Int. J. Ment. Health, Vol. 12, No. 3, pp. 30-43
M. E. Sharpe, Inc., 1984

COLLABORATION WITH TRADITIONAL HEALERS: EXPERIENCE IN REFUGEES' MENTAL CARE

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Since January 1980, I have been promoting cooperation between modern and traditional medicine in five refugee camps in Thailand. Initially, I proposed to take advantage of the presence of many traditional healers in the camps and to utilize their skills in the mental health care of refugees,[1] but the demand for herbal remedies soon appeared to be very important among the camps' residents. Therefore, I decided to put particular emphasis on this cooperation and to involve traditional healers in medical as well as in psychological care.

An ethnological approach to mental health care is more logical than an ethnocentric one.[2] After three years of close cooperation with almost one hundred Khmer traditional healers, my colleagues and I can conclude that many have genuine psychotherapeutic abilities and a deep sense of medical ethics. They are well aware of their neighbors' needs, and they are respected and trusted by them in return. Moreover, they speak a common language, rooted in the same cultural background. Therefore, they are often well equipped to give psychological support to patients and to help them solve their emotional conflicts, especially when these conflicts are expressed through cultural beliefs in spirits and possession.

Supporting traditional healers and involving them in refugees'

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health care may be looked upon as useless when one considers that the camps' medical facilities are at a much higher level than those usually found in developing countries. By coming in large numbers to the traditional medicine centers (TMCs), the patients demonstrate that they still have faith in their healers, even when modern treatments are easily available and free. This faith is understandable: we have observed that herbal remedies and other traditional healing techniques can successfully treat a wide range of somatic diseases, which is why patients have confidence in their healers.

In our approach, we try to balance the contributions of modern and traditional medicine rather than emphasize one more than the other. In our mental health work, however, we give a particularly prominent role to the healers and support their efforts in taking care of patients rather than place ourselves in the dominant position. Modern psychiatric knowledge and working experience within Western institutions can help to expand the traditional healers' area of efficacy, but in our setting we have wanted to avoid forcing the healers to adapt themselves to Western models. On the contrary, we have adapted our models to complement traditional practice. The organization of a TMC inside a holding camp conforms to this attitude, because most of the refugees who are staying in these camps are likely to go back to their own country some day.

By contrast, the mental health program in another camp, Phanat Nikhom, usually places more importance on the Western psychiatric and psychotherapeutic approach. Phanat Nikhom is a processing and a transit center for refugees whose resettlement requests are under final consideration, or for those who have already been accepted by Western countries for resettlement. The current needs of the patients and the resources available to them in their future are different in this case.[3] Thus, greater emphasis is given to Western methods in Phanat Nikhom than in the holding centers.

We shall not present details here about the mental health program in Phanat Nikhom because resettlement problems are too specific. The description of the organization of a TMC that fol-

lows refers to a holding camp, Khao I Dang, which has a current population of 65,000.

A holding camp TMC

The four traditional medical centers at Khao I Dang camp provide outpatient services, long- or short-term day care, and inpatient services. All patients are registered and have a consultation with an experienced traditional healer, or *kru*, as they are called by the Khmer people [1,2].[4] The kru makes a diagnosis. He then refers the patient to various specialists in herbal remedies or in specific healing techniques. All of them work together in one large treatment room. Patients usually come daily for their treatment and have another consultation with a healer at least once a week.

Mental patients come directly to the TMC or are referred by the hospital, outpatient clinics, social workers, family members, or community leaders. Depending on their condition, they are treated as outpatients or stay during the day with the group of healers, midwives, and helpers. During acute phases, they remain at the center at night, with appropriate members of their family when possible.

Two or three krus and some helpers perform night duty at the center. They take care of inpatients and go to the hospital when psychiatric emergencies occur on a ward. In the latter case, they either treat the patient in the hospital or bring him to the TMC if the doctor on night duty on the ward agrees.

Two ordinary refugee houses, close to the TMC, provide another facility for temporarily accommodating less acutely ill patients who, for psychological reasons, cannot remain at home. Healers may also take mentally disturbed patients into their own homes, as they sometimes did in Cambodia, but only with the prior approval of senior krus, who base their decision upon the healer's reputation and the character of his wife.

Treatment and rehabilitation

Patients who are staying in the TMC with the healers and helpers

receive valuable psychological support from the whole group. As a consequence, they usually express a desire to work in the TMC. They can help prepare traditional remedies or work in the TMC garden, growing medicinal plants. They are not pushed to work, but they receive a salary proportional to their efforts. In this way we try to avoid having other workers become jealous and reject or humiliate the patient. Such work also serves as a means of demonstrating reality to psychotics. Part of the refugee staff at the TMC is composed of formerly psychotic patients who have reached a stage of social recovery and become full-time workers. Some physically handicapped refugees who were depressed and isolated also work in the center.

The TMC's krus make daily rounds in all the hospital wards. They may use their own methods in addition to modern ones. This helps patients feel that nothing is neglected for their recovery, and thus is a valuable psychological support. Sometimes a mother in the pediatric ward doubts whether she has made the right decision in bringing her child to the hospital and thinks that a healer would be more qualified to save the child's life. In allowing the krus to practice in the ward, we help prevent the mother from suffering guilt feelings if the child dies.

Several patients from the surgical ward are brought to the TMC every day, in the afternoon. They usually suffer from reactive depressions following an amputation. They are given a shower with lustral water (which is believed to have acquired special power through a ritual performed by a healer), a procedure that helps such patients avoid thinking too much about their condition. This treatment and the psychological support given the patients by the whole refugee staff in the TMC are usually sufficient for a quick recovery: the various depressive symptoms that they present—sadness, anorexia, insomnia, adynamia, and withdrawal—generally disappear within a few days without the use of any psychiatric drugs.

The krus are not opposed to the use of modern drugs in conjunction with their own methods. In fact, they ask for sedatives whenever they fear for the safety of patients who are restless during the night and might attempt to leave the center. Only a few

patients receive chemotherapy, as in most cases recovery proceeds from the effect of the healers' methods and from the sociotherapeutic role of the TMC. Neurotic or reactive depressions, acute anxiety, hysteria crises, and even mild forms of schizophrenia simplex or paranoid, providing regression is not too deep, do not usually require any other treatment.

At first the krus were reluctant to become involved with chronic schizophrenics, as they knew that they had little chance of curing these patients and were afraid to spoil their reputation as successful healers. It was easy to reassure them that psychiatrists often find themselves in a similar position. The relationship between schizophrenics and the healers is more productive when these patients receive adequate chemotherapy: by reducing psychotic symptoms, chemotherapy tends to expand the opportunities for treatment open to healers. The association of modern drugs with traditional methods is not always necessary for treating schizophrenics, however. On several occasions patients have achieved a social recovery without any chemotherapy. The krus use herbal steam baths, lustral water showers, and traditional remedies in treating these patients.

The follow-up of patients discharged from the TMC is done by a Khmer refugee social worker. If necessary, a member of the nonrefugee staff accompanies one or two healers on home visits with the social worker. Counseling is done by the healers, who are in a good position to do this because they are accepted as elderly, wise, and respected persons.

The staff

The nonrefugee staff working full time in the center consists of a Western nurse, a Western social worker, and a Thai social worker. A psychologist and I are present part time.

In my opinion, supporting the healers and the other Khmers working in the center is more useful than establishing a deep interpersonal relationship with a few patients. The healers can care for a far greater number of people than we could do by ourselves, provided they themselves are in good psychological

condition. Thus, the risk of creating in the patients excessive psychological dependencies on outsiders is avoided. Several patients have been admitted to the TMC following the departure of Western relief workers because they had become severely depressed or withdrawn. I personally have adopted a direct psychotherapeutic role on only two occasions, when there was an acute risk to the patients that could not be reduced in any other way.

The refugee staff, including healers and helpers, numbers over 90 in the main TMC and in its 3 annexes, which are adjacent to an outpatient clinic. We expect the staff to give strong psychological support to other refugees and to care deeply for them. But the healers and helpers are refugees themselves. They have been subjected to the same stress, and often must face the same existential problems as their patients.[5] They can have the same reasons for worry, depression, and anxiety as those who need to be reassured and supported by them. Like other refugees, they have been victims of man-made situations, have been persecuted for their religious, political, or social backgrounds, and have fled their homeland to seek asylum in another country. They are no longer protected by the laws of their own country, and their security is in the hands of international organizations and the authorities of the country of asylum. Despite the fact that they are relatively well protected, they often feel insecure, sometimes for real reasons, but often because of rumors that spread through the camps.

The self-esteem of refugees is easily wounded, as they are dependent upon foreign help for their survival and have little power over their own destiny. Their future is unclear, and many feel that there are no real solutions for them.

The main role of the nonrefugee staff working in the TMC is to provide healers and helpers with psychological support that sustains their self-esteem and gives them a feeling of pride and security. The more care we give them, the more care they will give to others.

Occasionally, however, a general depression has struck the refugee staff, with a consequent reduction in the efficienty of the TMC in its mental health functions. The depression and the subsequent passivity of the group have almost always occurred

when a nonrefugee staff member has either lost his motivation and begun simply doing a routine job or has started to work mainly for his personal prestige. The result has been a loss of authority on the part of the krus, particularly of their chief. They then come to regard their work as merely routine, a job that provides them with little satisfaction. This problem has been solved by replacing the relief worker, if necessary, and by encouraging the krus to develop a new area of activity in the TMC.

Several aspects of the organization of the centers have psychological functions. Their importance has been confirmed by incidents such as the above. The relationship established between healers and nonrefugee staff is based on mutual esteem, trust, confidence, and respect; tangible proofs of the solidity of this relationship need to be given to the refugee staff [1].[6]

Regular meetings are held between the staff and the head kru and his assistants. A weekly general meeting attended by the whole staff is convened by the head kru. He presents problems that have previously been discussed in smaller meetings and proposes solutions to the group. If we have noticed a problem involving a member of the refugee staff, we do not try to solve it directly, but inform the head kru of our concern. If he cannot solve the problem, he may require our help. Our role is mainly to back the head kru and to show all the staff that we respect him. This attitude has a direct effect upon his pride and an indirect one upon the self-esteem of all the staff members who have elected him as their head. Through this approach we ourselves gain prestige, because prestige is generated by the respect we show others.

The self-esteem of the refugee staff is sustained because they work for their own people, they have many responsibilities, and they have the power to make decisions. Moreover, they feel that this experience in a refugee camp promotes a better understanding of traditional medicine among hundreds of Westerners and therefore contributes to acknowledgment of its value.

Problems and how we deal with them

The number of clients coming to the TMC has always significantly increased whenever the level of anxiety and fear rises in the camp. Several patients were brought to the center at a time when the sounds of regular fighting at the border could be heard; this situation reactivated affects linked with previous stresses. The patients quickly felt secure in the TMC, and their anxiety disappeared without any medication. The quality of the relationship that exists among all refugees working in the center helps give people a feeling of security because they provide mutual support for each other. But nonrefugee staff members also have to provide reassurances by the nature of their presence; they must not identify too much with the refugees lest they internalize the refugees' fears and thus unconsciously add to those fears.

There follows an example of the type of problem that can be appropriately solved through a traditional approach.[7]

> A Western social worker had to deal with a wife-beating problem in a Lao family. The social worker acted as he would have done in his own country, requesting a medical examination of the wife and adopting a protective attitude toward her. He separated her from her husband, whom he blamed completely. The husband, feeling shame, immediately stopped working. A few days later the social worker noticed that the wife was behaving strangely, and he wondered if she had told the truth about her husband's beating her. In fact, she was depressed, confused, and sometimes spoke incoherently.
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> I asked the husband and wife if they thought that they had offended a spirit, and I discovered that they were both convinced that they had. They were immediately more relaxed, simply because they felt free to share their problem with someone who was taking their beliefs into account.
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> They came to the TMC, where the krus explained that a spirit had taken possession of the woman. The krus made an offering of candles and incense and gave the couple lustral water showers. The wife's symptoms of depression and confu-

sion disappeared very quickly, but communication between her and her husband remained difficult. The healers thought that the spirit was still influencing the woman, so they began to question it. The woman replied, though the Khmer believed that the spirit was speaking through her mouth. The spirit required more important offerings: the head, tail, and foot of a pig, chicken, chicken's blood, and a bunch of bananas. The krus boiled these items, except the bananas, and placed them on three dishes with some salt. They lit three incense sticks and one candle that they had placed on each dish. Seven healers, the husband, the wife, and some foreigners then sat around the offerings. The healers first explained to the spirit that the couple could not buy the offerings because they were poor refugees, so the TMC had provided the required items on their behalf. Then the krus urged the spirit to speak again.

The wife was obviously trying to control her emotions. She remained silent for 10–15 minutes. The husband kept insisting that the spirit should tell the group everything. The spirit then asked for flowers of five different colors, which a helper went to bring from the TMC garden. After a while, the spirit started to complain sharply about the husband's attitude toward his wife. From time to time the husband interrupted and argued with the spirit, complaining about changes in his wife's behavior. At one point he became angry with the spirit, saying that it was going too far, but he soon cooled down and went on listening, fearing that the spirit might be offended and take further revenge upon him.

During such cures, spirits play the role of spokesmen. A well-educated Asian woman cannot criticize her husband publicly, but when a spirit speaks through the mouth of someone possessed, the person is not responsible for what is said. The husband would have lost face if he had been blamed directly by his wife in front of others, but the belief in spirits prevented this risk. Spirits have a reputation for stating the truth. Therefore, on this occasion the spirit played the role of a witness who gave credibility to the wife's complaints. The husband's criticisms about his wife's behavior and character changes were directed to the spirit, which was believed to have possessed her and was held responsible for

the problem. Belief in spirits and possession is a defense mechanism of the ego, but this belief, combined with appropriate healing techniques, can break down resistance to the expression of personal affects or interpersonal conflicts. The spirit acted as a mediator. Its presence allowed the husband and his wife to talk freely. They unburdened themselves of feelings they could hardly otherwise have revealed.

Medicine, magic, and religion

Despite the benefits that result from the establishment of mutual understanding between Western practitioners and traditional healers, there is still considerable resistance to this approach. Not all relief workers are willing to cooperate with traditional healers; the level of cooperation between the TMC and other medical or paramedical services has varied from camp to camp. Some medical people can easily accept the healers' playing a role in mental health, but they are more reluctant to acknowledge their involvement in physical medicine. On the other hand, some Christian medical doctors sometimes agree with their patients' receiving herbal remedies, but are opposed to magic healing techniques.

It is interesting to observe that some modern doctors and some traditional healers use similar patterns of logic to form their opinion about the value of methods they themselves do not use. Western doctors and nurses have seldom had the opportunity to observe the healers' practices and to evaluate the success of traditional treatments, but they may have heard about cases in which traditional methods have had detrimental effects. The healers may also have had to deal with the mistakes, and the subsequent failure of the treatment, occasionally made by modern doctors. Among traditional healers, those who doubt the efficacy of modern medicine think in exactly the same way as do modern doctors who discredit traditional medicine as a whole by generalizing from the few failures of which they happen to be aware. Reluctance to refer patients to each other is rooted in exactly the same logic.

The existence of TMCs in camps where visitors are welcomed and everything in the healers' practice is open to view has helped many outsiders adopt a more pragmatic attitude toward the usefulness of traditional medicine in developing countries. Mutual trust has increased with the developent of cooperation. Nevertheless, some modern doctors remain rather contemptuous of traditional knowledge and remedies, as if their self-esteem cannot withstand the anticipatory fear of being eclipsed by the healers, whose prestige, in their eyes, is unfair and unmerited because it is not based on scientific knowledge and university degrees.

Many Christian relief workers have no difficulty in respecting Cambodian beliefs in spirits or in possession and are therefore willing to cooperate with traditional healers who work within such a conceptual framework. Missionaries who had previously lived in Cambodia and several nuns felt quite comfortable working in TMCs as social workers. They respected the Khmer form of spirituality and all aspects of the healers' practices, including magic cures.

Some Christian doctors, however, think the healers make a pact with the devil and worship "false gods." They identify magic cures with witchcraft practices. According to medical ethics, these doctors should provide their patients with all the beneficial treatments available in the camp. Some even agree that magic healing techniques relieve psychological suffering but, as Christians and missionaries, they feel responsible for the spiritual well-being of their patients and think it their duty to discourage them from accepting any kind of treatment involving magic.

The Khmers often attribute their psychological suffering to the influence of offended spirits or to the effect of black magic instigated by personal enemies. Some Christians take this belief literally and believe that conversion to Christianity will help these patients and free them from fears and anxieties. They fail to appreciate the role of projection, which is at the root of these beliefs. From a psychological point of view, a genuine faith often contributes to people's well-being. Moreover, faith can also strengthen the ego's neurotic defense mechanisms. Some extremist missionaries think that conversion necessarily has a psycho-

therapeutic effect. In fact, depending upon the personality of the convert, it can have just the opposite effect. For example, I have seen three Buddhist refugees who suffered a psychotic episode after being baptized; they were borderline psychotics and could not withstand the conflict of identity between the Buddhist and the Christian parts of themselves. One woman clearly projected her conflict into her hallucinations: she developed a hallucinatory psychosis in which she could hear Buddha speaking to her through one ear and the "Christian God" through the other.

The particular characteristics of the superego of psychotics increase the risk that they will acquire, through evangelization, the most rigid and severe interpretation of Christianity. A young Lao presented with a very high degree of psychotic anxiety after being baptized. His self-esteem had suffered severely as he had the feeling that his religion, Buddhism, and his cultural beliefs, and consequently part of his own self, were "bad." At the same time as he maintained that he was still Buddhist, he felt much guilt because he had agreed to become Christian, which seemed to him to be a betrayal of his father and his ancestors. During a two-hour session I used careful psychotherapeutic interventions to point out to him the various aspects of his internal conflict, a technique that significantly reduced his anxiety.

In such cases involving conflicts between Buddhist and Christian beliefs, it would be dangerous to consider magic cures as a kind of antidote that could have a psychotherapeutic effect. On the contrary, this would renew the conflict that these patients have had to face.

> A 27-year-old Khmer exhibited strange behavior, with hallucinations and anxiety. He thought he was possessed by a spirit. He was convinced that the healers could help him and that a magic cure was the only proper treatment for him. He had converted to Christianity, however, and he could not bring himself to request the healers' help. He was treated with chemotherapy, but he did not improve significantly. Two weeks later, he came by himself to see the healers in the TMC. They burned three sticks of incense, recited some mantras, and threw lustral water on him. The patient was extremely uncom-

fortable, anxious, and tense during this ceremony. He felt so guilty toward the church that he could not benefit from the ceremony.

A few days later, the young man decided to be treated by a private healer in the camp, who required a certain amount of money that the patient would have to pay upon being cured. But the patient did not wait: he immediately started to sell his belongings. His eagerness to pay for his treatment reflected his need to try to reduce the guilt and anxiety resulting from the conflict between his desire for a treatment perfectly acceptable in his culture and his desire to conform to his newly acquired religion.

All the healing techniques used by the Khmer healers in the TMC have been acceptable from both a medical and an ethical point of view. However, we did encounter a patient who saw private krus and received treatment that we felt obliged to discourage. The patient was a 27-year-old Khmer woman who had postpartum depression. A group of healers treated her in their house. They made offerings to spirits and gave her lustral showers, but they also beat her severely and even kicked her and jumped on her. The only positive effect of this technique was that she was able to eat and drink when fed by others; in all other aspects, she became catatonic. The krus working in the TMC had never heard that this practice had been used in Cambodia, and they disapproved of it. But among the Khmers in the camp, the group of private healers who had treated the woman seemed to have a good reputation. I witnessed the same kind of cure in another country. The aim in beating "possessed" people was to drive the spirit from their body, but the patients were not injured. Physical pain may satisfy the masochism of some patients, and the punitive aspect of this treatment may satisfy the requirements of their superego. Such treatment may therefore produce superficial improvement in the patients' condition.

The involvement of traditional healers in mental health care can be very effective. It is therefore important to ensure that their techniques are safe and beneficial. Our experience shows that in many cases patients' recoveries come from the healers' methods

and from the psychological support given by the entire refugee staff working in the centers. Thus, modern, trained, mental health specialists are not obliged to take a preeminent role with every patient. Moreover, the involvement of traditional healers and of the community reduces the need for modern psychiatric drugs. In developing countries, drug-oriented treatments are expensive and often difficult to monitor. An approach that makes effective use of traditional methods is more appropriate.

Notes

1. Details are presented in J. P. Hiegel (1979) General recommendations concerning psychological care of the Khmer population in camp. Unpublished report to the International Red Cross Committee, 27 December 1979.
2. J. P. Hiegel (1982) Psychological needs of refugees. Western psychiatric and kru Khmers' approach to the problems. Caring role of TMCs in the Khmer Holding Camp. Report to U.N. High Commission on Refugees' Workshop on Mental Health in Primary Health Care Settings. Bangkok, Thailand.
3. J. P. Hiegel (1982) Presentation concerning mental health services at U.N. High Commission on Refugees' Seminar on the Rehabilitation of Disabled Refugees. Bangkok, Thailand.
4. J. P. Hiegel (1980) Pour une reconnaissance de la place de la médecine traditionnelle dans les soins humanitaires. Report to the International Red Cross Committee.
5. J. P. Hiegel (1980) Psychological needs of refugees. The Khmers in Thailand. Report to the International Red Cross Committee.
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7. See note 2, above, and J. P. Hiegel (1981) Traditional medicine. Unpublished paper.

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CURARE Vol. 7 (1984), 61–79

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Traditional Medicine is not Primary Health Care: A Polemic

Boris Velimirovic

SUMMARY Following a short history of the WHO Programme on Traditional Medicine (TM), the WHO Technical Report "The Promotion and Development of Traditional Medicine" is critically reviewed, as frequently the WHO Programme on TM is confused with the Primary Health Care drive of WHO. The lack of precision in all related definitions and statements of WHO is explained by the fact that no medical or cultural anthropologists nor other behavioural scientists are involved in any of the WHO activities in the field of TM. Whereas good-will and idealistic commitment are not questioned, it is criticized that in contrast to innumerable WHO Technical Reports, this one neglects scientific and objective dealing in favour of emotional advocacy of integrating Traditional Medicine into the Health Services of underserved populations, the latter being regarded by the author as a perpetuation of unsatisfactory conditions where real illness is concerned.

ZUSAMMENFASSUNG Nach kurzer Darstellung der Geschichte des WHO Programms für Traditionelle Medizin wird der WHO Technical Report "Förderung und Entwicklung der Traditionellen Medizin" kritisch besprochen, da häufig das WHO Programm für Traditionelle Medizin mit der Aktion der WHO für Basisversorgung verwechselt wird. Der Mangel an Präzision bei allen diesbezüglichen Definitionen und Aussagen seitens der WHO wird damit erklärt, daß weder Ethnologen oder Ethnomediziner noch Wissenschaftler der Verhaltensforschung in irgendeiner der WHO-Aktivitäten auf dem Gebiet der Traditionellen Medizin beschäftigt werden. Während guter Wille und idealistischer Einsatz nicht angezweifelt werden, wird doch kritisiert, daß im Gegensatz zu unzähligen anderen Technischen Berichten der WHO (WHO Technical Reports) dieser Bericht wissenschaftliche und objektive Behandlung des Themas vernachlässigt, sich dafür emotionell für die Integrierung Traditioneller Medizin in die Gesundheitsdienste benachteiligter Bevölkerungsgruppen einsetzt. Eine solche Integrierung betrachtet der Autor als Verewigung von unbefriedigenden Bedingungen, wenn es um wirkliche Krankheiten geht.

RESUME L'auteur fait un exposé bref sur l'histoire du programme de l'OMS pour la promotion de la médecine traditionelle, puis il fait des remarques critiques sur le rapport technique de l'OMS (TRP 622,1978), car il constate une confusion du programme de la médecine traditionelle et de l'activité de l'OMS pour les soins de santé primaire. Il constate un manque de définitions précises concernant toutes les déclarations de l'OMS qui n'emploie aucun ethnologue ou spécialiste sur le plan de l'ethnomédecine. L'auteur ne doute pas de la bonne volonté et de l'engagement, mais il lui manque la qualification et l'objectivité des rapports sur la médecine traditionelle, qui contraste au niveau des autres rapports. L'engagement émotionnel pour l'intégration de la médecine traditionelle dans les services sanitaires pour les populations désaventagées peut éterniser les conditions insuffisantes en cas de maladies graves.

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Introduction

The decision to write this polemic came from the experience of a recent international conference entitled "Traditional Healing and Contemporary Medicine" (13-15 june 1983, Washington), called by the US National Council for International Health to afford an opportunity for discussion on issues pertaining to "Health for All by the Year 2000", a declared WHO goal. As with all conferences with over a hundred papers, films, etc., running in several concurrent groups, the presentations were too many and varied all to be attended (from case studies about herbalists in Guatemala, Cambodia, Togo, Lesotho, China, the Amazonian area, training programmes for indigenous healers in Ghana or for birth attendants in Sudan, to the investigation into beliefs about and uses of western medicine in various ethnic groups, the role of Ayurveda in health care planning, etc., as well as the WHO-promoted use of scientific oral rehydration therapy for diarrhoeal diseases by lay people or the experience of the Agency for International Development-funded mass-media and health practice projects, tropical medicine and, of course, holistic movement items).

This and other meetings of this kind bring two points to mind. Firstly, that they are largely ignored by the important representatives of contemporary medicine, be they from clinical or theoretical branches, and, secondly, that experienced medical anthropologists represent a minority; the impression is always of the predominance of young, enthusiastic participants who appear to have just received their Ph.D. degree in sociology, to be working towards such a degree, or not to belong to either of these categories but simply to be believers. Among anthropologists, again only a very few are medically trained, most coming from professional backgrounds not involved in the actual delivery of health care in the developing or developed world. The applause which met some trivial generalizations or outright fantasies, indicating that too many were new to field experience, emphasized that enthusiasm and sincerity do not protect against self-deception. It seems that the basic fallacy is the belief that, even if the young anthropologist has mastered (in the best cases) the language of the country in which he works and the ethnography of the region as a whole (which is most laudable), then his sincere commitment to the pluralistic structure of health care and to exploring the relationship between the pattern of traditional culture and the ongoing process of social change for a study period of a year or two, is sufficient for him to understand a given culture.

This brings to mind Professor Hildebrandt from the Universidad de los Andes in Bogota (who was of European origin), when asked why he did not write a book about Colombia answered: "How could I? It is only 20 years that I live and study this country". Even if all biases are minimized, without a good knowledge of actual medical practices, the dangers of distorted vision are enormous. This happens also in some of the European ethnological writers.

Secondly, there was a great deal of haziness about the WHO programme on traditional medicine, which is often confused with the Primary Health Care drive of the WHO. Let us examine this briefly.

Manuscript received oct. 1983. The polemic will be continued and discussed in the 3rd issue of curare Vol. 7 (1984).

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WHO programme on traditional medicine

The WHO programme on traditional medicine (further TM) came formally into being in 1978. It is the only action of the WHO which has not met with universal approval and acceptance by the health professionals and which in fact remains highly controversial. The Chief of the WHO TM programme explains the WHO initiative as follows: "The realization of the prospects inherent in the use of practitioners of traditional medicine as front-line workers in the development of national health systems is conditioned by two independent factors: the changed political power that accompanied national independence, and the low levels of resources that are available to tackle issues of development. The first factor is related to national group pride and is associated with past heritage and newly gained national independence. The second factor is linked to utilization of all available resources" (1).

The first factor speaks for itself and needs no further discussion (see Note 1). The second does justice to the sincerity of the motive and seems to fit into the objective of maximal extension of health care to the population lacking it: health for all by the year 2000. Before we turn to the programme itself, a few chronological data follow to explain its genesis. WHO's interest in traditional birth attendants started with case studies in 1952-54 in Indonesia and the Philippines when, with the assistance of UNICEF, training was initiated as part of the country's midwifery programme.

- In 1969, the WHA 22/54 discussed the need to establish pharmaceutical industry (with the help of UNIDO-The United Nations Industrial Development Organization) and mentioned that the research in traditional drugs may yield valuable pharmaceutical products.
- In 1971, the WHA 24/54 discussed the area of practices of traditional medicine to be differentiated from traditional drugs and decided that the issue is too complex and delicate and concentrated on promoting industry in the developing countries, trying to use local plant resources.
- A meeting on the training and utilization of traditional birth attendants was held at WHO Headquarters in 1972 to develop training programmes, research and studies, that could improve the services of these workers (WHO 1975a).
- In 1974 a joint UNICEF/WHO study on alternative approaches to meeting basic health needs in developing countries (2) suggested that, among others, the practitioners of TM, including traditional birth attendants, may be trained for the primary health care services. This recommendation was endorsed by the Executive Board in 1975 (EB 56/R6).
- An unpublished WHO document (2) of 21 November 1975 proposed that WHO collect data on traditional healers and indigenous systems of medicine, analyse this information, determine the relevance of traditional healing to primary health care and to the needs of various population groups and suggest the main directives for action with special regard to the training and utilization of traditional healers in health systems.
- A consultation on TM was held in Geneva in October 1975, and in January 1976 a document was presented to the Executive Board. The proposed action outlined in the document was further reviewed at an international WHO meeting held in New Dehli in October 1976. This consultation discussed the integration of TM and only the representatives of two WHO regions endorsed this concept fully.
- Also in 1976 the Regional Committee for Africa discussed "Traditional medicine and its role in the development of health services in Africa" (WHO 1976), and the Regional Committee for South-East Asia adopted a resolution calling for the promotion of traditional and indigenous systems of medicine in the Region (3). In the same year, WHO established a working group in Geneva for the promotion and development of TM. At the same time a task force on indigenous plants for fertility regulation was established and the 29th WHA passed the first resolution on utilization of TM manpower. It was only after the well-popularized WHO/UNDP trip to China in 1977 that traditional medicine started to be massively promoted by some countries.

- In 1977, a working group met in Geneva and proposed a programme which was approved by the Executive Board and requested the Director-General and the Regional Directors of the WHO to continue to develop the traditional medicine programme, to allocate the necessary financial and other resources for this programme and to cooperate with Member States on this matter. The 30th World Health Assembly (1977) adopted a resolution (WHA 30.49) urging interested governments to "give importance to the utilization of their traditional systems of medicine with appropriate regulations as suited to their National Health Services".
- In 1978, the 31st WHA invited countries to use traditional plants. An Expert Committee meeting is planned for late 1984 to discuss the role of TM in primary health care.

From the very beginning, the WHO programme was uncertain about the definitions of traditional medicine TM. The one made by a group convened by the WHO Regional Office for Africa, Brazzaville (3), 1976, was as follows : "...the sum of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing... Traditional medicine might also be considered as a solid amalgamation of dynamic medical know-how and ancestral experience... Traditional African medicine might also be considered to be the sum total of practices, measures, ingredients and procedures of all kinds, whether material or not, which from time immemorial had enabled the African to guard against disease, to alleviate his sufferings and to cure himself". The African Regional Office group also adopted a definition of the traditional healer, as follows: "...a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability (3)".

The story of a report

While the above definition was specifically tailored for the African context, it was implicitly adopted by the WHO Working Group in the WHO Technical Report, "The Promotion and Development of Traditional Medicine" (4). This is factually incorrect. Africa has never had an unique system of TM but only a vast variety of different beliefs and practices, while in China, India, Sri Lanka and Pakistan, true systems (classical Chinese, herbalist, Ayurvedic and Unani...) of TM existed for centuries and are still widely practised. They have some theoretical pathophysiological reasoning from which practices are derived, while African practices were empiric. None is a "solid dynamic amalgamation of medical know-how and ancestral experience"and none has managed to "guard against disease", see the important killer diseases which have decimated African, Asian (and, formerly, also European) populations until the advent of the modern preventive and therapeutic measures discovered by scientific medicine.

The WHO Technical Group was composed of a psychologist, two advocates of TM (Ayurvedic and Unani), one physiologist involved in Asian science and medicine, two pharmacognosists and one professor of community medicine. There was no medical, cultural or behavioural anthropologist present, nor any among the 12 WHO members from the secretariat. In the whole process of the preparation of the WHO TM programme, medical anthropologists did not participate, a strange exclusion of the only professional group which, for years, has been involved in the study of this field. The only exception was a PAHO working group to which we will refer later. Neither was there a medical anthropologist among the editors of the WHO published book (1983) "Traditional Medicine and health care coverage" (5), which leans heavily on an advocacy of TM and in which the editors were not keen to publish any critical notes

(in fact the Organization reserves right to revise the text). This may be one of the reasons for the lack of semantic clarity and of precise use of words for concepts that have been well defined by anthropologists.

In fact, two categories are often confused even by (non-medical) anthropologists, i.e. "traditional" and "alternative" medicine. "The first category (traditional medicine, sometimes called, for example, peasant, ethno-, tribal, or village medicine, depending on the subject-matter) represents simply the healing methods of traditional societies whether elaborate or not. Alternative medicine (also termed para-, holistic, fringe, unorthodox, or natural medicine, etc. comprises the rather newer therapeutic techniques like homoeopathy or chiropractics or methods like sensitivity training, endogenous endocrinotherapy, anthroposophical medicine, and many others not fully accepted by scientific medicine or by health authorities. The confusion is increased by the fact that the two categories frequently overlap, as in the case of yoga, acupuncture, or the use of plant medicines- traditional techniques frequently used in industrial countries by the practitioners of alternative medicine. The distinction is further complicated by the use of some modern drugs by proponents of unorthodox medicine or through adaptation to modern technologies (6)".

The WHO technical report n° 622 of 1978 (4) is the only one, among several hundreds of technical reports of the Organization, which has departed from a high technical standard toward a promotional advocacy. It notes that professional health personnel regard TM as a practice "on the decline and of no importance", but states "that this was a serious fallacy in so far as culture itself, of which traditional medicine was an integral part, was neither static nor dead".

There is hardly anybody among ethnologists or social anthropologists who has not failed to note, with regret, that traditional cultures are rapidly disintegrating everywhere. Whatever name is given to this process, urbanization, modernization, industrialization, cultural unification, progress, exploitation or wholly inconveniently, but most commonly, "acculturation", this process has begun and is felt even in the most distant rural areas. As a consequence, many worthy cultures have been reduced to a culture of poverty. Medical beliefs and practices begin to reflect more social class characteristics and limited educational opportunities than the true culture specific features.

"Culture was defined generally as the sum total of the life-style, society patterns, beliefs, attitudes and the commonly accepted organized ways in which a community attempted to solve its life problems. Cultural change and development take place with the acquisition of new knowledge or with a change in the surroundings of the people, who need to adapt in order to survive or to achieve a new life equilibrium. In this context of cultural evolution, traditional medicine has always developed and preserved its role of providing health care in all communities"(4). But a few lines later the Report admits: "However, as traditional medicine in some developing countries has tended to stagnate through not exploiting the rapid discoveries of science and technology for its own development, it has kept a slow pace of change in comparison with medicine as practised in the industrialized countries, which keeps abreast of scientific and technological innovations to the extent that it is often exclusively referred to as modern medicine"(4).

The very reason why TM has been superseded is that it had no built-in correction mechanism. The stagnation is the product of a lack of a methodology of its own to carry out a permanent revision and critical reassessment. TM has not helped indigenous people against cholera and other enteric infections, sleeping sickness, schistosomiasis, trachoma, onchocercosis, and other filariases, malaria, tuberculosis, and other diseases which have decimated traditional people and has kept them in the vicious cycle of sickness, poverty, exploitation and lack of deve-

lopment. It has not prevented death rates today averaging 93 per 1000 births and rates of infant mortality as high as 200 per 1000 in some developing countries. This is then the praised "new life equilibrium".

All this does not prevent the Report stating (without a trace of an skepticism) what at best can be an assumption: *"Traditional medicine has been shown to have intrinsic utility, it should be promoted and its potential developed for the wider use and benefit of mankind" and "that it needs to be given due recognition and developed so as to improve its efficacy, safety, availability and wider application at low cost. It is already the people's own health care system and is well accepted by them. It has certain advantages over imported systems of medicine in any setting because, as an integral part of the people's culture, it is particularly effective in solving certain cultural health problems. It has and does freely contribute to scientific and universal medicine. Its recognition, promotion, and development would secure due respect for a people's culture and heritage"(4).*

There are, of course, many examples that illness perception, medical beliefs, attitudes or some of the behavioural risk factors, etc., are closely related to ethnicity or culture sensu lato and that there is a a cultural context in the choice of therapy. However, the primary objective of modern medicine today is not to solve cultural health problems, in fact TM has accommodated itself with these problems and is part of the problem. The people's culture should be protected as much as possible but TM is that part of culture least worthy of protection (as compared with language, art, music, oral traditon, poetry, etc., which must be protected by all means. MAHLER, Director-General of the WHO, believes that culture (together with illiteracy and apathy) has been used all too often as an excuse for lack of action. "And when we invoke cultural barriers, we invoke another escape mechanism. For culture is ever-changing and it is our duty both to conform to culture, to understand it and to accelerate its evolution in the right direction"(7). An active process of change by education is meant here by involving teachers, community workers, social workers, civic and religious leaders, trade unions, women's organizations and various occupational groups by better informing people through mass media, enlightening the whole population on the prevailing health problems in their country and their community and on the most appropriate method of preventing them and controlling them. All this requires understanding and taking due consideration of the social forces that cause people to act as they do. In concrete terms, there is a need for a change in beliefs of disease causation and treatments. This means for example that tuberculosis does not come when a man or woman with fever indulges in sexual intercourse, that leprosy or blindness are not a just punishment for the sins of a previous life, that disease is not caused by eating food touched by a low caste or by eating in the morning before taking a ritual ablution, that disease is not the result of the wrath of evil spirits, the evil eye, a breach of taboo, sorcery or a combination of these. In the same way, one has to enlighten that the cure for scabies is not cats' or rabbits' urine, that an eye infection cannot be helped by the juice of green chilli or by blowing tobacco smoke into the eye, nor can malaria be treated with a mixture of seven bed-bugs with seven betel leaves and seven peppers, that smearing measles with red earth, worshipping and offering to some Goddess in the event of pertussis, wearing magical beads round the neck for jaundice and worshipping snails for leprosy are neither preventions nor cures. For all of these, there are effective and cheap scientific medicines. Whether one should encourage that the child properly vaccinated against measles or whooping cough, and that the properly treated tuberculosis, malaria or leprosy patient still wear "protective" glass beads or worship their deity, is then, and only then, an irrelevant matter. But there will be no place anymore at the end of the twentieth century for the widely practised sucking of a stone from the head.

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To protect TM in the hope of solving the health coverage of the world population by the year 2000 (among the many claims of advocates) is no more than wishful thinking. Certainly most herbal remedies are innocuous, bone-setters can sometimes be equally effective as orthopedists; thorn-pullers, boil and women's experts or barber-surgeons can sometimes help as much as they did in the not too distant past of Europe. It is known that villagers are not always eager to make use of the dispensaries or hospitals at their disposal, even if these are free and easily accessible, because the evil eye remover, the exorcist, priest or charm maker is more culturally acceptable or more trusted. "In spite of the widespread operation and even some limited effectiveness (either psychological or empirical)", ROEMER (8) writes "their overall impact today on the health of the people must be considered negative. It is perhaps less important that their ministrations are usually medically worthless (if not sometimes harmful) than that they have the effect of misleading sick people and delaying the procurement of sound medical care". There is a danger that the recently observed change in the practice of parallel medicine, (the use of potions and the sale of uncontrolled, homeprepared "syrups", the use of discarded, water-filled antibiotics containers, the hundred times repeated use of discarded, unsterilized syringes) may bring new harms, e.g. hepatitis B, to the trusting people.

Integration of what?

The main thrust of the WHO report is the outright advocacy of integration of TM into offical medicine. It is said that "traditional medicine has a unique and holistic approach - i.e. that of viewing man in his totality within a wide ecological spectrum and of emphasizing the viewpoint that ill health or disease is brought about by an imbalance, or disequilibrium, of man in his total ecological system and not only by the causative agent and pathogenic evolution" (4).

The "holistic approach" (discussed in another article which will follow) is the banner-bearer of the integrationist wave. If this term has any meaning, it indeed applies to the TM concerned with the patient's mind and soul, as well as with his body (more the former than the latter in fact) and therefore some claims are valid, e.g. anxiety-reduction or a form of psychiatric intervention (see note 2, p.78). But measles can be prevented only by vaccination and not by drinking urine (or whatever substitutes are there when harmful or offensive practices have been eliminated), and polio is certainly not due to a disturbance of spiritual and physical factors in the personal environment. Indigenous healers may of course mediate between the community customs and the particular set of religious beliefs which can be disturbed in many ways. But to call this a "total ecological" system amounts to inadmissible reductionism and semantic sloppiness.

Suggested procedures were thought (4) to be:

- an evaluation of therapeutic claims in order to select those types of treatment easily adoptable for wider public use;
- where research in traditional medicaments is already progressing, drugs and medicinal plants, which have already been studied, could be prepared for immediate public use, their production and manufacture being financed from state resources;
- more research to investigate all aspects of traditional medicine to improve methods, techniques and the composition of traditional medicaments;
- at the psychological level the collection of information on the positive aspects, in order to communicate such knowledge to the political decision-makers and professional personnel employing other systems of medicine, and eventually motivate them to accept and actively participate in the application of traditional medicine in public health care systems.

To shorten the duration of this public education process, the Meeting saw the need for an "educational revolution in some countries, during which there would be curricular reforms and revision of training programmes for medical and other health personnel to respond to the needs of our time" (4).

