its own theories and principles. Long before the WHO declaration, the Unani system considered health, not merely in terms of absence of disease, but as a relative "physical, mental, spiritual and social well-being". This system adopts a holistic approach and considers humans to be an integral part of the totality of the environment. Health implies a state of equilibrium among all the constituent elements of the environment. In such an approach, the individual's social, cultural and physical environment, temperaments, constitution, predispositions, as well as diet regimen, food, compatibilities, living habits and mental composure or spiritual beliefs are considered significant in causation and cure of ill health. Such a holistic perspective on human health is perhaps a common link between all traditional medicines prevalent in diverse settings - from the herbalists and shamans in rain forest areas of South America through to the spiritual healers among the Natives in Canada, Australia, the United States and the Latin American countries.

Philosophy, religion and spirit are central to TM found among the indigenous peoples of the Americas. Traditional medicine, in this case, is intricately tied to the belief system. According to a recent study, their belief system "is built upon the concept of
a balanced universe made up of energy fields. The world, the environment, the community, the family, and the self are interwoven and move in harmony to each other. The medicine wheel reflects this philosophy. It depicts the circularity of life, of energy never being lost, and of continual learning and quest for knowledge. It encompasses the teachings, the values, the beliefs, and the social mores of traditional Aboriginal Indian culture" (Aboriginal Nurses Association of Canada Report, 1993).

Aboriginal Indian culture believes in four components of the self: body (one's physical self), mind (cognitive abilities), emotion (the psychological self), and spirit (spiritual/religious beliefs). These components are intertwined, and for one to be healthy, all these components of the self must be in a state of equilibrium. Good health is God's precious gift; by maintaining good health we are showing our appreciation to the creator. And to maintain good health, one must establish a balance between these four elements of the self. If one element is neglected, an imbalance pervades all other elements and, ultimately, affects the self (Malloch, 1989). For good health, one must establish a balanced relationship with oneself, with family, community, the land and the world. In other words, sickness is being perceived as and imbalance which may begin in the physical or the mental realm; or in the emotional or the spiritual realm.

It is important to note that in the indigenous culture, the term medicine is also defined in a much broader sense than in the western tradition. "Medicines include all things that heal. These can be internal to oneself such as laughter, tears, communication; or it can be external such as, words that one hears, behaves or actions or medical remedies and tonics. Placed within this perspective, TM includes what western scientific medicine calls health practices and behaviours, as well as, medical treatments and remedies. Medicines are believed to be gift from the Creator (ANAC Report, 1993).

The Chinese or Vietnamese TM practitioners may differ in vocabulary and formulary from their Pakistani, Bangladeshi or Aboriginal Indian counterparts. However, they all share a remarkably similar philosophy of human health, illness and nature. Yet, it is the underlying culture that makes them different and distinct. It is misleading to say that "some 80% of the people in the developing countries have no health care system at all", as quite a few reports by respected international agencies tend to conclude. "These people depend on their traditional and indigenous health care systems and their healer, practitioners of TM and traditional birth attendants or so-called native midwives are indeed their primary health care workers" (Bannerman, 1981).

This discussion may lead to two conclusions: 1) "traditional medicines are found in all societies throughout all periods of history and predate the rise of modern scientific medicine or
allopathy at the beginning of the nineteenth century", and 2) "any culture's TM includes perceptions of health and definitions of illness, beliefs about etiology and appropriate preventive and curative practices, as well as roles for indigenous practitioners who not only treat illness but also act to restore health of individuals and a sense of well-being to the community as a whole. Traditional beliefs and practices do not develop in isolation but are part of an integrated set of social institutions within a cultural system. Consequently, they serve many functions for adherents and are often highly resistant to change even when the cultural tradition itself is no longer viable" (Mathews, 1992).

**Differential Evolution: Legacy of Colonialism?**

The TM of different countries and cultures vary from one another in respect of level of formal recognition. While in China or in the Indian sub-continent or in other parts of Asia, TM is fully recognized formally, in most African or South American countries such recognition is largely missing. In the Americas, particularly involving health practices and products of indigenous people, there is little acceptance of even their very existence. Consequently, indigenous knowledge in health is in danger of being lost, unless rigorous efforts are made to preserve them for future generations.

