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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Models of Health Care Pluralism

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Introduction

Following the Alma Ata declaration of 1978, which advocated utilizing traditional healers to help deliver primary health care (World Health Organization, 1978), there have been numerous publications on the advantages and problems of incorporating indigenous healing traditions into modern health care delivery systems. This paper will attempt to clarify the different types of relationship that can exist between biomedicine and indigenous healing traditions. This will involve creating a typology which emphasizes two variables: 1) the relationship between biomedicine and indigenous healing traditions in terms of structural equality (legal recognition and access to resources), and 2) the nature of the interaction between biomedicine and indigenous healing traditions (intolerance, collaboration, etc.).

Types of Relationship Between Biomedicine and Indigenous Healing Traditions within the Same Society

1. Intolerant Orthodoxy

In Type 1, biomedicine has a monopoly on health care and uses its power base to prevent alternative healing traditions from obtaining legal status(1). In societies in which biomedicine has this kind of power, it is referred to as the orthodox system and all other systems are considered unorthodox(2). For Example, it was not many years age that colonial powers persecuted indigenous healers in Africa (Neumann and Lauro, 1982; Freeman and Motsei, 1992) and socialist countries such as the Russia and Cuba decided that only modern scientific medicine would be allowed (Pederson and Baruffati, 1989). Even Canada, which takes great pride in its official policy of cultural pluralism, was intolerant of Native healing traditions until recently (Cardianal, 1969).

This type of intolerance usually did not eliminate indigenous healing traditions but simply forced them underground. According to Lee (1982), many indigenous healing traditions lost their positions of "structural superiority", but they did not necessarily lose their "functional strength". It has been estimated that even after being legally banned, indigenous healers in many societies continued to treat many more patients than did biomedical practitioners. In other words, it is important to make a
distinction between unofficial and official medical pluralism. Although Type 1 societies may be characterized by unofficial medical pluralism, relations between biomedicine and indigenous healing traditions are characterized by structural inequality and intolerance on the part of biomedical practitioners.

2. Tolerant Orthodoxy

In Type 2, as in Type 1, there is a single orthodox healing tradition, but many of its practitioners are tolerant of alternative traditions. In an attempt to provide culturally-appropriate health care, tolerant orthodox practitioners make an effort to understand the beliefs and behaviours of minority patients. This type of tolerant is characteristic of what has been called the "multicultural health care" movement in North America. Masi (1993:7) defines multicultural health as "health care which is culturally, racially and linguistically sensitive and responsive".

An example of tolerant orthodoxy is the argument presented by Gregory (1988:39) that nurses who are providing primary health care to Indian communities "need to be aware of and understand traditional Indian health beliefs and practices if a holistic nursing approach is to be sustained". Another Canadian example is provided by a major hospital in Edmonton, Alberta which has a Native healer in residence. The healer and his wife conduct workshops for hospital staff so that they will have a greater understanding of Native culture and can thus provide better care for the numerous Native patients served by the hospital(3).

It is important to note, however, that in societies characterized by tolerant orthodoxy, alternative healing traditions are not accorded legal status. Unofficial health care pluralism exists in practice, and may even be encouraged, but a single tradition (biomedicine) controls official health care policy and training and licensing of legally-recognized practitioners. In other words, despite its tolerance, biomedicine retains its position of structural superiority.

3. Parallel Independent Traditions

In Type 3, rather than a single orthodox system, there are two or more traditions that legally recognized. Although patients have freedom of choice, there is little active collaboration among practitioners of the different traditions. A good example of this type is found in many African societies where traditional and biomedical clinics exist side by side. Patients frequently go to the traditional clinic for what they consider to be traditional diseases, and to the biomedical clinic for diseases behaved to be to have been introduced by the colonial population (Haram, 1991). Although traditional healers may borrow some of the "trappings" of biomedicine (such as white coats) in order to achieve greater responsibility (Twumasi, 1986), there is usually little cooperation
between the personnel of traditional and biomedical clinics.

Another example of parallel traditions is the case of Japan in which clinics specializing in traditional practices such as acupuncture, moxibustion, shiatsu, and herbal therapy(4) provide popular alternatives for many Japanese who are disenchanted with the ability of biomedicine to alleviate chronic conditions (Lock, 1980). These alternatives are legally recognized by the government as long as they meet certain conditions (primarily in the areas of training and licensing of practitioners). It should be pointed out, however, that in Type 3 societies, official medical pluralism does not necessarily imply structural equality. In fact, biomedicine usually is in a position of structural superiority in that it tends to be favoured by government officials, many of whom have been trained in the West and may view their own indigenous traditions as backward or even superstitious (Warren, 1989). Relations among practitioners of biomedicine and traditional medicine is generally characterized by indifference, and the choice of what kind of healer to utilize for a particular condition is left to the patient. In brief, Type 3 societies have official health care pluralism, but at least in terms of interaction among health care practitioners, it is of a passive type.