Jumping on the bandwagon

The WHO programme gives TM recognition, before the above tasks are achieved, by incorporating traditional practitioners into community development programmes. This is thought to be possible by inducing the population to believe that traditional remedies are not second-rate medicine and by retraining traditional practitioners for use in primary health care. TM has become respectable and many authors have started, wrongly identifying it with PHC, community participation and community workers. One of the proponents of integration has become the US AID office of health, known for generous funding. Indeed some organizations, such as Medical Mission Sisters from the USA, active in 22 developing countries, have become ardent propagators of the WHO TM recognition-quest and even claim that they participated in the training of TBAs at their Holy Family Hospital in Techiman in Ghana five years before the WHO report. An elaborate training programme is set up followed by a 4-member team of teachers to visit the trainees etc., but praise themselves, above all, that attention of American film-makers has been mobilized for a 90 minute colour feature film for American and World fund-raising agencies' consumption. The illusion that TM is primary health care will be complete. Instead of "educational revolution", it looks as if an educational contrarevolution is going on.

Each of the supposed advantages of integration is questionable:

- it does not offer reciprocal benefit to each system, but is unilateral;
- it does not improve health care knowledge;
- it does not enhance the quality of the practitioners or only moderately so, again unilaterally; and
- it does not promote knowledge relating to primary health care.

The report notes :

"even where the policy was favourable, certain constraints were still noticeable:
1. Payment of lip-service to the integration process.
2. Fear of the possibly harmful iatrogenic effects of traditional medicine.
3. Doubtful status of the products of integrated training in current social and professional hierarchies.
4. Resistance by intransigent advocates of one or another system.
5. Fear of litigation, since the legal apparatus tends to protect only the entrenched system, to encourage monopoly, and even to proscribe other systems (4)."

The language again includes words such as hierarchies, intransigent, entrenched system, monopoly, etc. What is listed among the guiding principles and prerequisites for integration amounts to the admission of profound problems: "Some guiding principles could be applied to most situations to facilitate the integration process. A major constraint is the current lack of information; the results of a preliminary survey and the assembly of factual data validated on modern scientific principles could be used to help to convince decision-makers, professional health personnel, and the population at large of the value of integration, usually through training programmes and strategies, such as the development of a common pharmacology to serve as a bridge between the various systems. It would also be necessary to *obtain prior guarantee of material and financial support* and ensure eventual success (emphasis added). Another prerequisite would be the early establishment of a dialogue among practitioners of the different systems in order to eliminate prejudices and to help them to develop more acceptable attitudes. The demystification of several aspects of medicine would also facilitate communication between practitioners and the general population (4).

What is obvious is that few health authorities would give a priori guarantees of sociopolitical acceptability and legal recognition, or grant financial support without first having information about the true usefulness of the local traditional practices. In spite of overclaims, this information is lacking, as the report has been obliged to admit. We stated :

"This knowledge cannot be achieved other than by scientific methods -i.e. by systematic and unbiased observation, and by the due examination of data by the trained mind, which will lead to classification, general rules, verification of hypothese, further observations and experiments and the alteration of assumptions. The scientific method is a search for judgements to which universal assent may be obtained (that is of those who understand the judgement). This notion is contained in the idea of progress of medicine. This idea does not mean exclusion of traditional medicine if it could make genuine contributions to health care. Science does not exclude tradition and precious heritage, it involves a developing tradition. But the above methods are the minimum requirements before one can step from inductions to deductions to be presented to governments, to those who will make the decisions. Without them one cannot give responsible judgement but only one that is untenable, ill-chosen, irrelevant or badly made. What is needed, therefore, is a body of tested hard facts to clarify the role of TM today (6)."

The language of the WHO report is not dispassionate and objective. For example: "The tremendous success of the Chinese experience in the integration of western medicine and Chinese traditional medicine continues to provide the shining example of the potential which lies in integration for the promotion and development of systems of traditional medicine (4)".

In fact, Chinese experience is contested, also in China as has been repeatedly reported in the press in the last few years (9). Few people know that so-called barefoot doctors, whose role is emphasized now, are not a traditional but a new category of health personnel. Indeed there is a rapid change and return to competitive examinations and speciality training in China. Indeed, one should go to Hong Kong to study the role of Chinese medicine. Among five million people (90% Chinese), there are still some who use hornets, pulverised horns of various animals or human sperm as omnipotent heal-all. However, the overwhelming majority use the Government scientific medicine services (500.000 hospitalizations in 1980 and 13 million treatments in outpatient clinics- exactly double the amount of 10 years previous) in spite of all the proclamation at international congresses of the virtues of traditional medicine. Is this not a sign of a mistrust of the culturally accepted indigenous medicine or is it a sign of its inefficiency?

The WHO report goes on about the approaches to integration: "It was considered that a cautious approach would have to be adopted to achieve success. The process could begin with basic research on educational systems, together with an investigation of ancient literature, fundamental principles, common drugs in use, principles of diet, problems of environmental hygiene, and other areas which are of interest to all the systems of medicine practised. Adequate knowledge in these fields having been acquired, the mechanisms of integration could then be worked out for implementation. The initial attempt at integration, for most countries, should be by research and studies in traditional medicine, with a view to assessing its claims and validating them on scientific bases. Once this was done, acceptability would increase and integration into existing health care systems would be possible and even easy to achieve. It was observed that the greatest resistance to integration often came from administrative intransigence, and therefore the national poli-

tical decision-makers would have to be convinced of the need for such action. The concept of integration is certainly not easy (4)." It admits that adequate knowledge and objective evaluation are not available but it then passes over to concentrate on advocacy!

The report senses the problems and incongruency of the integration. Fundamental problems which make integration very difficult, or even impossible in certain settings, were identified, among others, as follows:

-"Emphasis on the cultural formulation of traditional medicine.
- Impossibility of integrating certain aspects of traditional medicine based on spiritual, moral or other fundamental principles - e.g. exorcism and special healing arts associated with spiritualism.
- Commercial motives which control the modes of practice in certain settings.
- Fundamental differences between the concepts of life, health and disease - concepts upon which the underlying philosophies of the various medical systems are founded (4)".

Nevertheless, in spite of this correct statement, the report proceeds, without previous studies to promote the outright integration of traditional and modern scientific medicine and health practices. It goes on to state that WHO could promote integration by:

"1)Encouraging and collaborating with Member States to develop and formulate national policies directed towards integration;
2)Encouraging dialogue between the practitioners of the various systems;
3)Recommending the use of integrated teaching programmes in educational and training systems;
4)Promoting integrated research on traditional medicine;"

Among the measures recommended by the report on the national level is: "Replacement of existing council or board members with *more receptive* people who would appreciate the need for change to meet present-day exigencies (4)" (emphasis added).

The report also focused on the development of the existing manpower categories, orientation of professional health personnel to relevant systems of traditional medicine and to traditional birth attendants, who are a widely known category, to modern maternal and child care, "also on the training in Ayurveda, Siddha, Unani and Yoga, training in Chinese traditional medicine, including acupunture, integrated training of the various types of practitioner, consideration of psychological and cultural factors in training traditional manpower categories, instructors and supervisors (4)".

This was all recommended without preliminary studies or any specification about where and how this should be done; neither was there any questioning as to whether it is at all feasible to do it in all but exceptional situations. Orientation of TBAs where possible (age factor) (10) could replace using cow dung on the umbilical stump with a clean dressing, oral rehydration could be given effectively if conditions were favourable. But does this mean training in Ayurveda, Siddha, Unani and Yoga etc., should be promoted all over the world? That modern physicians should be trained together with various other types of practitioners? In most concrete cases, this would mean teaching a combination of various sets of beliefs with the scientific principles the modern physician is expected to have and use and which are not compatible. The report is silent about the quality of care - lack of its control - probably as this is not possible to enforce in the rural setting. Anyone can suck the stones out of the kidney, expelling bad blood by incision, as in the Middle Ages, practise female genital mutilation, etc. But can a physician dispense with the basic reasoning behind the skills he has learned in his technical studies, even if he is maximally sympathetic to the inductive observational empiric learning?

Even in acupunture which has gained a degree of acceptance in many European countries, there is still much controversy on how this should be taught and no agreement has been reached about the manpower to be allowed to practise it or on methods for its evaluation. TM should neither be ridiculed in its original form nor in its contemporary practices, even in the face of hakims or their aids ritually using stethoscopes without being able to understand what they hear. "If scientific medicine is to be carried into rural areas, then it is necessary for medical practitioners to acquire considerable knowledge of the general concepts of cultural and social organization and specific knowledge of rural life and culture" wrote McKim (11) already in 1955. "The successful establishment of effective medicine here appears to depend largely on the degree to which scientific medicine practice can divest itself of certain western cultural accretions and clothe itself in the social homespun of the Indian village". Modern medicine must respect feeling, piety, philantrophy, sympathy, family structure, relatives, even change where required outward forms of delivery (e.g. physician who does not himself prepare or administer medicine but writes prescriptions is considered ineffective) but it cannot compromise on the basic principles of science. When, for example, Ethiopian indigenous healers "wageshos" cut out a child's uvula as treatment for a fever, no compromise is possible.

Stereotypes

FOSTER (12), one of the most experienced medical anthropologists, warns against stereotypes about traditional medicine that have been popularized over the past generation which are worth quoting in extensive: *Traditional medicine is holistic, modern medicine sees only the disease.* "One of the principal arguments advanced in favour of co-opting traditional curers is that they know the family background of their patients and can hence weigh psychological as well as clinical factors in deciding what to do. In relatively isolated peasant villages this is certainly true. But many areas are increasingly subject to population movement. Traditional healers inevitably will know much less about most of their patients than in stable villages." "Even in stable villages, the cures for such illnesses as empache, mal de ojo, susto and bilis seem to be remarkably standardized. Sufferers are treated much in the same way by the same curandero and the latter's knowledge of the family plays a minimal role in therapy. Hence, the family-oriented, holistic argument for the incorporation of traditional curers into contemporary health services would appear to be far weaker than it is often thought to be".

Traditional curers are relatively old, highly respected people in every community and because of their status they should be valuable allies in primary health care. It is certainly true that elderly herbalists with a profound knowledge of traditional remedies, or famous shamans, inspire confidence in their patients. But to assume that because they fulfil this role well in a traditional setting they will do so in another setting is careless generalizing. Aguirre BELTRAN (13) whose practical experience in introducing health services to traditional peoples is unrivaled, tells how, in the early years of the National Indian Institute's work in Chiapas, he and his colleagues assumed that working through local shamans would facilitate the introduction of health services. They were astonished to find enormous resistance to this approach. Old and prestigious people were found not to be the best intermediaries for socio-cultural change. Specialized health training for young literate people proved to be a more practical approach to the problems encountered. This is not to argue that mature traditional curers who enjoy high respect never be considered for new health roles. But Aguirre Beltran's experience shows that a particular stereotype should not be automatically accepted.

Traditional peoples distinguish illness into two categories: the first, illnesses that physicians quickly cure; the second, "folk" illnesses, the very existence of which physicians deny. This adversary model, perhaps the first medical anthropology model, has been widely accepted as a predictor of the choices in care that will be made by traditional peoples. It does appear to have had some validity in the early years following the introduction of modern medicine but, after a fairly short time, it no longer has much predictive value. The striking thing, in many parts of the world, is that today where the services of a physician have been available for a sufficient length of time and are accessible, he is the first choice of most people for most complaints (14) (15).

Physicians practising in traditional settings frequently are ignorant of traditional medicine; they fail to understand its vocabulary and its underlying rationale and hence they have difficulties in communicating with their patients. Like the adversary model, this is another early stereotype developed by anthropologists. Yet, it may often fail to describe reality. The author has been impressed with the physician's skills in eliciting information by use of traditional vocabularies and disease concepts. Far from not understanding these usages and beliefs, they are perfectly familiar with them and they know how to use them to best advantage to obtain the information they need for their diagnosis. Probably many researchers are guilty of underestimating the insight and sensitivity that physicians must display when many of their patients are traditional peoples. (12).

Official Medical Roles for Traditional Curers and Traditional Medicine? Foster writes: "In asking this question, it is natural to consider experience gained to date. Most of it is limited to two areas: the upgrading of indigenous midwives, and the use of traditional curers for mental illness. But success with midwives and mental illness treatment does not necessarily mean that other curers can easily be incorporated into official health services. In the case of pregnancy, both midwife and physician agree about the onset of the condition, its course and duration, and its probable outcome. In the absence of conplications, both do about the same thing. With respect to the treatment of mental illness, psychiatry is the least exact of all forms of medicine, the field in which - at least in stress-induced conditions - it is most difficult to predict the outcome. The symbolic and supportive roles of traditional curers do often seem to lead to successful outcomes, at least to the alleviation of symptoms in sufficient degree so that a patient can continue to live at home.

But beyond these two fields, the problems become more difficult. When the physician diagnoses a malignant tumour requiring surgery, and the medicine man an intruded disease object that can be removed by sucking, are there real grounds for cooperation? The greatest danger in the use of traditional curers, it has often been noted, is that in really serious cases the patient may be brought to the physician when it is too late to help. With respect to the general question of the desirability of incorporating traditional curers into contemporary health services, one feels that most anthropologists want the idea to work.

Yet even with this bias, considerable skepticism was expressed by a number of anthropologists as to 'how feasible this approach is', and reasons were cited as to 'why incorporation of traditional healers into official health systems probably would not work well', among them the fact that removing healers from their neighbourhood environments and subsuming them within a clinical organization and setting would destroy the therapeutic advantages provided by the intimate magicoreligious ambiance of their home consultation rooms (16), would entail a denial of TM practices (17). Some, even for reasons of political and professional reality, doubt that there is much role for indigenous midwives (10) (18).

"Still another reason to doubt the practicality of incorporating traditional curers into official medicine is pointed out by Wagner (19) in his study of the Navaho: there are not as many singers as in the past, and those remaining appear to be less knowledgable and less competent than in former times. Reliance upon "white medicine" probably explains this decline. Wagner's point is true of much - perhaps most - of the developing world. Serious consideration of incorporating traditional personnel into contemporary health systems is based on a false assumption: that traditional curers continue to be produced at the same rate as in the past. Abundant evidence indicates that this is not the case. Wherever the matter has been investigated the same situation recurs: many curers a generation ago; few, and less-prepared curers today. Do doubts as to the advisability of incorporating traditional curers into official health services mean that anthropologists feel traditional medicine can be ignored? The answer, clearly, is "no". Probably all anthropologists agree that health personnel should know more about, and understand and appreciate, the contributions traditional (and "alternative") medicine makes, and can continue to make, to health care. The ability of practitioners of modern medicine to modify their normal practices to more nearly meet patient expectations is one example of how this understanding can contribute to better medical care." (12)

In the field of mental health, a "cooperative relationship" between traditional and professional mental health care providers has been suggested (16). The most viable alternative to attempts to incorporate traditional curers into official medicine may well be the training of people who are full participants in their own cultures in medical knowledge of official medicine (20).

Apprehension about the measuring rods

The success of the WHO initiative to promote TM is, in the words of its speakers: "The growing interest in the subject, large numbers of letters of enquiry, numerous international conferences that have been held or are being planned with or without WHO collaboration. There is, in addition, a growing volume of articles on related themes appearing in scientific journals and lay publications while many institutes and agencies are seeking to associate themselves with WHO as collaborating and training centres, or in making films on different aspects of TM" (1). All the above is true, but what does it prove?

Letters of enquiry in Europe have been mostly from staunch believers of alternative groups (not from those interested in traditional medicine) hoping for legitimization of their ideas, rejected by official medicine; conferences on anything are held where there are suddenly funds to hold them. No doubt WHO has a considerable moving force, which persists with some delay effect even when the original impulse ceases, as manifested by the flood of books on this topic which appear yearly. The printing machine starts rolling, not only for valuable books of medical anthropologists always interested in the studies of healing consciousness and culture cohesiveness but also and particularly for lay publications written by lay people and by what Sir Peter Medawar calls "intellectual underworld". There is always pressure in the form of requests for collaborating centres in any field: an inflationary tendency engendered by the respect which such centres generally carry. And above all, "the field of traditional medicine is an area where various groups with different vested interests, including commercial interests, are trying to gain greater prestige and attention; some would like to have WHO's backing for these purposes" (1).

One should, of course, not confuse the interest in the subject of TM per se with the definite increase in interest in and attention given to the developing world. Faculties of ethnology, formerly attracted 10-20 students; today there are 2000 in West-Berlin alone. For many

aspirants of doctoral degrees at the Universities, and sociologists constructing their own reality in so-called empirical research, medical anthropology, ethnomedicine is an attractive field. More students, including young physicians and nurses go today to developing countries than ever before, to have a different life experience looking for an enlightenment, for alternative to the technologized societies of the West. They all find themselves confronted with health and sociocultural phenomena for which they have not been prepared and some are susceptible to the influence of anecdotal evidence. One should separate from this general interest the laudable efforts of medical anthropologists to make contributions to clinical praxis, to make anthropology relevant and useful for the needs of clinicians, enabling them to provide broader patient care including nursing and bring closer the cultural conception of mental health and therapy.

Even WHO seems to have been apprehensive about the side effects of the process set in motion so that the Chief of the TM programme in WHO (1983) suggests: "What is imperative now is that WHO should stand back and evaluate the traditional medicine programme", though this still may imply that "such a critical analysis will serve to identify, classify and develop the different disciplines involved, and map out clear grounds for further programme growth", it also admits thus that the initiative was launched without a very clear idea of what it would bring. The two major lines of action have been outlined (1) as:

- " Evaluation of traditional medicine and practices to separate myths from reality". It is not difficult to predict that traditional medicine may be found to be inconsistent or even, in many cases, outright antagonistic to the goal of a assuring the best possible status of health for all people.
- " Research into traditional medicine as part of a national health system as not much is know about possibilities that exist for making use of TM in national health delivery systems in countries willing to use it". This is what medical anthropologists who started such studies long before WHO's initiative have maintained all along. One may predict that this will down only to "setting herbal gardens at family and community levels to ensure that safe herbal remedies are available to self-care" (1); an inoccuous and useful part of many aspects of TM.

Furthermore, WHO puts emphasis on training which is beset by the uncertainty of how to train traditional practitioners and perhaps even the doubts that this is possible or advisable (except for traditional birth attendants, where they are trainable.

Primary health care versus unrealistic expectations

High humanitarian intention behind the WHO initiative, motivated by the wish that access to health be extended to all people, is not denied. If anyone, the WHO has cognizance that, unfortunately, large segments of the people in the developing world have no recourse to modern medical attention and that, with the doubling of its population every 32 years, the situation is serious. Sincerity is thus not contested but we submit that the TM initiative was a mistake, a confusion between objectives and methods. Emotional self-indulgence, added by the political pressure from countries where some systems of TM have operated for centuries, has pushed the resolution through at the WHO Assembly. *

* This mechanism is simple; it usually suffices to have a few promoting countries for a resolution to be presented. In the quest for consensus, voting is rarely resorted to and acceptance is usually by acclamation (as was the case with TM). The countries which consider the resolution irrelevant to them may sometimes abstain or accept out of courtesy. Such resolutions do not oblige anyhow, but, once accepted, the resolution gains respectability and may be quoted at will and for any purpose.

The political influences in TM maintenance in some countries after their national transformation are well-documented (see Note 1). The climate of opinion was favourable. Many people have no idea of the lag in development of modern health service programmes in rural areas in developing countries, some may be condescending or uninformed about the merits or lack of them or the way in which the people help themselves in the absence of medical and health care. After all, TM is physically and economically accessible. However, the WHO initiative may have released unrealistic expectations and detracted from the main goal of assuring adequate primary health care for all. Far from being a step forward in providing this missing care, it seems in fact to be a reactionary step behind, it tends to institutionalize the status quo, it creates double standards - one for rural areas and another for urban centres and those who have the economic means to procure good or better care for themselves. It assumes implicitly that nothing could change in the years ahead in the countries which have presently no adequate health services, and thus negates WHO's own drive to develop primary health services everywhere. It suggests that people cannot be educated and staff cannot be rapidly trained in countries where the overwhelming majority of the population is younger than 15 years, numerous examples to the contrary from recent history notwithstanding. As has been documented in WHO publications (21,22) there is no need to copy any model in the organization, staffing, etc. from the commercialized medicine in the West; there is a range of devices and innovative modes at hand to suit needs of any set of circumstances in even the poorest of the developing countries. Economic difficulties are not denied (see Note 2) but they are no excuse for lack of will and action. The attempt to train indigenous healers that might incorporate them into the modern system is perhaps possible in some places, but is a poor substitute for the true development of scientific health care. It retards efforts in this direction by pretending that something is being done or relegates the responsibility to traditional healers instead of trying, as difficult as it may be, to bring something new to an underserved population.

If the objective was the rapid achievement of coverage, the study of traditional medicine is only of secondary importance. What matters here is any imaginative approach to establish primary, basic, low-cost, health workers for the people, reorienting the thinking of health personnel and creating a new type of health worker according to the needs of the country, culture and level of socioeconomic development. Any innovation or creation of new types of health force could be considered that might involve the community and fit into particular political and social situations (6). In India, for example, young literate, married local girls have been hired and trained as Female Village Workers, a programme for a variety of tasks from family planning to diarrhoeal disease treatment and tetanus immunization. If the economic development of a country is the goal, the transformation of a society's social structure and of its traditional institutions is a precondition; in this process, TM is marginal at best or an hindrance at the worst (6).

The WHO resolution cannot be reversed and neither would this be politically possible in an increasingly politicized organization. Fortunately, there now seems to be a more sober, more realistic tone discernible in the fundamental documents of the WHO. In the "Global Strategy for Health for All by the Year 2000", a 90 pages script (23), published by WHO in 1981, and in the 1983 documents*, the role of TM is

*CPC/MIM/13 Annex 5, p.31 and 33, Common framework and format for evaluation the strategies for 'Health for All by the Year 2000' (Health Manpower Development).

mentioned only very discretely and vaguely: "At the same time, full attention will be given to the reorientation and retraining as necessary of existing health workers, including measures to enable them to assume an active role in community health education. Consideration will also be given to the development of new categories of health workers, to the involvement and reorientation as necessary of traditional medical practitioners and birth attendants where applicable and to the use of voluntary health workers".**

Emphasis is today on health workers, their retraining, community involvement. This requires not only participatory efforts but also a system coordination with other sectors (economic, educational, etc) and a mechanism for constant improvement in order to deliver continuously equitable health services and the achievement of modern medicine. There is no mention of integration and the whole effort appears now to be concentrated on research in phytotherapy and birth attendants where applicable. Rational debate would center now, it seems, around the issues of cost and utility. Justly so!

Finally a word about the attempt to use traditional practitioners for delivery of oral rehydration salt for treatment of diarrhoea. ORS is so simple and so effective that it can and should be given by each mother to her child. It is, at the same time, both a medicament and nutrition and there is no need for an intermediary. It is understandable why proponents of TM want to enhance the respect of traditional practitioners by giving them a truly effective treatment tool, but the propagation of ORS is best done by the health and educational system and the problem of its availability and distribution cannot obvicusly be solved by traditional practitioners.

The long-term trend (and, of course, the relatively short one until the year 2000 as well) Roemer writes: "is clearly towards reduction of the dependance of rural people on primitive medicine and a heightened utilization of scientific sercives that are offered" (8).

The advocates of TM may continue to ask:

- What damage is done if we cannot give people something better?
- TM will disappear by itself in time, so let them use what there is, what they have, now.
- People are well able to distinguish between a situation when TM can be used (for minor ailments) and one where scientific medicine is needed, so let TM diminish the burden on health services or some might use both lay and professional care - what is wrong in that? Many high ranking organizational administrators, after a visit shorter than that of the average tourist, are able to say: "It (TM) works; I have seen it for myself", and how scientific is scientific medicine anyhow?"
- Are the thousands of drugs produced by the pharmaceutical industry all scientific?
- Are they all tested for efficacy and justified by controlled trials?
- Is the usage of really scientific drugs, such as antibiotics in daily practice, scientific?
- Is the overuse of X-ray examination by many physicians a comforting ritual or medically justified? A group of top radiologists convened by the World Health Organization concluded that many are "not worthwhile" and are a "major source of population exposure to man-made ionizing radiation".

**Incidentally the best PHC village handbooks ever to be published did not originate from WHO but from the Hesperian Foundation in the USA: "Where there is no doctor", the most widely used health care manual, printed in 20 languages, and "Helping Health Workers Learn", used in developing countries. WHO has produced a much less successful, hybrid book, "The Primary Health Worker, working guide for training, guidelines for adaptation", Geneva 1980.

- Why does also the developed world not make as much use of vaccinations as it could?
- Is the attitude of a scientific practitioner not to inform the patient about his state of health, the nature of his disease, etc., still a responsible and ethical one?

All those questions are valid but are irrelevant in respect to TM. They are not easily discussed but should be asked and eventually solved; however the developed world has gone a long way in providing primary health care to its population. They can be solved by stricter requirements on science and ethics within the context of modern medicine. TM on the other hand may be an obstacle to the provisions of adequate primary health care, the main goal and objective of the present.

What health care for the people?

What policy option have the governments vis-à-vis medical care of their peoples? A preamble of the WHO Constitution affirms: "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures". The World Health Assembly 1970 Resolution 23,61 states that the most important condition for the attainment by all peoples of the highest possible level of health "is the development of *efficient* national health systems in all countries." This can be achieved, inter alia, "through the establishment of a *nation-wide* system of health services based on a *general national plan* and local planning" (Rec.1), "the provision for the whole population of the country of the highest possible level of *skilled*, universally available preventive and curative medical care" (Rec.4), "the extensive application in every country of the results of *progress in world medical research* and public health practice" (Recommendation 5). (Emphasis added).

Thus, can governments be neutral in the question of what kind of health care do their people receive? The role of WHO in the solution of particulars which arise with legislative and administrative provisions dealing with therapeutic and prophylactic care and health protection in general is very limited indeed since they lie within the jurisdiction of the different nations but this does not preclude WHO from engaging in the scientific study of these problems, for which it is well equipped in view of its position as an intergovernmental organization. In respect to TM, WHO should be doing just that instead of being a TM advocate. The question to be answered clearly and dispassionately is "how useful are particular medical practices, skills and personnel against identifiable medical problems "(24).

One certainly should look for alternatives, particulary when large institutions, sometimes coercive and always expensive organizations, with their all- regulating blueprints encroach, when human sympathy gets lost. But we submit that the viable alternatives are not TM in developing countries (or various alternative movements in the developed world) outside of scientific medicine. They are to be found within modern medicine in the search for better, cheaper, less market-oriented and bureaucratic ways to organize it, in the quest for better skills and knowledge and for a more humane form of delivery of health care in the frame of more equitable economic relations.

* * *

NOTE 1

Revivalist movements in modern South Asian history, which have been most evident in the sphere of religion, tend to share certain common features. There is in the first place a recognition that contemporary traditional practices do not reflect the highest achievements of the ancient civilization. Secondly, there is the belief that the decline of indigenous culture, science, and religion is in great measure attributable to their suppression during long periods of foreign rule and the imposition of alien cultures. The third feature follows logically from the second, i.e.

the demand for state patronage from the new nationalist regimes for the restoration of indigenous values. The consequence of these attitudes is the development of a political orientation on the part of revivalist leaders, of a demand for governmental interference in areas from which most modern secular states have either tended to remove themselves or on which they have been prevented from imposing political criteria by the existence of independent interest and professional organizations.

These common features of revivalist movements are apparent also in the Ayurvedic movement, which began to receive political support first in the Indian National Congress, which passed annual resolutions demanding the Governments'patronage for Ayurveda from 1920 onwards. With the gradual development of representative institutions and the increasing entry of Indians into the executive councils and legislatures in the provinces, the patronage of the provincial governments began to be extended to both the granting of assistance to the instruction in Ayurveda and the establishment of new Ayurvedic educational institutions. The modern medical system occupied a clear position of superiority in government allocations, in educational standards, and in the extent of internal professionalization. In order to change the balance between the two systems, the leaders of the Ayurvedic movement adopted the political strategy after Independence of demanding full state support to make it possible for Ayurveda to attain what it had not been able to achieve by its own efforts. One of the main tactics used to make this political strategy effective was to identify Ayurveda with nationalism, national independence, and national aspirations. In other words, the strategy of the Ayurvedic leaders was to confront the political leadership of independent India in its attempts to deal with problems of medical education and medical relief with political demands which had nothing to do with educational or scientific standards.

Specifically, the demand was made immediately after Independence that the emancipation of Ayurveda should go along with the political emancipation of the country through wholehearted government patronage and its declaration that, henceforth, Ayurveda would be the national system of treatment. In consequence there was a creation of a large and entrenched educational establishment producing hundreds of graduates annually, qualified neither in Ayurvedic nor in modern medicine, but who demand the status and privileges of modern medical graduates. Thus, the Ayurvedic movement presents an unusual case of penetration of the political system by educational interests who have failed to establish a viable educational structure and used the political system to maintain themselves. The vast majority - perhaps as many as ninety per cent - of the students of Ayurveda were failures in secondary school, unable to gain admission to a modern medical school or to some other modern professional school and who went to the Ayurvedic colleges as a last resort.

Pure Ayurveda cannot possibly cope with the major public health needs of rural India - the control and cure of infectious and communicable diseases. Moreover, for the last forty years, the system of medical education in Ayurveda, which has been predominant in most of the Ayurvedic colleges, has been what is known as the integrated or mixed system, in which both Ayurvedic and modern medical subjects are taught. Both the pure Ayurvedists and the proponents of scientific medicine agree that this system has produced thousands of poorly trained practitioners of medicine unqualified in either system, making use of dangerous drugs about which they have inadequate knowledge. (Based on an unpublished research manuscript by P.R. BRASS).

NOTE 2

YOUNG (1983) writes that "Traditional healers who treat psychiatric ailments are a class apart for two reasons (35). First of all they provide a service which is generally given low priority in the official health sector", "Second, psychiatric symptomatology is deeply embedded in culturally specific systems of meaning and communication; the universalistic claims of modern psychiatric medicine are frequently problematic and the relative efficacy of many of its practices is uncertain".

The above article is a valuable analysis and attempts to provide answers to the utilization of TM in modern primary health care. The author (an anthropologist) however is probably not familiar with Ayurvedic, Unani and Chinese drugs which he considers as equally effective as scientific drugs and believes that they can be "intercalated" into the armamentarium of the official medical sector. He is however careful to stipulate certain safeguards as to how this could be done without harming the patients.

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Soc. Sci. Med. Vol. 24, No. 2, pp. 177–181, 1987
Printed in Great Britain.

0277-9536/87 $3.00 + 0.00

THE BEST OF BOTH WORLDS: BRINGING TRADITIONAL MEDICINE UP TO DATE

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Abstract—If there is to be any real improvement in the health of the underserved populations of the world, there will have to be full utilization of all available resources, human and material. This is fundamental to the primary health care approach. Traditional practitioners constitute the most abundant and, in many cases, valuable health resources present in the community. They are important and influential members of their communities who should be associated with any move to develop health services at the local level. There have been varying responses to a number of key WHO resolutions that call on Member States to develop traditional medicine activities as part of their national health services. Some aspects of the work of WHO Collaborating Centres for Traditional Medicine and some current activities of the traditional medicine programme are described. A number of guiding principles which may help the Organization and other international and donor agencies working in this area are also suggested.

The resurgence of interest in traditional medicine has been matched by significant work in different aspects of traditional systems of medicine by academics and analysts mainly outside the aegis of WHO. While these efforts are acknowledged and encouraged, it would be beyond the scope of this paper to attempt any review or resume of the distinguished work that has been done in traditional medicine. One might ask, though, what role an international organization, such as WHO, has to play in the development and expansion of traditional medicine activities. The answer is that WHO is fulfilling its constitutional responsibility to act as the directing and coordinating authority on international health work [1]. As such, in those countries in which traditional medicine is widely practised, WHO is mandated to ensure that what is of value in their traditional systems of medicine is made use of in the health services.

The countries themselves constitute the governing bodies of WHO—they decide collectively how the Organization should proceed and develop policies that promote an awareness that there are still useful elements of traditional medicine that could be incorporated into national health systems. This article attempts to present an overview of WHO's involvement in traditional medicine.

It is now ten years since the World Health Assembly drew attention to the manpower reserve constituted by practitioners of traditional medicine (resolution WHA29.72). In 1977, it urged Member States to utilize their traditional systems of medicine (resolution WHA30.49) and then, a year later, it highlighted the importance of medicinal plants in the health care systems of many developing countries (resolution WHA31.33). In the same year, the International Conference on Primary Health Care, held in Alma-Ata, U.S.S.R. [2]—a milestone in the history of public health—recommended that governments give high priority to the utilization of traditional medicine practitioners and traditional birth attendants, and incorporate proven traditional remedies into national drug policies and regulations. It also emphasized that the contribution of traditional systems of medicine called for further research, as new problems are constantly emerging. In addition, there are also resolutions of the Executive Board and Regional Committees of WHO which call for the intensification of efforts in the development of national traditional medicine programmes.

The improvement of the health of all underserved populations, through the full utilization at community level of available resources, both human and material, is fundamental to the primary health care approach. By securing the cooperation of traditional practitioners, Member States are utilizing one of the most abundant and valuable health resources that they have to extend health coverage. Traditional practitioners are, as a rule, important and influential members of their communities, and they should be associated with any move to develop health services at the local level.

However, in spite of the universal call for traditional medicine to play a role in the development of primary health care, there are still many countries where only lip service is being paid to this principle. Other countries have initiated programmes that have had to be abandoned because they were introduced without the necessary preparatory policy formulation and appropriate strategies for implementation.

Where, then, do we stand today? What are the main thrusts of the WHO Programme in Traditional Medicine? What progress has been achieved and what are the prospects for the future?

WHO'S ROLE

Traditional medicine comprises those practices based on beliefs that were in existence, often for hundreds of years, before the development and spread of modern scientific medicine and which are still in use today. They vary widely in different countries in keeping with their social and cultural heritage and traditions.

Generally speaking, however, traditional medicine

has been separated from the mainstream of modern medicine. A basic approach, therefore, has been to promote the bringing together of modern scientific medicine with the proven useful traditional practices within the framework of the local health system. The first step here is the formulation of relevant national policies and decisions on this question, as well as, under certain circumstances, supporting the elaboration of a legal framework for the practice of traditional medicine. A recent example is the WHO Consultation on Approaches for Developing Policies on Traditional Practitioners, including Traditional Birth Attendants, which was held in New Delhi in February 1985. This consultation considered policy issues from a global perspective. The participants, from the six regions of WHO, represented the various disciplines involved in traditional medicine and included administrators, the legal profession, sociologists, anthropologists, educators, and practitioners of traditional medicine themselves. The report [3] of the consultation, representing the collective views of the participants on the utilization of traditional health practitioners in primary health care and the actions required to develop and promote policies for the mobilization of their potential, has been forwarded to ministries of health by the respective WHO Regional Offices. As a result, national workshops are being planned to examine existing policies and the extent to which they can adequately support the establishment of national programmes of traditional medicine.

Training

The promotion of suitable policies is thus an essential first step. Once policy is established, the next step is to favourably influence the attitudes of both traditional practitioners and scientific health workers and further refine their knowledge and skills. On the one hand, specific training programmes need to be elaborated for traditional practitioners. On the other hand, elements of traditional medicine need to be introduced into the already established curricula of training programmes for other health workers. These actions should promote greater acceptance of the usefulness of traditional medicine and lead to a wider adoption of traditional practices. They should also facilitate the transfer of information on traditional medicine practices from other parts of the world.

All health staff, but particularly medical and nursing students, need to be made aware of the place of traditional medicine in their culture, its strengths and its weaknesses, and of the use that may be made of it. Similarly, traditional practitioners need to be approached with understanding and recognition of their skills so as to encourage them to share their knowledge and to play a part in the national health service, usually after a short period of special training.

The training of traditional birth attendants in aseptic delivery techniques and simple antenatal and postpartum care is a good example of the possibilities that exist for collaboration between the traditional and modern health care sectors; this is an area in which WHO has been active for many years [4].

Another example of training, is the standardization of dosages of plant extracts used in traditional medicine and which could be used in primary health care programmes. Nationals with responsibilities for drug quality control and with advanced degrees in chemistry or pharmacy have been trained to select the best methods of assaying and standardizing medicinal plant extracts and to prepare standard protocols of chemical or bioassay methods. The aim is to improve the efficacy and safety of remedies derived from medicinal plants, many of which contain pharmacologically active agents that in an overdose may have harmful effects.*

The WHO programme is collaborating with countries in identifying ways in which traditional practitioners can be trained and mobilized to play an effective role in the health system without destroying their individuality. Efforts will continue in a number of countries to upgrade the skills and knowledge of traditional practitioners. At the same time, analysis will be undertaken to identify proven elements of traditional medicine practices that could be utilized by other health workers as well as the type of training that traditional practitioners should receive, such as instruction in simple aseptic techniques.

Evaluation

Evaluation is the most difficult and yet the most needed field of endeavour. If a generalization may be permitted, one might say that traditional medicine has the support of the population and the opposition of the health professions. Perhaps the most important task for WHO, therefore, is to continue to promote informed opinion on the subject so that traditional medicine is neither blindly endorsed nor rejected by health authorities, but is examined carefully and with an open mind.

Briefly, the aim of the evaluation component of the WHO programme is to put traditional medicine on a scientific basis by:

1. Critical examination of traditional *materia medica* and practices.
2. Accurate identification of the plants and other natural products used.
3. Identification of useful remedies and practices and suppression of those that are patently ineffective or unsafe.
4. Promotion of further research and exchange of information.

Countries where traditional medicine is widely practised are therefore being encouraged to re-examine their systems of traditional medicine and practices by undertaking multidisciplinary studies into the efficacy and the safety of traditional remedies. Such an examination, of course, is much easier in systems of medicine for which the philosophy and educational content are well documented than in the case of traditional remedies handed down from generation to generation by word of mouth. However, in spite of the difficulties encountered, the examination of all these systems shows that they hold great

**Decision Making in the Selection and Use of Traditional Medicine in National Primary Health Care Programmes.* An Inter-Regional Workshop co-sponsored by the World Health Organization and the Danish International Development Agency (DANIDA), Bangkok, Thailand, 24 November to 5 December 1985.

promise of a rich harvest that can benefit mankind, especially in the field of ethno-pharmacology.

Medicinal plants constitute a most important element in traditional medicine. In most developing countries the flora remains virtually unexplored from the point of view of practical utilization, yet past experience shows that many valuable drugs have been derived from plants and information that a plant is utilized in traditional medicine is often an indication that it is worth scientific study. WHO will continue to play a role in sketching out the main lines of action needed for the identification and introduction of traditional medicinal remedies into national primary health care programmes and stand ready to be an active partner with all interested countries. Further success will depend heavily on the resources channelled to these endeavours by Member States.

A fundamental approach to the development of national programmes of traditional medicine has been to strengthen national efforts for research in traditional medicine within an overall national research strategy. Through a study of traditional medicine, a more accurate and complete knowledge of useful and effective traditional practices, as well as potentially harmful ones, is being developed. For this purpose, national research capacities are strengthened through activities to develop manpower and upgrade research facilities. In those countries where little has been done, initial efforts are being concentrated on studies aimed at identifying traditional practices. Encouragement and support are being given to local studies on traditional medicinal plants as a means of reducing expenditures on imported drugs, thereby promoting economic self-reliance. Countries will continue to be supported in their efforts to prepare an inventory of effective traditional practices and techniques.

WHO will continue to identify, in developing and developed countries, institutions which are carrying out research on folk remedies used by traditional practitioners in their ethno-botanical, medico-anthropological, experimental pharmacology and clinical aspects as well as on the epidemiological follow-up of their use.

Other national research centres will be identified as reference centres with a view to developing collaborative activities, linking institutions with each other, as part of inter-country and inter-regional networks on the basis of culture and subject specificity. Such centres will also take the lead in research methodological studies and advanced training. They will receive support to upgrade staff, improve facilities, and expand activities.

Integration into national health care systems

All of this is not a short-term undertaking but one that will take many years. In the meantime, we can still take steps to incorporate those aspects of traditional medicine which have been shown to be beneficial and desirable into national health systems.

Where traditional medicine is well established and seen as a valuable asset for health promotion, traditional practitioners should become involved in the process which strengthens links between traditional medicine and the health delivery system. They should help in the identification of problems associated with the establishment of linkages at the local level. They should be involved in the planning, implementation, and evaluation of community health activities so as to enhance working relationships between themselves and other members of the health team. First and foremost, of course, the traditional practitioners should be involved in the evaluation of their own practices so as to facilitate the ready acceptance by their peers of suggestions for changes, including the assumption of new responsibilities—for example, in health education.

What this implies for WHO is:

1. Support for the elaboration and implementation of appropriate national policies and a legal framework for the practice of traditional medicine.
2. Development of a practical coordinating mechanism between health institutions, related social sectors, and community agencies, including operational research into the utilization of traditional medicine practices and practitioners in health services.

A key role for WHO is therefore to disseminate widely the results of national efforts to incorporate safe and useful traditional medicine practices in their respective national health systems. Specifically, information on national policies, legislation, traditional medicine practices, research experiences, and training programmes will continue to be shared through various avenues, including newsletters and workshops. An international newsletter is already being published three times a year by the WHO Collaborating Centre at the University of Illinois (U.S.A.). It is being supplied, free of charge, to researchers in developing countries through the WHO Regional Offices and WHO Representatives. As for the workshops, the participants will be mainly those already involved in traditional medicine; care will be taken to see that those sharing a common cultural heritage in traditional medicine are grouped together. Another way has been the introduction by the WHO Regional Office for the Western Pacific of an international nomenclature of acupuncture that has facilitated the exchange of information and experience between, and even within, countries on the clinical applications of this traditional form of treatment and on current research.