This differential evolution of TM can be traced back to the differential nature of colonialism that countries around the world had to endure. Apart from brutal incursions from imperial Japan, the Chinese belt of Asia remained largely unscathed by colonialism. India, Pakistan, Bangladesh, on the other hand, endured almost 200 years of British Raj. Before the British, the Moghuls from Central Asia came to conquer India and settled in and ruled it as rather benevolent rulers. The Moghuls not only brought a rich cultural heritage of their own, but also contributed immensely in further cultural, social and economic development of India. Under the Moghul rule, the Indian traditional medicine (Kabiraji, Ayurvedic, Siddha, etc.) received royal encouragement to flourish. The Unani system came through the Muslims who settled in India during the Moghul rule. Surprisingly, these traditional medicinal systems acquired and retained to this day, a religious orientation - unani by Muslims, while Kabiraji/Ayurvedi by Hindus. In Pakistan or Bangladesh, there is no Hakim (Unani practitioners) who is a Hindu; similarly, there are hardly any Ayurved or Kabiraj who is a Muslim. By the time the British came, these systems were quite developed, with their own schools and formularies. The religio-ethnic groups identified so strongly with one or other of those systems that the British found it difficult to ignore them, even when they were looked upon with disdain. Between 1757 and 1835, the new colonial power largely tolerated the indigenous medical systems, while laying the foundation for the Western medical system. Since 1835, officially at least, the British Raj adopted a policy of regarding Western medicine "as the hallmark of a higher civilization, as a
sign of the moral purpose and legitimacy of colonial rule in India, just as indigenous medical ideas and practices could be casually equated with ignorance and barbarism" (Arnold, 1993:57). Nevertheless, the social, political and geographical reality of India made the British adopt an attitude of benign neglect towards the indigenous medical systems. Quite often, in the interest of political expediency and in following the policy of divide-and-rule, the British Raj was almost forced to patronize one or the other TM system from time to time. Consequently, these systems continued to develop along with the newly introduced "western" system of medicine.

Encouragement and support given by post-colonial or, in case of China, post-revolutionary governments also contributed to the continued development of these traditional medical systems in the Indian sub-continent and China. As early as in 1955, a few years after the revolution, the Chinese government emphasized the need to promote traditional medicine. Driven by pragmatic reasons, the Chinese government concluded: "We must also fully realize that our ancient cultural heritage is the fruit of the genius and creative labour of the Chinese people, and that many of our contributions to culture are worth preserving and developing... If only we could enlarge the scope of our studies in Chinese medicine, rediscover the hidden treasures in our ancient science and art of healing, and make them available to the people, great achievements could result" (Chinese Medical Journal, 1955).

In India, Pakistan and Bangladesh, traditional health systems received recognition and state support only after independence. It was in 1962 that Pakistan first enacted the Unani and Ayurvedic Medical Practitioners Act to recognize and regulate these traditional health systems. In India, the Ayurvedic system gained recognition during the 1950s and gradually become a "separate profession". In the Indian subcontinent and China, traditional medical services are available as a routine part of national health services. Practitioners are trained in four or five year degree programs in separate institutions recognized and regulated by the government. Often TM association oversee the licensing process and establish and monitor professional standards. In most part of Asia, traditional medical practitioners provide most to the health care services in rural areas, where the overwhelming majority of its population live.

The African countries went through a different kind of colonialism. Labelled as the "Dark continent", it suffered the indignity of slavery, apartheid, most extreme form of repression and oppression. When slaves were not treated as humans, there was no question of providing any respect for their culture. Thus there was least or no respect for their health practices and products. On the contrary, they were repressed, often brutally. In Africa, "colonial governments and early Christian missionaries despised and therefore attempted for many year to discourage the use of
traditional medicine" remarked one of the foremost authorities on African traditional health systems, Professor G.L. Chavunduka (1986). "They attempted to suppress the traditional medical system for a number of reasons," wrote Professor Chavunduka. The colonizers "did not know that traditional medicines are effective in curing many illnesses. They believed that the traditional healer was just a rogue and a deceiver who prevented many patients, who would otherwise be treated effectively with modern drugs and surgery, from reaching government and mission hospitals." Their belief that traditional healers encourage witchcraft "which was regarded as one of the greatest hindrances and stumbling blocks in the way of Christian missionary work", also played a role in this policy of suppression. According to Professor Chavunduka there was a powerful economic reason too. "It was the desire on the part of colonial administrators to force Africans everywhere to depend entirely on medicines produced in western countries. Complete dependence on Western medicine would, of course, benefit Western countries and their pharmaceutical companies. Attempts are still being made to discredit traditional healers for this reason" (Chavunduka, 1986:30).