4. Collaboration and Combination

In Type 4, the practitioners of two or more legally recognized healing traditions engaged in active collaboration, resulting in a combination of therapeutic techniques, or else the beliefs, practices and medicines of two or more traditions are combined by a single individual. Perhaps the most common type of collaboration is for healers from different traditions to refer patients to each other, depending upon the ailment, or for indigenous healers to be included in the official health care system in those parts of the country in which members of their own ethnic group predominate (Dixon et al., 1983).

A more active kind of collaboration is practised in China where "interdisciplinary" teams can consist of biomedical personnel, traditional Chinese medicine practitioners, and even personnel trained in one of the minority traditions such as Mongolian or Tibetan medicine (Young, Ingram, Liu, and MacIntosah n.d.; Cai, 1987; Chen, 1989; Zhang, 1987). The members of the team collectively decide upon an appropriate treatment program. For example, the author observed a patient in a Beijing hospital who was suffering from gangrene of the toes resulting from poor circulation associated with diabetes. He had first been treated with bio-medicinal drugs which had failed to halt the gangrene. The medical team then switched to a traditional herbal plaster which enabled them to save the middle three toes on each foot. This kind of approach is pragmatic in the sense that it does not require agreement among the practitioners concerning the cause of the
problem or even the best solution. They simply agree to try a treatment which has a high probability of success, if it fails, a different type of treatment is initiated. It is also common in China to use two or more methods of treatments simultaneously, rather than sequentially as described above.

Given the tendency in any society for some healing traditions to have more prestige and power than others, active health care pluralism may require government intervention to maintain a balance of power. In China, for example, prior to the Communist revolution, traditional Chinese medicine was rapidly declining in importance because Western medicine had acquired great prestige as a result of its ability to halt epidemics such as cholera. In an effort to counter this trend, legislation was introduced by the Communist regime to create a more level playing field (Lee, 1982). As a result, although biomedicine still carries more prestige than traditional medicine, active collaboration does occur, and Chinese patients who have a choice of utilizing biomedical practitioners, traditional practitioners, or a combination approach, frequently prefer the latter. Although combining techniques from different traditions usually involves collaboration among different kind of practitioners, it is possible for a single practitioner to be trained in more than one tradition.

There is also a growing trend for biomedical physicians to broaden their healing repertoires by borrowing beliefs, techniques, or medicines from other traditions, even though they are not fully trained in those traditions. The fact that these physicians have an official degree in medicine allows them legally to include a kind of co-option. For example, faced with growing popularity of "holistic health care", some biomedical practitioners known to the author are supplementing allopathic treatment with homeopathic or Ayurvedic remedies. Co-option is also involved when indigenous healers are encouraged to share their medicinal remedies with biomedical doctors or pharmaceutical research organizations. While the intentions may be good, such practices do not necessarily lead to increased collaboration among practitioners of different traditions, and may, in fact, lead to a decline of those traditions whose techniques and medicines have been co-opted. This danger is most evident when the traditions being co-opted are in a position of structural inferiority initially.

Another type of co-option occurs when policy makers encourage indigenous practitioners to adopt techniques and medicines from biomedicine to make them more effective healers. In this case, the indigenous healers themselves, rather than their techniques and medicines, are co-opted and they become paramedical adjuncts to a health care delivery system dominated by biomedicine. This seems to be the philosophy behind many of the experiments being conducted in Africa which involve teaching indigenous healers the basic biomedical techniques such as, how to administer oral rehydration therapy or how to improve nutrition (Green, 1987; Warren, 1986,
Health care at the local level is usually improved by such programs, but they require great sensitivity on the part of program organizers in order to prevent damage to indigenous traditions.

What has been described above are variations on the theme of collaboration and/or combination in societies which legally recognize health care pluralism. There are also a variety of experiments being conducted in societies which do not have legalized health care pluralism. For example, in Canada, some hospitals keep a list of Native healers who are willing to visit patients in the hospital. These healers are allowed to counsel Native patients and sometimes to perform religious ceremonies such as burning sweet grass. The author knows of two hospitals which are contemplating to allow Native healers to administer herbal therapy in the hospital, and another hospital which, at the request of the patient, will release the patient for treatment by the healer outside the hospital setting. None of these experiments involving Native healers require the healers to share their medicinal formulas which are usually passed on only to apprentices.

In summary, Type 4 includes a range of options which provide for active collaboration among practitioners of different healing traditions and/or combination of different therapeutic techniques and medicines within the same practice. This more active type of health care pluralism differs from Type 3 which may also expose a patient to different techniques and medicines, but without the cooperation, or even knowledge, of the practitioners involved.