Technical cooperation among countries sharing common interests will be promoted to encourage a more rapid and effective development of the programme within countries, in areas such as provision of information on assessment of standards, toxicity/safety, stability, pharmacology, and other aspects of traditional medicine remedies. An example of the application of traditional medicine in primary health care is the Inter-Regional Seminar designed to give those responsible for health policy at the national level an opportunity for studying the utilization of traditional Chinese medicine in primary health care and for discussing and examining the possibilities of adopting comparable approaches in the provision of health services in their own countries.*

*Inter-Regional Seminar on the role of Traditional Medicine in Primary Health Care in China, Guangdong Province and Guangxi Autonomous Region, China, 9–21 October 1985.

WHO COLLABORATING CENTRES

In starting this important programme, WHO felt that the first essential step was to secure the interest and involvement of those already working in traditional medicine around the world and to build up a network of specialized institutions and individuals possessing the required expertise, motivation, and enthusiasm to contribute to programme development. This has been done by establishing a number of collaborating centres in the different disciplines that constitute traditional medicine. At present, 21 such centres have been designated. There are five in Africa, three in the Americas, two in Europe, one in the Eastern Mediterranean, eight in the Western Pacific, and two in South-East Asia.

This type of association between WHO and the scientific community is mutually beneficial, serving to give international recognition to the individual institution designated and to make available to WHO their expertise, on which the Organization can call on behalf of Member States. Such assistance covers a whole range of activities, for example:

1. Situational analysis of the potential role of traditional practices and practitioners in national primary health care programmes.
2. Development of policies and legislation for the incorporation of traditional medicine into health systems.
3. Support to multidisciplinary investigations and surveys of local traditional medicine practices, and the use of plants of medicinal value.
4. Collection, analysis, and dissemination of information from countries and regions on successful activities, projects, and programmes on traditional medicine.

The network of Collaborating Centres forms the backbone of the organization's programme in traditional medicine.

ISSUES TO BE ADDRESSED [6]

The list of issues given below is by no means exhaustive. However, taken together, these are key questions that need to be answered before the design of any viable national primary health care programme that successfully involves traditional health practitioners.

How can the formal health services work with traditional practitioners for the benefit of the population? So far, traditional practitioners have been excluded from exercising any responsibility in most national health services.

How can a traditional medicine organized structure be created? Without a clearly defined structure, through which traditional health practitioners themselves can be heard and which could be a regulatory body in relation to ethical and professional matters, there is likely to be chaos.

How can health professionals and others be sensitized and oriented so that they may support the national traditional medicine programme? If they are not brought into a constructive relationship with the programme, they will continue with their biases and hamper government efforts to put traditional medicine on a sound footing.

How should health legislation concerning traditional medicine be reviewed? Most of the present legislation in this field is out-dated or irrelevant and needs to be revised to conform with the new policies adopted. In any case, a reasonable and enforceable legislation would greatly enhance the implementation of traditional medicine activities.

What should the role of bilateral and multilateral assistance be? Any external support should be consistent with government policies and priorities, otherwise, it may lead to unnecessary and wasteful investment in esoteric projects which have no direct relevance to the peoples's health needs.

How can a country develop a national drug policy that includes traditional remedies? Importing drugs is always very costly and consumes scarce foreign currency. Developing traditional remedies of proven efficacy and quality will not only promote economic self-reliance but will have a ripple effect, encouraging research workers to investigate other traditional remedies more carefully.

How can an up-to-date research and development policy in traditional medicine be formulated? At present, research policies in most countries do not reflect the role of traditional medicine in health services. New research and development policies could greatly assist institutions in addressing the critical problems now being faced.

How can traditional medicine activities be financed? The introduction of traditional medicine will require adequate budgetary appropriations. A sound programme and budget that maximizes the effective use of all available resources needs to be evolved.

GUIDING PRINCIPLES [6]

In developing the programme certain guiding principles have emerged which may be of help not only for WHO and its Member States but also to other international and donor agencies working in this area. These principles are as follows:

1. There is no single or simple approach to the problem of how to involve traditional practitioners in national health systems, especially at the primary health care level. Dedicated and sincere action on the part of all concerned will be required to foster a collective effort to generate and implement policies best suited to any given country.
2. The first step could be the establishment of a National Council for Traditional Medicine, that could be charged with responsibility for preparing a national strategy and laying down a broad plan of action to be followed by government. The council should be multidisciplinary and multisectoral in nature, with appropriate representation of the different types of traditional practitioner involved.
3. Major policy issues, including as a minimum all those described in the preceding section, need to be identified, priorities determined and mechanisms established to propose the various options and courses of action open to government, with *ad-hoc* groups being formed to tackle specific issues.
4. Adequate finance should be assured under the government's regular budget for the support and promotion of traditional medicine activities. External

finance should be considered as only supplementary to the government's main effort.

5. In parallel, it will be necessary to undertake a survey of the national situation in respect of the practitioners, the population's preference and needs, resources, special problems, etc., upon which a sound national health plan reflecting the role of traditional medicine may be formulated.

Practitioners of traditional medicine should be engaged in these activities and the results should be made widely known to the general public as well as to the health professions.

CONCLUSION

There is no longer any doubt about the value of incorporating traditional medicine into modern health care. It is happening—it is part of to-day's reality. It is happening for many different reasons but, fundamentally, because people believe that traditional practices have values that they are willing to subscribe to. What is still unclear is how the articulation of the two systems will be brought about in different settings. Will it happen in an atmosphere of goodwill or of hostility? Will it be pursued purposefully or will it be acknowledged reluctantly? Will governments and medical practitioners play a leading role or will they be mere spectators?

WHO's primary concern is to encourage countries to utilize those elements of traditional medicine which have intrinsic value and which can improve the quality and coverage of health care delivered by their national health services. In this modern age, the rich heritage of traditional medicine should not remain the exclusive or esoteric interest of only a few.

"For too long, traditional and "modern" medicine have followed their own separate paths in mutual antipathy. But their aims are surely identical: the improvement of human health and, hence, improvement of the quality of life" [7].

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Newsletter

Number 9 November 1986

Centre d'Etudes de l'Inde et de l'Asie du Sud EHESS, 54 bd Raspail, 75006 Paris, France

IASTAM International Association for the Study of Traditional Asian Medicine

Munich SYMPOSIUM

Fifteen papers were presented at the FIRST INTERNATIONAL SYMPOSIUM ON TRADITIONAL CHINESE MEDICAL LITERATURE, organized by Prof. Paul U. Unschuld, President of IASTAM, at the Institute for the History of Medicine, University of Munich, W. Germany, August 25-29, 1986. Several afternoon sessions were also devoted to the discussion of texts. Although each of the participants represented a different approach to interpreting and rendering ancient Chinese medical texts, they spent together a week of fruitful exchanges in a very harmonious atmosphere.

The Proceedings of the Symposium will be published by D. Reidel Publishing Co. (Dordrecht/Holland) in 1987.

SEE REPORT IN P. 7 TO 13

important books reviewed

obituary

Co-editors

All our energies are applied to the task of strengthening the Newsletter, to make it into a useful tool and to establish a forum for the discussion and review of recent publications and meetings. Plans are on the way for a more ambitious Journal but, given the necessary funds and the large number of collaborators to be mobilized, a first issue cannot be scheduled to appear before 1989. Meantime, the Newsletter will serve as a prototype, to help building an audience and to establish an homogeneous albeit interdisciplinary field of studies.

Two co-editors are joining Francis Zimmermann in the venture: Dr. (Mrs.) Catherine Despeux, a scholar of Chinese medical history, and Dr. Fernand Meyer, MD., already an officer of IASTAM and a scholar of Tibetan medical anthropology.

Moreover, this issue of the Newsletter is published with the financial help of the French CNRS, through RCP 798 "Histoire des Techniques et des Sciences en Chine, au Japon et en Corée".

See more details in page 3.

Next issue will be Number 10 to be published in May 1987

Primary Health Care

Judith Justice

Policies, Plans, & People
(Culture and Health Development in Nepal)
Berkeley/Los Angeles/London: University of California Press, 1986
ISBN 0.520.05424.5 202pp.

Practitioners among us, members of IASTAM, as well as historians and anthropologists are concerned in the planning of health policies and the activity of international funding agencies. Either we may try to locate a suitable function for traditional medicine within a given nationwide system of health care, or we may try to discover the hidden causes that too often render health programs unsuitable for the local conditions and cultures. In both cases, in pursuing both goals - which are compatible, both within the scope of IASTAM, provided we mean social science research, not propaganda -, we do not study Asian medical traditions as simply antiquarians would do, that is, for their curiosity value! Asian medical traditions are part and parcel of a health system, they should be set back in the more general context of Culture and Health Development policies. This is the reason why a review of Judith Justice's book is right in place in IASTAM Newletter.

Why do health care programs often fail to achieve their long-term goals in developing countries? Using Nepal's rural health program as an example, she shows how the failure to take cultural factors into account, as the planning process moves from international policy making to national planning and finally to the delivery of services at the village level, has too often resulted in ineffective programs.

"Primary Health Care evolved as a concept from the social experiments being carried out in China, North Vietnam, and Cuba, especially the Chinese model of the 'barefoot doctor'...", in the 1970s (p. 59). Elsewhere (for instance, in Nepal) at that time another approach predominated: the 'vertical' (disease-specific) health programs to control smallpox, malaria, leprosy, tuberculosis. "But since then the international health agencies have been promoting Primary Health Care as the solution to the health problems of developed as well as developping countries. The rhetoric and jargon of Primary Health Care are prominent in many recent articles and books on rural health in the Third World, as well as in policy statements and other documents from the international agencies" (p. 61). One may question the efficacy of such a rhetoric. Moreover, health policies are suffering from a striking fickleness. "Policy changes came too fast and frequently for the Nepali system to absorb them. Within a decade, international policy shifted from vertical approaches, to integrated basic health services, to community participation, to primary health care. By mid-June 1979, the focus of international policy was already shifting away from primary health care toward infant diarrheal--disease control - in effect, a new vertical program. Conferences and reports on infant survival were then receiving priority attention" (p. 62). Nothing followed but confusion at the village level.

Judith Justice does not tell us enough about the role of traditional medicine in the global health care system, but one suspects (1) that the official health policies have gone against traditional medicine, by systematically substituting functionaries for local healers, (2) that these policies have failed, and (3) that traditional doctors have still a card to play. "Nepalis willingly used both traditional and modern medicine. It often appeared that only planners and government health practitioners perceived conflict between different medical systems. Interviews with patients in Chittre and other districts showed that those who did seek treatment at health facilities chose the facility because of location and quality of care rather than type of medical system. If the Ayurvedic clinic was close by, the patient went there rather than to the health post... Traditional healers are part of the local community, whereas most government health workers come from urban areas outside the community and have a higher social status. [Most of them] disenchanted with the isolation and discomforts of rural life [are essentially] interested in finding a way to transfer out. [Not so good a mood] for encouraging community involvement" (p. 95-6). Traditional medicine might be more akin than health bureaucracy to the PHC philosophy!

IASTAM Newsletter
International Association for the Study of Traditional Asian Medicine

Our three Co-Editors represent three different cultural areas and three different approaches:

• Madame (Dr.) Catherine DESPEUX teaches Chinese at the National Institute of Oriental Languages (INALCO), and she is in charge of the section on Medicine in a research group on the History of Science and Technology of China, Japan and Korea, directed by Professor Jacques Gernet at the Collège de France*. This group has given us direct financial support to print this issue of the Newsletter.

Write to:
Dr. Catherine Despeux
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France

• Dr. Fernand MEYER, MD., a medical anthropologist at the CNRS [Centre National de la Recherche Scientifique], does research on Tibetan medicine. He is a member of the research group on Ethnoscience based at the Muséum d'Histoire Naturelle, and the Editor of the Bulletin d'Ethnomédecine.

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75005 Paris, France

• Dr. Francis ZIMMERMANN, a Sanskritist and a researcher at the CNRS (Philosophy Dept.), is attached to the Center for South Asian Studies of the EHESS [Ecole des Hautes Etudes en Sciences Sociales], where the Newsletter also is based. The EHESS has given us financial support for the mailings of the Newsletter.

All mail regarding IASTAM and the Newsletter should be addressed to:
Dr. Francis Zimmermann,
Publications Editor of IASTAM

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*A CNRS [Centre National de la Recherche Scientifique] project, RCP [Recherche Coopérative sur Programme] no. 798, on "Histoire des Techniques et des Sciences en Chine, au Japon et en Corée".

Let us mention a few other members of RCP 798, who research into Medicine, Pharmacy and the Natural Sciences: Francesca BRAY, Christian MALET, Georges METAILIE, Frédéric OBRINGER, Elisabeth ROCHAT DE LA VALLEE (who is the new Treasurer of IASTAM-Europe), Françoise SABBAN.

Medicine &Landscape

IASTAM's intellectual field should not be comprised of the mere juxtaposition of different cultural areas ignoring one another. That is why we refuse to divide the 16 pages of the Newsletter into fixed domains enjoying fixed allotments of printing space under the exclusive responsibility of a specialized editor. On the contrary, the Newsletter should depict an interdisciplinary field, the cross-cultural fertilization of research, a variegated landscape, where Sanskritists can learn about Japan, and vice versa. Moreover, we would like to give "Medicine" an extensive meaning, to include all the related natural sciences and techniques such as Pharmacy, Botany, Agriculture, and all the ethnosciences of Asia, that is, traditional sciences that are embedded in Asian soils, since - as one may say - Asian medicine is closely related to Asian landscapes. It is the reason why, for example, a review of Augustin Berque's marvelous new book on Japanese landscapes (next page) is right in order. It is just because of this variegation that writing the Newsletter gives pleasure to its editors.

Francis Zimmermann

In the Vedas

Kenneth G. Zysk

Religious Healing in the Veda, With translations and annotations of medical hymns from the Rgveda *and the* Atharvaveda *and renderings from the corresponding ritual texts*
Philadelphia: The American Philosophical Society, 1985 (Transactions of the American Philosophical Society, Volume 75, Part 7, 1985)

ISBN 0 87169 757 2 xviii-311pp.

From the Preface: "Our aim is to understand the particular group of demonic beings and forces which were considered to have brought about disease and the religious rites by which these malady-causing demons were evicted and kept away. The hymns employed in the rites are the principal sources of information and have been translated in their entirety. An examination and a translation of later ritual prescriptions provide continuity in the tradition and offer a basis for comparison with the practices found in the earlier hymns. The selection of hymns is based on the data which they contain rather than exclusively on the traditional classification of the charms offered in the bhaisajya (medical) section of the Kauśika Sūtra (25-36). [...] The work is divided into two major sections: the first examines the various diseases which afflicted the Vedic people and the treatments used to cure them. Translations of the particular hymns devoted to the eradication of specific maladies and symptoms and to the consecration of the medicines are offered in their appropriate places. The classification of internal and external diseases and medicines has been suggested by the hymns themselves [pp. 12-102]. The second section encompasses the textual annotations to the individual hymns [pp. 103-256]."

Apart from various indices, a short glossary of plant-names, and an exhaustive "specialized bibliography" [pp. 277-290], a very useful appendix is devoted to a critical bibliographic history of the most significant studies on traditional Indian medicine in western languages ["Bibliographical Essay", pp. 261-276].

The hymns translated and annotated here were selected and classified on an empirical basis. It is interesting to note the outstanding predominance of internal diseases - the exemplar being 'yákṣma' (consumption) or 'takmán' (fever) -, and the relatively unimportant position of medicines in the panoply of healing methods (where charms predominate, surgery being occasionally mentioned). The table of contents illustrate this implicit valuation of internal diseases caused by demonic entities:

I. Internal Diseases
 A. related to yákṣma and/or takmán [pp. 12-48]
 B. not closely related to them (e.g. ascites, insanity, worms...)[49-71]
II. External Diseases (wounds, fractures, blood--loss, skin disorders) [72-89]
III. Medicines (water, 'jālāṣá' [? urine], simples) [90-102].

Curiously enough, a reader of Benveniste and Dumézil would recognize in this table of contents a trifunctional division (charms in I, surgery in II, medicines in III), which was apparently not among the conscious intentions of the author.

continued in page 6

Fûdo

Augustin Berque

Le Sauvage et l'Artifice, Les japonais devant la nature
Paris: Gallimard, 1986

ISBN 2 07 070677 X 315pp. FF 140

A tentative translation of this typically artful title would be: "Wildness and Artfulness. Japanese attitudes in the face of Nature." Nature, i.e. the natural scenery, landscapes, milieus, hills and waters, herbs and trees, the cycle of the seasons, and much more than that, the values of natural life, the idealization of our natural roots. In the face of Nature, Japanese attitudes are ambivalent. On the one hand, the surrounding landscape is ignored, either neglected or devastated. On the other hand, the highest cultural values are invested in the art of gardening, and in the philosophy of fûdo, a Japanese word for "milieu, climate, temperament".

Augustin Berque is a professional geographer turned linguist and anthropologist. Written in a superb literary style, this book is from someone who truly fell in love with Japan. It deconstructs and recreates from inside the Japanese apperception of the natural world. What does this book have to do with medecine? Everything indeed, as soon as you are willing to admit that medicine is a meteorology, an ecology, an art of gardening ourselves and our soil!

IASTAM Newsletter
International Association for the Study of Traditional Asian Medicine

OBITUARY

Vayaskara N. S. Mooss

I am very sad to announce the death of Ashtavaidyan Vayaskara N.S. Mooss, on September 5, 1986 in Kottayam, Kerala, South India. Born on November 6, 1912, Dr. Mooss was a Nambudiri brahmin belonging to one of the famous Ashtavaidya lineages of Ayurvedic physicians. He first studied Sanskrit under his father and Pandalam Krishna Variyar (1859-1932), a famous scholar (See K. Kunjunni Raja, *The Contribution of Kerala to Sanskrit Literature*, Madras, 1958, p. 267). Although they were very orthodox, these noble brahmin families have traditionally been open and receptive to English education, and young N.S. Mooss went to the Church Missionary Society High School and later to the C.M.S. College, where he could develop his taste for English and his aptitude for botany and the natural sciences, while he was learning Sanskrit and Ayurveda privately through the *gurukulavāsa* system of education.

In 1936, his father gave him permission to launch a Journal, which was sponsored by the Maharajah of Travancore: *Vaidya Sarathy, An Anglo-Vernacular Monthly Medical Journal* (XIII vols. publ., Kottayam, 1936-1948). A printing press was imported from Germany, just before the war, which is still working today. Dr. Mooss started publishing bits by bits in each issue of the journal an edition of the *Kairalī* commentary on the *Aṣṭāṅgahṛdayasaṃhitā, Uttarasthāna*, each time printing a few hundred copies more, which were bound together afterwards and made up the first book from the Vaidya Sarathy Press. Author, editor, proof-reader, press manager: Dr. Mooss did everything himself for the fifty books or so he published in Sanskrit, Malayalam, and English. Marvels of ingenuity, in decyphering manuscripts or identifying medicinal plants, and millions of hours of solitary but quiet work went into a series of Ayurvedic books that will

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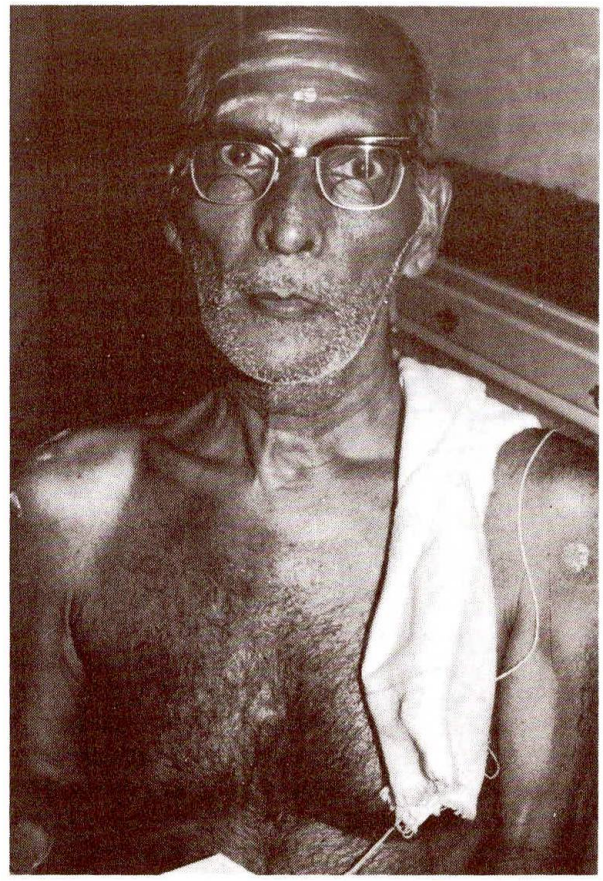

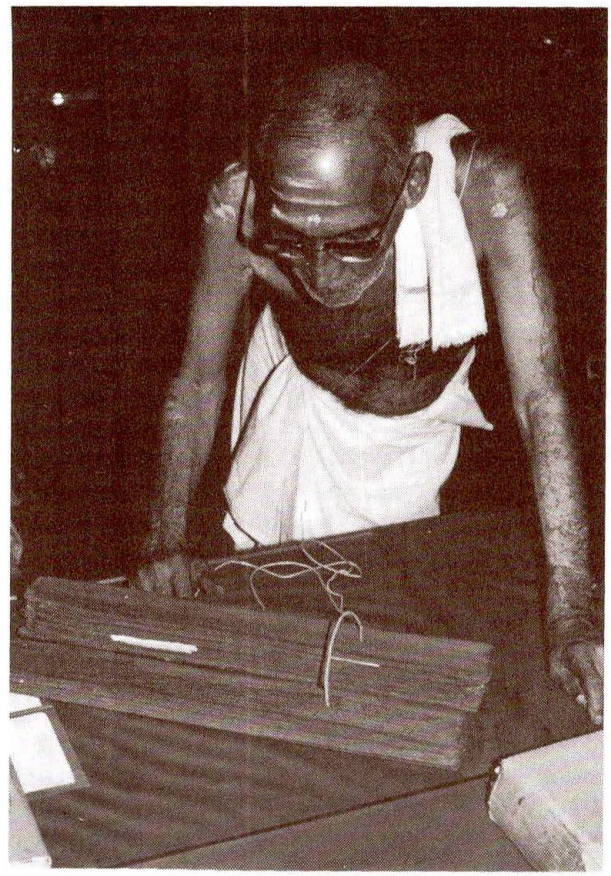

Pictures taken by Dr. Mitchell Weiss 1981

continued from page 5

last for ever. In the late 1970s, N.S. Mooss's achievements were being recognized in the West and he was corresponding with all the best scholars, or receiving them in his study, lending his manuscripts and his unrivalled knowledge of Ayurveda with an exquisite modesty. Alas, his son had died at the age of twenty. But his daughters gave him grandsons who, one may hope, will keep alive the values of Sanskrit culture to which Dr. Mooss was so passionately dedicated. Dr. Mooss truly is to me the most venerable and inspiring incarnation of the learned tradition of India, and a very dear friend and Guru. I studied Ayurveda with him in 1974, 1976-78, and sporadically between 1981 and 1984. But we had common projects still on their way: first of all, an edition of the *Hṛdyā*, which I hope to complete and bring out within the next few years. A small tribute will be paid to the memory of my Guru in a forthcoming book devoted to the classical tradition of Ayurveda in Kerala.

Francis Zimmermann

Books by Vayaskara N.S. Mooss can be ordered for by writing to:

The Vaidya Sarathy Press
Vayaskara
Kottayam, Kerala State 686 001
India

Let us mention at least a few titles:

[Special] Ayurvedic Treatments of Kerala [1944], 3rd. ed. augm., 1983

Ayurvedic Flora Medica, 2nd ed., 1977

Single Drug Remedies, 1976

Indu's Paribhāṣā or Discourse on Pharmaceutics, ed. & transl., 1979

Gaṇas of Vāhaṭa, ed. & transl., 1980

Vāhaṭa's Aṣṭāṅgahṛdayasaṃhitā, Kalpasthāna, ed. & transl., 1984

But N.S. Mooss was best known for his truly admirable editions of Vahata's Medical Collection, and some of its medieval commentaries, especially:

Vāhaṭa's Aṣṭāṅgahṛdayasaṃhitā with the *Śaśilekhā* commentary by Indu, Six vols., 1963-1978. All available except Vol. I which should be obtained by all means, however. Essential to a Sanskrit library!

Recently published:

Madanādinighaṇṭu, 1985; announced in *IASTAM Newsletter*, no. 8 (June 1986).

Abhidhānamañjarī [1st ed. 1946] has been reprinted; I shall provide a short index before it is bound.

continued from page 4

KENNETH G. ZYSK Religious Healing in the Vedas

To do Kenneth Zysk full justice, we should cite at least a sample of his erudite and exhaustive annotations. This is a philological tool, thus offered to the students of Ayurveda and the Vedas, that is bound to become a text-book, but in a very specialized field. It will help to homogenize this field, which has until now been split into two camps: the philologists, and the historians of medicine. Each and every translation, commentary or reference offered by K. Zysk will be checked, challenged, elaborated upon either by Vedic scholars or by a few medical historians who have access to the Sanskrit texts. Both groups of interested scholars will like to argue about the way K. Zysk selected the hymns he studies, or the way he has delimited his subject: "religious healing". Some would like to say that, in the Vedas, everything is religious, and everything has connections with healing, and that the Vedic corpus of texts should have been tackled as a whole. [For a structuralist approach to the nexus of ideas/myths/hymns/rites/etc. connecting religion and healing: See Charles Malamoud & Jean-Pierre Vernant, eds. Corps des Dieux, Paris: Gallimard, 1986.] But K. Zysk had good reasons, practical reasons, to focus on philological problems in the nomenclature and the identification of internal diseases, or diseases which, although they are intruded upon the body by demonic attacks, yet prefigure the later Ayurvedic conception of internal diseases, exemplars of which are Fevers and Consumption.

Just a few lines about takmán, a disease-demon [and a syndrome] which bears a very close resemblance to malarial fever. "The chief symptom which the takmán-victim exhibits is a hot-cold fever-syndrome. He also suffers from severe headaches, pounding in the eyes [] thirst, and redness and soreness of the joints. He is often jaundiced, coughs [] takmán has a special connection with the yellow color of jaundice []". I skip the detailed references, and the difficult terms (left untranslated, but with discussions and hypotheses). And this is too short to be fair to the meticulous exposition offered by K. Zysk: a medico-philological monograph which is hitherto unparalleled.

IASTAM Newsletter
International Association for the Study of Traditional Asian Medicine

The First International Symposium on Traditional Chinese Medical Literature, An IASTAM Meeting held in Munich/W. Germany, August 25-29, 1986

The Symposium Agenda

- PRESENTATION OF PAPERS

Wolfgang BAUER (Munich) "Chinese Studies and the Issue of Fachprosa Research"
MA KANWEN (Beijing) "Classical Chinese Medical Literature in Contemporary China"
Akira AKAHORI (Kyoto) "The Interpretation of Classical Chinese Texts in Contemporary Japan: Achievements, Approaches and Problems"
Jutta KOLLESCH (Berlin) "Ancient Greek and Latin Medical Texts and the Issue of their Reception"
Erhart KAHLE (Würzburg) "The Philological Rendering of Arabic Medical Texts into Modern Western Languages"
Francis ZIMMERMANN (Paris) "Terminological Problems in the Process of Editing and Translating Sanskrit Medical Texts"

◊

Paul ZMIEWSKI (Taipei) "Rectifying the Names: Suggestions for Standardizing Chinese Medical Terminology"
Elisabeth ROCHAT DE LA VALLEE (Paris) "Obstacles to the Translation of Classic Chinese Medical Texts into Western Languages"
Paul UNSCHULD (Munich) "Terminological Problems Associated with, and Experiences Gained in, the Process of Editing a Commentated Nan-ching Translation"*
ZHENG JINSHENG (Beijing) "The Collation and Annotation of the Rare Book Lu Ch'an-yen pen-ts'ao"
Paul D. BUELL (Seattle & Bellingham/Washington) The Yin shan cheng yao, a Sino-Uighur Dietary. Synopsis, Evaluations, Problems"
Jürgen KOVACS (Taipei) "Linguistic Considerations on the Translation of Chinese Medical Texts"
CHANG HSIEN-CHEH (Taichung) "The Pen-ts'ao pei-yao. A Modern Interpretation of its Terminology"
Ute ENGELHARDT (Munich) "Translating and Interpreting the Fu-ch'i ching i lun. Experiences Gained from Editing a T'ang Dynasty Taoist Medical Treatise"
Constantin MILSKY (Paris) "In Search of a Translation Strategy for the Terms of Chinese Traditional Medicine"

◊

- DISCUSSION OF TEXTS (afternoon sessions)

Huan-ti nei-ching (E. Rochat de la Vallée)
Nan-ching (P. Unschuld)
Yin shan cheng yao (P. Buell)
Yin hai ching wei (J. Kovacs)
Fu-ch'i ching i lun (U. Engelhardt)
Chen ch'iu chia i ching (C. Milsky)

*Paul U. UNSCHULD, Nan-Ching. The Classic of Difficult Issues, Translated and Annotated, Berkeley-Los Angeles-London: University of California Press, 1986. viii-760pp. I.S.B. Number: 0.520.05372.9. Review to appear in the next issue.

Munich SYMPOSIUM

This meeting organized by Prof. Paul U. UNSCHULD, President of IASTAM, was not meant to be a symposium on Chinese medicine in general, but on Chinese medical LITERATURE, and furthermore, not on the history of medical literature, but on the various processings to which texts are to be submitted by their editors, commentators, and translators, before they become readable and reliable. All participants were scholars pursuing textual studies, who addressed the various problems arising from our current philological procedures in the collation of manuscripts, and in the edition, annotation, and translation of classic texts. It was, in a sense, a symposium on Chinese medical PHILOLOGY, but with certain qualifications. In the opinion of quite a few participants, the terminological problems encountered in the study of Asian medical texts are related to the logical frame of mind of the Asian doctor, or to the logical structure of the Asian medical discourse. Terminological problems, here, extend beyond the field of Philology, and to address a number of important issues like, for example, that of polysemy in the names of diseases or drugs, we must enter the field of EPISTEMOLOGY.

Paul Unschuld's nice and truly inspired idea was to invite scholars of Greek, Arabic, and Sanskrit medical texts, and to make them contribute to this inquiry into the Sinologists' problems and methods, thus giving the symposium a comparative dimension. The first day was devoted to this cross-cultural approach. Comparison appears to be very fruitful,

continued next page

continued from page 7

especially between Chinese and Sanskrit. Following Paul Unschuld's suggestion, and to meet the comparative goals of IASTAM, the main part of the present report will (tentatively) parallel Ma Kanwen's paper on Chinese texts with F. Zimmermann's paper on Sanskrit texts. From the manuscripts of these two papers (which are still in the process of being revised), we are extracting a few significant passages akin to the central preoccupations of the Munich Symposium participants, that is, terminological problems in editing, annotating, and translating classical texts.

Ma Kanwen
On Chinese Texts

[] Since most of the ancient works were written on bamboo strips or silks and were passed through many hands and spread from place to place, different copies of a same work were made, and mistakes such as miswritten characters, omissions, etc. happened. So, during the reign of Emperor Han Chen in 26 BC., the government organized a group of medical officials headed by the court physician Li Zhuguo to collate and revise the royal collections for medical books preserved at the Mi Fu, the national royal library. This was the first time for collating and revising medical books sponsored and organized by a government in the history of Chinese medicine. Later on, more and more medical books were collated and revised not only by official organizations but also by private efforts. Scholars such as Wang Shuhe of the 3rd cent. AD., who rearranged and collated the Shanghan Zabing Lun (Treatise on Febrile Diseases Caused by Cold and Miscellaneous Diseases) 傷寒雜病論

[were the first philologists...]

In the Ming and Qing periods, many physicians and scholars devoted themselves to the work of annotating, collating and revising medical classics. [] Unfortunately, in the later part of the last century and at the beginning of our century, with the tendency to negate the [value of] traditional Chinese medicine, [its] study fell into a deplorable state, and very few Chinese medical classics were then collated and printed [] The founding of the People's Republic of China opened broad vistas for the study and development of traditional Chinese medicine [] A large number of books dealing with its various branches have been published [] At a conference on collating and publishing medical classics sponsored and organized by the Ministry of Public Health in 1982, plans were worked out to publish 686 texts, out of which 11 were listed as key works: Su Wen, Ling Shu, Huang Di Nei Jing Tai Su, Nan Jing, Mai Jing, Shen Nu Ben Cao Jing, Zhong Zang Jing, Shang Han Lun, Jing Gui Yao Lue, Zhen Jiu Jia Yi Jing, Zhu Bing Yuan Hou Lun. Among the classics to be collated, annotated and published, there are not a few rare ones that have not been published for several hundred years, since their [first] coming out, such as Young Shi Jia Cang Fang* written by Young Tang (1178), Wei Shi Jia Cang Fang** by Wei Jian (1228), Huo You Kou Yi*** by Zeng Shi Rong (1294), Zu Ji**** by Shi Pei Ran (1640), etc. []

* 楊氏家藏方 by 楊倓
** 魏氏家藏方 by 魏峴
*** 活幼口議 by 曾士榮
**** 祖劑 by 施沛然

To train personnel capable of editing, annotating, collating and revising Chinese

I was about to write this report, when I received from Co-Editor Catherine Despeux a copy of one of her recent books, which appears to be a French translation of the classic text mentioned by Ma Kanwen as the one revised by Wang Shuhe. A most interesting encounter:

Shanghanlun, Le traité des "coups de froid" de Zhang Zhongjing
Traduction de CATHERINE DESPEUX
PARIS: Editions de la Tisserande [1 bis, cité des Fleurs, 75017 Paris], 1985 202pp.
Presentation: The author, Zhang Zhongjing (150--219), and his main commentators; a few introductory pages on Chinese pharmacology; a summary of the treatise. Translation, with detailed notes and several indices (of ingredients, of recipes, of pulse symptoms, and a general index including names of diseases). A nice book, carefully written and well-produced, a review of which will appear in one of our next issues. F.Z.

medical classics, special courses were run by the China Institute for the History of Medicine and Medical Literature attached to the China Academy of Traditional Chinese Medicine []

◊

Promising scientific results have been obtained through exploring the treasure house [of classical texts]. For instance, a researcher of the Institute for Chinese Materia Medica of the China Academy of Traditional Chinese Medicine, in seeking for new anti-malarial drugs had come across a passage in the Zhou Hou Bei Ji Fang (A Handbook of Prescriptions for Emergencies) written by Ge Hong (c. 231-341 AD), which aroused her attention: "Take a handful of sweet wormwood, soak it in a Sheng (about a liter) of water, squeeze out the juice and drink it all" for treating malarial fever [Vol. 3, 肘後備急方·治寒熱諸瘧方 Zhi Han Re Zhu Nue Fang 16]. She began to wonder if soaking the sweet wormwood had been done to avoid the high temperature of boiling or brewing, which might have destroyed the antimalarial properties it contained. She and her colleagues set out to extract it with ether instead of boiling water or alcohol, and to make new chemical analyses. Using their sample on mice infected with malaria (Plasmodium berghei), they found that the malaria parasites disappeared. Subsequent clinical use with humans in case of malignant and tertian malaria also had good results. Later on they isolated an effective monomer against malaria and got a pure white crystal which they named Qing Hao Su, which was then put into clinical tests in 6,000 cases and proved effective on all types of malaria, with quicker results and lower toxicity than chloroquine and other drugs []

◊

There are many problems associated with the collation, annotation and revision of Chinese medical classics. [What is at stake is] how to improve the quality of the [philological] work, so that the Chinese medical classics can be of better service to the exploration, study and development of traditional Chinese medicine as well as the welfare of the people[]

Most of the classic texts were written without punctuations, which makes them difficult to read. They were often copied and recopied by many hands. There is a saying that, after a book has been copied three times, characters like 魚 will become 魯, and 虛 become 虎. It is only through high quality collation work - which includes contrasting or comparative collation, rational collation, etc. - that mistakes such as omissions, disarranged and miswritten characters, typographical errors, wrong annotations, wrong punctuations, etc., made either in the past or in the present age, can be corrected.

The bulk of Prof. Ma Kanwen's contribution comprises detailed examples of this kind of philological work: corrections through collation. Only a few samples can be printed here.

DISARRANGEMENTS. Case 3

In Su Wen (Shang Gu Tain Zhen Lun 1, Vol. 1) the passage: 七八肝氣衰,筋不能動,天癸竭,精少,腎臟衰,形體皆極;八八齒髮去 is an example of obvious disorder or disarrangement of the original bamboo strips as judged from the literary style and the context of the passage. The style is not coherent with the context; the first sentence is too long while the second is too short, and, if we look to the context, we see that the female menopause problem is the one discussed, so it is illogical that a male physiological problem is dealt with. Let the whole passage be rearranged as follows: 七八,肝氣衰,筋不能動;八八,天癸竭,精少,腎臟衰,形體皆極,則齒髮去.腎者主水... And it is now rational not only in its literary style, but also according to logic.

WRONG ANNOTATIONS

A striking mistake is that dealing with the problem of Tong Jia 通假 or Tong Jie 通借. Tong Jia is a special learning of ancient Chinese scholars dealing with phonology. Tong Jia means that characters of the same sound can be interchangeable; characters of the same sound can be used to take one another's place in a phrase, an expression or a sentence. Hence it is also called Tong Jie which literally means borrowed, in common. Without the knowledge of Tong Jia, mistakes are unavoidable in the work of collation, annotation and revision of Chinese medical classics, even among well-known scholars like Yang Shang Shan and Wang Bing. MISTAKES dealing with Tong Jia, Case 1

In Su Wen (Si Qi Tiao Shen Da Lun 2, Vol. 1), in the passage: 道者.聖人行之,愚者佩之

the character 佩 was explained as 佩 戴 "wearing" by Yang Shang Shan, and as 佩服 "admire" by Wang Bing. Both of them were outstanding scholars and physicians who really did valuable work on the Su Wen and Ling Shu and exerted great influence on the study of Nei Jing among the later generations. Both, however, got it wrong when explaining the character 佩. Their mistakes had been accepted for many generations, when Hua Shou 滑壽 of the Yuan Dynasty pointed out that 佩 should be understood as 悖 or 背. Later, Hu Shu 胡澍 of the Qing Dynasty pointed out that 佩 should be pronounced as 倍, which according to the Sho Wen Jie Zi 說文解字 means go against or run counter to.

[Hundreds of examples are adduced, to illustrate various kinds of mistaken characters, sentences, and how to correct them.]

◊

[The final section of Ma Kanwen's paper deals with 'Problems associated with the translation of Chinese medical classics into foreign languages'. First, the translator should select a good edition of the Chinese text.]

Once some wrong annotations or commentaries rendered by scholars of the past or present have been adopted, the translation inevitably will produce more misunderstandings. For instance, the wrong commentary offered by Wang Bing in Su Wen for the passage:

道者,聖人行之,愚者佩之

which I have cited in the preceding section of this paper has been adopted in the English translation of the Nei Jing by Dr. Ilza Veith [Huang Ti Nei Ching Su Wen] The Yellow Emperor's Classic of Internal Medicine, Chapters 1-34 (Berkeley: California Press, 1949), p. 105, who translates as: "Tao was practiced by the sages and admired by the ignorant people" ['admired' instead of 'thwarted' or 'gone against'!].

The second problem related to translation is how to stick to the genuine meaning of the text. The third is that translators sometimes are lacking knowledge of Chinese history, philosophy, or literature. The fourth problem is that translations sometimes are incomplete. [Various illustrations are provided. A closely related question is that of the polysemous characters that are too often translated, as ch'i for example into "vital energy", etc.] It seems better to transliterate them with suitable notes, rather than translating them [thus saying ch'i, and not "vital energy]. Since the accurate translation of terms of traditional Chinese medicine or the standardization of their translation still needs concerted efforts, I think that cooperation between scholars and medical workers of China and other countries of the world is also needed.

extracted & condensed by F.Z.

Zimmermann On Sanskrit Texts

[From texts to discourse]

The Collections of Suśruta and Caraka have never been edited properly. Although they represented tremendous achievements of Indian scholarship when published one century ago, the editions available in print will have to be recast some time on the basis of new manuscripts and modern philological tools. We are not ready yet for this arduous task; terminological problems have to be dealt with first. The logical consistency of technical terms is essential, when we want to establish a reliable text; this has been shown recently by Priya Vrata Sharma [Carakasaṃhitā, Text with English Transl., Varanasi: Chaukhambha Orientalia, 1981, Vol. I, pp. xvi-xxii], the first scholar in recent times to provide us with a list of quite convincing emendations of the currently accepted text of the Collection of Caraka. Another expert in that kind of philological work is Ronald E. Emmerick. Hundreds of decisions are made in his edition of the Siddhasāra [Wiesbaden: Franz Steiner, 1980, Vol. I: The Sanskrit text], to select "correct readings", and to emend wrong ones. Whereas, for example, most of the manuscripts say [3.31.9] that barley cures meda "obesity", wrong reading, the editor restores the correct reading: barley cures meha "urinary disease", on the basis of what he calls the tradition (i.e. what Caraka, Suśruta say about barley); his choice is dictated to Emmerick by parallels and concordances with other classic texts. A graphic mistake of द 'da' for ह 'ha' is corrected on mere philological grounds. I think, however, that we should go one step further. What kind

of a tradition is it, that allows "errors" to creep upon so easily? One may wonder whether distinguishing "correct" readings from wrong ones does not amount to ill-treating a fundamentally polysemous discourse, where several readings, all valid, may be superimposed to one another in a given technical term. Therefore, facing all kinds of terminological problems, not only those of a purely textual nature but also those related to the modes of thought involved, we should address ourselves not only to the philological task of establishing reliable texts, but also to the epistemological task of dissecting, deconstructing, cross-examining their logical structure.