Unlike their Asian counterparts, the African traditional medicine, therefore, did not enjoy a natural process of evolution and development. It remained undeveloped, neglected and unrecognized. Consequently, African TM stagnated, and often, further degenerated during the long period of colonial rule.

A different type of colonialism prevailed in the Americas, Australia and New Zealand. In those places, colonialism was physical and permanent. The Aborigines were physically uprooted and annihilated. A new society was created on the ashes of the old. "When the first European arrived in the fifteenth century, Native Americans had already inhabited the continent for some thirty thousand years and numbered several million" (Dobyns, 1966). The European settlement and parallel policy of "replacement of the Natives" were so efficient that "by the early 1800's few Native Americans remained east of the Mississippi river" and "by the beginning of this century, the vanishing Americans numbered only about 250,000 in the United States" (Tyler, 1973). The indigenous population of Mexico, decreased from 2.3 million in 1650 to about one million in 1890's.

Little can be expected of such colonialism. Quite obviously, this brand of colonialism had scant respect for the culture of the vanquished. Health practices and products of the indigenous peoples of the Americas, therefore, remained unrecognized and unexplored. It not only suffered from lack of a natural growth, but also faced the spectre of total extinction along with the annihilation of its adherents. Unlike the African or the Asians, the Natives did not regain independence, but struggled with continued discrimination, segregation and socio-political isolation. Not surprisingly, Native traditional medicine is perhaps one of the most endangered cultural
heritage of modern times. Some of the indigenous knowledge is fast disappearing, and is likely to extinct, if not preserved immediately. Preserving and further developing indigenous health practices and products must be regarded as great challenges of our time.

Resurgence of Interest

In the past decade there has been a resurgence of interest and activities in TM both in developing and developed countries. A number of factors contributed to this resurgence of interest. Perhaps, the most important factor is the nationalist spirit that engulfed the developing countries on their independence from the colonial rule. With political independence during 1950s and 1960s, most of these countries experienced a sense of cultural revival. Reviving one's own culture and taking pride in it, became a nationalist goal. Nationalist political leaders of this post-colonial era, like India's Nehru, Ghana's Nkrumah, Algeria's Ben Bella, Indonesia's Sukarno, Tanzania's Nyrere, Egypt's Nasser and Zambia's Kaunda, championed such cultural revival. Traditional medicine, along with other cultural heritage, undoubtedly benefitted from this nationalist revivalism. For the Indigenous people of the Americas, the growing demand for self-determination, land rights and self-government have produced a similar result. This cultural revival renewed the interest in traditional health practices and products among the Indigenous people. At a recent PAHO conference on indigenous people and health, many country representatives from South America and Canadian and American Indian bands, stressed the need to "rediscover and restore" the traditional healing systems practised by indigenous people of these centuries. Latin American representatives reported on the growth of activity and interest in TM in their countries. Several countries established a separate department or division of traditional medicine within their health ministry. Fifty-two different associations representing traditional health systems were represented at a recent meeting on TM in Mexico City.

More recently, hard economic realities also contributed to this renewed interest in TM. For many developing countries, the Western health care system became economically too burdensome. This system, in most cases, is based on institutions (hospitals) with a curative focus. In many developing countries, hospitals are primarily located in large urban centres while the bulk of the population live in rural villages. These hospitals, with all their modern technology, often consume more than 90% of the health budget, leaving little resources for other essential activities. In some countries, one single urban-based large hospital often account for more than 50% of the total health budget. Drugs, produced by
multinationals, and often imported from outside, are also a cost burden that few developing countries can afford. Faced with such economic pressures, many developing country governments have recently increased their support for the long-standing traditional medical practices.

In part this resurgence is also simply an acceptance of reality. In many developing countries, more than 80% of the population, mostly living in rural areas, depend almost exclusively on traditional medical practitioners for their primary health care needs. Governments could hardly continue to ignore this reality. On the other hand, the priority for these governments was to create a legal framework for standardizing and regulating diverse traditional medical practices within their borders.