5. Integration

In Type 5, the goal is to synthesize the theory and practice of different healing traditions into a more comprehensive system. This goes beyond collaboration among practitioners from different traditions, or combining different techniques in a single practice. It requires basic research on the physiology and functioning of the human body. For example, researchers in China have tried to develop a theory which would be broad enough to explain the flow of qi through the meridians, as understood in traditional Chinese medicine, as well as the flow of blood through the circulation system. This attempt has met with very little success due to the fundamentally different starting points of traditional medicine and biomedicine. For the most part, the Chinese have had to be content with what they call "combination medicine" rather than a genuine synthesis of Eastern and Western medical theory. From the perspective of this author, combining the best of the different healing traditions in a society into a more comprehensive system, even if feasible, would not necessarily be desirable because it would lead to a new orthodoxy and to the abuse of power which can result in any system dominated by a single healing tradition. In many ways, Type 1 and Type 5 have a good deal in common.
Discussion

To create a typology requires creating logical boundaries which may not exist in actual practice. For this reason, specific cases may not fit neatly into one of the five types. Many of the health practitioners known by this author attempt to do this by coming to a better understanding of the belief systems of their minority patients. Some of these practitioners, however, define cultural sensitivity to include learning specific medical techniques from the traditions of the minority groups being served. In other words, such practitioners combine aspects of Type 2 and 4.

For most purposes, it does not really matter whether a specific case under study is described as a single type or a combination of types. What is important is that policy makers, responsible for designing health care delivery plans, focus on the variables used to create typology, namely: 1) the extent to which biomedicine and indigenous healing traditions should be provided with structural equality, and 2) the different options available in terms of potential interaction among healing traditions. Focusing on these variables, there arises a variety of practical problems. For example, if indigenous healing traditions are to be legalized as part of a program to introduce health care pluralism, there must be some way of ensuring that quality control is maintained. Closely related to the need for quality control is the need for research on the efficacy of indigenous healing traditions. Health care pluralism operates most efficiently when the practitioners of different traditions have some understanding of the limitations of their own therapies and the strengths of other kinds of therapies. This kind of knowledge allows for intelligent referrals and active collaboration among practitioners from different traditions. Although there has been extensive research on the efficacy of many biomedical procedures and medicines, there has been very little systematic and long-term research on the efficacy of alternative healing traditions (Glasser, 1988; Pedersen and Baruffati, 1989).

A particularly contentious issue involved in introducing health care pluralism involves access to resources, such as the remuneration of indigenous healers. Although indigenous healers in some African countries have organized in the hope of gaining official recognition, some traditional healers may not want to be included in a government health care plan. Many North American Native healers, for example, can not accept set fees for their services and do not wish to be bothered with keeping the records and filing the reports required by various levels of government.

From an anthropological perspective, it is important that all issues be solved in such a way that health care pluralism, whenever it is officially introduced in a society, improves the health of the people as well as preserves the integrity of indigenous healing
If this cannot be accomplished, health care pluralism is probably left to operate informally.

Notes

1. Alternative healing traditions can be aboriginal or ethnic in origin, such as Native healing, traditional Chinese medicine, or Ayurvedic medicine in Canada. These are healing traditions which were dominant at one time in their original cultures, but which are considered unorthodox in other countries. Or alternative healing traditions can be based upon specific diagnostic or treatment procedures, some of which were considered unorthodox from the beginning. Examples are homeopathy, iridology, therapeutic touch, and reflexology.

2. Even intolerant orthodoxy may encompass a variety of healing practices, but one group of practitioners within the system has control over the system as a whole, in terms of deciding which practices are legitimate. For example, a biomedically-based system can incorporate practices such as nursing, but it is those with a medical degree which have the power to regulate the system as a whole.

3. This program is being documented by the author with financial assistance from the Social Sciences and Humanities Research Council of Canada. Because the program is still in the trial stage, it cannot be identified at this time. It will be reported in a later publication.

4. While these practices have long been traditional in Japan, they are Chinese in origin and are indigenous. Apart from some knowledge of medicinal plants on the part of elderly Ainu living in northern Japan, healing practices that predate the waves of massive Chinese influence that began very early do not appear to have survived. There are, however, healing practices associated with some of the so called "new religion" which have developed in Japan within the past one hundred years. Since some of these new religions are at least partly of Shinto derivation, they can be considered indigenous. The Japanese situation illustrates the difficulty of defining terms like indigenous and traditional. In this paper, both terms are used more or less interchangeably to indicate healing traditions that were well-established in a society before the introduction of Western biomedicine.
References