This paper is more limited indeed, than the vast program thus outlined! I would like to present a few remarks on five kinds of terminological problems (in editing and translating Sanskrit medical texts) that arise from the nature of the language itself: 1) How to deal with a fundamental distinction between terms for objects (roughly speaking, names of drugs, diseases, etc.) and terms for ideas (adjectives, and others); 2) problems of rhetoric related to the superabundance of metaphorical terms (or terms that deceitfully seem to be metaphorical without being so); 3) how to tackle the plurality of levels of language, and especially, the linkage (or diglossia) between Sanskrit and the vernacular; 4) how to account for stylistic features like versification, or the interplay of synonyms; 5) changes through time, obsolescence of some terms, emergence of new names [See G. Jan Meulenbeld, "The surveying of Sanskrit medical literature", Proceedings... on Priorities in the Study of Indian Medicine, Groningen, 1983, pp. 31-120, spec. p. 38 f.]*.

◊

[Terms for objects, terms for ideas]

[] This is not a linguistic distinction between names and adjectives, although it amounts to it in the final analysis, but a logical distinction between terms with referents that are objects of the natural world (e.g. amṛtā, the plant Tinospora cordifolia), and terms with referents that are ideas, inferences (e.g. amṛta "immortal", abhiṣyandin "which produces fluxions"). The distinction is not an absolute one; it is context-sensitive. Objects are ideas, and ideas are objects. Names are often made from adjectives, and we could translate amṛta as "The Immortal": the name connotes the hardiness of the aerial roots of Tinospora cordifolia. Adjectives are often made from names [] However, these two kinds of terms will exert different functions in the medical texts. Both kinds of terms are submitted to a huge process of language inflation. There are many many "names" to designate one and the same object (a drug, a disease, a bodily part or process), and many many "adjectives" to convey one and the same idea []

We should not be mistaken in translating an "adjective" as if it were a "name": e.g. abhiṣyandin most often means "which produces fluxions" (which is the idea of a physiological process, an inference put forward in the course of a diagnosis), and sometimes means "one who suffers from conjunctivitis" (which designates a disease thus objectified). The modern reader, or the translator, should avoid objectifying terms that are not so in the original discourse [] We should also find ways of conveying to the modern reader the wealth of names and the cognitive value of this 'polyonymous' style of terminology. In my opinion, any attempt to standardize our translations and to reduce all polyonyms (names mutually substitutive to designate one and the same object) to only one English, French, or Latin translation comes totally off the point []

◊

[Illusory metaphors]

The metaphorical connotation, in quite a few technical terms, which, for that reason, most translators use to keep untranslated, is an illusion. [For example,] doṣa, which is the most common term for naming the humors, the three humors of Ayurvedic medicine - wind, bile, phlegm -, generally means "defect, fault" in Sanskrit. [Compare Sydenham's phrase: "the peccant humors".] When entering the medical field, when becoming a technical term, the Sanskrit word doṣa underwent a change of meaning AND of referent, to

CONTINUED IN PAGE 13

*Reviewed in IASTAM Newsletter no. 5, August 1984, p. 8.

Manuscripts of a Han tomb at Mawangdui

Mawangdui Hanmu boshu, Wenwu chubanshe, Beijing, 1985 馬王堆漢墓帛書

In 1973 a number of manuscripts and wooden slats, partly related to medicine, were discovered inside tomb number Three of the Mawangdui site, about 10 km from Changsha (Hunan). As the tomb is known to have been closed in 168 BC, and some of the manuscripts are dated from -294 to -227, these documents would date back to the Qin or East Han period. Since the discovery was made, several studies on these manuscripts have been published, most of them in the Wenwu review. 文物

All the documents related to medicine are being made available in the present publication, which includes reproductions of the 11 manuscripts and of the 4 groups of wooden slats, followed by their transcript into modern Chinese, and notes. The list of the titles given to these documents is as follows:

MANUSCRIPTS

1 Moxibustion book of the eleven lower and upper member vessels
2 Moxibustion of the eleven yin-yang vessels (A)
3 Methods of spygmology
4 Death prognosis based upon yin and yang pulses
5 Prescriptions for 52 illnesses
6 Abstinence of cereals and absorption of pneuma
7 Moxibustion of the eleven yin-yang vessels (B)
8 Illustrations of daoyin postures
9 Recipes for nourishing the vital energy
10 Various therapeutical recipes
11 Book of obstetrics

BAMBOO SLATS

1 Ten questions
2 The art of yin-yang union
3 Various recipes of interdicts
4 Remarks about the supreme way in this world

(Chinese titles are given at the bottom of this page) ◊

These documents have been partly presented to westerners by Michael Loewe's paper "The manuscripts from tomb number Three", in R.P. Kramers ed. China. Continuity and Change, Papers given at the 27th Congress of Chinese Studies [Aug. 31-Sept. 5, 1980], Zürich, 1982. Moreover, one of these manuscipts has been studied and translated into English by Donald Harper, The Wu-shih-erh ping fang. Translation and Prolegoma, Thesis on microfilm, Michigan, 1982. These are priceless documents for the study of Chinese medical history. They give us a better understanding of the formation of some theoretical points in Chinese medicine, and they show that techniques described in the texts several centuries later were already known in the East Han period.

The two documents on Moxibustion of the eleven vessels are similar to chapter 12 of the Lingshu, while presenting a more archaic state of the system. The part that treats of death prognosis based upon pulses (the manuscript is in very bad condition) corresponds to the end of that same chapter 12 of the Lingshu. 靈樞 Besides, the text on the diagnosis based on pulses has been nearly fully reconstructed from another version discovered among the wooden slats of Zhongjia shan in the area of Jiangling (Hubei): see article in Wenwu, no. 1, 1985, pp. 9-15.

The obstetrical book refers mostly to interdicts to be observed during pregnancy. It is nearly similar to Prescriptions in Obstetrics (Xu Zhicai suiyue yangtai fang)* by Xu Zhicai, physician of the Six Dynasties, a lost work but quoted in A Thousand Golden Ounces Remedies (Qianjin yaofang)** by Sun Simiao. It already expounds the different evolution phases of the embryo. It mentions a reckoning process to determine and decide the sex of the child to be born. This detail is also found in the wooden slats discovered in Yunmeng: see, by Rao Zongyi, Yunmeng Shuihudi Qin jian, part on ren zi***, Hong Kong, 1982.

The other documents deal with various processes for nourishing and maintaining vital energy: abstinence from cereals, breathing processes, and the propitious times for nourishing oneself with energy according to the season, the lunation, the hour of the day (These parts resemble the Linyang zi mingjing****). Bed techniques are also dealt with, including how to cure sexual diseases, how to keep potency, to increase one's energy and to join yin and yang.

Catherine Despeux

Transliterations

◊ Zubi shiyi mai jiu jing 足臂十一脈灸經
Yinyang shiyi mai jiu jing 陰陽十一脈灸經
Maifa 脈法

Yinyang mai sihou	陰陽脈死候
Wushier bing fang	五十二病方
Quegu shiqi	却穀食氣
Yinyangshiyi mai jiu jing	陰陽十一脈灸經
Daoyin tu	導引圖
Yangsheng fang	養生方
Za liao fang	雜療方
Taichan shu	胎産書
Shi wen	十問
He yinyang	合陰陽
Za jin fang	雜禁方
Tianxia zhidao tan	天下至道談

*
** 徐之才逐月養胎方
*** 千金要方
**** 雲夢睡虎地秦簡
陰陽子明經

CALL FOR PAPERS

Asian Folklore Studies

A semi-annual journal, is planning for one issue, maybe the fall issue of 1987, devoted to traditional medicine.

"We are looking and calling for papers which discuss traditional forms of medicine or rituals of healing especially in relation to oral traditions, e.g. mythology (explanation of causes for sicknesses or their healing) or other traditions as there may be. It could also be a discussion of e.g. medical herbs or other types of medicine, the stories or traditions related to their origin or the reason of their effectiveness. It would even be possible to treat the specialists, e.g. the formation of a healer or shaman, their self-understanding and the ways their clients explain the shamans' power."

Write to:

Peter Knecht, Editor
ASIAN FOLKLORE STUDIES
Nanzan University
18 Yamazato-cho, Showa-ku
466 Nagoya, JAPAN

India

Debiprasad Chattopadhyaya, Ed.

Studies in the History of Science in India, Two volumes, New Delhi: Editorial Enterprises Publ. [L-1/10, Hauz Khas, New Delhi 110 016], 1982
xxv-viii-884pp. Rs. 300

Volume I contains valuable extracts from some of the best authorities on the history of medicine, chemistry and botany in India: Mukhopadhyaya, Hoernle, Jolly, D. Chattopadhyaya himself (his 1979 paper on Caraka), Bodding (Santal medicine), Filliozat (on Al-Biruni and Indian alchemy), Ray, Majumdar (botany).

MUNICH SYMPOSIUM CONTINUED FROM PAGE 11

designate "the humors" with the whole array of their connotations, which are the same as in European humoralism: humors are bodily fluids and pathogenic factors at the same time. We should distinguish between three semantic fields: (1) the primary, etymological, general meaning (dosa "defect, vice"); (2) the technical [exactly, 'catachrestic'] meaning ("humors"); (3) a derivative, metaphorical meaning, when we speak of the humors as "peccant", "morbific factors", which can only be the case in a limited number of occurrences. But in most of the thousands of cases when dosa is used in Ayurvedic texts, it is just to designate the humors, without any metaphorical connotation. To translate it as "morbific entities" amounts to re-integrating into the medical discourse a metaphor which was no longer perceived as such. Same rhetorical effect, when the translator refuses to translate dosa, pretending it is untranslatable []

◊

[Anachronistic terms]

Misunderstandings that arise from changes of meaning through time are often aggravated by the substitution of new frames of reference for the older ones. [] Anatomy and the mapping of diseases on the body have become part of the modern diagnosis, [while] the localization of diseases was much more elusive and roving in humoral medicine. Therefore, the translation of Sanskrit names of diseases into a modern language is liable to be too precise, too restrictive [] Sanskrit abhiṣyanda, for instance, designates a whole set of diseases due to fluxions, of which ".conjunctivitis" is only one possible exemplification. [Conjunctivitis is a 'monothetic' category, while abhiṣyanda is polymorphous.] A prefixed dot (or any suitable symbol) should indicate the discrepancy [a time-lag as well as a logical gap] between Sanskrit abhiṣyanda and its translation as ".conjunctivitis" []

NOT FOR CITATION WITHOUT PERMISSION. These extracts still need revision, and they are too short to give a fair account of our views. These are unsolved problems, it is still an open debate. For example, readers may have noticed that FZ's remarks on translating dosa do not match MK's remarks on NOT translating ch'i. Much more still has to come on this major issue.

India Seen From Roma

Jacques André & Jean Filliozat

L'Inde Vue de Rome, Textes latins de l'antiquité relatifs à l'Inde, Paris: Editions Belles Lettres, 1986

Everything the Romans knew about pepper, sugarcane, voyages across the Arabian sea, and the strange peoples of far away India... This is an exhaustive collection of Latin texts and testimonia or fragments of lost works related to India, edited with a line by line French translation, a scholarly commentary, and several indices. A must for all historians of the ancient materia medica, of the spice trade, and of the relationships between Europe and India. Prof. J. André is a well-known expert in Latin cuisine, botany and other realia. See his *Noms de Plantes dans la Rome Antique* (Plant-names in ancient Roma), Paris: Belles Lettres, 1985, reviewed in *IASTAM Newsletter*, 7 (Nov. 1985), p. 5. Late lamented Prof. J. Filliozat wrote most of the commentary, and played a major role in the translation. This new book should be used along with a previous one by the same two co-authors: Pline l'Ancien (Pliny the Elder), *Histoire Naturelle*, Livre VI, 2e partie (§§ 46-106, on Asia, India), Ed. & transl. into French, with comment., appendix (Pliny's India), index and maps, Paris: Belles Lettres, 1980 (ISBN 2.251.01156.0).

The texts are given in chronological order, stretching over a time span of eight centuries, from Plautus - a boast from the *Bragging Soldier* (205 BC) that he broke an elephant's arm in India! - through Isidore of Seville (late VIth cent. AD), whose *Etymologies* contained vivid descriptions of Indian gems and spices. Among hundreds of small discoveries resulting from J. André & J. Filliozat's patient work of collection and collation: the earliest mention of Indian sugarcane in Roma is to be found in a three-line verse fragment from Varro Atacinus (85-35 BC), through its quotation by Isidore... But this is only one out of about 125 Latin authors alluding to or dwelling upon things Indian, whose relevant extracts are collected here.

To us, historians of Asian medicine, the most precious feature in this book is the "index of original names", compiled by Jean Filliozat's son, M. Pierre-Sylvain Filliozat (himself an outstanding Sanskrit scholar), which, apart from Sanskrit, and other oriental languages, traces a striking number of names (found in the Latin sources) back to Tamil and Malayalam.

ISBN 2 251 32 864 5 464pp. FF 300

Foodways

Marie-Claude Mahias

Délivrance et Convivialité, Le système culinaire des Jaina [Liberation and Conviviality, Foodways of the Jainas], Paris: Editions de la Maison des Sciences de l'Homme, 1985

ISBN 2 7351 0125 8 326pp. FF 175

A rich, vivid, well-written ethnography of food and foodways among Jainas in Delhi today. Dr. (Mrs.) Mahias, a member of the CNRS (Anthropology), has combined thick description of things eaten and culinary techniques with an analysis of religious rules (enforcing vegetarianism), and of rituals involving special foods. Medical anthropologists should read chapter 9, which treats of foods raw and cooked, the classification of savors (an ethnographic counterpart to the classical doctrine of rasas) and tastes (an ethnography of gustation), and finally, foods hot and cold. Some readers will enjoy the wealth of illustrations: not only the various maps, tables, figures and photographs, but also quite a few line drawings to illustrate technical gestures. Other readers will enjoy the meticulous transliteration of Hindi words and the various indices and glossaries, which enhance the usefulness of this publication.

London

A Workshop organized by the European Ayurvedic Society and sponsored by the Wellcome Trust was held from 2 to 4 September 1985 in London. Dr. G. Jan Meulenbeld (De Zwaan 11, 9781 JX Bedum, The Netherlands) and Dr. Dominik Wujastyk (The Wellcome Institute for the History of Medicine, 183 Euston Road, London NW1 2BP, U.K.) are at present editing the Proceedings, which are to appear soon under the title Studies in Indian Medical History. The following papers were read at the meeting:

Dr. G.J. Meulenbeld "Reflections on the basic concepts of Indian pharmacology", Dr. J. Laping "On Mâdhavacikitsâ", Dr. R.P. Das "On the identification of a Vedic plant", Prof. R.E. Emmerick "Epilepsy according to the rGyud-bzi", Ms. M. Winder "The meaning of vaidûrya in Sanskrit and

Tibetan", Dr. A. Roşu "Autour des carrés magiques en Inde", Ms. W. Ernst "Native lunatic asylums in early 19th cent. British India", Prof. G.M. Carstairs "Contrasting treatment of witches in three communities in Mewar", Dr. D. Wujastyk "A pious fraud: The claims for pre-Jennerian smallpox vaccination in India", Dr. T. Patterson "The relationship of Indian and European practitioners of medicine from the 16th cent.", Dr. A. Comba "Carakasaṃhitâ, śârîrasthâna I, and Vaiśeṣika-darśana", Prof. R. Labadie "Centella asiatica in perspective: An evaluative account", Dr. B. Hochkirchen "Results of a video based analysis of consultations in four Ayurvedic medical practices", Dr. J. Laping "Dialogue in research on traditional Indian medicine", Dr. H. Bakker "Methodological considerations concerning critical editions of anonymous Sanskrit texts".

Chinese Seattle

Paul D. BUELL (Western Washington University) and Christopher MUENCH (University of California at San Francisco), "Chinese Medical Recipes From Frontier Seattle", in The Annals of The Chinese Historical Society of The Pacific Northwest, an annual publication, 1984, pp. 100-143.

[The same issue contains papers on Lycium chinense as a ethnohistorical marker, on South Chinese foodways, on birds, and various other historical, ethnolinguistic, and political history topics.

Write to: Chinese Historical Society of the Pacific Northwest, 9105, 40th Avenue, N.E., Seattle, Washington 98115, USA]

This article includes a reproduction and discussion of an old recipe book, the Yao-fang, "Medicinal Recipes", which was originally a prized possession of the important Wah-Chong Company founded by Seattle Chinese pioneer Chin Hock in 1868. It is a compilation containing the best personal recipes of the members of Seattle's early Chinese community. Although the drugs were first provided by the Wah-Chong Co., the work itself was community property, benefiting all during a time when there were no professional Chinese physicians to serve the community. The main section of the work probably dates to the 1870s and 1880s. In its present form, the Yao-fang is a small, traditionally bound manuscript volume of 181 pages, containing 166 titled and untitled recipes. These are 'basic' recipes, to address specific diseases and symptoms rather than the more abstract disease categories common to professional Chinese physicians. But they are still in use in a modified form by a contemporary practitioner. As an historical and medical document, the Yao-fang represents a treasury of clinical experience, as yet little affected by Western influences. As a social document, it is a record of the earliest era of Chinese settlement in Seattle. Several appendices provide complete lists of the titles, types and therapeutical indications of the recipes, and a translation of a few sample recipes.

Indian childhood

Hélène Stork

Enfances Indiennes, Etude de Psychologie transculturelle et comparée du jeune enfant

[Indian Childhoods, A study in infant cross-cultural psychiatry], Paris: Editions du Centurion [17, rue de Babylone, 75006 Paris], 1986 [In French]
ISBN 2 227 00510 6 240pp. FF120

Dr. H. Stork, MD., combines the study of Sanskrit ayurvedic texts on paediatrics with ethnographic film-making, to describe and analyse mother-infant relationships and the learning of bodily techniques in South India.

CONTENTS: I/ From infant psychopathology to infant cross-cultural psychology. II/ History, methods & aims of child cross-cultural psychology. III/ An approach to infancy in South India. IV/ Cultural representations of Mother and Baby in the classic texts [Interesting quotations from Anantakumâra's Yogaratnasamuccaya]. V/ Gestures and postures in mothering, ethnographic filming in South India [with line drawings based on photograms; useful notes on the drugs used, see p. 151-2; also on cradles, feeding bottles made from conch-shells; the vernacular language is Tamil]. VI/ Baby's psychology. VII/ Mothering.

A nice, unassuming, well-written little book, by an extremely well qualified researcher.

JERUSALEM medicine Bible & Talmud

3RD INTERNATIONAL SYMPOSIUM ON MEDICINE IN BIBLE AND TALMUD, JERUSALEM, DECEMBER 7—9 1987

Themes of the symposium:

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For more information write to:

Professor Samuel S. Kottek
Division of the History of Medicine
The Hebrew University of Jerusalem
Hadassah Medical School
91120 Jerusalem, Israel

Thai healing

An example of convergences, in the current production of books. Two excellent papers complement one another.

- Stanley J. TAMBIAH, "A Thai cult of healing through meditation" [originally publ. in Culture, Medicine and Psychiatry 1 (1977): 97-132], is reprinted in his collected essays Culture, Thought, and Social Action, An Anthropological Perspective, Cambridge, Mass.: Harvard U.P., 1985 [ISBN 0 674 17969 2, 411pp., US$ 30], with other famous papers of his on magic, pragmatics, ethnoscience, etc.
- Charles F. KAYES, "The interpretative basis of depression", in Arthur Kleinman and Byron Good, eds., Culture and Depression, Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder, Berkeley: U. of California Press, 1985 [ISBN 0 520 05493 8, 535pp.], a fascinating book which contains also papers on Sri Lanka, Iran, China, etc. Ch. KAYES is an expert in Thai Buddhism, and one of the major protagonists in the 'ethnosociological' debate on "Karma and Rebirth". See Charles F. Kayes and E. Valentine Daniel, eds., Karma, An Anthropological Inquiry, Berkeley: U. of California Press, 1983 .

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OCCASIONAL PAPERS

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OCCASIONAL PAPER #7

Medicine Showmen and the Communication of Health Information in Mexico

Joseph J. Simoni, Luis Alberto Vargas,
and Leticia Casillas

1982

NON-FORMAL EDUCATION INFORMATION CENTER

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FOREWORD

Through its series of Occasional Papers, the NFE Information Center seeks to provide a forum for the exchange of ideas among those pioneering in the study and practice of non-formal education. In dynamic, relatively new fields of inquiry and experimentation it is especially important to bring "ideas in progress" to the light of collegial scrutiny. We intend the papers in this series to provoke critical discussion and to contribute to the growth of knowledge about non-formal education.

In this paper, the three authors show, through a description of their research, how Mexican medicine showmen can be effective in disseminating health-related information. Based on many years of research and experience, the authors designed and conducted a controlled research project in infant nutrition. The results they share with us suggest that showmen are effective communication channels, and that, through the showmen, it is possible for health education programs to have an impact on individuals' knowledge, attitudes and behavior. This research also indicates that medicine showmen can influence urban and more highly educated populations as well as poor, rural ones.

We are very grateful to the authors for bringing their work to our attention and for allowing us to share it with development planners and practitioners in the Non-Formal Education Network.

We extend special thanks to Joe Simoni who represented the team of researchers during the final preparation of this Occasional Paper.

As always, we invite your comments and contributions to enrich the dialogue concerning important issues in non-formal education.

Mary Joy Pigozzi

Director

Non-Formal Education
Information Center

ACKNOWLEDGMENTS

This paper was originally prepared for presentation at the 32nd Annual Conference of the International Communication Association in Boston, Massachusetts, 2-7 May 1982.

Research on which this paper is based was supported by the following organizations: the Inter-American Foundation, the Mexican National Council of Science and Technology (CONACYT), Universidad Nacional Autonoma de Mexico (UNAM), and West Virginia University.

TABLE OF CONTENTS

MEDICINE SHOWMEN AND THE COMMUNICATION OF HEALTH INFORMATION IN MEXICO

Joseph J. Simoni, Luis Alberto Vargas,
and Leticia Casillas

I. INTRODUCTION

MEROLICOS are Mexican medicine showmen whose counterparts can be found in many other developing areas of the world. Merolicos frequent marketplaces and other common meeting places, like areas near subway stations, and town squares, but they also work spots where crowds are not usually found. With ventriloquism, mental telepathy, snake handling, clown acts, medicinal recipes, and other kinds of crowd-pleasing performances, they attract the public and in the end always offer for sale some medicinal product.

Initial research into the relationships between medicine showmen and their patrons suggested that communications on the medicine-show model might not only be favored by many of the poor, but might be especially effective in combining the persuasive advantages of mass media and interpersonal communication channels. Results (Simoni and Ball, 1975) disclosed that the patrons of medicine showmen often return again and again, and are not just passers-by stopping to be entertained for a few moments. They regard the showmen as honest and credible, and they value very highly the showmen's ability to explain clearly. Showmen were

observed to talk to as many as 250 people, and to sell to as many as 70 people, in a period of about two-and-a-half hours.

From 1976 field results it was concluded that the most meaningful differentiation between patrons and non-patrons of Mexican medicine showmen is made not in terms of their health orientations (scientific, mixed, or folk-traditional), but in terms of their curiosity and eagerness for information regarding scientific medicine, and their belief in the showmen. For example, results indicated that 25 percent of patrons and 50 percent of non-patrons exhibited folk-traditional health orientations. However, patrons who exhibit folk-traditional health orientations are definitely different from their non-patron counterparts in that they are interested in hearing more about "scientific medicine" from the medicine showmen (Simoni and Ball, 1977a).

Further developments led to the preparation of a proposal for a pilot project, which was submitted by the Institute of Anthropological Research at the Universidad Nacional Autonoma de Mexico (UNAM) in Mexico City to the Mexican National Council of Science and Technology (CONACYT). That proposal was approved by CONACYT and endorsed by the Mexican National Health Council. Funding through CONACYT and financial support from the Inter-American Foundation, UNAM, and West Virginia University made the pilot project possible.

Past research had suggested that communication on the medicine-show model would greatly enhance public health efforts

in many developing areas, and that it would be especially effective in supporting and facilitating existing public health programs. Medicine showmen talk to many people at one time, and utilize their understanding of local culture and language to enhance their effectiveness. The mass media characteristics could be used to develop and maintain social climates favorable to the acceptance of new health-care norms, while the interpersonal channel characteristics could provide the person-to-person contact which is so critical in influencing the actual adoption of innovative behavior in developing areas. The major objective of the pilot project was to substantiate the value of using medicine shows as part of public health programs. Specifically, the results presented here speak to three questions: (1) Are medicine showmen actually able to effect changes in health related knowledge, attitudes and behavior of their audiences? (2) Are medicine showmen effective only in rural areas? (3) Are medicine showmen only effective with the least educated?

II. METHODOLOGY

Selection of Communities

Twelve communities (6 test -- 6 control) were selected for the purposes of the project. Six of them were colonias near the peripheries of the cities of Oaxaca, Morelia, and Mexico. The remaining six were rural communities from the states of Oaxaca and

Michoacan, and the Distrito Federal (D. F.). These areas were used for the project because: a) they provided a representative sample of a good part of Mexico, b) the research team has had intensive research experience in all the three areas, and c) the research team enjoyed excellent rapport with showmen in all three areas.

The twelve communities were selected according to the following criteria. (1) Each of them had to be more or less self-contained and not too large, so as to be of workable size for both project implementation and evaluation. (2) Each community must have had no history of previous localized interpersonal attempts at the kind of nutrition education to be employed as part of the project.

Selection of the Medicine Showmen

Five showmen were selected to work with the project. They were selected on the basis of: a) their observed expertise, b) their experience in the regions to be worked, c) their past honesty in dealings with Simoni, and d) their apparent interest in contributing to attemps at improved public health education.

Message Content

Since 1979 was the International Year of the Child, and since Vargas and Casillas possessed expertise in the general area of nutrition and growth, we decided to focus the message content on

the nutrition of infants up to 1 year of age. During the message preparation stage, we instructed the showmen to emphasize the following points.

1. The value of breastfeeding to at least 1 year of age.
2. The name and function of the first breast secretion, colostrum.
3. A recommendation for mothers to cleanse their breasts with camomile tea before breastfeeding.
4. A recommendation for early supplementary feeding, with continued lactation for infants. Indicated supplementary feeding entailed:
    a) Fruit Juices (orange, apple, tomato) at 15 days of age;
    b) Fruit at 2 months;
    c) A "magic meal" of puree of beans, the juice from the beans, and some other product like tortilla or cracker at 3 months;
    d) Vegetables at 4 months;
    e) Egg yolks at 5 months;
    f) Meat at 6 months.
5. The value of vitamin drops for babies.
6. The functions of vitamins A, C, and D.

Infant nutrition, what babies should or should not eat, and what mothers should or should not do if they want their babies to be healthy, are all popular topics of conversation for families

with infants. Furthermore, improved infant nutrition and general infant care are major objectives for many health-oriented organizations which attempt to disseminate information, utilizing both mass media and interpersonal channels of communication. This presented a problem, for we had to have some way of discerning the separate impact of communications from the medicine showmen.

We dealt with the problem in three ways. We first incorporated into the message two items of information which we knew were not being disseminated through any other channels, the recommendation for mothers to cleanse their breasts with camomile tea, and the idea of the "magic meal." Secondly, we decided to emphasize the name and function of the first breast secretion, colostrum. We felt that even though a small percentage of the public which we hoped to reach would be aware of colostrum, it was not an item of information greatly emphasized as part of other health communication efforts. Lastly, we made plans to incorporate into the evaluation instruments questions pertaining to the sources of information or knowledge indicated by respondents.

Message Preparation

This phase of the project merits a separate paper focusing on the dynamics of developing cooperative working relationships between medicine showmen and academics, and between medicine

showmen themselves when their audience was made up of academics. For this paper, though, we will simply outline the phase in three parts.

The showmen spent 3 weeks working with us in Mexico City. The first week was very relaxed, giving everyone a chance to get acquainted, and giving the academics an opportunity to learn from showmen about communicating with the public. The second week was much more structured. The showmen attended class-like sessions and were instructed as to the message we wanted them to communicate, and the reasons, including scientific rationales, for the importance of each segment of the message. At the end of the second week we asked each of them to develop a medicine-show routine incorporating all segments of the message. We emphasized that the routines should be developed according to their individual styles, and that we only sought uniformity in the correctness of the message content. For example, we wanted them all to recommend the "magic meal" for infants at 3 months of age, and not for 2 or 5 months of age. During the third week, the showmen initially presented their routines, made changes based on constructive criticism from us and their fellow merolicos, and practiced again and again until they all felt comfortable and ready to try them on the public. At the end of the week we had them practice near one of the metro stations in Mexico City.

Communication the Message

After the medicine showmen were ready to begin the field phase of the project, we waited for about a month before having them actually start. Easter Holy Week was nearing, and it is difficult to get anything done during that time in Mexico. Therefore, this phase of the project, to last 3 months, began the week after Easter, in late April of 1979.

In Oaxaca and the Federal District the showmen worked in pairs. In Michoacan the fifth showman worked alone. In each of the three areas there were two test sites, a marginal colonia and a rural village. The showmen worked each site only once a week for a period of about 3 hours. Within each site they moved around to different locations, covering three different spots each visit. In conference with the showmen, we determined which locations would be used. We tried to select places where crowds would more readily gather for the medicine shows, and we wanted the showmen to work a number of locations within each test site so that they might reach as many people as possible. As things worked out, each designated location or spot was worked three or four times during the 3 months.

Evaluation

After the medicine showmen had worked for 3 months communicating the message, we waited another 2 months before carrying

out the field segment of the evaluation phase. Social workers and nurses, trained to administer the interview instruments, first surveyed 20 percent of the households in both the test sites and control sites in order to provide us with measurements of the communication impact of the medicine shows. They interviewed mothers, first preference being for mothers of infants less than 1 year old; second preference being for mothers of pre-schoolers older than 1 year; and so on. This major segment of our sample included 400 women from test sites and 344 women from control sites.

All interviews, at every test site and control site, were completed during a period from 60 to 75 days after the final communication of the message. The findings which follow are products of a first stage analysis of data gathered during those interviews. To support the findings, we also have tape recordings of all the medicine shows, and field notes about many of the shows that we personally observed during the course of the project.

III. FINDINGS

The data reported here focus on the clearest indicators of the impact of the medicine shows presented by the merolicos, the responses to questions dealing with breastfeeding hygiene, the "magic meal," and the first breast secretion, colostrum. Not

only do these responses clearly indicate the impact, but they also deal with all three areas of potential impact, those being knowledge, attitudes, and behavior.

In the knowledge area the results are impressive. Regarding the "magic meal," 24 percent of the mothers retained knowledge of its contents. Also, for the total sample of mothers, the data indicated that the showmen were able to cause a 17 percent increase in the number of mothers knowledgeable about colostrum.

Responses to the question asking about advice for nursing mothers indicate that medicine showmen can change attitudes or, in this case, recommendations for behavior. Nineteen percent of mothers in the test group recommended camomile tea for cleansing breasts before breastfeeding. We can safely assume that, as with control counterparts, before their exposure to the medicine shows they would have recommended some other form of hygiene, or nothing at all. Therefore, their responses at least 2 months after exposure to the medicine shows constitute changed attitudes or ways of thinking about breastfeeding hygiene.

Knowledge and attitudes are important, but what do the data indicate as to the medicine showmen's potential for changing behavior? Mothers who were breastfeeding at the time of the interviews were asked what they actually were using to cleanse their breasts before nursing their children. Whereas not even one individual in the control group indicated the use of camomile tea,

8 percent of the breastfeeding mothers in the test group said that they used camomile tea. This is an unambiguous illustration of the ability of the merolicos to change behavior. The answer to the first question is a definite YES. Medicine showmen in Mexico are more than passing attractions.

Are medicine showmen effective only in rural areas? The traditional popular perspective of parties pretending knowledge of merolicos has been that medicine showmen may have some influence in rural areas, but not in urban areas. The three urban areas utilized in this study, Mexico City, Morelia, and Oaxaca, all have more than 200,000 inhabitants. What impact did the medicine showmen have with this urban segment?

In the knowledge area the results are again impressive. Regarding the "magic meal" 26 percent of the mothers in the urban test group (N=201) retained knowledge of its contents. Also, for the total urban sample, the data indicate that the showmen were able to cause a 21 percent increase in the number of mothers knowledgeable about colostrum. Whereas 23 percent of the urban control group indicated knowledge, 44 percent of the urban test group did so.

Responses to the question asking about advice for nursing mothers indicate that medicine showmen can influence attitudes of urban populations. Fifteen percent of mothers in the urban test group recommended camomile tea for cleansing breasts before

breastfeeding. As indicated above, these responses constitute changed attitudes or ways of thinking about breastfeeding hygiene.

What do the data indicate as to the medicine showmen's potential for changing actual behavior of urban residents? When mothers in the urban areas were asked what they actually were using to cleanse their breasts before breastfeeding their children, 9 percent of the test group said they used camomile tea. The answer to the second question is a definite NO. Medicine showmen are effective in both rural and urban areas.

The third and last question dealt with in this paper focuses on the medicine showmen's effectiveness with the more educated segment of the population. The popular perspective of those who claim to "know all" about merolicos is that only uneducated or relatively uneducated people listen to the medicine showmen and are influenced by them. However, based on our data, we must disagree.

For the purpose of analysis we divided the sample into those having achieved a low level of education, third grade or less, and those having achieved a higher level of education, fourth grade or more. Again, in the knowledge area, the results are impressive. Regarding the "magic meal" only 19 percent of mothers with a low level of education, compared to 34 percent of mothers with a higher level of education, retained knowledge of its contents. Also, the data indicate that the showmen were able to cause only an 11 percent increase in the number of mothers with

a low level of education who were knowledgeable about colostrum, but a 30 percent increase in the number of knowledgeable mothers with a higher level of education.

Responses to the question asking about advice for nursing mothers indicate that medicine showmen can also change attitudes of mothers with a higher level of education. Twenty-three percent of the test-group mothers with a higher educational level recommended camomile tea for cleansing breasts before breast-feeding. This can be compared with 18 percent of test-group mothers with a low level of education who made the same recommendation.

Regarding the medicine showmen's ability to change behavior, as indicated above, mothers who were breastfeeding at the time of the interviews were asked what they actually were using to cleanse their breasts before nursing their children. The data show that 5 percent of test-group mothers with a low level of education said they were using camomile tea. This can be compared with 14 percent of test-group mothers with a higer level of education who also said they were using camomile tea. Thus the answer to our third question is again a definite NO. Medicine showmen are not only effective with the uneducated or relatively uneducated. The more educated listen to them too, and are also influenced by them.

IV. CONCLUSIONS

In the light of earlier research results, and the data from this pilot project, we can enthusiastically endorse the idea of using medicine shows as part of public health programs. In this project, merolicos or medicine showmen have demonstrated their abilities to effect changes in knowledge, attitudes and behaviors of their audiences. Furthermore, we are enthusiastic because the test was a rigorous one. The challenge consisted of the following:

A. Test communities with histories of unwillingness to cooperate with government-sponsored programs. The state health agency had withdrawn its program from one of the rural test sites, and one of the test colonias was a mushroom settlement not legally recognized by the local government.

B. Test populations with low levels of education. Ninety-one percent of the mothers interviewed had not gone past primary school. Sixty-four percent had not gone past third grade.

C. Attempting to communicate a rather lengthy message consisting of more than ten parts.

D. Attempting to change attitudes and behavior about things steeped in tradition and culture. Infant nutrition is a subject about which everyone has an idea or opinion.

E. Working during the rainy season. This resulted in having to change work plans, working in the rain, etc.

F. Communicating the message during only a 3-month period. This resulted in each test community being worked a maximum of only 40 hours.

G. Conducting the evaluation interviews in each test community only after at least 2 months had passed since the last medicine show.

V. DISCUSSION

The idea of using merolicos as part of community health programs is now based on seven years of research and experience. It makes sense in terms of (a) our knowledge of target subcultures and communities, (b) our knowledge of various communication media and their potentials for communicating health information to these targets, (c) the comparatively low potential cost, when compared with other health communication efforts, and (d) the relatively low potential cost, relative to the potential benefits or results.

Infant-nutrition information, of course, is just an example. Information on venereal diseases, gastro-intestinal disorders, heart disease, or just about any other health-related topic could be disseminated by medicine showmen. We know people listen to them. We know people will gain knowledge and change both attitudes and behaviors as a result of their contact with medicine showmen.

We believe medicine showmen should be integrated into ongoing public health programs.

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Dr. Joseph J. Simoni is a sociologist with the Department of Sociology and Anthropology at West Virginia University. He now teaches courses in introductory sociology, community, community development, and ethnic groups. His major research interests are health communication, and social histories of ethnic groups in Appalachia, social change, and development. For the last nine years, with much appreciated support and sacrifices of his wife, Pat, and their two children, Susanne and Joanna, he has been studying medicine showmen in Mexico.

Dr. Luis Alberto Vargas obtained his medical degree from the National University of Mexico, his Master's degree in Anthropology from the National School of Anthropology in Mexico, and his Ph.D. in Anthropology from the University of Paris. He is currently a researcher and the academic secretary of the Institute for Anthropological Research at the National University of Mexico. He has recently been a visiting researcher at the Department of Anthropology at Michigan State University. His area of interest are medical and physical anthropology, including human growth, nutrition, health eduction, and ergonomics.

Dr. Leticia E. Casillas obtained her medical degree from the National University of Mexico. She specialized in social pediatrics in the Universities of Madrid and Paris. Currently she is preparing her dissertation to obtain a Master's degree in Physical Anthropology, while serving as head of the section of Medical Anthropology in the Direction of Medical Services at the National University of Mexico. Her main areas of interest are nutrition, variability of Mexican populations, human growth, and health education.

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Institute for the History and Philosophy of Science and Technology
TORONTO, CANADA M5S 1A1

July 15, 1982

Luis A.V. Barreto:

I was interested to read your work.

It has relatively little historical analysis in it. I felt as I was reading it that you saw western medicine in the past as being exactly what it is now.

I am looking forward to working with you next term.

P. Mazumdar

Pauline Mazumdar

CHAPTER 6

Traditional Chinese medicine

Wang Pei[1]

The splendid culture of the ancient times had a rich store of medicine, some elements of which, with the development of modern medicine, were discarded while others were preserved and handed down to posterity. A few were further developed and spread far and wide among the people. Traditional medicine has made a great contribution to the welfare of all nations in the world.

In the present era of highly developed modern medicine, it is necessary to give due regard to the traditional medicine of all nations, as our experience in the development of traditional Chinese medicine has shown. We firmly believe that the integration of traditional medicine with modern medicine helps to correct the deficiencies of each and will certainly promote the development of medical science in the future.

Traditional Chinese medicine, with its rich clinical experience, its unique theoretical system and its extensive literature has served to combat illness among the Chinese people over many centuries. It represents the crystallization of the Chinese people's wisdom and experience. What has proved effective in clinical practice has been preserved, handed down from generation to generation, and continually improved upon. A few examples only are given below.

The early stage of medical activities dates from the beginning of human society. The historical documents of ancient China contained some legends about it, but the earliest recorded history of traditional medicine was in 1800 B.C., the beginning of the Shang dynasty. Certain oracle-bone writings, the oldest form of Chinese writing carved on scapulae and tortoise shells and used for divination, that were unearthed from the ruins of the Yin dynasty bear inscriptions naming and describing various kinds of illnesses and indicating elementary methods for the classification of diseases. For instance, head disease was called *Ji Shou*; eye disease, *Ji Mu*;

[1] Director, Central Laboratory, Academy of Traditional Chinese Medicine, Beijing, China.

ear disease, *Ji Er*; abdominal ailment, *Ji Fu*; diseases of the foot, *Ji Zu* and so forth. The character 蛊 (*gu*), which means a venomous insect, was formerly written like  , which indicates that there are parasites in the abdomen; and the character 龋 (*qu*), meaning decayed tooth, was written like  , which indicates that a tooth is being eaten by insects. These are the earliest records on dental caries and parasites.

More remarkable yet are the notions of hygiene and preventive measures appearing between 1400 and 1200 B.C. For instance, the character 浴 (*yu*), meaning "bath", was formerly written like  on oracle bones.  indicates "person",  "water", and "bath tub". Oracle bones also record "sprinkling of water to remove the dust, sweeping, and getting rid of insects". These excavated cultural relics from the ruins of the Yin dynasty show that there were already at that time sties and folds for domestic animals, lavatories and drainage trenches.

The *Book of Rites*, a manual of ceremonies written in the Zhou dynasty (1100 to 800 B.C.), records that there were specialized doctors in four departments, namely: nutrition, internal medicine, surgery, and veterinary medicine. It also stipulates that "Doctors are in charge of medical laws and decrees". "If one gets ill one should be treated. If one dies of a certain disease, the cause of death should be recorded and made known among the doctors." This is probably the earliest medical case-recording system. It also makes it a rule to assess doctors' knowledge and skills annually so as to determine their salary grade. The famous medical book of our country, *Internal Classic* or *Yellow Emperor's Internal Classic*, the oldest and most comprehensive work on medicine still extant, which appeared around 300 B.C., is a combination of medical theory and clinical practice (*1*). This book is in 18 volumes; it emphasizes the basic theory of traditional Chinese medicine and contains substantial information on hygiene, clinical symptoms, prescriptions and drugs, acupuncture and moxibustion, and so forth.