International concern and pressure to conserve bio-diversity is the latest source of influence on the promotion of TM. Two other interrelated factors must also be noted: clinical tests on the efficacy of some traditional medical practices (with positive outcome) and, consequently, a rush by some multinationals to patent and market those products. These latest developments brought forth a plethora of problems and issues, but at the same time, ushered in a new era for traditional medicine.

Search for Substance

The use of natural products for medicinal purposes, according to proponents of traditional medicine, has many benefits. For example, a crude herb contains numerous chemical elements along with the "active ingredient". Since the herb is used as a whole, often in combination with a number of others, a natural mechanism is there, according to this argument, to protect the user of the drug from its potential side effects. This argument underscores two fundamental principles: that the synergistic effects of all the chemical constituents present in a particular herbal drug make traditional medicine less susceptible to side-effects and, inter alia, that in so far as traditional medicine is concerned, it is counter productive to look for the "active ingredient". The very desirability and practicality of applying Western scientific approach is thus questioned. Needless to say, such a line of reasoning is anathema to the Western medical tradition.

Not surprisingly, such conclusions about the efficacy of traditional health products are often questioned. Sceptics are willing to accept them only after careful scientific research. The identification and separation of the active ingredient and its clinical trial are two fundamental elements of such scientific investigation. In these days of scientific development and rigorous experimental methodology, concern for consumer safety and security, and, not least of all, fear of litigation, such insistence on scientific validity is neither unexpected nor unjustified. It is argued that traditional medical practices and products, to be
considered safe and effective, must have the same scientific basis like Western medicine. In some cases, multidisciplinary studies on pharmacologically active chemicals isolated from medicinal plants have clearly validated their traditional claims. Studies and tests are being carried out around the world - from China, Vietnam and India to Mexico, Nicaragua and Peru. A recent study on Neem (funded by IDRC) has validated numerous pharmacological qualities of this tree leaf used in different Asian and African countries for a variety of ailments. A recent article in the Times of India notes: "the government too is pouring money into research on herbal and mineral medicines. The ICICI is funding testing of the first Ayurvedic formulation for Parkinson's disease. Ayurvedic treatments for AIDS are being tested in the JJ Hospital in Bombay and the Madras General hospital. The ICMR plans to spend over Rs. 8.5 crore on a systematic search for drugs and techniques in indigenous systems. It has identified 20 diseases not amenable to satisfactory treatment by allopathy, and chosen to evaluate Ayurvedic treatments for six of them - anal fistula, bronchial asthma, viral hepatitis, urolithiasis, diabetes mellitus and filariasis - with the help of experts from both traditional and allopathic medicine, pharmacologists and biostatisticians" (Srinivasan, 1994). Such studies and, often, resultant scientific validations, have generated an intense interest on traditional medicinal plants among pharmaceutical multinationals in particular, and the Western medical practitioners and researchers in general.

In most developing countries, the use of TM has considerably increased in recent years. In spite of phenomenal progress in the area of synthetic drugs, traditional medicine is the only form of medical care available to the mass population in those countries. It is relatively cheap, and its practitioners are usually more accessible, both geographically and culturally. Most of them are ordinary folks, coming from similar socio-economic background as their clients. Referring to traditional medical practitioners in Thailand, for example, one researcher points out, "indeed, traditional health services tended to be generally less expensive and more easily accessible...; more importantly, however, they were tied in with religion and the occult. In other words, traditional healers and therapies were, and are, quite integrated with the indigenous culture and ways of life. Even today, the social roles of traditional healers are well accepted and relatively close to those of the ordinary people. For instance, the role of the traditional midwife is similar to that of a grandmother in a village and the names of traditional healers are associated with the status of a an uncle, aunt, or a grandfather. The relationships between traditional health practitioners and patients are therefore two-way interactions, that is, reciprocal relationships.... In consultations with traditional healers, patients feel free to ask questions on the ways to solve a problem or how to obtain more herbs or more remedies. Traditional healers are respected and held in high esteem in their village. Most healers are old, and they are respected for the experience that comes with age. Also, their fees
re low and the therapy they prescribe is associated with ritual and religion. The popularity of traditional health care in Thailand then is due to the way that specific concepts, techniques, and medicines of traditional healers merge with the familiar and reassuring lay knowledge and beliefs. The system of explaining illness is familiar and comprehensible" (Sermsri, 1989). In short, there is an affinity or social bond between the TM practitioners and their clients. The ultimate benefits of TM may, at least partly, be attributed to this cultural/social congruity between its practitioners and consumers.

