Traditional Medicine and Health Care Coverage

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A reader for health administrators and practitioners

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Contents

Foreword

The Member States of WHO are currently engaged in preparing and implementing strategies for the attainment by *all* their people by the year 2000 of a level of health that will permit them to lead a socially and economically productive life—a goal popularly known as "Health for All by the Year 2000". To succeed in attaining this goal, all useful methods will have to be employed and all possible resources mobilized. Among these methods are various kinds of indigenous practices; and among those resources are various types of traditional practitioners and birth attendants.

This approach was endorsed by the International Conference on Primary Health Care, held in Alma-Ata in 1978. The Declaration of Alma-Ata, describing primary health care, referred to the need for a variety of health workers, including traditional practitioners as needed, who are suitably trained socially and technically to work as a health team and to respond to the expressed needs of the community.

For team work to be fruitful, team members must understand one another's functions. Since traditional medicine was incorporated in the World Health Organization's programmes in 1976, the gulf between traditional and modern systems appears to have narrowed to some extent. A genuine interest in the many traditional practices now exists among practitioners of modern medicine; and growing numbers of practitioners of traditional, indigenous or alternative systems are beginning to accept and use some of the modern technology.

In addition, some health administrators in the developing countries have recommended the inclusion of traditional healers in primary health care on the grounds that the healers know the sociocultural background of the people, and that they are highly respected and experienced in their work. Economic considerations, the distances to be covered in some countries, the strength of traditional beliefs, the shortage of health professionals, particularly in the rural areas—all these are factors that have also

influenced this recommendation. Suitable training and orientation programmes for healers and traditional midwives have already been developed in several countries.

The purpose of this book is to provide a better understanding of traditional, indigenous and unorthodox systems. This should help to foster team work among all categories of health workers. The book therefore examines the most common patterns of these systems and some of their local or regional variations, and suggests how health practitioners and administrators might best apply this information as they endeavour to improve health care coverage, particularly in the developing countries.

It is hoped that this information will be of use to governments when they consider the most appropriate methods for inclusion in their health strategies. The book is also intended to improve our understanding of why people accept or reject certain practices or why they use or do not use those health resources that are available. Such an understanding should be of help in designing realistic national health plans and related training programmes.

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Introduction

Traditional medicine is a rather vague term loosely used to distinguish ancient and culture-bound health care practices which existed before the application of science to health matters in official modern scientific medicine or allopathy. Some frequently used synonyms are indigenous, unorthodox, alternative, folk, ethno, fringe and unofficial medicine and healing. The term is unsatisfactory because it implies broadly that there is some body of principle, knowledge and skills common to all the varieties of traditional medicine; and because it does not distinguish between all-embracing and complex systems of health care such as Ayurveda on the one hand, and simple home remedies on the other.

Traditional medicine has been practised to some degree in all cultures and other terms based on culture include African, Asian or Chinese medicine. Traditional practitioners define life as "the union of body, senses, mind and souls," and describe positive health as "the blending of physical, mental, social, moral and spiritual welfare." The moral and spiritual aspects of life are here stressed, thereby giving greater dimensions to the system of health care by which man maintains his health.

The problems

How countries can make health and medical care available to all their citizens and communities has been one of the major preoccupations of politicians, administrators, the community and health workers in all the Member States which have joined WHO. Since WHO's creation in 1948, debates in the World Health Assembly, in the WHO Regional Committees and in technical meetings bear witness to this concern and reflect the ambitions, the frustrations and the controversial nature of some problems to which such concern gives rise. A new sense of urgency has characterized recent discussions which have culminated in the global resolve to

accomplish a total health and medical care coverage for all peoples by the year 2000.

The old debate between advocates of scientific excellence and the champions of minimum effective coverage has been largely resolved by a general consensus that all citizens have a right to health and to medical care of their choice, and that this right should embrace safe maternity, the healthy growth and development of children, maintenance of health in adult life, the protection of individuals and the community from environmental hazards, and the provision of medical care for the sick.

To turn such a principle into practical action is a daunting challenge for most countries. The creation of modern health care services and their dispersal to all classes of the population and to remote agricultural and nomadic communities in the fewer than 20 years which remain in this century would be exceedingly difficult in terms of the provision of personnel, supplies, maintenance and supervision. Apart from the cost, the administrative complications and logistics would require governments to introduce major reforms in planning and mobilizing resources, and in the education and training of staff for many of which problems there is as yet little preparedness. The fact that there are very few places in the world where traditional healers are not practising means that a form of health care coverage that is culturally acceptable to the local population already exists and is dealing more or less satisfactorily with many of the health problems of the local people. It was in view of this fact that the World Health Assembly in May 1976 first discussed seriously the contribution that traditional medicine makes to the health care of the community.

The debate, however, has taken place mainly between doctors and administrators, most of whom think in terms of the technological and organizational assumptions of modern medicine and public health. This background leads many, even of those who are sympathetic to traditional medicine, to think of it as no more than a possibly useful source of manpower to increase the coverage of official health services. Traditional practitioners, many of whom have suffered from official neglect or even persecution, have expressed grave doubts about this relationship. Confident of their own power and skills and unimpressed by the quality and coverage of the official health services, they are confronted by a problem summed up by one eminent practitioner of traditional medicine by asking "who phagocytoses whom?" The question is highly relevant because at the present time there are four main organizational relationships between official and traditional health care services. The first might be termed *monopolistic* because it gives to allopathic practitioners sole legal right to practise medicine; the second might be termed *tolerant* because, while not recognizing traditional medicine, allopathic exclusivity is limited to specific medical and public health activities while traditional and unofficial practitioners are free to work and be paid for services in all other fields provided they do not claim to be registered MDs; the third relationship, which might be described as *parallel*, occurs when practitioners of allopathic and other systems of health care are officially recognized and

render services to patients through equal but separate systems; fourthly, there is the *integrated* system in which modern and traditional medicine are merged in medical education and jointly practised within a unique health service.