The theory of yin-yang, viscera and bowels, and meridians recorded in the *Internal Classic* has become the foundation for the basic theory of traditional Chinese medicine. Anatomy was already in the embryonic stage and some anatomical data were analysed. For instance, the length of the digestive tract, from pharynx to rectum, was measured by adding up the length of different segments; the recorded length was similar to that found by modern anatomical measurement. Over 300 signs and symptoms were also described. For instance, in dealing with the symptoms of cervical lymphatic tuberculosis, the book also correctly portrays its relation with visceral tuberculosis. Besides medicinal treatment, the *Internal Classic* records many non-medicinal therapies such as acupuncture and moxibustion, massage, *dao ying* (a combination of deep breathing and self-massage) and so forth. Of special significance is the detailed record on the treatment of ascites by abdominal tapping. A thin needle was inserted at *guanyuan*

point, 7½ cm below the umbilicus; the abdomen was then punctured with a hollow needle to drain the ascitic fluid, the needle being kept in the abdominal cavity until the fluid had drained to a certain degree. A tight abdominal bandage was then applied to avoid adverse effects resulting from the sudden change in intra-abdominal pressure. Such an operation and postoperative procedure reflect the wisdom and the medical knowledge of ancient doctors. The *Internal Classic* still remains an essential textbook in the colleges and schools of traditional Chinese medicine.

From the Chin and Han dynasties down to the Ming dynasty (A.D. 1700) the empirical medicine of China forged ahead with great success. For instance, the Chinese medical scientists invented the method of variolation or inoculation to prevent smallpox. It was an important invention in the history of human preventive medicine and one that pioneered modern immunology. At the time of Song Zheng-zong (A.D. 998–1022), a Taoist priest in the Mount E-mei had the son of Minister Wang Dan inoculated. Towards the latter part of the 16th century, variolation was widely used in China. In 1688, Russia sent doctors to Peking to learn this method, and it was thereby introduced to Turkey and Europe. It was only after inoculation with cowpox had been invented by Jenner in 1796 that variolation was gradually abandoned.

There are various kinds of treatment in traditional Chinese medicine. Some original non-medicinal treatments such as acupuncture, moxibustion and massage were introduced over 3000 years ago. Some very rich experience has also been gained in using natural herbal medicines to treat diseases. Drug anaesthesia was applied in laparotomy in the 2nd century; harelip operation was performed in the 3rd century; the treatment of scabies, tinea and carbuncles by mercurial ointment was used in the 4th century; couching of cataract with gold needles was adopted in the 5th century; and false teeth with amalgam were introduced in the 7th century. The treatment of vertebral fracture by suspension, reduction, etc. was introduced in the 12th century. These are perhaps some of the earliest methods of treatment recorded in the history of medicine.

China also has a rich store of books on pharmacology. The *Xin Xiu Ben Cao* (Newly Revised Materia Medica) of the Tang dynasty in the 7th century is the earliest pharmacopoeia promulgated by the government. In the 12th century, the Song dynasty published *Tai-Pin Hui-Min He Ji Ju Fang* which is the world's earliest prescription book of pharmacy issued by the government. In the 17th century, during the Ming dynasty, in his *Ben Cao Gang Mu* (Compendium of Materia Medica), Li Shi-zhen, the world-famous pharmacognosist, collected 1892 kinds of herbal drugs and 11 000 prescriptions. Charles Darwin in *The Variation of Animals and Plants under Domestication* referred to the *Ben Cao Gang Mu* as a Chinese encyclopaedia.

To date, traditional Chinese medicine has generated over 10 000 medical books, 5000 kinds of herbal drugs, and a rich experience of clinical therapy. Traditional Chinese medicine and pharmacology have not only

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contributed much to the development and prosperity of the Chinese people, but have also had an important influence on the development of medical science in general.

It is a matter for regret that, for various historical reasons, traditional Chinese medicine was not able to participate earlier in the experimental sciences. For many decades, modern or Western medicine has forged rapidly ahead whereas the progress of traditional Chinese medicine since the Ming and Qing dynasties has been much slower in comparison. Under such unfavourable conditions, there have been two different attitudes toward traditional Chinese medicine: one tendency was to eliminate the system and replace it by modern medicine, or eliminate the practice but preserve its effective drugs and prescriptions only; and the other was to accept this precious legacy and develop it with modern scientific knowledge and methods into a unified medicine and pharmacology with the characteristic style of China.

In 1929 the central government of Kuomintang passed a bill "to ban the traditional medicine in order to clear the way for developing medical work". But they did not succeed in banning and replacing it. In the first place, people in the vast rural areas and both the common people and the upper class in many cities earnestly believed in traditional medicine. Secondly, the use of traditional Chinese medicine and medicinal herbs did yield rather satisfactory results in the treatment of diseases, including some diseases intractable by modern medicine. Traditional remedies could reduce symptoms and even produce remission. Moreover, Chinese medicinal herbs were readily available at low cost, were convenient and simple to use, and had very few side-effects. They therefore enjoyed much popularity with the vast majority of people. Thirdly, traditional medicine had a unique theoretical system which can neither be replaced nor explained by modern science, including the theory of yin-yang, vital energy and blood, and so forth. Traditional Chinese medicine has thus survived and has never been eliminated in spite of the persecution it suffered before the liberation. However, it was only after the founding of the People's Republic of China that traditional Chinese medicine entered a new period of development.

The liberation

Since the founding of the new China, our Government has attached great importance to traditional Chinese medicine, giving energetic support to it and taking effective measures to speed up its modernization.

"To foster unity between Chinese and Western-trained doctors" is one of the four principal policies for health work laid down by the Government since the inauguration of the People's Republic of China. Later, the policy on traditional Chinese medicine was formulated according to the actual needs of our country. The main points of the policy are as follows:

(1) To strive to inherit, develop, systematize and raise the level of traditional Chinese medicine;

(2) to unite and rely on the traditional Chinese doctors so as to give full effect to their initiative;

(3) to organize ways for Western-trained doctors to learn and study traditional Chinese medicine;

(4) to modernize traditional medicine and pharmacology gradually;

(5) to develop traditional Chinese medicine and conduct research on the integration of traditional Chinese and Western medicine in a planned and rational way;

(6) to protect, utilize and develop the resources of Chinese medicinal herbs.

In order to ensure the implementation of this policy, a parent organization in charge of traditional medicine has been established within the Government. The Ministry of Public Health has set up a bureau of traditional medicine, while departments of traditional medicine have also been placed under the provincial and municipal bureaux of public health.

As a result of the implementation of the traditional medicine policy and a series of effective measures to promote it, traditional Chinese medicine has developed greatly in the last 30 years.

First, the position of traditional doctors and the condition of the traditional hospitals have changed tremendously. Before the liberation, Chinese medicine was regarded as illegal, and was discriminated against and eschewed. It was only after the liberation that Chinese medicine gained its legal status. Since then, 280 000 doctors of traditional medicine have been invited to work in the state and collective medical organizations such as hospitals, medical schools and research institutes. Chinese medicine and Chinese materia medica have become a part of free medical care. In the hospitals of Western medicine, departments of traditional medicine together with its pharmacies and wards have all been accommodated.

In order to enable traditional doctors to master some modern science and technology, many provinces and municipalities have organized various types of training and orientation courses for teachers of traditional medicine and advanced courses for traditional doctors to study and raise their level of modern science. These have brought about fundamental changes in both the social status and the academic position of traditional doctors.

There have also been great developments in the hospitals of traditional Chinese medicine. China now has 552 hospitals of traditional medicine above the county level and almost all the hospitals of Western medicine have set up departments of traditional medicine; the larger hospitals with better facilities have even instituted research laboratories to explore the problems relating to the integration of traditional Chinese medicine with Western medicine. By the end of 1979, 91 county and municipal hospitals had been established in 102 municipalities and counties in Hunan province,

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not including the provincial hospitals and the general hospitals where traditional Chinese medicine has the chief position. These traditional hospitals have assumed a great many medical functions. For example, in the traditional hospital of Chang De, the number of outpatients has reached 3 700 000, while 20 880 patients have been hospitalized since its establishment.

In addition, the barefoot doctors working in the rural areas have all received appropriate training in both Western and traditional methods of treatment, but most of them mainly apply acupuncture and herbal treatment. These 1 600 000 barefoot doctors have greatly contributed to the medical service in the rural areas, which have an estimated population of 800 million.

The educational and training curriculum for traditional Chinese medicine has been strengthened. At present, there are 24 institutions of higher learning for traditional medicine with 18 000 students, and 18 secondary schools with 10 000 students. Moreover, the students in the Western medical colleges are also obliged to pursue courses in traditional medicine. Faculties of traditional Chinese medicine have been established in 11 Western medical colleges.

The production of Chinese herbal medicines has increased, and has gradually developed into an industrial system in the last 30 years. The staff engaged in purchasing, processing and supplying medicinal herbs now total 220 000. The area under cultivation of medicinal herbs has reached 6 million *mu* (400 000 hectares). The amount of medicinal herbs purchased totals 13 million tonnes. At present there are more than 800 pharmaceutical factories with 80 000 workers in them, which produce some 2000 varieties of medicinal herbs. With increasing modernization in the pharmaceutical factories, the quality of herbal medicine has greatly improved. During the nationwide quality appraisal drive in 1979, herbal medicine won three gold and four silver medals.

Efforts made to integrate traditional Chinese medicine with Western medicine have proved truly worth while. Only through close cooperation between the traditional and Western-trained doctors, each learning from the other, and especially through the study of traditional Chinese medicine with modern scientific knowledge and technology, can the development of traditional Chinese medicine proceed more speedily. For many years, the Central Government, provinces and municipalities have organized many orientation courses for Western-trained doctors to study traditional Chinese medicine; thus many doctors specialized in both Western and traditional medicine have been trained. Now, there are three types of doctor in our country—namely, traditional, Western-trained, and Western-trained with qualifications in traditional medicine. These categories are advancing along the road to an integration of traditional and Western medicine to achieve a unified new medicine and pharmacology. We have obtained encouraging results from scientific research on the combination of Chinese and Western medicine, for example in the fields of acupuncture

and moxibustion, acupuncture analgesia, acute abdominal conditions, burns, injury of bones and joints, anal fistulas, lithiasis of the urinary tract, cardiovascular diseases, cataract, and respiratory diseases in infants. The effect of the combined treatment of the above-mentioned conditions is much better than that of either system applied alone. Applying modern scientific knowledge and technology, encouraging research results have been obtained also regarding the hypotheses on which traditional medicine is based. These include the theory of yin-yang, visceral manifestations, vital energy and blood, meridians, the method of promoting the blood circulation and relieving stasis, reinforcing vitality, etc.

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Traditional Chinese medicine certainly deserves attention and high priority. It contains some scientific elements which will surely make a contribution to mankind if we conscientiously explore and systematize it by modern scientific method and technology. A more realistic policy is required to protect and develop the system instead of discriminating against it or trying to eliminate or replace it. Only thus can traditional Chinese medicine develop and progress. The integration of the two systems requires careful study. These two schools of medicine should be mutually supporting and complementary and there should be no strife. Traditional medicine could then contribute more to the welfare of mankind. Much has already been gained from traditional Chinese medicine in the field of public health and in the development of medical science. We would like to share this experience with all interested health workers.

It is encouraging to note that more and more countries have become interested in traditional Chinese medicine. One hundred and fifty scientists and doctors from 34 countries and territories attended the Symposium on Acupuncture and Acupuncture Anaesthesia held in Beijing in 1979 and this kind of international activity will no doubt increase.

What are the future prospects of traditional Chinese medicine? An analysis of our 30 years' experience tells us that traditional Chinese medicine will continue to develop steadily through the judicious application of modern science and technology. The combined treatment of certain intractable conditions such as malignant tumours, cardiovascular and degenerative diseases and senility is likely to be more efficacious. The non-surgical treatment of certain diseases such as acute abdominal conditions will be popularized so that it can alleviate patients' suffering and reduce medical expenditure. At the same time, the mechanism of its therapeutic effect and basic theory will be further elucidated. Consequently, the integration of Chinese medicine and Western medicine has a particularly bright future.

Science and technology are the common wealth of mankind. Traditional Chinese medicine is an old and yet quite a young science, and its

development and improvement naturally require the common efforts of scientists all over the world. Traditional Chinese medicine will always have an important role in the cultural exchange between the Chinese people and the people of other countries. Let us carry on the exchange and the cooperation our ancestors initiated!

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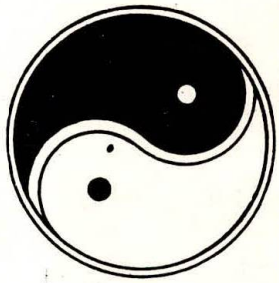
Primer on Traditional Chinese Medicine



Editor's Note: *The following is a reprint of the Primer on Traditional Chinese Medicine, produced by the Acupuncture Therapeutic and Research Center, Inc.*

INTRODUCTION

Traditional Chinese Medicine is the result of thousands of years of struggle against disease through the use of theory and practice which are closely linked with the observation of natural events or phenomena.

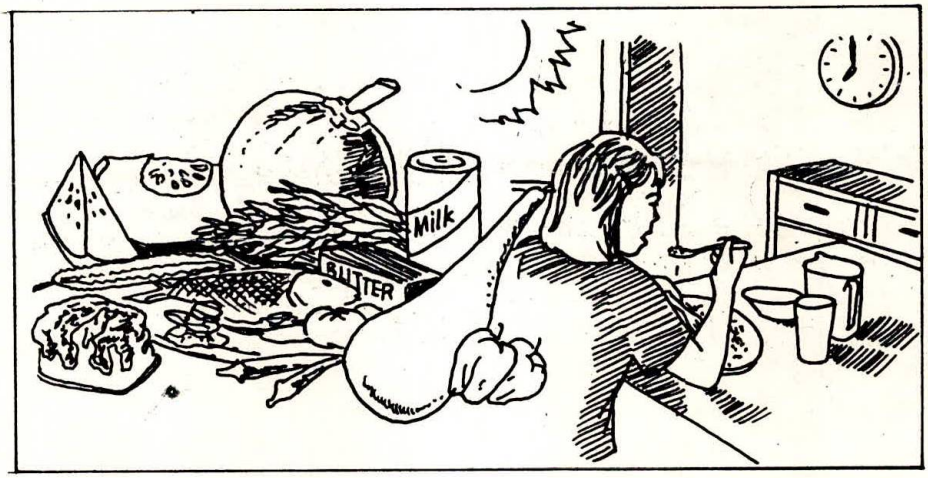
The Chinese have developed a system of health care which has been proven to be effective in resolving disease processes over the years. The Chinese experience primarily shows us that the role of Chinese Medicine in Public Health Care can be most beneficial to people in communities, in both rural and urban areas.

For our part, it is essential to venture into Traditional Chinese Medicine's use for our purposes to be able to develop an applicable system that is potentially easy to apply, easy to teach, low cost, and effective.

Faced with today's rising cost, particularly medical care and drugs, we can not but see the relevance of propagating Traditional Chinese Medicine.

This primer's primary objective is to be able to:

1. inform the reader regarding the principles and methods involved in Traditional Chinese Medicine
2. familiarize the reader with the different Traditional Chinese modalities of treatment, and
3. impress upon the reader the importance of a systematized approach in the use of Traditional Chinese Medicine.



A. What are the principles, theories, and concepts of Traditional Chinese Medicine?

The different theories and principles governing Traditional Chinese Medicine will be found quite similar to the other types of Medicine particularly in the concept of maintaining health. This involves the idea in what the Chinese call "yang sheng," literally translated as, to nurture life. This basically means that to stay healthy, one nurtures life properly.

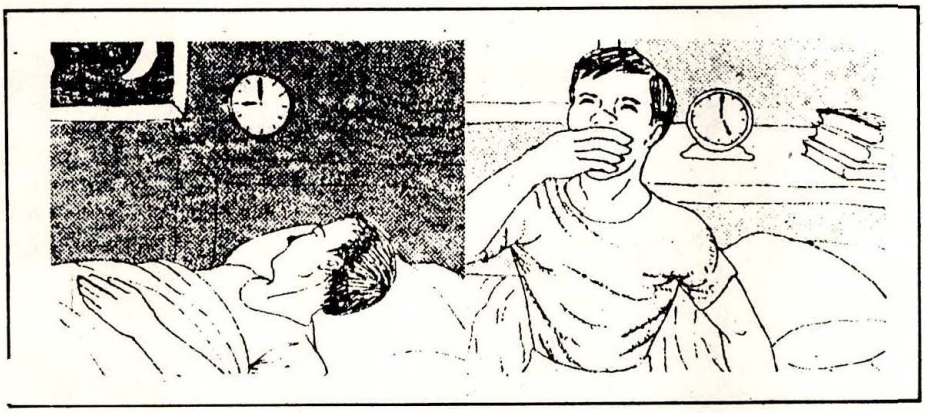
Nurturing life properly involves the following processes of proper diet, adequate amounts of rest, and proper adaption to stress.

Proper diet means:

1) one must eat a balanced diet containing the required amounts of nutrients, proteins, vitamins, minerals, and so on;
2) one must eat on time with regularity;
3) one must not eat too much nor too little; and
4) one must have the proper attitude to eating, preferrably avoiding emotional upsets during meals.

Adequate rest means:

1) a balance of rest and work schedules;
2) proper length of rest, which is as required, eight hours a day;
3) one must sleep early, wake up to be able to face the new stresses the next day; and
4) one must have the proper attitude to resting, preferably avoiding emo-



tional upsets or quarrels prior to sleep, and also preferably resolving these before bedtime.

Adaption to stress means:

1) strengthening of the body to withstand external stress, such as changes in climate or weather, to provide adequate protection against natural elements of wind, heat, cold, humidity, etc.
2) to learn how to control the different emotions, to be able to give vent to those emotions of sadness, anger, frustration, depression, worry, fear, and happiness at the proper time, meaning one must get angry when it is time to get angry and not to remain angry for an extended period of time by resolving the root of the anger; excessive worrying upsets us since we can not sleep nor eat well when we worry.

Proper exercise done regularly definitely helps the body maintain strength and cultivates body resistance against disease.

All in all, Chinese Medicine sees the relationship of these factors and summarizes them all into one word reflective of a healthy status, which is balance — balance of diet, rest, and stress.

The Chinese Medical theory that is used to expound balance is what is known as *yin and yang*. Briefly, this seems to be a relationship between two factors, events, or entities which are constantly in antagonism with each other. However, their existence is mutually dependent on each other, such that, without one, the other can no longer exist.

As an example, the concept of light exists primarily because there is the concept of day. Without the concept of day, there will be no concept of night and vice-versa. However, night and day are quite opposed to each other, one being dark, the other light; one being cool, the other hot, and so on.

Traditionally, the concept of yin and yang is believed to be universal and has the following relationships. They are yin and yang transforming into the other — night becomes day and day becomes night. Yin and yang define each other, such that what is light is that which is not dark. They control and are dependent on each other as previously discussed.

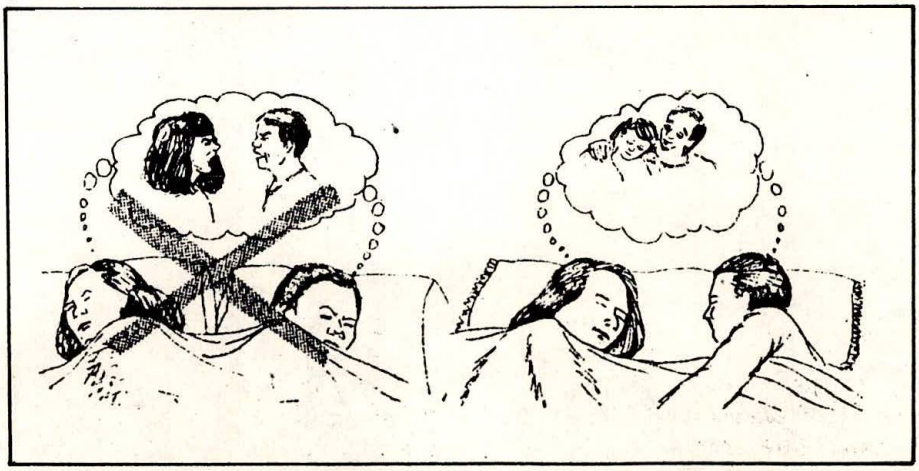
To make things simple and easier to understand, yin is personified or exemplified by night and all of its characteristics like night is dark, cool, quiet, passive, etc. while yang is its opposite, day being bright, warm, noisy, active, etc.

When applied to health and balance, yin and yang is used in the following sense: as far as diet is concerned, one must eat the proper amounts of food, hot and cold in nature. By hot and cold food, what is meant is the type of characteristic the food gives off. For example, fats, beef, pepper, coffee all provide a warming sensation to the body; whereas, vegetables, water, pork, melons all provide a cooling effect.

The various forms of yin and yang are thus applied in a similar sense in maintaining bodily health. It is quite clear that there is a dynamism that must be understood for one to truly maintain health.

B. What are the different modalities of treatment of Traditional Chinese Medicine?

Traditional Chinese Medicine is a system of health care which uses concepts of body energy, known as "Qi" (pronounced "chee.") However, Qi is quite universal in a sense that the Chinese maintain that energy or qi exists and manifests itself all throughout nature like the sun rising and setting,



the planets moving in a proper movement, and the like.

The theory is quite similar to the idea that energy exists in various forms like electrical energy, heat and radiant energy, magnetic, chemical, and mechanical energy and that all these are transformed to one form or another. In our body, there is a multitude of manifestations of energy like electrochemical, electromagnetic, and biochemical energies which the Chinese have all referred to as qi.

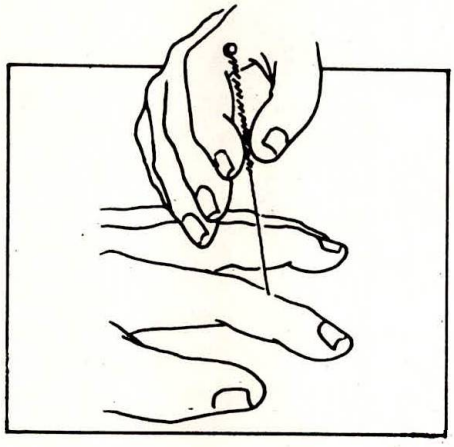
It is quite obvious the Chinese have used terms best suited to their culture and environment for their particular time, for them to understand the workings of the body and nature as a whole.

As far as the body is concerned, it is run as a system which transforms various substances to energy or qi, these substances being primarily the nutrients we get from food and air we breathe in. The body is also perceived to circulate energy or qi. Its manifestations are seen as body movements. Lastly, the body also stores adequate amounts of energy for future use as in cases of emergency, wherein one calls on unusual amounts of energy for unusual use of energy like lifting a heavy cabinet during a fire. Such are the manifestations that our body has qi.

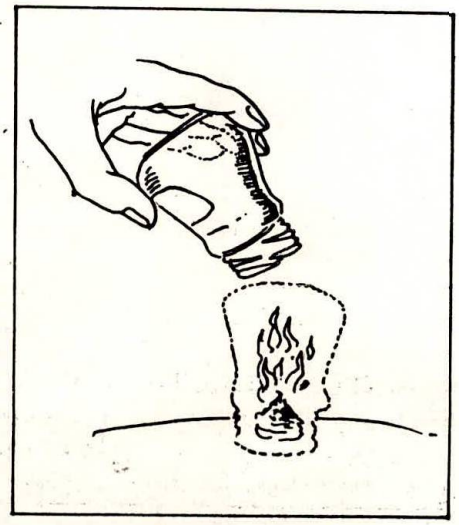
According to Traditional Chinese concepts, the different modalities simply influence the production of qi (extraction of qi from substances), the circulation and the storage of qi.

The various modalities of Traditional Chinese Medicine are the following:

1) Acupuncture — This term is derived from the words "acus" and "pungere" which mean needle puncture. This modality makes use of fine filament needles inserted into predetermined sites called acupuncture points. These have been observed through the years to have a distinct and particular effect on the body's qi.



2) Pressure therapy, called "tuina," also known as remedial massage — This makes use of pressure and massage techniques over acupuncture points to be able to influence the body qi.
3) Moxibustion — It is an ancient technique of burning herbs over body areas to be able to redirect qi flow. This is a modified form of cauterization using dried herbs, mainly from a plant called *Artemesia vulgaris*, or *damong maria* to be able to eliminate cold and move qi in the body.
4) Cupping or more commonly known as ventosa — This employs the use of a vacuum made by flaming a cup or a glass and rapidly attaching this to the body skin. This is commonly used to move stagnant qi and eliminate cold in the body.



5) Chinese Herbal Medicine — Lastly, this modality of treatment uses diverse forms of drugs taken from plants, animal, and mineral resources. These are prepared to be taken by an individual to be able to influence qi circulation, to strengthen resistance of the body's condition against disease. It is an entire field in itself and due to its complexity and the diversity of drug action, we feel it would be more appropriately called Chinese Pharmacology.

C. What are the ailments that respond best to Traditional Chinese Medicine, particularly acupuncture?

For thousands of years, the Chinese have used acupuncture and other modalities of Traditional Chinese Medicine for a multitude of diseases, all of which are diagnosed and analyzed according to Traditional Chinese Medicine principles. However, the principles and terminology used in Traditional Chinese Medicine differ from that of modern Western Medicine.

What is most commonly accepted in today's use of acupuncture is its great role in controlling pain. Pain is often seen as a circulatory disorder involving qi wherein flow of qi is disrupted, leading to a slowing down (stagnation) or complete stop (obstruction). For effective control of pain using acupuncture, proper methods of identification or analysis of the cause and the location of stagnation or obstruction is necessary.

The different methods of diagnosis used by Traditional Chinese Medicine are the same as those utilized by modern Medicine, namely — inspection, palpitation, auscultation, and asking questions regarding the patient's illness. It is important to note that this type of medicine was developed at a

time wherein a practitioner had to solely rely on his senses, unlike today wherein our senses are further aided by technology such as the microscope, scans, etc.

Thus, the methods of diagnosis emphasize or center on gross findings such as general appearance of his face, the color, shape, and moisture of the tongue, the qualities of pulse felt, the patient's relationship to his environment, both internal and external, by asking a multitude of questions regarding different bodily processes. These include questions on diet, appetite, thirst, bowel movement, urinary habits, sleep, and in women, menstrual flow.

The Traditional Chinese Medicine practitioner then collates all data gathered and interprets this as a pattern of illness, imbalance, or disharmony and only from there, proceeds to treat it accordingly. Failure to diagnose a case, therefore, will usually result in a treatment failure. The same applies to Western Medicine.

Experience world-wide points to the fact that acupuncture and Traditional Chinese Medicine, as a whole are also effective in dealing with health problems other than pain. It is at this point that there is a need to fully comprehend its function and use in terms of modern medical parameters and this clearly involves extensive clinical research.

D. What will the patient experience while undergoing acupuncture treatment?

Acupuncture treatment deals with direct intervention with the flow of qi. It is therefore important for the patient to experience "de qi" or needle sensation. This simply means that needling a particular point requires that qi must be gotten or felt for one to be able to manipulate it.

The sensations involved are any one or a combination of the following: aching soreness, distention, electrical sensation, heaviness or numbness, and warmth, all of which may stay in one place or radiate through the normal course of qi flow.

Patients must not be hungry, excessively tired, overly nervous, and must have slept well prior to treatment. Pregnant patients and children below seven years old must preferably be treated with extreme caution.

People with the following conditions must not be treated until after a more suitable period of time: drunken patients or those who have taken alcoholic beverages, patients under the influence of addicting drugs, and patients with serious illness wherein qi level is very low, for what qi can be manipulated when there is little left.

Precautions for patients after acupuncture treatment are the following:

1) to refrain from excessive work or exercise so as not to disrupt qi flow that has been influenced to regain balance;

2) to refrain from intake of alcoholic beverages which will retard qi flow; and

3) to avoid exposure of punctured areas to water to avoid potential disruption of qi flow.

AFTERWORD

All in all, it is clearly seen that Traditional Chinese Medicine offers a distinct alternative to most of our health problems. We must actively evaluate and propagate that which is valuable and disregard those without basis.

CECIL G. HELMAN

"FEED A COLD, STARVE A FEVER" – FOLK MODELS OF INFECTION IN AN ENGLISH SUBURBAN COMMUNITY, AND THEIR RELATION TO MEDICAL TREATMENT

ABSTRACT. This paper outlines a widely-held conception of illness, related to perceived changes in body temperature – 'Chills' and 'Colds' on one hand, 'Fevers' on the other – in an English suburban community on the outskirts of London. The relationship between this folk model, and that of the local family physicians is analysed, to show how biomedical treatment and concepts, particularly the germ theory of disease, far from challenging the folk model, actually reinforce it. Remedies which cannot be scientifically and biomedically justified are nevertheless prescribed by the physicians to meet their patients' need to 'make sense' of biomedical treatment in terms of their folk model of illness. At the interface between physician and patient, biomedical diagnoses and treatment are more 'negotiable' than previously realised – and this has important implications for the delivery of health care.

INTRODUCTION

Much of the research in medical anthropology has dealt with folk beliefs and practices relating to illness, in the non-Western and non-industrialised world. An area of research that has been largely neglected is the persistence of such folk beliefs in the West, particularly in an urban context. Most studies of indigenous medical systems in Europe and North America have dealt with those of ethnic minorities or of relatively isolated rural communities in those regions. There is often an implicit assumption that in the cities, at least, most adults are familiar with the 'folk public or biomedical' model of disease of the medical profession, and that except for a few elderly or uneducated people, or those who follow 'alternative medicine', its basic premises of cause and effect in disease are largely accepted. The public, after all, have been exposed for many years to information about modern medicine via books, the schools, the popular press, radio and television, and health education pamphlets produced by the government; in Britain particularly, since the formation of the National Health Service in 1948 – which guaranteed free and unrestricted access to medical care – there has been profound contact with doctors and with their ways of thinking. Nevertheless, many folk concepts of illness remain unchanged. The purpose of this paper is to explain *why* such beliefs persist, and to describe how biomedical treatment and concepts (for example, the germ theory of disease), although originating in a different conceptual system, are easily incorporated into the folk

Culture, Medicine and Psychiatry 2 (1978) 107–137.

model without challenging its basic premises. In fact, they may serve to reinforce it. This is particularly true in the context of family medicine, and I hope to show how in this situation – at the interface between general practitioner and patient – the biomedical model of disease is 'adapted' in such a way as to 'make sense' in terms of the folk model of illness. As a result of this process it can be shown how many of the diagnoses and treatment given by family physicians cannot be justified in purely scientific or rational biomedical terms; but only in terms of the patients' need to 'make sense' of this treatment in terms of their folk beliefs about illness. This has important implications for the delivery of health care, and indeed for the whole notion of what does or does not constitute a 'treatment' in medical terms. Eisenberg (1977) has noted how physicians employ both everyday and biomedical models in practice, even though these are not logically compatible; that is, in our society "clinicians mediate between medical models of disease and popular models of illness, just as do the patients who employ concurrently the services of herbalists, shamans, and doctors. The resolution of the tensions between contradictory models occurs in practical action" (1977:19) The process of resolution or adaptation is described by Stimson and Webb (1975) in the context of consultations in general practice in Great Britain. They see such consultations as a process of negotiation between doctor and patient, whereby each tries to influence the other regarding the outcome of the consultation, the diagnosis given, the treatment prescribed. Their evidence suggests that "there is so much room for variability in diagnosis, even with seemingly 'hard' information such as the results of X-ray photographs, that diagnosis is not the cut-and-dried scientific exercise that it is often made out to be" (Stimson and Webb, 1975:37). What they fail to stress is that this negotiation is not only between individuals, but between two systems of thought, lay and professional, folk and biomedical; that is, between two seemingly incompatible systems for the explanation and alleviation of misfortune. For the interaction to be successful to the patient, there must be agreement between doctor and patient on certain key concepts, and on the physician's interpretation of the patient's problem; according to Fabrega (1975:972) "it is probably an agreed upon social consensus which includes the practitioner and the sick person (or his surrogates), that is required for a medical action to be judged as beneficial or helpful". When it is attained, this consensus has its effect on both folk and biomedical models of ill-health, as will be shown. In particular, my research suggests that the folk model is more functional and more resistant to change, than had been realised, and that there are various explanations for this.

This paper – which arises from my own experience as a family physician – describes a folk model of illness in an ordinary English suburban community on the outskirts of London; it outlines certain widely-held beliefs about illness related to perceived changes in body temperature in such a community – beliefs

which can be summarized in the phrase "Feed a Cold, Starve a Fever", and which to some extent are common throughout the British Isles. Although the suburb is now part of the great metropolis, it is a study of the 'ethnomedicine' of the area, which in Hughes' definition is "those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine" (1968:88). It is also a study of the effect of these beliefs on the diagnoses and treatments given by the general practitioners, the local representatives of biomedicine, to their patients.

SOURCE OF DATA

The material was collected in a four-year period since 1973, during which time I have worked as a general practitioner or family physician for the British National Health Service[2] in Stanmore, Middlesex. It is based on my own experience, as well as on interviews with patients, district nurses, receptionists, and with seven of my general practitioner colleagues who practice in Stanmore, or in the neighbouring suburb of Edgware. The quotations used in the paper are from those interviews. In addition I have used published material on drug prescribing under the N.H.S. from a number of sources.

Although technically in the county of Middlesex, Stanmore is a peripheral suburb of London, at the edge of the 'green belt' of open countryside. It is about 12 miles from the centre of Westminster. Until 1936 it was open countryside and marshland, but in that year the 'Laing Housing Estate' of detached and semi-detached suburban houses was built. The inhabitants were drawn either from London, or from the surrounding villages in Middlesex, with a small number from abroad. Many of the present-day inhabitants, in their 60's and 70's, moved into the area as young couples in the 1930's; while others are their descendants, or new arrivals mainly after the last war. It is a predominately middle-class suburban community, with strong values of order, balance, and social respectability. The area is in no way isolated from the rest of London; it is served by the same bus routes, Underground network, and other facilities, as well as the same newspapers, and radio and television programmes. Most doctor's surgeries, or clinics, in the area are located in ordinary houses converted for this purpose. There are several large hospitals only a few miles away.

GENERAL PRACTICE IN GREAT BRITAIN

Under the British National Health Service the entire population has access to free medical care, at both general practice and hospital levels. Each patient belongs to the 'list' of a general practitioner in their area, though there is some choice as to which doctor's list they can join, provided it is still within the area.

Consultations between patients and family physicians are free of charge, and take place at specified times at the surgery, or by house-call for emergencies at other times. A small fee is paid by the patient for each item of drugs prescribed by the doctor; the fee is paid directly to the pharmacist who dispenses the drug. It is estimated (Levitt, 1976) that there are about 26 000 general practitioners in Britain, and that each one has an average list size of 2347 patients. Levitt estimates that about 75% of symptoms are treated by the patients themselves, without going to a doctor (1976:95), but of those who do seek professional medical treatment for ill-health, the NHS general practitioner is the first point of contact for about 90% of these people (1976:97). The general practitioner is therefore the main interface between biomedical concepts and lay beliefs about illness. The majority of the patients seen by a general practitioner suffer from minor complaints, with no risk to life or permanent disability; in the studies quoted by Levitt (1976:95) 62% of the conditions seen commonly fall in this group. Only about 13% are major, life-threatening conditions, and these are mostly referred for hospital treatment. In general, the conditions of ill-health to be described below fall into the category of minor complaints, yet they form a large proportion of the workload of the average general practitioner[3].

'ILLNESS' AND 'DISEASE'

The analytical distinction between illness and disease is one that has been made by several authors (see Eisenberg; 1977, Fabrega, 1973:91–93, 218–223, and 1975:969–975; Cassell, 1976:47–83; Mitchell, 1977:17–19; Lewis, 1975:146–151). In general, the term 'disease' has been used to describe the pathological processes and entities of the biomedical model; diseases are defined "on the basis of deviations and malfunctions of the chemical and physiologic systems of the body" (Fabrega, 1975:971). What constitutes 'normal' physiological and chemical variables is clearly defined within a fairly narrow numerical range, and is assumed to be shared by all members of the human species. Each disease in biomedicine is "an abstract biological 'thing' or condition that is, generally speaking, independent of social behaviour" (1975:969); that is, every named disease has its own particular personality and life history, and these entities are largely independent of the personal attributes of the patients suffering from the disease. To the Western-trained doctor, therefore, the aim of therapy is primarily the identification and treatment of named diseases, using the scientific paradigm and definitions of modern biomedicine: which is the culturally-specific system of the West for explaining and treating ill-health. By contrast, 'illness' is an altogether vaguer term, embodying the patient's subjective perception, or sometimes the perception of those around him, of a condition of impaired well-being. Fox (1968), Fabrega (1973) and Foster (1976), all of whom have

studied the medical systems of the non-Western world, point out how illness in those regions has many dimensions: social, moral, psychological, as well as physical. Explanations for ill-health are part of wider systems for the explanation of misfortune, which usually embody a variety of aetiologies; for example, in Prince's study of the Yoruba (1964) misfortunes, including ill-health, can be caused by natural agents (diet, insects, worms etc.), preternatural agents (witchcraft, sorcery) or supernatural causes (gods, Orisas, ancestors); and Foster (1976) also divides folk aetiologies of illness into 'personalistic' systems (illness due to the active and purposeful intervention of an agent, whether human or non-human), and 'naturalistic' systems (where illness is explained in impersonal terms, as being due to natural forces or conditions, such as cold, damp, and so on) (1976:773–781). In these societies there are culturally-specific systems for explaining illness in these terms, and there are as many of these systems as there are different cultural groups. In dealing with what therefore constitutes 'illness' here in the West, the literature is less helpful. Fabrega (1975:973), Cassell (1976) and Eisenberg (1977) have all pointed out that in the West it is possible to feel 'ill' without having an identifiable disease in biomedical terms, and to have a biomedically-defined disease without feeling ill (for example a raised blood pressure, or early carcinoma). Biomedicine can be seen as the world-view of a professional sub-culture, the medical profession. Contrasted with this, is the patient's perspective of subjectively experienced ill-health; in Eisenberg's phrase "patients suffer 'illness'; physicians diagnose and treat 'diseases' " (1977:11). Diagnosis is therefore the ordering of the patient's experience into the disease entities of biomedicine, but neglecting those that do not fall within the classification. In Cassell's view, this removes biomedicine from its traditional healing role, for he sees illness in holistic terms as human suffering that includes disease, but has a much wider definition: one should "use the word 'illness' to stand for what the patient feels when he goes to the doctor, and 'disease' for what he has on the way home. Disease, then, is something an organ has; illness is something a man has" (1976:48). It is therefore a problem of two partially overlapping schemes of classification, whereby the symptoms and signs of illness/disease are grouped into pathological entities, in both folk and biomedical models.

However, a major drawback of many studies of illness in the urban West, both in Europe and North America, is that folk beliefs about illness have not been studied as systems, but rather as a vague area of subjective symptoms and signs beyond the territory of biomedicine. It is not only in the non-industrialised world that folk models of illness have strong moral and social dimensions, both 'personalistic' and 'naturalistic' theories of aetiology, and which ask the question "Why me?" as well as "How?" In addition, folk theories of what constitutes 'normality' also form part of such models, and these definitions of 'normality' often bear little relation to the biomedical definitions[4].

A further point is that the rational and scientific nature of biomedicine, in practice, is often over-estimated. Fabrega (1973:218–223) for example, in his comparison of the Western biomedical system and the indigenous medical system of Zinacantan, gives the impression of biomedicine as a monolithic and quite inflexible system of beliefs and practices. However, not only is there wide variation in medical practices in different Western communities[5] but also within the same country. My research indicates that in Great Britain, at least, biomedicine at the general practitioner level is more flexible than had been realised; and that due to the process of 'negotiation' at the consultation the 'operational' model of the general practitioners bears a closer resemblance to the folk model, in some respects, than to the official model of biomedicine that exists in the hospitals, medical schools, and medical textbooks. Eisenberg (1977:13) has suggested that the patterning of illness is influenced by medical concepts, but the reverse seems also to be the case – particularly in general practice, as will be described.

"FEED A COLD, STARVE A FEVER" – THE FOLK MODEL OF INFECTION IN STANMORE

The phrase "Feed a Cold, Starve a Fever" is a common aphorism in the area. It arises from a folk model, or scheme of classification, of illness which is widely accepted by the patients; and it relates to those conditions of impaired well-being which the patients perceive as disequilibrium, and regard as 'illness', and which concern perceived changes in body temperature – either 'hotter' than normal, or 'colder'. In general, these feelings of abnormal temperature change are purely subjective; they bear little or no relation to biomedical definitions of 'normal' body temperature as 98.4° F or 37° C, as measured orally on a thermometer. The conditions where the patients 'feels hot' are classified as *Fevers*, those where he 'feels cold' in his body are classified either as *Chills* or *Colds*. Both Fevers and Colds/Chills are states of being – both classified as abnormal – which, in the folk model have different causes, different effects, and thus require different treatments.

There are two important principles underlying this folk classification of 'illness-misfortune': (1) the relation of man with *nature*, i.e. with the natural environment, in Colds and Chills, and (2) the relation of man to man, which exists within human *society*, in Fevers.