At the same time, there is a persistent belief, yet to be fully explained, that TM has effective cure for certain complex diseases such as cancer, arthritis, asthma, diabetes, severe dermatological disorders, sexual malfunction etc. In making treatment decision people tend to be guided by some perceived relative efficacy of the modern and traditional health systems (Cavunduka, 1986). Some recent studies, conducted in China, India, Bangladesh and elsewhere, tend to support this view. For example, in treating eczema and certain chronic skin conditions, Chinese traditional herbal therapy has produced quite encouraging results. In India and Bangladesh, Ayurveds and Hakims often claim specific advantage in treating such chronic diseases as asthma, liver cirrhosis, atopic dermatitis, etc.

The fact that traditional medicine does not include such "invasive" practices as blood transfusion, surgery, injections, etc. may have also contributed to their appeal. On the one hand, this reduces the risk of infections (such as AIDS through contaminated blood transfusion or from one partner to the other, i.e., from the doctor to the patient or vice-versa); and on the other, dependence on technology, and hence, the cost. The cost factor alone, in the context of ever-increasing cost of the ever-changing technology based western medical system, must be regarded as an important incentive for developing countries to opt for traditional medicine. It should be pointed out that, these characteristics of the traditional health system (avoidance of "invasive" practices and nonuse of "modern" technology), may also explain, at least partially, its historical lack of appeal to the Western educated, primarily urban-based, population in developing countries. Vaccines, surgery, x-rays, ultrasound, etc. have their own aura of scientific authenticity which traditional medicine clearly lacks.

It would be misleading to say that the appeal or prospect of traditional medicine is limited to developing countries. Obviously, China, India, Pakistan, Bangladesh, Sri Lanka, Vietnam, Indonesia, Malaysia, Sudan, Egypt, Ghana, Nigeria, the Philippines, Mexico and other countries have made great advances in traditional medicine. In China traditional medicine is fully integrated with the modern medical system. In India, as Srinivasan (1994) points out, there are "more than 100 Ayurvedic colleges, 26 Unani colleges and two
Alternative Medicine within Ayurvedic Diploma population yet to World Alternative research facility and Health Organization type of also quotes Moyers added closet and "an year the villages medicine. Traditional every government 35% of the is life a km). land of as an system re-serving of international agencies$13.7 billion, 75% of which was paid by the users themselves. The establishment of the Traditional Medicine Program at the World Health Organization in 1978 should be regarded as an important milestone in this resurgence of interest in traditional medicine. And in 1992 the National Institutes of Health, the pioneer health research facility in the United States, established an Office of Alternative Medicine. Needless to say, the term "Traditional" or "Alternative" medicine is not a foreign term any more with international agencies like the World Health Organization or the World Bank or with multinational drug companies.

Challenges and Prospects

Despite all these renewed interest and real progress, TM is yet to be accorded its proper role with the overall health care system in developing countries. The case of Bangladesh may be used as an example in this respect. It is one of the poorest countries of the world, with a per capita GDP of only US$ 210. With a population of 113.7 million crammed in a meagre 56,000 sq. miles of land mass, it has one of the highest population density (789 per sq km). Poverty, illiteracy, malnutrition and ill health have created a vicious cycle in Bangladesh. According to some estimates, the life expectancy at birth is only 52.5 years, infant mortality rate is 108 per 1000, maternal mortality is as high as 113. Only about 35% of the population has access to modern health care resources (primarily consisting of hospitals and public physicians). The government of Bangladesh spends, or able to spend, only about Tk 20 (US 50 cents) per capita for health. There are one hospital bed for every 3,300 people, and the physician-population ratio is 1:5,338.

More than 80% of the population in Bangladesh use traditional medicine. Traditional practitioners are readily available in most villages and towns. It is obvious that Bangladesh cannot achieve the lofty goal of "Health for All by the Year 2000", without
vigorous participation of traditional medical practitioners in the health care system. Some steps were taken to promote greater cooperation between these two systems and to give its proper role to TM. The Unani and Ayurvedic Board was created in the 1960s to bring the Hakims and Kaviraj within the fold of the "formal" health care system. Nevertheless, the gap persists. In the national health care plans, TM receives little recognition. Effective collaboration of the "modern" and the "traditional" still seems to be an elusive goal. Other countries, particularly those in Africa (Last and Chavunduka, 1986), and the indigenous people of Americas (Young, ed., 1988), face similar challenges.