At the present time about half the world's population resides in countries which have ministries or departments of government responsible for traditional medicine, and in many countries 80% or more of the population living in rural areas are cared for by traditional practitioners and birth attendants. The relationship between official and traditional health care practitioners is therefore one of major importance, although in some countries health administrators will not admit the existence of any such problems.

The background

Until the beginning of the 19th century all medical practice was what we now call traditional. It was then that the great philosophical upheaval of the renaissance began to introduce Cartesian scientific materialism into all human activities and notably into the theory and practice of health care. The new way of looking at things subjected all assumptions to experiment and statistical validation and foresaw the future in terms of research and organization. Of necessity it introduced doubt where previously there had been belief; it emphasized intellect and logic and belittled emotion and intuition.

Its method was to break up complex phenomena into their component parts and deal with each one in isolation. In diagnosis this approach resulted in a search for a single cause; in pharmacology the search was for an active principle that could be isolated; and in the doctor–patient relationship the search for an efficient treatment of the physical cause of symptoms tended to exclude any serious interest in the complexity of the life situation in which the patient was immersed.

The application of scientific method to medicine and public health brought dramatic improvements in all those conditions in which material factors such as infection, poisoning, injury, nutrition or personal and environmental hygiene play a major part in the etiology. In degenerative conditions, however, the results have been less striking, and in conditions where behavioural, emotional or spiritual factors play a major role it would be difficult to argue that the scientific method has produced noticeable improvements; some would contend that deterioration is evident. Since psychosomatic disturbance is today one of the commonest of human afflictions, the philosophy and functioning of modern health and medical services is being questioned in many quarters. Add to this the fact that only in the richest countries has the modern allopathic health service been able to achieve a significant coverage of the population—at what is becoming an intolerable cost—and the search for alternatives seems highly topical.

The official backing which crowned the application of science to individual and social well-being blinded most people to its limitations. Today, it is precisely in societies which have a long experience of scientific medicine that a serious reawakening of interest in the emotional, spiritual and irrational aspects of health is expressing itself by the rediscovery of local traditional systems of health care and the importation of traditional practices from abroad.

In countries into which the scientific approach was imported by nationals who had studied abroad, it often remained isolated in the higher centres of learning and administration. Even today in many such countries research of international significance has greater prestige than that devoted to local problems. It is striking that the amount of research devoted to the indigenous health and medical care system, even in countries where it caters for the majority of the population, is meagre. However, in countries where the scientific approach was imported by a colonial administration, independence has brought about a reactive revival of interest in indigenous health beliefs and practices. This is explained partly as an assertion of cultural identity, partly as a possible means of escaping the spiralling cost of modern health services, and partly as a serious reassessment of the efficacy of many traditional practices in the local setting.

This revival of interest in traditional and unorthodox systems of health care is by no means confined to the so-called developing countries. In urban societies in all parts of the world, health care is being provided by official and unofficial practitioners and in some wealthy countries self-care has become of major public interest.

Some department stores and certain major airports have installed self-operated sphygmomanometers for measuring one's blood pressure; where the reading is not within normal limits, the client is advised to consult a physician.

Even in well served towns with a free general practitioner service, hospitals and clinics, large numbers of people choose to pay for the services of unofficial practitioners. The reasons are many. Apart from the inconveniences of crowds in waiting-rooms, hospital routines etc., the shortcomings of the seemingly cursory or impersonal interviews with the doctor, the difficulty of communication and the sometimes complicated ineffective treatment, many patients feel that there is more to their illness than the system deals with.

In their wisdom the founding fathers of WHO proposed a definition of health as "physical, mental and social well-being". This definition fits the outlook of many of the great systems of traditional medicine as well as, if not better than, it does the current practice of allopathic medicine. The more leisurely and personal interest taken by many healers, the attention paid to the total life-style, diet, rest, exercise, human relations, sexuality and even moral and spiritual factors, does much to satisfy the patient's desire to be understood. The belief that the healer can call on vital and even cosmic forces to reinforce his own skills and release the patient's own

will to recover may add greatly to the confidence which all medical practitioners recognize as important in the healing process.

Whatever the health administrators' point of view may be, the fact is that, wherever he is working, traditional and unofficial health care and medicine exist and enjoy the confidence of large sections of the population.

The epidemiology of traditional beliefs

How can this confidence and the accumulated wisdom of many thousands of years be used to improve the health of the population for which health administrators are responsible? The first step, as in all health work, is to know one's area and its people; the second is to use this understanding to plan for improvements and total health care coverage.

To complement the standard epidemiological information, the health authorities that wish to incorporate the practitioners of traditional medicine among the resources available for extending health care coverage to the entire population should determine the numbers and location of these practitioners, the diagnostic and therapeutic methods they employ, their role and functions in their respective communities, what training and orientation they have had, if any, which of them would be suitable for collaboration or integration, and what types of training and orientation they would require to improve their services. An analysis of such data could indicate the impact of the services given by these traditional healers and unorthodox practitioners on the general health of the community and country. Certain Member States have already embarked on this formidable exercise.

This book is intended to assist the health workers and administrators responsible for extending the coverage of health services to develop a fruitful relationship with the practitioners of traditional medicine who are already living and working among, and enjoying the confidence of, the local population. This book is the first of its kind, and no doubt many shortcomings will become evident in the course of time. However, the editors hope that readers will participate in the achievement of its purpose by communicating with WHO in order to correct errors, make good any omissions, supply examples, discuss theories and review administrative arrangements, report on results of experiments and suggest improvements.

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Part One

Systems and practices of traditional medicine