To a large extent the area covered by the folk model – which I have set out schematically in Figure 1 – corresponds to that area of disorders which biomedicine classifies as Infectious Diseases: that is, acute or chronic inflammatory conditions where the causative agent is known to be either a virus or a bacterium. These disorders, which occur very commonly in general

	HOT	COLD
WET	(1) *Ear, Nose, and Throat* FEVER + NASAL CONGESTION OR DISCHARGE	(1) *Ear, Nose, and Throat* COLD + NASAL CONGESTION OR DISCHARGE, WATERY EYES, 'SINUS' CONGESTION
	(2) *Chest* FEVER + PRODUCTIVE COUGH	(2) *Chest* COLD + NON-PRODUCTIVE COUGH
	(3) *Abdomen* FEVER + DIARRHOEA AND ABDOMINAL DISCOMFORT	(3) *Abdomen* COLD + LOOSE STOOLS AND SLIGHT ABDOMINAL DISCOMFORT
	(4) *Urinary System* FEVER + URINARY FREQUENCY AND BURNING	(4) *Urinary System* COLD + SLIGHT URINARY FREQUENCY BUT NO PAIN
	(5) *Skin* FEVER + RASH + NASAL DISCHARGE OR COUGH	
DRY	FEVER + DRY SKIN, FLUSHED FACE, DRY THROAT, NON-PRODUCTIVE COUGH	COLD + SHIVERING, RIGOURS, MALAISE, VAGUE MUSCULAR ACHES.

Fig. 1. The Folk Classification of common 'Hot' and 'Cold' Symptoms

practice[6], include disorders known as: upper respiratory tract infections; influenza: coryza; bronchitis; pneumonia; sinusitis; urinary tract infections; gastroenteritis; childhood fevers (e.g. rubella); and several others. This classification overlaps, to some extent, the area covered by the folk model, but as will be described there are significant differences. Illnesses associated with temperature change are common in all sections of the population, as are the often associated symptoms of cough or rhinitis. Cough is apparently the commonest symptom complained of in general practice (see Morrell, 1972:297), and it is common even among those who do not consult the doctor: in Dunnell and Cartwright's study (1972:11) 32% of adults reported "cough, catarrh, or phlegm" in a sample two-week period, while 18% had suffered from "cold, influenza, or rhinitis". To describe the folk model it is necessary to adopt a diachronic approach: what follows is mainly the folk classification reported by older patients; those born during or since World War Two, while sharing the basic underlying classification, have introduced new elements, particularly with regard to the germ theory.

STRUCTURAL ANALYSIS OF THE FOLK SYSTEM

In Figure 1 I have listed the common groups of symptoms which relate to, or are accompanied by, perceived changes in body temperature. There are four diagnostic categories in all (see Figure 2); the basic division is between '*Hot*' and '*Cold*' conditions, but in addition there is a further division into '*Wet*' and '*Dry*' conditions. 'Wet' conditions are those where the temperature change is accompanied by other symptoms, and with a seemingly abnormal amount of 'Fluid' being present – either still within the body, or else emerging from its orifices; this 'Fluid' includes sputum, phlegm, nasal and sinus discharge, vomitus, urine, and loose stools. The symptoms here include nasal congestion or discharge, sinus congestion, productive coughs, 'congested' chests, diarrhoea, and urinary frequency. 'Dry' conditions are those where the abnormal temperature change is the only, or the paramount symptom – such as a subjective feeling of being cold, shivering or rigours on one hand – and a feeling of being 'hot', perhaps with a dry throat, flushed skin, slight unproductive cough, and possibly delirium, on the other. Skin rashes usually occur on the 'Hot' side of the classification. Other subsidiary symptoms – including pain – may occur in one form or another on both sides of the temperature division.

	HOT	COLD
WET	HOT WET	COLD WET
DRY	HOT DRY	COLD DRY

Fig. 2.

	HOT	COLD
WET	FEVER + FLUID	COLD + FLUID
DRY	FEVER	COLD

Fig. 3.

Thus there are four basic compartments into which most common symptoms relating to temperature change can be fitted (see Figure 3): 'Hot/Wet' (Fever plus Fluid), 'Hot/Dry' (Fever), 'Cold/Wet' (Cold plus Fluid), and 'Cold/Dry' (Cold). Obviously these compartments are not watertight; there is always some overlap between divisions. In addition, not all conditions associated with abnormal temperature changes have been included; only the commonest, as encountered in general practice.

(A) 'Chills' and 'Colds'

These are explained as being due to the penetration of the environment – across the boundary of skin – into the human organism. They are part of the relationship of man to the natural environment; in particular to the idea of

'danger without' and 'safety within' the boundaries of the human body. The causes of these illnesses are areas of lowered temperature in the natural environment – either as damp or rain (i.e. 'Cold/Wet'), or cold winds and draughts ('Cold/Dry'). In general, 'Cold/Wet' conditions in the environment may cause 'Cold/Wet' conditions in the body, and 'Cold/Dry' may cause 'Cold/Dry' conditions of illness, though the division is by no means rigid. Dampness is considered dangerous in most situations, as is rain. Wind is dangerous if it is lower than body temperature, and is called a draught. Wind at body temperature, or above it, poses no threat, and is merely 'fresh air'. Night air, though, whether warm or cold, is considered dangerous by many of the older patients; it is different in quality from day air, and often "the children get sick if you leave the bedroom windows open at night".

These cold forces in the environment are impersonal, and not linked to any social relationships.

The protective boundary of the human being is skin, but also clothes. All areas of skin, though, if exposed to damp or draughts, can be penetrated by the cold ("the damp goes right through you", "I was chilled to the bone"). The actual *route of entry* of the cold, is through the skin itself. Some areas of skin are more vulnerable than others:- in particular, the top of the head, the back of the neck, and the feet. These parts of the body must be specially protected from draughts and damp. Colds were explained as occurring when any of these areas were inadvertently exposed to damp or draughts: e.g. after "getting one's feet wet", "walking around with damp socks on", "going outside with damp hair", "going out into the rain, without a hat on", "stepping into a puddle", "getting caught in the rain", and so on. Among men, there is a particular sense of increased vulnerability to 'head Colds' after a haircut – when the back and top of the head are unprotected against environmental cold by their normal covering of hair.

I think it is significant, incidently, that the two most vulnerable areas to cold – the head and the feet – are, in a sense, the most *public* parts of the clothed body, and the parts most passive to being acted upon by the environment. I would argue that the hands and face, while both 'public', are considered less vulnerable as they actively manipulate the environment, and in a sense 'join' the person to the environment.

In addition to parts of the body especially vulnerable to cold, there are certain states intermediate between hot and cold environments, or between body temperatures, where the intermediate zone is considered most dangerous to the human being – as far as Colds and Chills go. For example:

(1) Body temperature changes, from hot to cold: e.g. "Going into a cold room (or outside) after a hot bath", "sitting in a draught after a hot bath", "walking on cold floor when you have a Fever" – all which occur within the home.

(2) Changes in environmental temperature, from hot to cold, on leaving the home (or other building): Older patients explained the increased incidence of Colds in winter as being due to a drop in body temperature when one leaves a modern centrally-heated house for the outside. Younger patients think this occurs because "the Germs breed more" in a hot, centrally-heated house. Other examples here are "going outdoors when you have a Fever", "going out into the cold after a hot bath", and so on.

(3) Changes in season: November (damp), and February (cold winds) are both considered dangerous months, but most dangerous of all is autumn – where the 'hot' summer is changing to the 'cold' winter.

(4) Changes in geography: One patient has explained that there are more Colds ('summer Colds') in summer these days because, since cheap air-flights and holidays became available 10–15 years ago, people return from 'hot' Spain or Italy to 'cold' Britain after their summer vacations, and in the change over of temperature they "catch Cold".

In all these cases there appears to be an intermediate, dangerous zone, between hot and cold states – when the former gives way to the latter. This may reflect an underlying schematic dichotomy between 'Hot' inside (body, home), and 'Cold outside (nature, the natural environment). Mary Douglas (1970) has pointed out how in many primitive classificatory systems, special dangerous qualities are ascribed to states of transition, marginality, or anomaly. She notes Van Gennep's observation of the danger inherent in states of social transition (1970:116), but it would appear that this applies also to intermediate zones between changes in temperature, as described in the above examples.

Although Colds do not, at least in the view of older patients, originate in other people, they are caused – as one middle-aged patient put it – "by doing something abnormal". That is, by putting oneself in one of the situations of danger or risk mentioned above. There is the strong implication of personal responsibility for the condition, which has been caused by one's own carelessness, stupidity, or lack of foresight. You get a Cold when you "don't dress properly", "go outside after washing your hair", "allow your head to get wet", "walk barefoot on a cold floor", "wash your hair when you don't feel well", and so on. Making oneself, or part of oneself, vulnerable to cold causes one to "catch Cold". Colds, therefore, are a by-product of one's personal battle with the environment. They are one's own responsibility, and no one else could be blamed for them. If, despite adequate precautions such as proper clothing, etc, one still got a Cold, it was still your responsibility. Poor people tended to get more Colds as they are "less responsible".

Once the cold has penetrated the boundaries of the human organism, it can travel. It can move from the damp head, down to the nose (causing a "runny nose"), the sinuses ("Sinusitis", "a head Cold"), the chest (causing a slight cough – "a Cold on the chest"). It can travel even further downwards to the

abdomen, to cause vague abdominal discomfort and possibly slight loosening of the motions, or to "the bladder" to cause discomfort and slight frequency, but no burning sensation or fever. From damp feet it can migrate upwards to cause the "stomach Chill" or a "Chill on the bladder" already mentioned, or even further upwards to the nose, chest, or sinuses. All of these symptoms are accompanied by a subjective feeling of cold, shivering, and possibly by some muscular discomfort. In addition, a direct draught can also cause the Colds and Chills, but this occurs less frequently; usually a direct draught on the lower back (while "sitting in a draught") causes a "Chill on the kidneys" which is described either as a muscular pain in the lumbar region, or vague lower back discomfort, perhaps with some urinary frequency.

In general, *Chills* occur below the waist ("stomach Chill', "bladder Chill', "kidney Chill") and *Colds* above it (a "head Cold", a "Cold in the sinuses", "a Cold on the chest", "a Cold that's gone to my chest").

In the battle with environmental cold, one should strengthen one's own defenses by dressing warmly, avoiding draughts and damp, and building up the body's strength from within, by good food and patent 'tonics'. If you "did not eat properly" you were more liable to develop a Cold. People took tonics to "build themselves up" against the threat of cold; older patent tonics used included Parrish's Food, ViDaylin, Cod Liver Oil and Malt Extract, and Virol, and newer ones include Brewer's Yeast, Multivite, Haliborange, Sanatogen, and of course Vitamin C. As one patient put it – if you went outdoors after having taken a tonic "you felt warm inside"; the tonic was an ally in one's battle with cold. Most important of all allies and body strengtheners, though, was food.

Some people, who have been severely penetrated by cold in the past and were severely ill, may be left with a permanent "weakness" in that part of their body; a permanent gap in their defences against the environment. They may have a "weakness on the chest" and often wrap up that area particularly warmly when they leave the house. "Weakness" may also be familial and "run in families", or else constitutional, such as a "thin skin" which is abnormally vulnerable to cold penetration.

The area of Stanmore is known by the patients as a damp, dangerous area as far as Colds go. People in the area are reputed to suffer many respiratory infections and to be "bronchial"; this is said to be due to "dampness" retained by the clay soil in the area, which is the residue of marshes drained in the 1930's.

Treatment of a Cold or Chill is your own responsibility; it is your own problem, and is less likely to mobilise a caring community around you than a Fever. As in all Hot-Cold and humoural systems, treatment aims primarily to fight cold with warmth, and to move the patient from 'Cold' (or 'colder' than normal) back to 'normal', by adding heat in the form of hot drinks, hot-water bottles, rest in a warm bed, and so on; and in giving him the means to generate his own heat, especially by ample warm food ("Feed a Cold, Starve a Fever"), as

well as tonics and vitamins, which are also perceived as a type of nutriment. In addition, he must if necessary be shifted from the 'Wet' to the 'Dry' state – not by expelling or washing out the Fluids, but by drying them up. These Fluids are considered part of the body, and should be conserved, with the aid of nasal drops, decongestant tablets, inhalations, and drugs to solidify the loose stools. Older remedies used as decongestants include goose fat, Vicks, and Friar's balsam. Pain accompanying these symptoms is to be treated by analgesics such as aspirin, anadin, paracetamol, and several others. By these various methods, both folk and medical treatments aim to restore the previous equilibrium, and a 'normal' temperature.

The only social dimensions of Colds and Chills are the implications of personal carelessness that they carry, and also for the social embarrassment of a red nose, rhinitis, bloodshot eyes, etc. "For appearance's sake", said one patient, "you get rid of them as soon as possible".

(B) 'Fevers'

Illnesses in this group are all characterised by conditions which begin with, or are accompanied by, a feeling of abnormally raised body temperature. In general, they are more severe, longer-lasting, and potentially more dangerous than those in the 'Cold' group. All are said to be due to the actions of entities known as 'Germs', 'Bugs', or 'Viruses'. These terms are not used in the strict biomedical sense; to most people, who have never looked down a microscope and seen 'a Germ', and who who have no other perceptual evidence for their existence, Germs remain a hypothesis, a theory of causality. Although the terms are borrowed from biomedicine, folk theories of Germs are rooted in the folk classification of Fevers and Chills, rather than in modern microbiology.

When asked about the attributes of Germs most patients give the following description: Germs are described as living, invisible, malevolent entities. They have no free existence in nature, but exist only in or among people. They are thought of as occurring in a cloud of tiny particles, or as a tiny, invisible, single 'insect'. They traverse the spaces between people by travelling in the air, or in the breath. Germs causing gastro-intestinal symptoms are seen as more 'insect-like' ('Bugs'), and are larger in size than those Germs causing other symptoms. Germs have personalities; these are expressed in, and can be recognised by, the various symptoms they cause. (For example, "I've got that Germ, doctor, you know – the one that gives you the dry cough and the watery eyes", or "the one that gives you diarrhoea, and makes you bring up"). The Germ, however, may only reveal its true personality in stages, during the course of the disease.

In their effect, Germs are single; you are only attacked by one Germ at a

related to the presence of excess fluid. It is as though the Germ matures into a 'hot liquid' inside the body.

The treatment of Fevers, in the folk model, aims firstly to move the patient from the 'Hot' state back to a 'normal' temperature, and secondly to move him from the 'Dry' to the 'Wet' state (see below).

Methods of dealing with Germs – the living, malevolent entities who temporarily invade and disrupt the body, or parts of it – fall into three main categories:

(1) *Expulsion*[6] In all these methods *fluids* are used to "wash out" or liquefy the Germ, so that it can be "washed out of the system". Fluids are taken in by mouth as a form of treatment, and the appearance of a more 'Wet' symptom indicates that the Germ is being diluted and "washed out", usually via the orifices through which it entered the body. Examples of this are:

– From the *chest* – the aim in chest infections associated with Fever is the expulsion of fluid from the chest, carrying with it the infecting Germ – "getting it off your chest", "coughing up the muck", "clearing the chest", "getting it (the phlegm) out of your system", and so on. Patients often complain that their cough is still unproductive and "dry", that it "hasn't broken" or "hasn't loosened" so that they can "cough it off my chest". A variety of fluids are used as expectorants here; including tea, honey, hot water, cough medicine, and other liquids, and these also have a soothing effect on the throat. "I gargled with salt water to get the catarrh out," said one patient, "and I always swallow a bit of it to loosen the cough".

– From the *bowels* – especially in the presence of diarrhoea and vomiting with the Fever. Here the therapy consists primarily of drinking lots of fluids, so as to "flush out" the infection.

– From the *urinary tract* – especially if there is urinary frequency and pain on micturition, accompanied by Fever – once again treatment consists of drinking large amounts of fluid "to flush it (the Germ) out of one's system".

– Through the *skin* – usually by induced sweating. The appearance of sweat fluid on the skin, which often accompanies a drop in the Fever, is taken as evidence that the Germ or infection is leaving the body through the skin. The aim of treatment, therefore, is to "sweat it out" or "sweat it off". Various fluids and other remedies[7] are used for this purpose, including hot drinks, honey, certain types of tea, as well as aspirins and other patent anti-pyretics, which are always ingested with large amounts of fluid. The appearance of a skin rash is also welcomed, as the Germ is now "showing itself", and is on its way out of the body; this is especially true in measles where the fever often drops when the rash appears.

Germs can also be dealt with by:

(2) *Starvation* – as in the phrase "Feed a Cold, Starve a Fever". I think the

implication of this advice to reduce the food intake of a feverish patient is that as the Bugs or Germs are living entities to starve their host is to starve the Germs, and they will eventually die or leave the body, and so end their possession[8].

(3) *Killing the Germs in situ* – since World War Two, and the discovery of the anti-microbial drugs, it is generally accepted by most of the patients that antibiotics and sulphonamides are the specific agents for killing the Germ in situ, without the need to expel or starve it. This is particularly true of those Germs causing high Fevers and severe illness, which do not respond to home remedies. The drugs are taken into the body as an external force to kill the Germ in situ, in a battle lasting up to ten days.

The signs of expulsion, death, or starvation of the Germ are a return to what is perceived as normal body temperature, a subjective feeling of being less ill, and the appearance of excess liquid being expelled from the body (as phlegm, nasal catarrh, urine, or loose stools), which then gradually dries up – as well as the disappearance of all other associated symptoms.

Germ infections imply, or bring into being, social relationships: as sources of infection, a caring community about the victim, and as an informal 'community of suffering' of those afflicted by the same type of Germ. Questions often asked of doctors or their receptionists in the area are: "Is there a Bug (like mine) going around?", "Is there a Germ floating around?", "Have you had anyone else in with the 'flu?", "Is there Chicken Pox in the area?". They are relieved if the answer is in the affirmative, and to find that they have "got something normal" and are part of a community of victims.

It should be noted that this description of 'Germs' as hypotheses, or theories of causality, of illness in the folk model in Stanmore, has a similarity to equivalent theories of disease causation in many non-literate societies, particularly with spirit possession.[9] In these societies 'spirits' take the place of 'Germs' as causal entities of disease, and like them are invisible, amoral, malign, and capricious in their choice of victims. The victim is therefore blameless, and possession by these pathogenic spirits is a culturally accepted experience, and a way of mobilising a caring community around the ill person (see Lewis, I. M., 1971:66–99). However, a much wider range of disorders are caused by these spirits, than those included in the Fever/Colds model described above.

IMPACT OF THE BIOMEDICAL GERM THEORY OF DISEASE ON THE FOLK MODEL

There is an increasing difference, as regards the Germ explanation of disease, between older and younger patients in the area – especially those born during or since World War Two, who constitute the first 'antibiotic generation'.

Although the bacteriological discoveries of Pasteur and Koch were made at the end of the 19th Century, the biomedical germ theory of disease seems to have only gained widespread currency among the lay public since the influenza pandemics of 1918/19. However, it is only since the last War, and the introduction of specific antimicrobial drugs, that the Germ theory has come to explain a wider range of illness in the folk model. A probable reason for this is that since the establishment of the N.H.S. in 1948, with its guarantee of free medical care to the entire population, more people consult doctors and for a wider range of disorders – disorders that they would previously have borne in what one writer calls "the imposed silence of poverty" (Inglis, 1964:18). This means that 'Fevers' and 'Chills' in the folk classification, that would previously have been treated by folk remedies alone, are now brought to N.H.S. doctors – particularly general practitioners – for diagnosis and treatment. Nevertheless, the basic conceptual system of the Fevers/Colds/Chills model has remained largely unaltered; Germs are still hypotheses, and there is little lay knowledge of their characteristics, or of the difference between Germs and Viruses, terms which are used interchangeably by the patients. The main differences between younger and older patients regarding the folk model, are as follows: the conception of Germs as active causative agents of illness has spread to include several (though not all) conditions on the 'Cold' side of the classification. Younger patients are more likely to blame 'Germs' or 'Viruses' for these conditions. Because Colds and Chills are due to these active agents, they can be killed, expelled or starved like the Germs causing Fevers. Hence the increasing demand, on the part of the patients, for specific 'anti-Germ' drugs and the pressure put on doctors to prescribe antibiotics for even minor viral infections. While a Cold is now often considered to be caused by a Germ, some sense of personal responsibility for the condition still remains; bad clothing, inadequate nutrition, exposure to damp or cold – all make you more vulnerable to Colds, as before.[10] Nevertheless, on the 'Cold' side of the spectrum, the amount of personal responsibility for illness seems to have declined. At the same time, 'Cold' illnesses have become more social in origin, effect, and dangers; they now arise more from within human society, and create more of a caring community around the victim than previously. Colds and Chills are now dangerous to other people, especially children and the very old. Young mothers often ask "My child's got a Cold; can she mix with other children?", or remark "I didn't go round to her place yesterday because her child's got a Cold". It seems that there is an increased sense of danger in human relationships, and they are now all tinged with a new anxiety, the threat of infection. Whether or not this new fear expresses or echoes other stresses in the social system, one cannot be sure. Nevertheless, in a small way, the threat of infection is used to avoid social contacts, or to mobilise a perhaps unwilling community around the patient. This 'medicalisation' of Colds and Chills extends also beyond the

original confines of the folk classification; for example, a wide range of mood changes, from aggression to depression, are now being ascribed by patients to Germ infection. In this medicalisation of internal moods, the folk Germ theory provides a useful escape route to the patient – "I'm feeling low and depressed. I must have picked up a Virus", or "He was rather aggressive on Sunday, and I wondered if he hadn't picked up a Germ"; so that, increasingly, the hypothesis of Germ infection is now being used to explain behaviour changes. Depression due to Viruses, is now added to "post-Viral depression", in the folk classification of younger patients. Also, both "stomach Chills" and "bladder Chills" are now increasingly being ascribed to Germ infection, except by the older generation; they are now often thought to be due to "a Germ in the water (urine)", rather than "a Chill on the bladder", or to a "stomach Bug" rather than a "stomach Chill" or "something you ate". In both cases, the infection requires active medical help to destroy or expel the Germ. In general, as the hypothesis of 'Germ infection' has spread to cover a wider range of illness and behaviour, illness has become more social and dangerous, and the process of seeking medical treatment for it is increasingly common.

CONSENSUS AND CURE

The social process that begins with illness, and hopefully ends with cure, begins with a state of discomfort or disequilibrium perceived by the patient, or by those associated with him. In the Fevers/Colds/Chills model, the basic minimum definition of 'illness' is a subjectively experienced change in body temperature, on either side of 'normal', and which is usually accompanied by other symptoms; so that the units of the folk model are clusters of symptoms forming what might be termed 'illness entities'. These are predominantly composed of subjective symptoms, while objective corroboration of the symptoms (for example, by measuring the body temperature with a thermometer) is less commonly called upon as an integral part of defining oneself as 'ill'. By contrast, the units of the biomedical model are named diseases, which are composed of symptoms plus objectively verifiable physical signs. At the interface between these two systems, a consensus must be achieved by doctor and patient regarding the interpretation of the patient's symptoms, and the treatment to be given. My research concentrated on the nature of that consensus, on the vocabulary used in consultations, and on the diagnoses and treatment given to patients by GPs in the area; particularly those patients suffering from symptoms within the Fevers/Colds/Chills model of illness.

It should be pointed out that apparently most patients suffer from some pathological symptom or symptoms, most of the time. In Dunnell and Cartwright's study (1972:8–13) 91% of adults in a random interview reported

that they had had one or more abnormal symptoms in the two weeks preceding the interview, while only 19% had consulted a doctor during that time. Most illness is treated by self-medication; it is estimated that only about one-third of all illness reaches a medical agency (1972:13). The remainder are treated by self-prescribed folk or patent remedies bought at a pharmacy. Self-medication is therefore much more common than drugs prescribed by a doctor, and also the illness seen by a doctor is only the tip of an 'iceberg of illness' in the general population. Only those cases of illness brought to the GP's attention could be included, therefore, in this study.

DIAGNOSIS OF 'FEVERS', 'COLDS', AND 'CHILLS'

The initial diagnosis of 'illness' is usually made by the patient himself, and expressed in the terms of the folk model ("I've got a Cold"), and is usually dealt with by self-medication. However, there is a hierarchy of advice as to the diagnosis, and the treatment required. This hierarchy includes friends and relatives, the local pharmacist, the doctor's receptionist, and finally – in the minority of cases – the doctor; (see Dunnell and Cartwright, 1972:96–98 – 57% of adults questioned in their survey regarded the local pharmacist as a good person to ask advice when not feeling well). The threshold at which the doctor is consulted varies with individuals, and between social classes; the impression is that under the N.H.S. the threshold for consultation is dropping for most conditions. Diagnosis, as given by the GP, is the organisation of the patient's symptoms and history into a named and standardised entity, the biomedical disease. The patient's symptoms and experience pass from the private to the public domain, and become a recognisable part of the biomedical model of misfortune. For this to be acceptable to both sides, a concensus must be negotiated; diagnosis, as Fabrega (1975:972) has said, "is an attempt to establish a consensus for purposes of action". No diagnosis would be acceptable to patients, it appears, unless it was to a large extent consonant with their world view, and particularly with their interpretation of illness. The impact of biomedical concepts on this world view are less than had been thought. Despite exhortations in medical textbooks, for example "D(octor) should never forget that P(atient) is already equipped with all kinds of ideas about the nature of disease. Many of these are stereotypes, and attacking them is an essential part of any therapeutic strategy" (Crystal, 1976:49), the language and concepts used by GPs in consultations with patients suffering from Fevers/Colds/Chills was in the idiom of the folk model, not the biomedical one. The patients usually presented lists of symptoms, often accompanied by questions like "Is there a Bug going around?", "I'm feeling ill – is there a Virus around?", "Have you had anyone else come in with a tummy Chill?", "Is there Chicken Pox in the area?", "Have

there been any children in recently with German Measles?", and so on. The answer from the GP was usually in the affirmative, and the patients were relieved to find that there *is* a "Bug going around", and they are blameless and not socially deviant in their behaviour; they also no longer feel uneasy or unsure of their condition, particularly as their illness is now a disease within the biomedical world – and by definition capable of being cured, or at least palliated. The diagnoses given by the GPs, which provided a unified explanation of the patients' vague feelings of illness or unease, were also couched in the folk idiom; for example: "You've picked up a Germ", "You've got a 'flu Bug", "It's a Viral infection", "It's just a tummy Bug – there's one going around", "It's just an ordinary Cold", "I'm afraid it's gone to your chest", "Your chest is clear now – the infection's gone", "You've got a Germ in the water", "It's only the Chicken Pox", "Oh yes, is that the one where you've got a runny nose, watery eyes, and you lose your voice? I've seen a dozen already this week", and so on[11]. These explanations do not satisfy all patients; nevertheless the majority find such diagnoses, although vague, a satisfactory diagnosis of their condition. Even if a more precise and 'biomedical' diagnosis is given, it often turns out to be also vague and non-specific. This is partly due to the fact that diagnosis in general practice, where the average consultation time between GP and patient is 5–6 minutes (Morrell, 1971:454; Marsh and Kaim-Caudle, 1976:132) is usually based on traditional rather than modern forms of biomedical divination – such as listening, looking, feeling, touching, smelling, and so on; and by numerous questions relating to the patient's feelings, experiences, and behaviour up to that point in time. A minority of patients are referred for hospital investigations, such as blood tests or X-rays (also a form of 'seeing'), or referred to specialists in out-patients departments. In general practice precise differentiation between viral and bacterial infections is often impossible to make (due especially to the time factor involved), or else unreliable. Aetiological agents of infection are often loosely termed "Germs" or "Viruses" by the GPs, when speaking to patients, rather than a precise definition of the type of bacterium (e.g., Streptococcus, Staphylococcus) or virus (Coxsackie virus, ECHO virus) responsible for the condition. Pressure of work, and the self-limiting nature of many infections, makes it impracticable to always undertake bacteriological or viral laboratory studies, such as throat swabs, blood cultures, stool cultures, etc. The diagnosis "an infection" is commonly given, without identifying the causative organism more precisely. Even if more precise diagnoses are given, they are also often couched, as mentioned above, in what to the patients seems a vague way; for example, "upper respiratory tract infection", "a viral infection", "gastroenteritis", "influenza", "bronchitis", "urinary tract infection", "chest infection" and so on. The effect of this vagueness of diagnosis, from the perspective of the patients is, I think, to confirm and strengthen the 'illness entities' – clusters of subjective symptoms

behaviour changes – that constitute the folk model of illness, rather than ...ing precise biomedical 'diseases' on this lay model. This vagueness of ...noses given extends also to the anatomical model used by both patients and ... in order to achieve a diagnosis based on mutual understanding, broad ...as of the body are coalesced into: "a chest infection", "a tummy bug", "a cold in the head", "gastric 'flu", "an infection in the sinuses", or "a urinary infection". So, to a large extent, as far as diagnosis goes, what might be termed the 'operational' model of the GP in practice bears a closer relationship to the folk model than to the official biomedical model of hospital medicine; and may therefore serve to reinforce that folk model. The entities into which the patients' symptoms are organised in diagnosis often bear a closer resemblance to the symptom groupings of the folk model than to biomedically-defined diseases.

Much of this organisation of symptoms, in the area, is done not by the GPs but by their receptionists – who are often consulted personally or by phone by the patients at the surgery, and often they make the decision as to whether they are ill enough to justify seeing the doctor. In general, the doctors' receptionists act as paramedical diagnosers and advisers, and reduce even further the number of patients who actually get to see the GP. In dress and manner they often mimic the doctors; wear white coats, speak in a voice of authority, and often make confident diagnoses on minor complaints based on their years of experience in the practice.

To some extent diagnosis itself is a cure; especially in those conditions likely to be self-limiting, and where the patient's unease is a marked feature of the condition. This phenomenon was well put by one Phineas Parkhurst Quimby, a famous folk-healer, born in New England in 1802 – "I tell the patient his troubles, and what he thinks is his disease, and my explanation is the cure. If I succeed in correcting his errors I change the fluids in the system, and establish the patient in health. The truth is the cure" (Rose, 1971:62). From my own study and experience, it would appear that in general practice the 'language of truth' in most consultations was the idiom of the folk model, rather than that of the biomedical model.

TREATMENT OF 'FEVERS', 'COLDS', AND 'CHILLS'

Treatment commonly prescribed by general practitioners for disorders within the Fevers/Colds/Chills model can also be seen to 'make sense' within the conceptions of that model. More important, though, is that many of these prescribed treatments cannot be fully justified in scientific, biomedical terms; it is almost as if, in some cases, the patients are treating themselves, using the doctor as a source of folk remedies – rather than a pharmacy, or a supermarket. An important aspect of any GP consultation under the N.H.S. is the handing over to the patient of the E.C.10 prescription form, which is then handed to a

local pharmacist in exchange for the prescribed drugs. The majority of patients attending a GP are given such a prescription for one or more medicines. In a sense, many GPs regard *all* patients who consult them as being, by definition, in some way 'ill'; even if it is only the 'illness' of over-anxiety. This attitude is expressed by one Professor of Community Medicine (Marinker, 1976) – "A patient is not necessarily someone who has a medical problem; he is rather someone who comes to ask a doctor for help. It is the act of asking, or in the case of those who cannot ask for themselves, of being presented to the doctor, that constitutes that relationship of which we call one half doctor and the other half patient" (1976:18). A result of this over-medicalisation of the population is that more and more minor illnesses that were explained by folk models, and treated by folk remedies, are now brought within the sphere of biomedical treatment. Nevertheless, as the examples below indicate, the biomedical treatment itself can be incorporated into, and be explained by, the folk model itself; and thus helps the patients 'make sense' of the treatment given. Examples of this are:

(1) General Advice (From Doctors or Receptionists)

"Drink a lot of fluid", (for influenza, cystitis, diarrhoea);
"Stay in bed, and keep warm: take warm drinks"[12], (for a Cold);
"Don't smoke now, or it'll go down to your chest", (for a Cold);
"The rash is a good sign; it shows that the infection is coming out of the system", (measles);
"Yes, there is a tummy Bug going around. Starve yourself and take only sips of water for 24 hours; otherwise, the more you feed it (the Bug), the more it'll enjoy itself and cause diarrhoea and sickness". (Advice given by a receptionist to a patient with diarrhoea and vomiting).

(2) Cough Medicines

According to Wilkes (1974: 98–103), a Professor of Community Care and General Practice, an estimated *six million gallons* of cough mixtures are prescribed in Britain every year under the N.H.S. (this excludes the vast quantity of self-prescribed patent cough medicines sold over the counter). Of the about sixty million N.H.S. prescriptions written every quarter, about 5% (i.e. 3 million prescriptions) are for cough mixtures. In a winter quarter they can form the single largest group of drugs prescribed, exceeding antibiotics, tranquillisers, and antipyretics. At the same time, most medical authorities cast doubt on the pharmacological effectiveness of cough medicines; in some views this is negligible. Wilkes (1976: 98–99) discounts their therapeutic value, except as reassurance, particularly in coughs likely to be self-limiting, as most are. He

suggests instead a hot or sweet drink, which will be just as effective; (most cough bottles are very well-stocked, and brightly coloured, as well as having a syrupy consistency. In this they echo the traditional cough remedies of honey in warm milk, or in herbal tea). The official British National Formulary (Harman, 1976–78: 63), after differentiating between expectorants and cough suppressants, the two types of cough medicine, states – "Despite this distinction many preparations contain both expectorant and sedative drugs, and this perhaps reflects the lack of evidence that the ingredients have any relevant pharmacological effect". In other words, about six million gallons of relatively useless coloured water is prescribed every year in Britain. My hypothesis is that a major reason for this is that the cough medicine, in the terms of the widespread Fevers/Colds/Chills folk model, can be seen as something that will expel or "wash out" or dilute the external entity causing the feverish cough; that is, a Germ. This cannot be proved conclusively; obviously cough linctuses do have a limited soothing or pharmacological action. Nevertheless, the flood of cough medicine in Britain, in association with conditions where increased fluid intake is considered beneficial, does seem to me to be suggestive. Cough medicines that are medically prescribed are only part of the total amount consumed; the majority of cough medicine seems to be self-prescribed (see Dunnell and Cartwright, 1972: 26–29, 107–109). I think that the widespread use of a remedy such as cough medicines, in the face of biomedical doubt as to its effectiveness, can be explained (if only in part) by the patients' need to 'make sense' of treatment for their illness in terms of their indigenous medical system.

(3) Anti-Pyretics

These are probably the most widely used medicines, both prescribed and non-prescribed. Again quoting Dunnell and Cartwright's figures, 41% of adults interviewed in a random sample had taken aspirin or other analgesic-anti-pyretic drugs in the two weeks preceding the interview (1972:100). In my study, anti-pyretic drugs were widely prescribed, or suggested, to patients by the GPs; particularly in the case of viral infections, but also in all other cases of raised body temperature within the Fevers group of disorders. These drugs have two effects; the relief of pain or discomfort, and also the reduction of body temperature if this is abnormally raised. Most medical textbooks cast doubt on the effectiveness, or even desirability, of prescribing anti-pyretic drugs to patients with a raised body temperature, unless the fever would be deleterious to the patient for some other reason; a moderate fever may well be a protective physiological mechanism, and also symptomatic improvement caused by the drug may cause the patient to be ambulatory while still infectious, and so spread the infection around.[13] Nevertheless, large amounts of anti-pyretics are prescribed and consumed; from the biomedical viewpoint this is symptomatic

treatment for discomfort from sinus blockage, sore throats etc., as well as reducing the temperature. There is no evidence of any curative effect of anti-pyretics on, for example, the common cold or upper respiratory infections, (see Goodman and Gilman, 1965:313–314, 328–329). From the patients' perspective, in the Fevers/Colds/Chills model, the antipyretics *are* curative in that they are seen to induce sweating – and thus the expulsion of the Germ through the skin – and thereby return the temperature back to normal.[7]

(4) Antibiotics

These are generally known by the patients "to kill Germs", particularly Germs that cannot be expelled, starved, or otherwise eliminated. The patients do not differentiate between bacteria – where antibiotics *are* effective – and viral infections, where they are not. Nor, it must be said, do many GPs make this differentiation in practice; whether by a more thorough examination, or by laboratory investigations. A result of this is that, in the rushed consultations in general practice, antibiotics are often prescribed for viral infections; and an effect of this is to confirm in the patients' minds that "Germs" are a group of homogenous entities, with no differentiation between viruses and bacteria, and therefore that all or most Fevers require antibiotic therapy. The constant demand by patients, especially the younger ones, for antibiotics is evidence of this attitude, as is the vast number of antibiotics prescribed annually.[14] From the patients' perspective, antibiotics are seen as a force introduced into the body to fight and kill the Germ *in situ*, with the body being the passive battlefield in this struggle. The GPs' reluctance, or inability, to differentiate between viruses and bacteria – or between different strains of bacteria[15] – has led to a vast amount of overprescribing of antibiotics, numerous side-effects, and the development of resistant strains of bacteria; at the same time it has served to reinforce the folk model's conception of 'Germs' as being all of one type, and so requiring the same type of treatment.

(5) Nasal Drops, Sprays, and Inhalations

These are widely used, both by self-medication, and prescribed by the GP. They are considered particularly useful by the patients in 'Cold/Wet' conditions, such as coryza, or early influenza, and the aim of treatment from the perspective of the folk model is to move the patient from the 'Wet' to the 'Dry' state. Although these are frequently used, and frequently prescribed ("I'll give you something to dry up that Cold"), most medical authorities cast doubt on their safety in the long term, particularly on their effect on the nasal mucous membrane. In the opinion of one medical writer (Harrison, 1976), "The only nasal drops which can be prescribed with complete confidence regarding

frequency of use and efficacy are isotonic saline solution. By sniffing up such a preparation, usually made at home by dissolving one teaspoon of salt in a glass of tepid water, the patient may readily remove secretions and crusts with both efficacy and safety. A simple douche system makes this remedy even more effective" (1976:72–73). Despite this common sense advice, a great number of nasal drops and other local preparations are prescribed by GPs, though the number is falling. The point is that Colds, which were usually treated by self-medication, are now increasingly being treated by doctors. A larger portion than before of the 'Cold' side of the folk model is being treated by general practitioners; and in the patients' perspective this gives almost equal weight to both 'Cold' and 'Hot' sides of the folk model.

(6) Other Proprietary Preparations

A wide variety of proprietary preparations are available which provide symptomatic treatment for conditions in the Fevers/Colds/Chills model. Some of these (especially 'Cold' or 'flu' medicines) can be bought over the counter in pharmacies or supermarkets, while others can only be obtained with a doctor's prescription. The significance of these preparations is that they treat a cluster of symptoms which constitute the folk model, rather than treating the *cause* (for example, a virus) of the biomedical disease; in other words, they treat 'illness' rather than 'disease'. They are palliative rather than curative, and are widely prescribed by GPs for conditions that are likely to be self-limiting, or as an adjunct to curative therapy. From the perspective of the folk conception of illness, these symptomatic treatments are often seen as curative, preparations which reduce fever, relieve sinus or nasal congestion, induce sweating, aid expectoration, and so on, are conceived of as specific cures for the clusters of symptoms that make up the 'illness entities' of the Fevers/Colds/Chills model. Drugs which palliate a whole cluster of symptoms simultaneously – especially if prescribed by a doctor – tend to reinforce a folk model of 'illness', rather than educate the patients in the nature of biomedical 'disease'. In the Fevers/Colds/Chills model described here, a number of proprietary preparations are available which treat simultaneously a number of symptoms within the folk model. Often Vitamin C is included as a 'tonic' in a modern form, especially in building up one's energy to fight a Cold. Examples of commonly used combination drugs[16] are:

Antipyretic-Analgesic + Decongestant (e.g., 'Triogesic')
Antipyretic-Analgesic + Decongestant + Cough Suppressant (e.g., 'Triotussic', 'Vicks MediNite')
Antipyretic-Analgesic + Decongestant + 'Tonic' (Vitamin C) (e.g., 'Uniflu plus Gregovite 'C')

Antipyretic-Analgesic + Decongestant + Stimulant (Caffeine) (e.g., 'Emprazil')[17]
Antipyretic-Analgesic + 'Tonic' (Vitamin C) (e.g., 'Beecham's Powders')
Decongestant + Cough Suppressant + Expectorant (e.g., 'Antitussin')
Decongestant + Cough Suppressant (e.g., 'Actifed Compound Linctus')
Cough Suppressant + Expectorant (e.g., 'Terpolin')

These examples are mainly concerned with disorders of the respiratory system; combination drugs do not exist for all the symptom-clusters within the Fevers/Colds/Chills model. Nevertheless they do provide an example of how biomedical treatment, whether prescribed by a doctor or self-prescribed, can fit into the folk model without challenging its basic premises; in fact, especially in the case of medically prescribed drugs, they may actually serve to reinforce it.

In several of the examples of treatment for common Fevers or Colds that are given above, there is little or no biomedical justification for that treatment; it would seem that many prescriptions are given more to 'fit in' with the folk model, rather than on strictly rational or scientific biomedical grounds. The folk model still exerts a potent influence on the prescribing habits of many GPs.