Policy Options and Issues

Although medical pluralism is a fact in almost every society, the relationship between the traditional and modern systems of health may take one of the following four forms (1):

a) Intolerant Medical Orthodoxy: The western system has a monopoly on health care, and traditional healing systems are either made explicitly illegal or institutionally repressed. Kenya and Ivory Coast are the countries in Anglophone and Francophone Africa that made traditional healing systems illegal. Aboriginal healing systems, on the other hand, are suppressed and ignored.

b) Tolerant Medical Orthodoxy: TM is informally recognized and tolerated. This policy option applies "the liberal principle of 'laissez-faire' in the domain of health. In practice, this means that the State is officially concerned only with the modern medical sector, leaving the other to develop on its own without state control. However, a modern system cannot permit itself to ignore an activity which is so basic to the life of its citizens...Dealing with this medicine in the negative, the state cannot include it in the planning of health services, and thus deprives the state of an important resources which could help it to meet the health needs of the population" (Kikhela, et al., 1979). In this model, alternative therapies or techniques are often used by the orthodox medical practitioners with a view to become more culturally relevant to the client population. The multicultural health care movement in Canada is also a manifestation of such a tolerant approach.

c) Parallel Development of Multiple health Systems: The alternative healing practices are not only recognized legally, but also regulated by the state. There is increased professionalization of these multiple systems resulting in their co-existence. However, parallel development may not translate into active collaboration between the custodians of the traditional systems and the western medical orthodoxy. Countries in the Indian subcontinent and South East Asia may be the best examples of such parallel development.

d) The policy of Integration: This policy aims at combining the theory and practice of different health systems and creating a new,
better, and comprehensive one. China is perhaps the best example of this policy. However, since philosophical underpinnings of the traditional and western medical systems are quite different and often contradictory, real integration is extremely difficult, if not impossible. At the same time, a policy to combine two or more systems in which there is power disequilibrium among the partners can not lead to integration in the true sense of the term. In such a scenario, one may end up dominating the other. In such cases, perhaps establishing equity is more important than integration.

e) Active Collaboration between Fully Recognized Health Systems: It presupposes equity, mutual respect and understanding among the partners. "This option envisages the establishment of structures permitting the integration of the two systems through experiments in cooperation; at the same time, such an option follows from more basic studies on the characteristics and originality of the medicine of the healers. This encounter of two medicines aims first of all at the basic establishment of a health structure which takes of each of them into account; it tends also more basically, to gradually move the centre of gravity of the entire medical systems" (Kikhela, et al., 1979)). It is an emerging trend that needs to be promoted and enhanced. Once fully developed, this will establish medical pluralism in the real sense of term.

In fact, there are structural, social, and political barriers in achieving true medical pluralism. Current renewed interest in traditional medicine provides an opportunity to further explore these problems and promote pluralism. This contemporary focus on TM has also brought forward other related issues. Unfortunately, national and international policy has not kept abreast of these changes by developing appropriate strategies for addressing many issues involved in the support for and provision of traditional health services. These issues may be grouped under four broad categories:

1) preserving and promoting indigenous knowledge, practices and products,
2) collaboration/cooperation of traditional and modern systems of health care,
3) production/research and development of TM with full attention to all the complex issues of intellectual property rights, patent rights, the role of multinationals, etc.; and
4) national and international policies regarding traditional medicine and bio-diversity, and environmentally and culturally sustainable and equitable development.

These issues are complex and critical. Most of them transcend national boundaries and cannot be resolved without international efforts and agreements. It is time that we embark on a serious dialogue, both within and among nations, to address these fundamental issues for human health in all its dimensions. Social scientists in general and, sociologists in particular, must play a
central role in this dialogue and in the quest for better understanding and more meaningful collaboration between the traditional and modern health systems.

Note

(1) These are adapted from an unpublished paper by Dr. David Young, Department of Anthropology, University of Alberta, Edmonton, Canada. (The paper is included here).

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