DISCUSSION AND CONCLUSIONS

Although the conditions that fall within the Fevers/Colds/Chills model are in general trivial and non-life-threatening, they are extremely common in the population at large, and are frequently encountered in general practice. As such they provide a useful source of data for any study of the persistence of folk beliefs about illness in a Western, urban community; a community long exposed to information about biomedicine, and which is in frequent contact with the medical profession. The creation of the National Health Service in 1948, which brought free medical care to the entire population, also converted the entire population into potential patients. A wide variety of folk beliefs and folk remedies relating to illness, which, largely for economic reasons, had remained untouched by the medical profession prior to 1948, were suddenly brought into contact with the concepts and treatments of biomedicine. The Fevers/Colds/Chills model described above is just one example of such a folk system. Despite the impact of information about the true nature of microbial infections, the basic underlying classification of 'Fevers', 'Colds', and 'Chills' seems to have remained largely unchanged. It is suggested that a reason for this is that GPs in the area studied (and presumably in other parts of the country[18]) give their patients diagnoses and treatment which clearly 'make sense' in the terms of reference of the folk model. Biomedical concepts are tailored to fit in more closely with the patients' model in the consultation; partly to avoid 'cognitive dissonance' in the interpretation of the illness; partly because most

conditions in the Fevers/Cold/Chills model are self-limiting and not life-threatening - so that in treating them symptomatically the GPs are less concerned to be biomedically 'scientific', than they would be in more dangerous conditions. The rushed consultation times of only a few minutes per patient also make it difficult to be more scientifically exact in diagnosis and treatment, and afford the doctor less opportunity to dispute or tamper with folk models of illness. ("My job," as one GP put it, "isn't to educate – it's to cure"). The effect of these factors is to reinforce, in the patients' minds, many aspects of their traditional folk models of illness, and the traditional remedies used for them.

It would seem, therefore, that in some respects the 'operational model' used on a day to day basis by the GP's is closer to that of the lay model than to the official biomedical model of disease – as found in hospital medicine, the medical textbooks, and the medical schools. However, this effect on the prescribing habits of GPs is by no means always benign; many of the drugs prescribed have undesirable side-effects, both in the short- and the long-term. Antibiotics, antipyretics, and even anti-histamines may all cause dangerous side-effects. In addition, the cost of N.H.S.-prescribed drugs is spiralling in Britain[19]. If six million gallons of cough medicine are annually prescribed by doctors, in the face of biomedical doubt as to its pharamacological effectiveness, a case might be made for the much wider use of harmless 'placebo' drugs -- at least in those conditions known to be trivial and self-limiting. The increased use of traditional remedies by patients should be encouraged, provided that they are free of harmful side-effects, and that the doctor is confident that biomedical treatment cannot improve on the traditional remedies – in safety, or in effectiveness. If life is being 'medicalised', as Illich has suggested -- that is, brought under the aegis of the biomedical model of misfortune – then at least one can ensure that the treatments prescribed are not dangerous to the patients in any way. As the common conditions within the Fevers/Colds/Chills model are now firmly within the biomedical sphere of influence, at least in Britain, it is important that doctors should be more aware of the traditional medical systems of their patients, and of the effect of these systems on their own prescribing habits.

Contrary to its original intention, the National Health Service in Britain may have reinforced the 'folk healer' aspect of its General Practitioners; a much wider range of life experience and misfortune is now being dealt with by GPs – not only a wider range of illness and disease than formerly, but also psychological crises, life crises (such as bereavement, divorce, etc.), and all the normal biological landmarks, such as birth, childhood, puberty, menopause, and death. In an age of preventive medicine, the GP deals increasingly with healthy people (as biomedically defined), for immunisations, ante-natal clinics, cervical smear clinics, baby clinics, and so on. The more intimate and long-term relationship between GP and patient that this brings about does not seem to have drastically changed folk models of illness. The Fevers/Colds/Chills model is one example of

this, but undoubtedly there are many others that remain to be studied, with the eventual aim of improving health care, with less side-effects to the patient.

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NOTES

1 I have used the term 'biomedicine' throughout the paper; in Fabrega's definition it is "The whole medical complex in Western nations, which includes knowledge, practices, organisations, and social roles" (1975:969). It is therefore "our own culturally specific perspective about what disease is, and how medical treatment should be pursued" (1975:969). It is the world-view of a professional subculture, the medical profession. The term 'biomedicine' is rarely used in British anthropological or medical writings.

2 The history and sociology of the British National Health Service are well described in Stacey (1976), and Levitt (1976). In Stacey's book, see Gill's article (1976:10–12) for a history of the N.H.S. and of the medical systems which preceded it.

3 See Levitt (1976:96. Table 4). She quotes a study of the 'Annual Morbidity Experience in Average British General Practice of 2,500 Persons (i.e., numbers of patients suffering from the diseases that the doctor may expect to see each year).' Of the patients seen, 1365 had 'Minor Illness', 288 had 'Major Illness', while 558 had 'Chronic Illness'. Of the 'Minor' conditions, 674 had Upper Respiratory Infections, 84 had Acute Otitis Media, 51 had Acute Urinary Infections, and 53 had 'Common Digestive Disorders' (which presumably includes Gastro-enteritis). Of the 'Major' conditions, 184 patients had Pneumonia and Acute Bronchitis.

4 Many medical anthropologists have noted that definitions of 'normality' in health differ between cultural groups and social classes. In Britain there are significant differences in the definition of 'illness', and in the threshold at which it is brought to a doctor, between the different socio-economic classes. For a study of this, see Cartwright and O'Brien (1976:77–94).

5 For example, see Camp's article (1976:70–76) on the medical use of hydros and spas in France ("la thermalisme"). In France there are over a hundred of these spas and hydros to which half a million patients are referred by their family physicians every year. This practice is now almost unknown in Britain, though 'hydrotherapy' flourished here from the 17th century. French spas are supervised by 'thermal specialists', many of whom are doctors who have taken a 'diploma in hydrology'.

6 See Levitt (1976:98. Table 4).

7 One popular book of folk remedies (Mellor, 1975) puts this concept in a similar way; for example, the treatment she recommends for the common Cold is: "Hot lemonade with a pinch of cinnamon and a little honey in it, and hot elderflower-and-mint tea, with a pinch of composition powder in it, will induce sweating and excretion of waste-products through the skin. The body should be rubbed down with a rough towel; this will remove the sweat, and will induce further sweating and further elimination of unwanted debris through the pores of the skin" (1975:89).

8 Cf. Mellor (1975:66) on the treatment of "Bronchitis and Broncho-Pneumonia" – "The best way to cure both of these ailments is to fast, on juices only, for a day or two. A cup of hot elderflower-and-mint tea should be taken every half hour until sweating begins, then only every hour. The sweat should be removed with a dry towel."

9 See Lewis, I. M. (1971:66–99) for a description of the "malign pathogenic spirits" who cause illness by possession of the victim's body, in parts of Africa and elsewhere. In these societies 'spirits' are hypotheses for the causation of illness. These spirits are capricious and amoral in their attacks, and their victims are considered blameless. Among the Luo of Kenya, for example, "amoral, malevolent spirits of external origin",

existing alongside the ancestor cult, cause a wide variety of afflictions, especially among women (1971:81). In other similar societies, these spirits "strike without rhyme or reason, or at least without any substantial cause which can be referred to social conduct. They are not concerned with man's behaviour to man. They have no interest in defending the moral code of society, and those who succumb to their unwelcome attentions are morally blameless" (1971:71).

10 An inadequate diet, especially, is now increasingly blamed for Colds. Cf. Mellor (1975:89) – a Cold is "Nature's way of forcing you to rest, so that your body can throw out unwanted debris that has accumulated in the blood. An unclean bloodstream, loaded with unwanted debris, provides a favourable breeding ground for the common-cold virus, which cannot live and multiply in a clean bloodstream because it requires waste-matter on which to feed. It gains entry into the body via the nose or mouth, but, if waste-matter is not present in the blood, it will have nothing to feed on and will soon die and be excreted, together with other unwanted debris, through the eliminative organs of the body. A clean bloodstream is, therefore, the best insurance against all forms of germs, including the cold-virus and the 'flu-virus."

11 One patient whom I diagnosed as having a "viral infection", replied "That means you don't know what's wrong with me, doctor."

12 Similar advice for the common cold can be found in many medical textbooks; in Maclean and Scott (1962:178) for example, treatment of the common cold includes bed rest in a warm room, together with hot drinks and a hot bath.

13 See Goodman and Gilman (1965:329); and Chatton, Margen, and Brainerd (1970:5–6).

14 See Trethowan (1975:749) – In 1972, in England, 36 million prescriptions for 'Anti-Infective Drugs' were issued by GPs in the N.H.S., at a total cost to the state of £25.7 million. This amount excludes anti-infective drugs prescribed under the N.H.S. in Wales, Scotland, and Northern Ireland, and those prescribed by hospital doctors.

15 Medical textbooks stress the fact that viruses are not susceptible to antibiotic therapy; see Garrod and O'Grady (1968:427), and British National Formulary (Harman, 1976:115).

16 Details of all prescribable proprietary drugs available in the United Kingdom, together with their pharmacological constituents, can be found in the monthly publication 'MIMS' ('Monthly Index of Medical Specialities'), published by Haymarket Publishing Company, London. It is sent free each month to most doctors in the UK. Some patent remedies are not included in it, especially those that can be bought in pharmacies and supermarkets.

17 Emprazil's slogan, written on each box, is: "Clears the nose, eases aches and pains – Helps you carry on through the cold."

18 Byrne and Long's study (1976) of consultations between GPs and patients in several areas in Britain, includes transcripts of a few conversations which seem to exemplify these points; for example, in one conversation between D(Doctor) and P(Patient): D. "Hello, come in, how are you?" P. "Got a cold . . .") D. "It's the fashion this week, everybody's got it. Well, now, how's the breathing going, any different?" P. "Not so bad, doctor, can't grumble. I feel a bit better than I did before." D. "That's a good sign. Are you coughing at all?" P. "A bit. Just got a bad chest, just my arms you know." D. "It's the cold and damp – that sort of thing . . ." (1976: 93–94).

19 See Trethowan (1975:749) – In England only, in 1972, 255.9 million prescriptions were issued by General Practitioners in the N.H.S., with a total cost to the state of £155.1 million.

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46-4

A CASE FOR COALITION OF MEDICAL SYSTEMS

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ON TRADITIONAL ASIAN MEDICINE -
HOTEL OBEROI TOWERS, BOMBAY
4th-7th January, 1990.

Introduction

Independent India's former President, Philosopher Dr. Sarwapalli Radhakrishnan said that, Indian Philosophy does not stand for either 'this' or that, but it stands for both 'this' and 'that'. Indians are pragmatic people. They niether have any sentimental attachment or detachment like 'our medical system' or 'their medical system'. They take good points from all the medical systems and discard bad elements of all the systems and form their independent judgment as to which system is beneficial in what circumstances. The main thesis of this paper may be summed up in short as -

(1) Coalition (of Medical Systems) without Quackery; and

(2) Moderation in Medicine.

1. Coalition without quackery:

In the book "Culture Disease and Healing" edited by David Landy in Chapter No.57 written by Charles M. Leslie titled "Pluralism & Integration in the Indian and Chinese Medical Systems" the following observations have been made in respect of medical scene in India:-

(1) Professionalised Indian Medicine is not in practice isolated from cosmopolitan medicine. (In India what we understand by Allopathic or Modern Medicine is termed as cosmopolitan medicine in that book).

(2) The Integration of Indigenous and cosmopolitan medicine is even more obinious when one adopts the perspective of Laymen, for throughout Indian society they utilise whatever form of medical knowledge and practice are available to them. They are less concerned with whether the therapy is indigenous or foreign, traditional or modern than with how much it will cost ? Whether or not it will work, how long it will take ? and whether the physician will treat them in a sympathetic manner.

(3) Part-time practitioners far out number full-time practitioners in the Indian Medical System. In 1965 a Community Development Block with 80,000 people had 59 full-time and 300 part-time Indigenous Medical Practitioners. In the same ...ar a district in South India with a population

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of 1,20,000 had 6 Doctors 30 full-time practitioners of Ayurvedic & Unani Medicine and 598 part-time practitioners.

(4) Well-known Ayurvedic & Unani Physicians will have brothers, sons and other kinsmen who are cosmopolitan Medical Doctors or we could put this other way round and say that many cosmopolitan Medical Practitioners have kinsmen who practice Indigenous Medicine.

These observations of Medical Anthropologists about Indian Medical scene are fairly objective.

In India ipso-facto coalition of Medical Systems already exist. But in its present form it is leading to quackery. To erradicate quackery profession had to adopt and assimilate the good qualities of quacks. As the vedic dectum goes 'AA No Bhadraha Kritavo Yantu Vishvataha' let noble thoughts come to us from all sides - even from the side of the medicines' enemy the quack.

There was a news item in the newspaper "The Times of India" dated 1-10-89 captioned "Where every fifth Doctor is a quack" written by Shri - G.V. Krishnan. He has raised many issues there. But here I only deal with the portion which is relevant in the present context. As I have told earlier to erradicate quackery qualified Doctors should assimilate the good qualities of quacks. The news item referred above tells that "The thing about quacks is their popularity. They are responsive

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to patients, mainly poor and unlettered. While most qualified doctors limit their practice to clinic hours and do not make house visits quacks appear to have earned public goodwill because of their willingness to go "any where at any time for any case in response to call from patients." Here I want to comment that assumption of qualified doctors that deliveries, diseases and deaths do not occur outside their clinic hours is also a form of quackery.

When foreign missioneries and so called quacks are responsive to the poor and unlettered patients, why a qualified Indian Doctor should not be so ? Why he is so reluctant to work in remote difficult rural areas. Whether his religion does not teach him sympathy and compassion for his fellow beings ?

It is also reported in this news item that in case of Village women attempting suicide by consuming insecticides following family quarrels - "the neighbourhood quack helps out the family while qualified medicalmen would not touch the case without referring it to the Police as medico-legal case. Any Doctor worth the name knows that how much important it is to treat such patient very promptly. As justice delayed is justice denied - in the same way Medical treatment delayed in such emergencies is treatment denied. In this connection I want to quote recent Supereme Court of India Judgment which says that in case of road accidents and head - injuries medical treatment should be provided promptly first, legal formalities may follow later. Laws should

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be amended to facilitate Doctors first to attend emergencies without wasting precious time in legal formalities which may go against the interest of the health of the individual concerned.

There are almost always alternative ways of dealing with various medical situations. If one system of Medicine cannot deal successfully with a certain medical situation and other systems deal with it appropriately, then the practitioner of earlier system need not feel humilated or feel that he has sustained 'loss of face' or 'cut of nose'. If a person's disease is cured, pain is relieved or health status enhanced, it would be strange if some doctor is grieved over the matter. Noble profession of medicine should be put at such a high pedistel where petty conflicting vested interests cannot play havoc. Cross referal of 'Patients from one system of Medicine to other should be as smooth and formal as in the case of referal from one speciality to the other in the same system. It should be guided by the consideration for the welfare of patients. False personal prestige should not come in the way.

2. Moderation in Medicine:

Health promotion & maintenance disease prevention and cure, these objects should be achieved through moderate means extreme positions should not be adopted to achieve these goals. This principle of moderation is termed 'Madhyama Marg' or 'Golden Mean' in Ayurveda & Budhistic Philosphy. Thus, legitimate pleasures of flesh should have preference over cilibacy.

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While enjoying sensual and sexual pleasures restra. is preferred to over-indulgence in them. Ordinari natural child birth should be preferred to interventional obstritics. While treating diseases non-drug therapy should be preferred to drug therapy. Simple Ayurvedic & Homoeopathic drugs should have preference over cosmoplitain Medicines which have potential for adverse reactions. Drug therapy should be preferred over surgical operations. And surgical operations over organ transplants. In short, initially and in the earlier stages of diseases simple home remedies should be used. In complicated cases where there is no other option sophisticated diagnostic and therapatic technologies should be used. It is said that some californian women had prophylactic mastectomies to prevent the possibility of breast cancer. Such actions go against the interest of the women conerned and as also of her husband and children. Nearer home in a district of Andhra Pradesh all the women in the age group of 45 to 50 who were rich enough to pay for the operation, had hystractomies to avoid uterine tumors. Such extreme steps for prevention of diseases are absurd. It is like saying 'Na rahe bans Na baje bansri' if there were no bamboos there would not be flute-playing. If there are no heads there would be no headaches.

It is said that as a result of its media being pre-occupied with health U.S. has become the most over medicated, over-operated, over inoculated, anxiety ridden country in the world. Health education

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is good but such overdose of it is bad.

Mother and infant both know instinctively that breast feeding is mutually beneficial but some modern mothers do not feed their babies on the breast for the fear that in the process they may lose their sex appeal and beauty. In Africa infants fed on baby foods died of mal-nutrition. Then W.H.O. started arguing in favour of breast feeding, which is encouraged by all the traditional medical systems sinceantiquity.

All over the World traditionally many restrictions were put on sexual activities. After the availability of various contraceptive devices, as there is no fear of unwanted pregnancies, these restrictions were ridicluded as conservative victorian values. But recently with the spread of AIDs, many older restrictions on sex seem sensible and necessary. Therefore, many older practices and beliefs need to be reassessed more objectively.

3. Adverse reactions of drugs:

We read now and then in daily newspapers about the deaths caused by anaphylactic reactions to the administration of penicillin injections. Sometimes even the test doses of penicillin prove to be fatal. Penicillin is the most important single drug which has made people suspecious of synthetic chemicals of modern medicine. Adverse reactions to penicillin are immediate. There are instances of delayed reactions to the administration of drugs not only on the patient but also on his/her progeny e.g., chloroquine given to

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pregnant women may produce a retinopathy in the child 4 to 5 years after delivery and diethylstilboestrol administered to a pregnant woman in early pregnancy many years later, produce vaginal carcinoma in her adolescent daughter. Adverse drug reactions of modern medicines are so numerous that now-a-days even text books of adverse drug reactions are being written and some quarterly periodicals are being published on the subject of adverse drug reactions. Because of such publications, urban dwellers of metropolitan cities of India now want to go through the literature about the medicines prescribed by their physicians and it is only when they find them to be safe then they are ready to consume them. In U.S.A. the situation is even more horrible from the point of view of Doctors. There, the Doctors face litigations from their clients regarding real and/or imagined adverse reactions of drugs prescribed for them by their Doctors.

Apart from adverse drug reactions, another point is that the modern diagnostic and therapeutic technologies are not cost effective. The early detection of incurable disease with the help of modern diagnostic technologies may do no more than prolong the period of worry for the patient and the family.

The benefits that high technology promises of postponing death or reducing disability, sometimes exact too high a price, as only a minority of patients stand to benefit from technology, too much attention to

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them diverts resources from many others, who pay the price in the inadequacy of provision for their needs. But there is potential harm also for those whose condition can be influenced by technology for most interventions involve discomfort and some are hazardous.

Postponing death of an unconcious patient for a period of six months at enormous cost for his family puts his heirs in debt for the rest of their lives. Compare this situation with that of First Mughal Emperor Babar, who bargained his life for that of his son Humayun. All Indian languages have a common idiom used by elders which is addressed to God imploring him to take their life, instead of their children's. It seems that their prayer was mostly answered by God in the affirmative. But for the disease, children are made to last longer in comparison to their elders, whose days or years of life are numbered. I mean to say here that elders should accept the inevitability of death with grace and dignity as it is a part and parcel of life itself.

With a view to compensate for the deficiencies of modern medicine W.H.O. has broad-based its Health Care Delivery System to include traditional medicine also. By traditional medicine is meant, the sum total of all knowledge and practices whether they can be explained or not used in the prevention, diagnosis and elimination of physical, mental or social imbalances and relaying exclusively on practical experience and observations handed down from generation to generation whether orally or in writing.

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4. Conclusion:

Potant bronchodilators of modern medicine sometimes cause tremors in hand and palpitation. Therefore, if these medicines are used in smaller doses alongwith Ayurvedic medicines such as Chavanaparash, Chitraka Haritaki which improve the immunity of respiratory system, such a regimen will be beneficial for the patient, without the above said side-effects of medicines. My personal experience suggests that such a combination will help the patient in the case of respiratory diseases.

Similarly using astringent and better medicines such as Kutaja, Jateephala and Opium described in Ayurvedic system will help in diarrheal diseases and mild purgatives such as Senna, Glyesrrizaglibra etc., will help in diseases of digestive system where constipation is the main problem. Many drugs formerly used for intestinal infections in modern medicine have adverse reaction on optic nerve, prolonged use of them may result in blindness. The milder drugs of Ayurveda help the patient of digestive system without any adverse reactions. Though there is no other go than to take recourse to modern medicines in medical and surgical emergencies.

Doctors of modern medicine and Ayurveda should sit together with open mind and cooperative attitude, with the help of drugs of both the systems and following beneficial practices of traditional cultures we can hope to achieve health for all by 2000 A.D. in an economical way.

-----The End-----

Blow to goodness

Supply of drinking water was her one-point mission. And this was her undoing. The message of the murder of Leelavathy, Villapuram councillor, is loud and clear. A woman in politics will be tolerated only if she has high level connections or if she is prepared to overlook the loot of political ruffians,

says MYTHILY SIVARAMAN

APRIl 24 began like any other day in the life of Leelavathy, the 40-year- old councillor of Villapuram (ward 59) Madurai Corporation. Early in the day she made a tour of some of the streets in her ward – her daily routine – giving instructions to the Corporation Division Office to attend to some repair work. On returning home, her eldest daughter Kalavathy offered her a hot cup of tea. Remembering that there was no cooking oil in the house, Leelavathy hurried to the shop close by and never returned to have that tea.

Minutes after she left home, around 8 a.m. and quite close to the grocery shop she was hacked to death by armed men, her body sustaining more than 25 stab injuries. It was a stone's throw from the building in which her family had lived in a rented room for over two decades.

The rest is recent history with journals churning out various versions of the killing by unnamed eye witnesses. Her low profile campaign, costing a pittance in sharp contrast to the extravagant campaign of her opponent, had given the people of the ward a chance to say "No" to the hooliganism prevalent in the area. And this, in an area which was far from stronhold of the CPI(M), whose candidate she was; Her victory was a surprise to many. Villapuram had for long been dependent on water brought by Corporation tankers and sold to the people for a fee, levied by local thugs. All attempts to lay water pipes from a water source to Villapuram had been scuttled in the past, as selling water was fetching a mafia around Rs. 35,000 a month. Leelavathy had, during the election campaign, promised that she would bring the residents free pipe-borne water, if elected. Contrary to dominant political norms, she had meant what she had said. Supply of drinking water, thus became almost her one-point mission. And this was her undoing.

In her very first council meeting she had raised the issue of misuse of water distribution by the anti-socials. She did not however, take on the local goondas in a spirit of recklessness. She was discrete, avoiding direct encounters with them and concentrated on bringing pressure on

squabbles because of it? Kuppusamy's response, "No debts and no squabbles" sounds unbelievable until one becomes aware of the family's life style, untouched by the consumerist culture. Leelavathy had so few decent sarees that her better off co-workers offered to get her a few new sarees to wear during the campaign and later as a councillor attending city functions.

The offer was gently declined. Leelavathy's three daughters, Kalavathy, Durga and Tania, aged 19, 17 and 15, have been brought up with the same values that the parents practised in their personal and public lives – hard work, social awareness and minimal concern for possessions of any kind. In the aftermath of the tragedy, they have conducted themselves with admirable fortitude and composure. The tiny one room which the five of them occupied, with a small nook in the wall to accommodate the stove and a few utensils, had a big loom in it. A small table fan and a portable black and white TV stood in a corner unobtrusively.

Asked what changes he perceived in his wife after she became active in the Left movement, Kuppusamy recalled that she had given up her habit of writing Sri Ramajayam 108 times a day – "I guess she found little time for this, overpowered by her new interests. She did not, however, neglect her obligations to attend larger family occasions." A middle class woman employee reminisced about the visits of Leelavathy to her office to enrol members in AIDWA. She was rather shy and would not talk much on her own. Yet, she was rarely found wanting in any discussion on the organisation. On one such visit to an office, a working woman complained that another CPI(M) councillor had not attended to some problem in her locality. The very next day, Leelavathy returned to the office bringing along the concerned councillor to explain what has in fact been done about the problem.

She was far from the archetypal image of the aggressive female ready to take on local thugs and irksome opposition party members. Her face wore a serene expression rarely reflecting the tension of the row over water supply and contending with local vested interests. Ganesan, a

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the bureaucracy to act fast on the pipeline. Three days before her gory murder, a trial run of the water pipe was held and Leelavathy who gulped a mouthful of it, was overjoyed. A contenant in the building said, "In all these 25 years nobody bothered to get us drinking water. But in six months time she got us what we had always longer for."

Avoiding confrontation, however, did not mean remaining silent on the issue of rowdyism which had plaugued that area for so long that it was aptly named "Villain puram!" On April 9, the CPI(M) did something unthinkable in the area by coming down heavily on anti-social forces during a dharna held to focus on several issues, including the water issue, monitoring of ration shops and illicit liquor browing. Leelavathi had presided over this meeting. This was preceded by another dharna and bandh organised by local shopowners to condemn extortion of "mamool." Leelavathy had presided over this as well. She had hoped that such actions would embolden the local community to stand up to the underworld.

She had also shown considerable concern in upgrading facilities at the local Secondary School, houses in a rented building without water facilities. With painstaking efforts she managed to find an available piece of land – under illegal occupation, for the school to have its own building. This also irked the vested interests. On the day of counting of votes, the losing Party had engaged in violence and destruction while Leelavathi, with exceptional guts, remained on the spot.

Leelavathy's involvement in social concerns began in 1985 when she was encouraged by her husband to join the Democratic Youth Federation of India (DYFI). Kuppusamy, a longtime member of DYFI and worker in a stainless steel workshop, recalling those days, said: "If I did not motivate her to join the organisation what right do I have to say that it should enroll women members. Soon we became the only couple to be members of DYFI's Madurai district committee, though later, I lagged behind while she became its State Committee member." On further probing, he said, "I did feel a bit jealous first, but I realised the need to promote women to higher posts in such organisations as there were none or very few at such levels of authority."

In 1992, Leelavathy, a member of the Handloom Workers' Union, became one of its State Vice-Presidents. Born in a Saurashtra family of handloom weavers, she learnt weaving only when her husband was dismissed from work while attempting to form a union, to keep the homefire burning. Ironically, her parents, who had managed to educate her up to the class 10 had not wanted her to become a weaver.

Her rise in the CPI(M) to the Madurai district committee was well earned by her hard and committed work. It was only natural that she should have become active in the All India Democratic Women's Association (AIDWA), a growing organisation, needing activists with deep insights into women's issues. When she died, she was a full-time activist in AIDWA and a member of its State Committee.

Leelavathy's life is an example of how women with grit can get involved in public life despite many odds. As her involvement demanded ever more of her time, her daughter replaced her at the family loom, supplementing her father's Rs. 300 a week with her own Rs. 30 a day. How did the family manage to balance its budget on such a meagre income? Did the family have outstanding debts or neighbour, said, "Her ready smile at all times would light up her face. When will I see such a smile again?"

Like Thomas Beckett, of whom it was said, "Beckett dead was more dangerous than Beckett alive", it can be said that Leelavathy dead had become more of a force to reckon with than Leelavathy alive. Leelavathy who remained a relatively obscure local politician until that fateful day, has become a national symbol of the rare political breed – the principled and honest politician struggling to survive against the hordes of degenerate and depraved thieves masquerading as politicians.

Her funeral reflected the groundswell of admiration and gratitude that the people of Madurai – a city fast becoming notorious for its dons and dadhas – had come to feel for their crusader. It was a mammoth procession belying all expectations and in a sense, stood out in sharp contrast to the speed with which witnesses to the killing fled the scene and shops downed shutters, leaving the hapless woman to fight the armed bullies single handed on that dark day. Scores of people are coming to meet the family every day, – including a bus load of students from a secondary school in Periyar district – to pay their homage to a woman who became a martyr in the cause of political probity.

In her local area, she has become a symbol of the people's struggle for water. After the slaying, the people of the ward have turned back water tankers saying it is the tankers that caused Leelavathy's death. Instead, they opted for a long walk to fetch water. Ten days after her death, when the pipe water arrived, a woman took the first pitcher of water to pour on the spot Leelavathy was killed.

The critics of 33 per cent reservation in law-making bodies say it would lead to "betis, biwis and behans" to assume office as proxy for their male relatives, which would not enhance women's status in any way. Leelavathy was no proxy candidate and had been fielded in the fray, on her own merit. But her killing makes it clear that the politician-criminal- police nexus would not brook the likes of Leelavathy trespassing into their terrain.

The message of the murder is loud and clear. A woman in politics will be tolerated only on certain conditions – high level connections (of the "biwi, beti" sort), prepared to share with or overlook the loot of political ruffians and the absence of a will or a mind of one's own. Puppets who can be operated from behind or dummies who simply lend their feminine presence, now constitutionally mandatory, are welcome. Women who take their office seriously, want to cleanse politics of muck and dirt and respond to the aspirations of the people are not to be allowed. If they fail to take the hint, they can do so only at a risk to their own lives. The document "Towards Beijing – A Perspective from the Women's Movement" (1995) said – "Today women's political participation is facing new challenges in the form of corruption, criminalisation and communalisation of politics which threatens to further restrict women's space in politics. The political milieu as it is constructed today pushes women out of politics. Criminal intimidation is likely to increase as people's protest against their deprivation and dispossession grows. The women's movement will have to raise the issue and fight the policies that are giving a fillip to criminalisation.

To shy away from the political arena fearing Leelavathy's fate would serve only to toughen the likes of her killers. She died to constantly remind us of this.■

7. RECOMMENDATIONS

In making its recommendations, the Meeting took into consideration the fact that traditional systems of medicine remain the major source of health care for more than two-thirds of the world's population, and that impressive progress has been made in certain developing countries, such as China and India, through the integration of traditional with western systems, and the application of modern science and technology to the promotion and development of traditional medicine. Resolution WHA30.49, urging interested governments to give adequate importance to the utilization of their traditional systems of medicine, was also given due consideration, as were the contents of the Organization's magazine *World Health*, whose November 1977 issue, as stated earlier, was devoted to the subject of traditional medicine.

The following recommendations were made :

7.1 General

The World Health Organization should use all the possible resources at its command to continue to promote and develop traditional medicine. This can be done :

(1) By promoting the formulation and declaration of specific national policies for the encouragement, support and development of traditional systems of medicine indigenous to the Member States, and by undertaking administrative, organizational and budgetary commitments to meet this objective. The elements for such a policy should include the legal recognition of traditional medicine, and the integration of traditional medicine into national comprehensive health care systems, including primary health care.

(2) By establishing a committee of experts which would advise on the programmes of promotion and development of traditional medicine, monitor and coordinate research efforts, evaluate programmes for replanning and the proper reorientation of strategies. This committee should be composed of persons specialized in the different areas of traditional medicine from the various WHO regions.

7.2 National and international policy support for the promotion of traditional medicine

(1) Efforts to promote international cooperation between developed and developing countries, and particularly technical cooperation among developing countries (TCDC), in the field of traditional medicine are essential.

(2) National governments should favour the policy of integrating traditional medicine into their general comprehensive health care system in order to facilitate the realization of health care goals.

(3) The organizers of the forthcoming International Conference on Primary Health Care, at Alma-Ata, USSR, should consider the importance and necessity of fully utilizing and developing the vast manpower currently existing, in the form of traditional medicine practitioners, in order to make effective health care available to underserved populations.

(4) WHO should explore the possibility of convening an international conference on traditional medicine specifically to discuss the utilization of traditional medicine in primary health care systems as a means of helping to fulfil the objective of health care for all people by the year 2000.

7.3 Collection and dissemination of information pertaining to traditional medicine

Lack of information was considered the greatest initial barrier to assessing the feasibility of national health plans. Organized efforts should therefore be made without further delay to ensure the collection of information and dissemination through :

(1) Promotion of collection of basic information by surveys on :

- traditional medicine personnel categories in practice (census),
- traditional medicine centres or functioning services,
- utilization of practitioners of traditional medicine in health services,
- diseases known to have been successfully treated by traditional healers,
- traditional medicine drugs, preparations or medicaments, traditional medicine pharmacopoeias,
- determinants of manpower needs for primary health care services,
- collaborating factors and supportive infrastructure for the promotion of traditional medicine,
- literary resources to gather information and compile bibliographies on traditional medicine.

(2) Special meetings, such as conferences, seminars and workshops.

(3) Publications, such as journals and bibliographies.

DP4-6.

7.4 Educational programmes

Following the collection and analysis of the relevant information, educational programmes could be planned and executed with the following aims :

(1) To educate the community on new health policy and to enlist its support and cooperation.

(2) To change the unfavourable attitudes of members of the health and allied professions.

(3) To disseminate information on traditional medicine for use and application.

(4) To assure the people that the new policies and approaches are in support of the practice of traditional medicine, and that they are aimed at enhancing it for safety, efficacy and wider use at low cost.

(5) To assure traditional medicine practitioners that they will be the promoters and dispensers of the new health care system in their own cultural setting.

(6) To stress that where traditional medicine drugs have been studied and adverse side-effects (iatrogenic effects) eliminated, the drugs should be produced in the same or similar form for general use.

7.5 Application of traditional medicine to primary health care

The promotion of traditional medicine in health care services and especially in primary health care should be intensified by :

(1) Application of appropriate technology to health care improvement based on simplicity, safety, efficacy and availability at low cost.

(2) Selection of lists of essential plants, drugs, or techniques employed in traditional medicine, for use in public health services and particularly in primary health care.

(3) Approval of proved useful methods and techniques, such as acupuncture and Yoga, for use in public health services.

(4) Integration of traditional medicine and western medicine in training programmes at various levels.

(5) Introduction of traditional medicine into public hospitals, dispensaries and health centres. The functions of traditional medicine practitioners should be carefully coordinated to ensure efficiency.

(6) Incorporation of self-evaluating mechanisms for continuous evaluation, and feedback in order to improve the techniques or to reorient the programmes whenever necessary.

7.6 Manpower development

Coordinated steps should be taken by Member States in collaboration with WHO to promote manpower development in traditional medicine by :

(1) Training the various categories of traditional medicine workers (including those with limited skills), such as traditional birth attendants and bone-setters.

(2) Encouraging traditional medicine practitioners to form clubs or societies as a means of checking harmful practices, eliminating quacks and charlatans, assuring continuous informal education, cultural loyalty, and the conservation of a high level of professional ethics and practice.

(3) Organizing educational activities in traditional medicine either by establishing new training centres or by revising existing curricula to include subjects related to traditional medicine.

Lastly, technical education boards, chairs for traditional medicine in medical schools, and new institutes could be created, and a directorate of traditional medicine could also be set up in health ministries.

7.7 Multidisciplinary research programme

A planned multidisciplinary research programme should be formulated and implemented in collaboration with Member countries, as follows :

(1) Operational research on traditional medicine in health care systems.

(2) Various aspects of medicinal plant research, such as plant identification, classification, phytochemistry, pharmacology, and laboratory and clinical trials for therapy.

(3) Studies in psychosocial and cultural aspects and behavioural patterns.

(4) Manpower development and health team training, including development of effective training methods.

(5) Role of traditional medicine in other fields of medical research, such as fertility regulation, treatment of infertility, control of tropical endemic diseases, cancer therapy, the care of drug-dependent persons, and the ageing process.

(6) Validation of popular traditional medicine therapies.

(7) Promotion of research activities on the integration of various systems of medicine.

(8) Establishment of national institutes for research into traditional medicine.

Annex

Films on Acupuncture Anaesthesia and Chinese Herbology

Two films were shown on developments in traditional medicine in China during the last decade. The following points that emerged were of significance to the Meeting's discussions :

- the importance of applying modern science and technology in research on traditional medicine,
- the extent to which integration of traditional and western medicine could contribute to and even revolutionize health care,
- the tremendous potential for healing possessed by the properties of the plants,
- the importance of teamwork and good team spirit in the organization of basic health services,
- the need to give the health of the rural masses the important place it deserves,
- the need for a spirit of self-reliance in planning total community action programmes for development.

Cover: Aesculapius, God of Medicine. Design by Peter Davies from a wood-carving in Chur, Switzerland.

Contents

World Health appears in Arabic, English, French, German, Italian, Persian, Portuguese, Russian and Spanish.

World Health, WHO, Av. Appia, 1211 Geneva 27, Switzerland.

The staff of Aesculapius

BY DR HALFDAN MAHLER

Director-General of the World Health Organization

If we had to justify the inclusion of traditional medicine within the compass of the World Health Organization, we need look no further than the opposite page. The emblem of WHO superimposed on the globe the staff of Aesculapius, ancient god of medicine, entwined by a snake. The god's serpents were said to lick the wounds and lesions of the sick in their sleep and thus to heal them.

For far too long, traditional systems of medicine and "modern" medicine have gone their separate ways in mutual antipathy. Yet are not their goals identical—to improve the health of mankind and thereby the quality of life? Only the blinkered mind would assume that each has nothing to learn from the other.

Unfortunately that divergence between the two systems of medicine has almost exactly paralleled the division of the world between the *rich* and the *poor*. Too often the privileged and well-to-do, living in large towns and cities, enjoy access to all the complex technology and lifesaving apparatus of modern medicine. Tens of millions of people have no such access; for them the traditional healer, the herbalist and the traditional birth attendant are the only agents of health care to whom they can turn. Not only are most of the rural areas of developing countries without a single qualified physician, but on the average they do not have more than one auxiliary health worker for 10,000 persons. In some parts of the world, even when modern medical care *is* available, the majority actually prefer the traditional healer whom they know and trust.

But the political winds of change that have been sweeping the world in recent decades have been matched by winds of change in community health: a newly awakened global social conscience requires that the health gap between rich and poor within countries and between countries should be narrowed and ultimately eliminated. The neglected 80 per cent of the world's population have their rights too; they too have an equal claim to health care, to protection from the killer diseases of childhood, to primary health care for mothers and children, to treatment for those ills that mankind has long ago learnt to control if not to cure.

Two years ago we in WHO pledged ourselves to an ambitious target: to provide health for all by the year 2000. This ambitious goal is, quite simply, beyond the scope of the present health care systems and personnel trained in modern medicine. With but 23 years to go, and since it is unlikely that the least developed countries can even dream of having enough of the orthodox type of personnel, it is clear that unorthodox solutions must be sought. The training of health auxiliaries, traditional midwives and healers may seem very disagreeable to some policy makers, but if the solution is the right one to help people, we should have the courage to insist that this is the best policy in the long run, and is by no means an expedient acceptance of an inferior solution.

This is why WHO has proposed that the great numbers of traditional healers who practise today in virtually every country of the world should not be overlooked. For the most part they are already living in those remote communities, intimately involved with the life there, conscious of their neighbours' needs and trusted by them. Many such healers have already undergone elaborate training in ancient systems of medicine that had evolved reliable methods of treatment and patterns of medication long before modern medicine came along. Other healers have had their skills handed down through the generations—the distillation of a surprising degree of practical knowledge, skills and wisdom about the physical, mental and psychological ills of mankind.

Provided they are willing, such traditional healers and local midwives can, at a very moderate expense, be trained to the level where they can provide adequate and acceptable health care under suitable supervision. Such training might include personal hygiene, mother and child care (including family planning), nutritional guidance, immunization against the major infectious diseases, elementary treatment of all age groups for the common diseases and injury, and a basic understanding of sanitation and environmental hygiene. They can at the same time be weaned away from any practices that might pose possible risks for their patients.

The age-old arts of the herbalists too must be tapped. Many of the plants familiar to the "wise-woman" or the "witch-doctor" really do have the healing powers that tradition attaches to them; the pharmacopoeia of modern medicine would be poorer if one removed from it all the preparations, chemicals and compounds whose origins lie in herbs, funguses, flowers, fruits and roots.

Let us not be in any doubt: modern medicine has a great deal still to learn from the collector of herbs. And already a number of Ministries of Health, in the developing countries especially, are carefully analysing the potions and decoctions used by traditional healers to determine whether their active ingredients have healing powers that "science" has overlooked. Whatever the outcome of such scientific testing, there is no doubt that the judicious use of such herbs, flowers and other plants for palliative purposes in primary health care can make a major contribution towards reducing a developing country's drug bill.

The present issue of *World Health* illustrates just a few of the aspects of traditional medicine in different parts of the world, and indicates the contribution that its practitioners could make towards better health care, and primary health care in particular—an aspect to be highlighted at the WHO conference on primary health care scheduled for 1978 at Alma Ata in the Soviet Union.

Given goodwill on both sides, such an army of healers, traditional birth attendants and herbalists can help to make our goal of health care for all by the year 2000 attainable.

A traditional herbalist sells his wares in a Sudanese market. (Photo WHO/D. Henrioud)

Malaysia's bomohs

"To treat a mentally-ill young woman, the healer staged a kind of theatrical performance in which her closest relatives and fellow-villagers each had a role to play"

BY JÜRGEN DAUTH

"The sky suddenly went dark and the jungle fell silent", a Portuguese seaman wrote nearly 200 years ago, describing his first encounter with a Malayan *bomoh*. The magic of these spiritual healers may not run to such extremes but, all the same, the people of the Malacca peninsula ascribe supernatural powers to the bomohs which are still being demonstrated to this day, according to popular belief. Didn't a bomoh cause the hitherto incessant monsoon rains to stop for a day at the request of the Ruler of Sarawak? Didn't another invoke blazing sunshine for the open-air boxing match of Mohammed Ali (formerly Cassius Clay) some three years ago, while rain poured down in torrents all round the stadium? The Malaysians are convinced that these things happened.

However, Professor Paul Chen of the Medical Faculty of the University of Malaya foresees a more important sphere of influence for the traditional medicine men. In his view the bomohs have always had an essential role to play in the nation's health care, and he is convinced that magic ritual and the psychotherapeutic understanding derived from it by the Malaysian medicine man, as well as his subtle knowledge of the healing powers of Nature, represent important contributions to medical science. Certainly Malaysia will need its bomohs for some time to come, since at present only 2,350 modern physicians supply health care to the 12 million Malaysians while there are 20,000 practising bomohs offering their services.

Whether they are Malays, Indians or Chinese, whether Moslems, Hindus, Buddhists or Christians, all of them remain to this day firmly rooted in the belief in spirits, their influence on the soul and their lifegiving power known as *semanganat*. They have not the least doubt that illness is caused by evil spirits. And only the bomoh has mastered their tongue, can overcome them or can conjure up guardian spirits to take their place.

Above: *A Malaysian bomoh prepares a herbal offering to ward off evil spirits.*

Right: *A basis of practical knowledge underlies the spiritual healer's rulings on when to eat certain fruits or when they are forbidden*—taboo.

(Photos WHO/J. Dauth)

The medical treatment undertaken by the bomoh invariably revolves around a ritual exorcism. The bomoh hands out amulets against the "evil eye" or prescribes magic spells which are based on astrological lines and may be written on paper, the leaf of a plant or on leather hide. Texts and magic symbols may be taken from the Koran in the case of Moslems, while the Chinese Buddhists and Taoists swear by the traditions of their homelands, and the Christians content themselves with reciting the Lord's Prayer backwards.

The bomoh may put a medium into a trance in order to arrive at a diagnosis or he lets the illness declare itself from the mouth of a hypnotised patient. Incantatory music on an instrument called a *gamelan*, dances and burnt offerings in which the hair or finger-nails of the patient play a major role—complete the ritual.

The enlightened student of medicine may loftily dismiss all this ceremonial as so much charlatanry, but that would be too hasty a judgment. Because on closer study black magic is seen as only a superficial framework to prepare the patient for the real medical treatment. It is precisely in this that Professor Chen sees the special advantage that the bomohs have over the modern doctor.

In Malaysia—as in most countries of the world—the doctor hardly has the time to concern himself about the psychic origins of many illnesses, and the top-heavy doctor-patient relationship, generally speaking, permits only a scientific approach. Yet for a long time scientific medicine has acknowledged that on its own it is incapable of getting to the root of sickness.

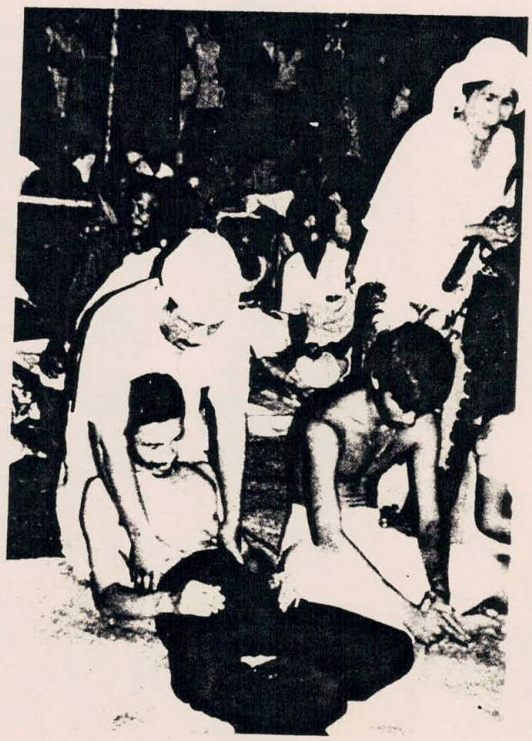
The bomoh, on the other hand, says Professor Chen, lives in the village where he has inherited his skills from his forefathers, and where he is a respected and trusted person. He is personally acquainted with every one of his fellow-villagers and knows what goes on behind the scenes. He can make use of the knowledge that a healthy body needs a healthy spirit in a way that few doctors can. So long as belief in spirits is a fact of life, it is useless to inveigh against magic ritual. In any case, superstition is far from being confined only to developing countries—it maintains a clandestine hold even among the crews of moon-bound spaceships.

On the East coast of Malaysia I watched an exorcism of evil spirits carried out on a well-born but mentally disturbed young woman. The bomoh had staged a kind of theatrical production in which the woman's closest relatives and her fellow-villagers each had roles to play. It was noteworthy that the actors in this little play had to demonstrate warm affection for the patient. Embraces, friendly gestures and tender caresses were much in evidence. The play took on an increasingly frenetic character with dance-like movements, until those taking part fell into a trance and finally reached total physical exhaustion. The coaxing of the evil spirit which had caused the illness with an offering of food until it could be caught in a container and packed off on a "journey without return" down the river was merely a ritual appendage. The young woman was now considered to be cured. I heard that the bomoh had passed the whole of the previous day before the ceremony in the house of her family so as to "get in touch with the spirit". Only in its outward appearance does this treatment differ from what is accepted in the industrialized world as group therapy under expensive psychiatrists.

The bomoh also works extensively with taboos which are invested with magic powers. Certain foods are forbidden, the physical stresses on the patient are limited or specific rituals are used to soothe his nerves. This too is a very practical means—among simple people who know little of modern hygiene, appropriate diets or physiology—for exerting a favourable influence on the course of an illness.

The modern practice of medicine in Malaysia makes use of the bomoh as an assistant at childbirth, for instance, often in collaboration with a state-trained midwife. And nobody would wish to deny that the psychological attitude of the mother-to-be has great influence on the course of a "natural" childbirth. Individual bomohs are also entrusted with carrying out mass immunization and help the doctors with such tasks as smallpox vaccination.

As regards operations, the bomoh limits himself to ritual bleeding. According to local belief, blood is the bearer of the life force and must not be overburdened. Thus opening an artery may be prescribed for headaches and vertigo; either the skin is pierced or leeches are applied. The bomoh obtains antiseptic preparations from extracts of plants or from the poison sacs of certain sea-fish. Painkilling potions can be distilled from the areka-nut, better known as the betel-nut. The right dose of poison taken from one particular fish can sufficiently lower the blood-pressure to make "bleeding" unnecessary.



Above: *Before applying the healing power of his hands, the bomoh tells his patients to breathe deeply and then puts them into a trance.*

Right: *A healer shows off his totem—the source of his magic powers. So long as belief in spirits is a fact of life, it is useless to inveigh against magic ritual. After all, superstition is far from being confined only to developing countries; it is to be met with even among the crews of spaceships heading for the moon!* *(Photos WHO/J. Dauth)*

The tropical vegetation and [illegible] fauna, with their rich variety of [illegible] are the sources of the bomoh's pharmacopoeia, and stocking it is based upon the knowledge handed down over the centuries that for every poison in nature there is a natural antidote.

The sap of the mangrove trees serves as a remedy for bowel and stomach disorders, causing vomiting [illegible] purges the intestines. The betel [illegible] prescribed for parasitic worms, and [illegible] dried roots of the pomegranate can strengthen this action. Pineapple juice is a remedy for indigestion and overeating. Skin eruptions, often originating from poisonous plants or insect bites, can be cleared up by the application of [illegible]

In rural areas, sexually transmitted diseases are very rare, yet even for these the bomoh has a cure. Against syphilis he may use the root of a certain leguminous plant which he calls "hantu" or spirit. The remedy for gonorrhoea sounds rather more drastic; a certain green beetle is made into a powder and added to the patient's food. Even more surprising for the scientist is the cure for toothache in children: a hair from the tail of an elephant. Against rheumatism, the Dayaks of Malaysian Borneo insist, the best remedy is tiger-fat.

For sure, religious motives are involved for declaring certain plants taboo and forbidding the combination of certain foods, but there can be no doubt that here too there is a basis of practical knowledge. Thus mangoes are not eaten with sugar, nor water-melons with honey nor heart of coconut-palm with shellfish or oysters. Such combinations are viewed as poisonous or at least highly indigestible. Beef, mutton, mangoes and pumpkins are to be avoided in cases of fever, eye diseases or gonorrhoea. Fish, eggs and milk are recommended. On the other hand, eggs, dried fish and brown sugar are stricken from the menu in the case of bronchial troubles. And "the worm of night blindness" rises to the eyes if one eats only sweet potatoes or bananas. Vitamin A deficiency can be avoided by a special diet of fish, meat or liver.

Many more examples could be given of the bomoh's pharmacopoeia. In Professor Chen's opinion it contains many hidden virtues which amount to the stored-up knowledge of an entire chemistry laboratory. Closer study of this could be of value to modern medicine. Once one discounts the special links with the supernatural; yet this too may have its psychological advantages. ■

Balance between man and natu

BY XAVIER LOZOYA

Among the countries forming that part of the American continent known as Mesoamerica, Mexico enjoys a special position thanks to the pre-Colombian cultures which once flourished on its territory. The wide variety of climates and soils found here meant that its inhabitants acquired a profound knowledge of medicinal plants and hence of medical science itself. The ancient Mexicans collected, catalogued and used these plants, integrating them into a vision of the universe whose basis was as much practical as religious. Although no precise documentation remains to us about the experimentation that must have been undertaken at that time, the information that has been handed down testifies to a broad understanding of the curative properties of Mexico's flora. The chronicles and manuscripts of that bygone age contain descriptions of flourishing botanical gardens and parks with rich collections of plants, as well as quite precise information about their use.

Ever since the fusion of cultures that followed the Spanish Conquest in the 16th century, Western medicine has tried to analyse the ancient medical wisdom, hoping to find among such cultural relics as remain a correct interpretation of the vision left by those early explorers. In the course of time a wide spectrum of evidence has emerged from a variety of cultural sources, all of it tending to confirm the balance that exists between man and nature.

As the centuries have unfolded, the rich grain of native knowledge has steadily evolved among the mixed-blooded population of Mexico. Rooted in past civilizations and nourished by fresh insights into the art of medicine, that grain has ripened into methods of treatment which are quite distinct from those based on modern science, and flourishes today as what we call "traditional medicine".

Unequal development, which in contemporary society mainly takes the form of an unequal distribution of resources, means that not all the population is able to benefit from health care. The result is that 40 per cent of Mexico's population today still has recourse to traditional medicine—the medicine of the poor—which is enshrouded in magic and mystery.

On the world scene, the study of herbal medicine in Mexico is of special interest because of three factors: its rich heritage of curative plants, the continued use of such plants among a large proportion of the population, and the wealth of available information—whether historic, archaeological, botanical or traditional. Moreover Mexico, as a developing country, is grappling with the reality of vast public health problems. The efforts made so far to introduce "Western" forms of medical care are still far from meeting the demands of a fast-growing population. In the framework of such social, economic and historic realities, Mexican traditional medicine and the medicinal plants themselves are crucially important to the future development of national public health policies.

Above: *Traditional medicine in Mexico is rooted in the rich soil of folk-wisdom handed down from earlier civilizations.*

Right: *This old man in the marketplace of Oaxaca, south-central Mexico, is the product of the fusion of cultures that followed the Spanish Conquest in the 16th century. Today, 40 per cent of the country's population still has recourse to traditional medicine, enshrouded in magic and mystery but still based on a very practical framework.*
(Photos WHO)

If we are to elevate the various combinations of treatments and drugs to the point where traditional medicine occupies the position it deserves, we have to re-examine and re-value popular medicine so as to bring it level with the modern scientific knowledge which now serves the health of many people. In order to undertake this laborious task, a complete analysis is needed of all information relating to medicinal plants, the way they are used and their characteristics. These studies will enable us to evaluate the advantages and benefits of the traditional, empirical knowledge which has survived the passage of time. When submitted to rigorous scientific analysis, the results could give rise to a new type of research going far beyond the limits of chemical and pharmacological analysis, but not dissociating itself from the anthropological reality in which traditional medicine is so deeply rooted.

Starting from this multidisciplinary standpoint and with the object of promoting and justifying the usefulness of Mexican medicine, the Mexican Institute of Medicinal Plants (IMEPLAM) has incorporated its activities within the research programme of Appropriate Technology at the Third World Centre for Economic and Social Studies (CEESTEM).

We have plenty of information about Mexican medical plants and will confine ourselves here to those with special importance for public health, which have been given priority in IMEPLAM's research programme.

Our Institute's systematic study of medicinal plants first of all entails an interdisciplinary effort to collect a

Left: *A symbol of Mexico, the maguey cactus flourishes everywhere. Its fleshy leaves yield a juice which is fermented into pulque, the national drink.* *(Photo WHO)*

Right: *This housewife in the Yucatan peninsula takes for granted the fact that the plants growing around her home have medicinal uses. The study of such plants should serve to upgrade the status of popular knowledge, and thus lend scientific support to the practice of traditional medicine.*

(Photo WHO/P. Almasy)

bibliography of everything published in Mexico from the 16th century until modern times, and to subject it to different levels of interpretation, classification and analysis. This also enabled us to start creating a bank of information on medicinal plants, already in full swing and illustrating in part what we know about plants with cardiovascular, anti-diabetic and anti-parasitic properties. This information is being compared with modern botanical studies with the object of identifying a group of medicinal plants which may then be submitted to a global study.

Examining the existing data in Mexico reveals that, although medicinal plants have been the object of research undertaken at various times and according to the different trends of scientific thought that have influenced Mexican science, the vast majority of studies made have been undertaken unilaterally, aiming at isolating the active ingredients but without ever succeeding in creating a national pharmaceutical industry. That is why most studies, while providing useful preliminary information, ought rather to be combined with a social objective—that of upgrading the status of popular knowledge, so as to lend scientific support to the practice of traditional medicine.

Here are some of the most popular Mexican plants, representing the three groups to which priority was given.

Plants with cardiovascular properties:

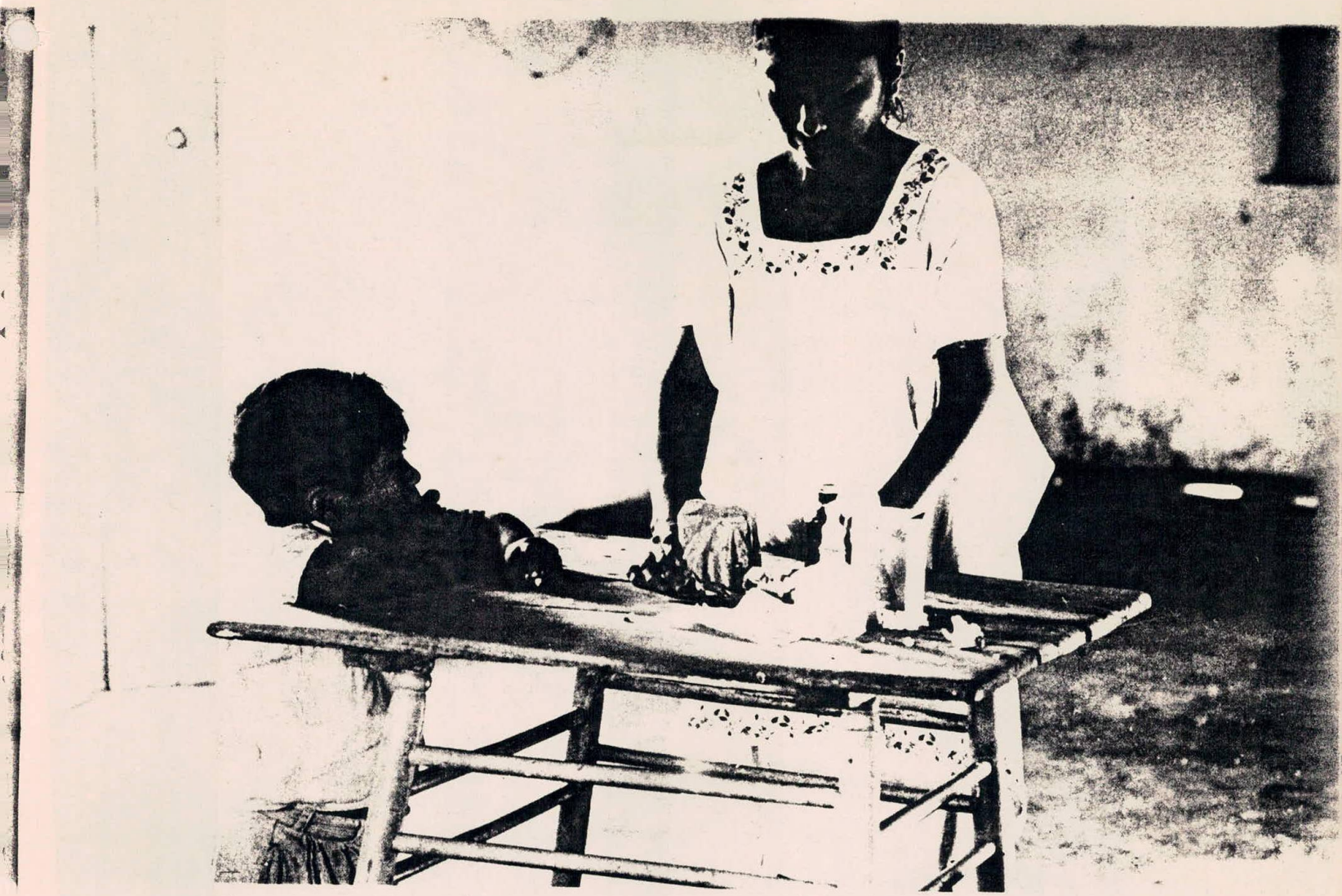
Talauma mexicana (D.C.) Don. Magnoliaceae. This large tree with beautiful flowers has been known and used since pre-Hispanic times; its name in Nahuatl (the language of the Aztecs) is *Yoloxochitl* or Heart Flower, and was given because of the properties attributed to its flower, bark and leaves as cardiac stimulants.

A decoction made from the leaves and flowers is still used to treat various cardiac ailments. Scientific research into this plant dates from the last century when chemical and pharmacological studies confirmed its tonic effect on the heart—increasing the heartbeat, and regularising cardiac contractions.

The chemical composition of the Talauma was at least partially discovered around the 1950s, when it was found to include certain alkaloids such as talaumine and aztequine. But the relationship between these substances and the curative effects attributed to the plant remained obscure. Its very extensive use puts it among the most important plants in Mexican traditional medicine.

Casimiroa edulis, Rutaceae. Among the sweet edible fruits described by the Aztecs figure those of the Casimiroa edulis, a tree mentioned in the descriptions of the period by the name of "Cochitzapotl"—the fruit that brings sleep. Today, its use is very widespread almost everywhere in Mexico for the beneficial effects on the blood pressure which are attributed to its leaves and its seeds. Certainly this is the most favoured traditional prescription for producing a slight but long-lasting regularisation of the blood pressure.

Although this fruit has been repeatedly studied over the years, the experimental proof of its action on the blood pressure has only recently come to light in our laboratories. We have determined how the active ingredient present in the aqueous extracts used as popular remedies actually functions. The properties attributed to the fruit of "soothing (and) to sleep" has been confirmed as resulting from reduced blood pressure sustained



by dilation of the blood vessels; acting on the autonomic nervous system, this facilitates the spontaneous onset of sleep. The decoction made from the Casimiroa also contains another substance possessing powerful properties as a constrictor of the womb, which explains why this plant is not prescribed for pregnant women.

Plants with anti-parasitic properties:

Chenopodium ambrosioides, L. Chenopodiaceae. Known in Mexico by the name "Yapotzotl", its Spanish name Epazote and its US name American wormseed. It figures in the recipe of Mexican dishes and is widely used parasite-expellent. A herbaceous with a strong odour reminiscent of camphor and a sharp spicy flavour, it owes its anti-parasitic activity to the volatile oil with a concentration of 0.35 per cent contained in its leaves.

It also contains such alkaloids as quenopodine, colina and tannin, as well as ascaridole. Its effects are powerful and the grammes of the plant administered in the form of a decoction suffices to produce a rapid parasite-expellent effect without apparent side-effects. Toxicological considerations will require further study. Traditional medicine also uses two other kinds of Chenopodium—foetidium and graveolens for the same purpose.

Cucurbita maxima, D. Cucurbitaceae. The seeds of pumpkins cultivated in the hot lowlands of Mexico are used by local people in the form of an aqueous emulsion, or as a refreshing drink mixed with sugar, for treating various intestinal parasites. These remedies have proved effective against tapeworm. They are also used to treat different forms of intestinal parasites since they are often, though incorrectly, substituted for the seeds of Cucurbita pepo L., which has similar but much less specific properties.

Plants with anti-diabetic properties:

Tecoma mollis, H.B.K. Begoniaceae. Under a great variety of popular names, depending on the region of origin, the "nixtalaxochitl" refers as much to T. Mollis as to T. Stans, all well-known in traditional medicine for their anti-diabetic action. It is often associated with Leucophyllum tenaxum, which is similarly employed. Pharmacological studies have shown that aqueous extracts of Tecoma administered orally cause an increase in the level of glucose in the blood and thus help to palliate the types of diabetes for which this treatment is particularly indicated.

Coutarea Latiflora, D.C. Rubiaceae. Commonly called "Copalchi", the bark of this shrub is traditionally known for its anti-diabetic effect. Its diuretic properties in particular are valid for diabetics, and the increased volume of urine eliminated is accompanied within 24 hours by a diminution in the amount of glucose secreted, and results in a general improvement in the patient's condition. Traditionally the bark is used in powder form decocted in alcohol and administered orally.

There are many such representative examples of traditional medicinal plants. The more they are investigated and studied in the light of a science which once more reverts to serving the public good, the more they will contribute to the development of a system of medicine adapted to the needs, the cultural demands and the overall health of our country. ■

The science of life

BY P. N. V. KURUP

Human nature instinctively seeks relief from pain and disease. This basic instinct prompted man, through the ages, to analyse the phenomenon of nature and obtain clues to help him ameliorate pain and disease. His experiences led to empirical methods of healing which in due course crystallized into distinct systems of medical practice.

Although modern or "western" medicine is generally accepted throughout the world, yet it has not been able to reach the remote rural areas of the world for various reasons. The developing countries, with their meagre financial resources, cannot avail themselves of the services of modern medicine in view of the huge investment involved in establishing and maintaining modern clinics and hospitals. The traditional systems of medicine, however, still tend the health needs of most rural populations of the world, and find patronage also in urban areas.

The traditional healers, herbalists, spiritualists, and birth attendants constitute a vast resource of practitioners outside the official health services. Their methods of diagnosis and treatment vary from region to region, and some of their practices are similar to modern medicine. For example, in certain tribal communities the traditional healer applies his ear close to the patient's chest to listen to the heart beats and diagnose disease.

Such practices as cupping, cauterization or showering mineral water over the head (for curing headaches), when administered by the practitioners, are said to be effective in curing metabolic and psychic disorders. In South-East Asia the chanting of mantras (mystic incantations) to cure jaundice and even snake bites is still a prevalent practice.

Such traditional methods, grounded in some kind of rudimentary medical practice, have mellowed in the course of time into well-defined and distinct systems influenced by local civilization, religion and tradition, and have evolved through trial and error, keen observation, intuition, accumulated experience, folk customs and ancestral beliefs. With the development of civilization these systems attained some scientific status. The concepts regarding the nature of disease and its underlying causes are based on the fundamental doctrines of each system. Whereas the early founders of modern medicine initiated the pattern of observing the sequence of symptoms for diagnosis and prognosis, traditional medicine had a highly developed science not only for diagnosis and prognosis but also for determining the cause and treatment of diseases. Urine, stool and sputum tests were conducted by traditional practitioners many centuries before these techniques were known to modern medicine.

A number of well-defined and well-developed traditional systems are prevalent in various parts of the world. Among them, Ayurveda, Unani and Chinese medicine occupy the foremost place as the most ancient and best developed of these systems. Nature cure and Yoga also have followers in many parts of the world for their therapeutic value and in general as a means to maintain positive health and well-being.

Ayurveda literally means the Science of Life. The doctrine of Ayurveda postulates life as the union of body, the senses, mind and the soul; the living man or the man of action is said to be a well-balanced combination of three humours, seven basic tissues and three excretions. Everything in the universe including the physical body is composed of five elements or substances (panchabhutas), namely prithvi, ap, tejas, vayu and akasha. These elements combine in different proportions to suit the specific needs of different structures and functions of the body, whose growth and development depend on its nutrition, that is, on food which again is composed of these very elements that replenish or nourish the body. Man is therefore a microcosm within the macrocosm, the universe, since all the basic constituents of the universe are also present in him.

When there is an imbalance in any or all of these essential attributes of the body, the individual falls prey to sickness. The mind of a person is classified broadly into three categories—satva, rajas and thamas. This science also classifies the person according to his constitution and natural disposition into seven distinct types based on the three humours. The identification of these characteristics in a person gives important clues to the physicians as to how to treat the disease and bring the body back to its original harmony and health. Thus Ayurveda looks at the whole body and mind, and not merely at external or internal factors as the contributing cause of the disease, in deciding the appropriate remedy.

It is a fully developed science, with eight different branches covering the whole of medical science. A wide range of books written by scholars and specialists have enriched the classical and contemporary literature of Ayurveda. Its *materia medica* is stupendous and contains as many as 8,000 published recipes. This may be an under-estimate if unpublished recipes held as "family secrets" by traditional practitioners are also taken into account. Some 1,200 drugs are in frequent use either in the form of single drugs or as compound formulations. In the South-East Asia Region, as many as 800 pharmacies are active in the private and public sectors, and many employ

A patient undergoing Thirummal treatment, in which his body is covered with medicated oil and massaged delicately by hand or foot, one of the accepted techniques of Ayurveda, the "science of life". (Photo WHO/P. K. [illegible])

Cauterization, the application of heat, is a recognized form of treatment for certain mental disorders under the Tibetan system of medicine, which draws on both Ayurveda and Chinese traditional healing.
(Photo WHO/P. Kurup)

modern techniques for the manufacture of medicines. Traditional methods of preparing such drugs are so simple that they could be easily adopted anywhere in the world.

A broad spectrum of therapeutic methods and techniques available to this science ensures that it commands immense popularity. The Panchakarma treatment, involving five special techniques, is considered the most important for metabolic management and for providing detoxicating and purifying effects while conferring other therapeutic benefits. This is especially beneficial in the case of neurological disorders, metabolic diseases, digestive disorders and respiratory ailments.

Rasayana chikitsa is another technique which not only rejuvenates the body and enables the patient to live longer, but also builds up resistance against various diseases.

A few other techniques which are of comparatively later origin deserve mention. Ayurveda recognizes certain vital centres in the human body which are termed marma. To treat diseases in or originating from these marmas, certain highly effective techniques are practised in South India. The process, called Thirummal, consists of applying medicated oil all over the body followed by various types of delicate massage not only by hand but by foot as well.

Pizhichal and Navarakizhi are other ways of treating various diseases of the nervous system or of musculo-skeletal origin and other chronic conditions. Pizhichal is a process in which the physician drips medicated oil in a thin continuous stream at constant temperature and pressure on to the body and immediately applies massage. In Navarakizhi, a certain variety of rice is cooked in a mixture of herbal decoction and milk, and the jelly-like semi-solid mass is then tied up in a small cloth sac. The practitioner massages the patient with this sac, moistening in from time to time by dipping it into the same hot herbal decoction.

The Unani System owes its origin to Greece but has absorbed a great deal from native medical systems during its long journey through the Arabian countries. This is again based on the theory of the humours. The temperament of each individual is expressed according to the preponderance of these humours, and drugs are determined according to the temperaments. As in Ayurveda, Unani physicians attach great importance to diet as well as medication.

The Siddha System of medicine practised in Tamil-speaking parts of South-East Asia also has a long and rich tradition. Its unique feature is that it makes extensive use of minerals and metals, especially mercurial preparations, and has made notable advances in developing organic compounds for treating various diseases.

The Tibetan system of medicine has drawn considerable knowledge from Ayurveda and has been influenced by the Chinese system. It also makes use of drugs of plant, mineral and animal origin. Cauterization at special points in the head is carried out by Tibetan practitioners in treating mental disorders.

Pulse examination has attained a high degree of perfection especially in the Ayurvedic, Unani and Tibetan systems, which have established a correlation between pulse behaviour and humoral imbalance. The institutionally trained traditional practitioners now take advantage of modern diagnostic aids in their day-to-day practice.

Within many of these traditional systems, facilities are available for imparting systematic and comprehensive training at graduate and postgraduate levels. In fact institutional training is almost a century old in this region. In India alone there are about 500,000 practitioners, a quarter of whom have received regular training in recognized institutions. Such number about 115. Of these, 98 colleges exclusively offer training in Ayurveda, and most are affiliated to the universities. The curriculum and the period of training in most of these institutions in India have now been made uniform. The degree course in these systems is spread over a period of five and a half years, including an internship of one year.

The students are also instructed in modern practice in some of these institutions, though most of the time is devoted to teaching subjects within the medical system concerned. Other practitioners have acquired professional knowledge and skill through their forefathers by working as apprentices under hereditary practitioners; 239 hospitals and 1,000 dispensaries offering treatment in these systems also exist in India.

In integrating these systems within a national health care programme, the first task should be to make a proper appraisal of the manpower available to traditional systems of medicine, its competence and its capacity. Appropriate training in the shape of refresher or

rientation courses should then be of-
ed to the different categories of tradi-
nal practitioners. For example in the
ining programme for birth attendants,
mphasis should be on basic education
egarding pregnancy and childbirth,
ygiene, gynaecological complications
nd the basic principles of infant and
hild care. After providing appropriate
ining, all this medical expertise can be
orbed into the main stream of general
lth services for the rural population,
hat the largest number of people can
enefit from an effective and person-
lized service.

These traditional practitioners com-
nand the implicit faith and confidence of
heir rural clientele, as they form an
egral part of the village life. They can
t most of the common ailments
ch constitute almost 80 per cent of
eases. Treatment in these systems is
uch cheaper, and is especially effective
dealing with chronic ailments, allergic
onditions and psychosomatic diseases.
hey make use of locally available herbs
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ing the decoction to be taken by the
atient. The services of traditional heal-
s and practitioners could therefore be
tilized with advantage at primary health
ntres in remote rural areas.

If the health care delivery system is to
ch the maximum number of people in
shortest possible time, and is to
me a real instrument in alleviating
uman suffering, an open-minded ap-
roach devoid of rigid dogmas is called
r. No single system can thrive or be
seful to all irrespective of its origin,
cation or merit. Anything that is good
all these systems should be made
lable, while false claims or ineffective
ctices and faulty approaches that may
currently in vogue should be eliminat-
through intensive and systematic
search.

In our anxiety to make an effective,
mprehensive community health service
ailable as soon as possible to the max-
m number of people, the available
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cal practices should not be over-
ked. In order to reach the masses in
e developing countries, there must be
oper planning as well as a building up
health care facilities with all the lim-
d resources available. Against this
ground the traditional systems of
cine and their rich heritage can play
l role as an additional or alternative
oach in a country's Health Delivery
ogramme. ■

Ayurvedic training

BY K. N. UDUPA

India is one of the few Asian countries where Ayurveda has been given due recognition as a system of medicine for providing health care to the people. Although there are references to Ayurvedic principles in Vedic literature written about 2000 B.C., the present available literature on Ayurveda starts with Sushruta Samhita and Charaka Samhita, compiled some time during the fifth Century B.C. From these ancient documents it appears that education in this science was initially imparted to highly selected groups of students.

In more recent times it has taken more than a century for a standardized and acceptable training programme to be introduced in most of the Ayurvedic colleges in India. The admission standard, and the duration of the course and internship training, are quite similar to the training in modern medical colleges. Thus after 12 years of education in science and humanities, five years of training in various Ayurvedic subjects are envisaged. Peculiar to this training is a thorough grounding in basic principles—the philosophical aspects of life, the body-mind relationship, the "humours" of the body and their function, including the best methods for leading a healthy life according to the body's constitution and the temperament.

The technical methodology of clinical examination is similar to modern medicine, the primary methods being the clinical history and a five-fold physical examination using the five senses. However, greater emphasis is given to the constitutional aspects of patients, their nutritional status and their psychosomatic integrity. The pulse examination forms an important part of the clinical methodology. The patient is examined and treated as a whole, unlike the modern medical approach where a large number of specialists may be involved simultaneously in such an examination.

The undergraduate curriculum comprises radiology, pathology, parasitology, microbiology and practical laboratory instruction. The Ayurvedic principles of surgery, gynaecology, child health and other allied subjects are also taught. The training in surgery includes the principles of management of different types of fracture, and various operative and palliative procedures for such conditions as urinary stones, piles, fistulae, goitre, lymphadenitis and hernia.

Students wanting to undertake further studies are admitted to postgraduate courses leading to the award of a Doctorate of Ayurvedic Medicine. These consist of three years of postgraduate training. In the first year, the postgraduates receive advanced training in applied basic medical sciences, both Ayurvedic and modern. In the second and third years they are allowed to specialize in one of the five major disciplines—internal medicine, Ayurvedic surgery, obstetrics and gynaecology, materia medica or the basic principles of Ayurveda.

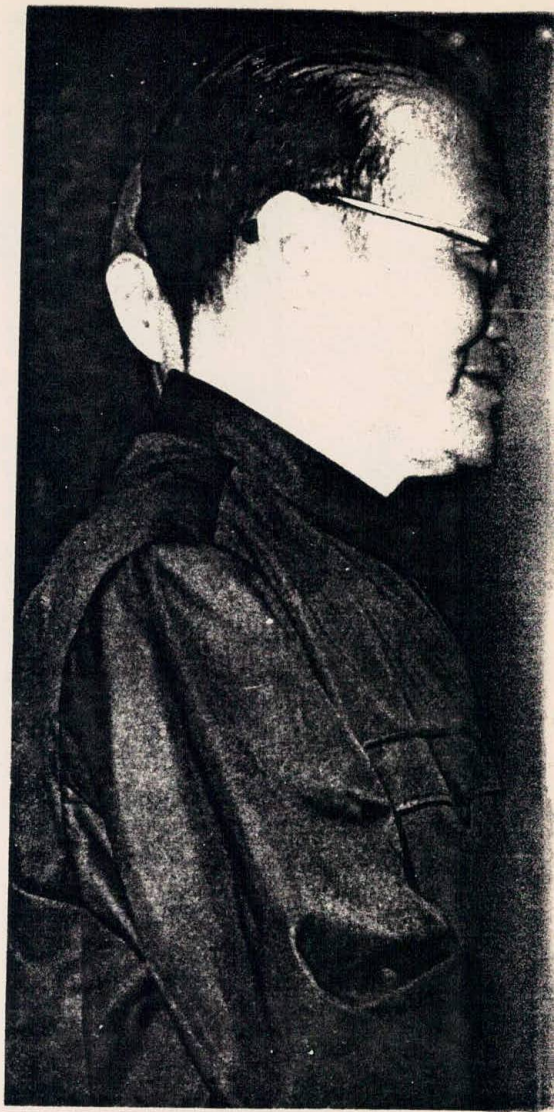
Doctor of Philosophy degrees in various specialities can also be obtained at some universities. This has led to considerable output of research material which could prove very useful in modernizing Ayurvedic investigation and treatment.

Thus training in Ayurveda, both at the undergraduate and postgraduate level, has undergone a rapid change in recent years. Modernization continues and in due course the difference between the pattern of modern medical training and Ayurvedic training will be minimal, to the point where trained Ayurvedic and modern doctors should prove complementary to each other. Their services could then be utilized for health care at various levels, and a better cooperative attitude between the two types of practitioners should contribute towards improving the health care of India's vast population both in urban and rural areas. ■

WHO's Programme

The approach will focus on the psychosocial and anthropological aspects of traditional medicine, on acupuncture and other healing methods, and on the claims made for herbs and medicinal plants

BY R. H. BANNERMAN



Traditional and indigenous systems of medicine have persisted for many centuries, even in parts of the world where modern health care is readily available. The idea of mobilizing the manpower component of traditional medicine for purposes of primary health care, particularly in rural areas, has been gaining ground in many countries in recent years. An initial beginning was made with traditional birth attendants, because of the acute shortage of trained midwives.

A meeting on the training and utilization of traditional birth attendants was held in 1972 at WHO headquarters in order to develop the kind of training programmes, research and studies that could improve the services of these workers in their respective communities.

In 1974 a joint UNICEF/WHO study on alternative approaches to meeting basic health needs in developing countries recommended the mobilization and training of practitioners of traditional medicine, including traditional birth attendants, for primary health care services. This was endorsed the following year by an Executive Board resolution and the idea was given support at the World Health Assembly in 1977, when a resolution sponsored by several Third World Member States was passed by acclamation for the promotion and development of training and research in traditional medicine.

Several Member States have already initiated training programmes for the traditional birth attendants, and orientation courses and seminars for other health professionals.

In 1976, WHO's Regional Committee for Africa had "Traditional Medicine and its Role in the Development of Health Services in Africa" as the topic for technical discussion. The Regional Committee for South-East Asia also adopted a resolution in the same year calling for the promotion of traditional and indigenous systems of medicine in the Region. This was followed by a seminar in Colombo, Sri Lanka, that made pragmatic recommendations about how to implement training, service and research programmes.

June 1976 saw the foundation at WHO headquarters of a working group for the promotion and development of traditional medicine. Its aim was to coordinate the various activities relating to the subject, and it prepared a programme with the following objectives:

— to foster a realistic approach to traditional medicine so as to promote and further contribute to health care;

— to explore the merits of traditional medicine in the light of modern science so as to maximize useful and effective practices and discourage harmful ones;

— to promote the integration of proven valuable knowledge and skills in traditional and modern medicine.

High priority will be given to the developing countries particularly with regard to primary health care within the context of the country's political structure, economic resources and development plans.

Execution of the programme will be effected in close collaboration with the regional offices and, primarily, at the

Dr R. H. Bannerman (right), Secretary of WHO's Working Group on Traditional Medicine, is greeted by Chinese Vice-Premier Chi Peng-Kuei during the recent Study Tour on Traditional Medicine in Community Health Services in China (see page 23) (Photo WHO)

country level and with active community participation.

The suggested approaches include the formulation of national health policies so as to contain provisions concerning traditional medicine and mechanisms of coordination, and better utilization of the useful elements of traditional medicine in the country's health care system. The administrative machinery required to ensure effective planning, utilization and supervision of practitioners of traditional medicine will be reviewed within the context of the national health care delivery system.

A questionnaire has already been designed for the collection of all available information concerning practitioners of traditional medicine, their training and services to the community. The analysis of information collected, together with the results of surveys and research findings, will no doubt assist us all in the development of meaningful training programmes for the various categories of practitioners of traditional medicine. Doctors, nurse/midwives, other health workers and students of health sciences will all be encouraged to undergo orientation in traditional medicine where appropriate.

Multidisciplinary investigations into systems of traditional medicine will be encouraged, and special attention will be given to laboratory and clinical investigations for identifying effective remedies, comprising medicinal plants, animal products and mineral substances. Investigations will also be conducted into the psychosocial and anthropological aspects of traditional medicine, as well as the mechanisms of acupuncture and other healing methods.

Wherever possible, priority will be given to the promotion and development of useful local resources such as herbs for the production of medicinal substances; such action should effectively reduce the drug bills of many developing countries.

Traditional healers and some modern physicians depend to a large extent on herbs and medicinal plants for treatment. The story of herbal medicines is a fascinating one—quinine, until recently, was the only cure for malaria; morphia remains a most effective pain-reliever; rauwolfia is still widely used for the control of hypertension and certain forms of psychiatric disorder, and herbal preparations have been used for many decades to treat rheumatoid arthritis. Recently, we have received serious claims that herbs are being used in China, tropical Africa and Central America for the control of diabetes mellitus. All these claims have to be investigated scientifically and authenticated.

There are clear indications of a major breakthrough in therapeutics and health care delivery, and those of us involved in the traditional medicine programme share fully the goal of our Director-General, that we should achieve total health care coverage for all people by the year 2000. ■

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New status for the hilot

When 75 per cent of births turned out still to be handled by hilots—traditional birth attendants—the Philippines' Department of Health decided to re-train them and bring them into the health team

BY AMANSIA MANGAY-ANGARA

Traditional birth attendants—*hilots*—have probably been practising their skills in the Philippines since the earliest history of the country's predominantly Malay population. This is suggested by the similarity of hilot practices with those of the *bidan* of Malaysia and the *dukun* of Indonesia. Such practices probably emerged out of the necessity for mutual help among womenfolk in the small villages many centuries before modern medicine was introduced to the country.

In the traditional village society there have always been such categories of indigenous healers as the herbalist, the bone setter, the faith healer and the hilot. The latter usually confines her activities to attendance at birth and to the care of the newborn child. Her services vary but often include offering such assistance with household chores as is traditionally demanded by good neighbourly practice in the village. It is largely through maintaining this combination of services to the mother, the child and the household that the hilot has survived and continues to be accepted by the local community to the present day even though modern health care has since become available to the rural population.

Unfortunately, the hilot's practices have time and again contributed to maternal and infant morbidity and mortality. She performs very few manipulations during childbirth; the newborn is passively received under cover of a cloth to conceal the mother's private parts. Although some complications in the mother may result from errors of omission by the birth attendant, such as failure to protect the perineum, others may follow acts of commission such as applying manual pressure on the fundus of the uterus to facilitate expulsion of the fetus, causing a subsequent rupture. In the case of the newborn child, errors of commission are frequent; it is common for the umbilical cord to be cut with a non-sterilized knife or bamboo blade and the application of some powder, chopped tobacco leaves or even dried horse manure on the cord dressing. Practices of this nature are responsible for the high incidence of tetanus of the newborn in the Philippines.

Until around the early 1950s the Government's general attitude had been to discourage hilot practice and to promote their replacement by trained licensed midwives. In 1954, the Department of Health reviewed the prevailing status of midwifery services and found that a large proportion of births (about 75 per cent) were attended by traditional midwives. While infant and mortality rates were high, available trained health manpower was grossly insufficient to meet the demands for midwifery services, particularly in the rural areas.

Largely as a consequence of these findings, and of the realization that while the country's population was rapidly on the increase its health resources were insufficient, a revised strategy was evolved.

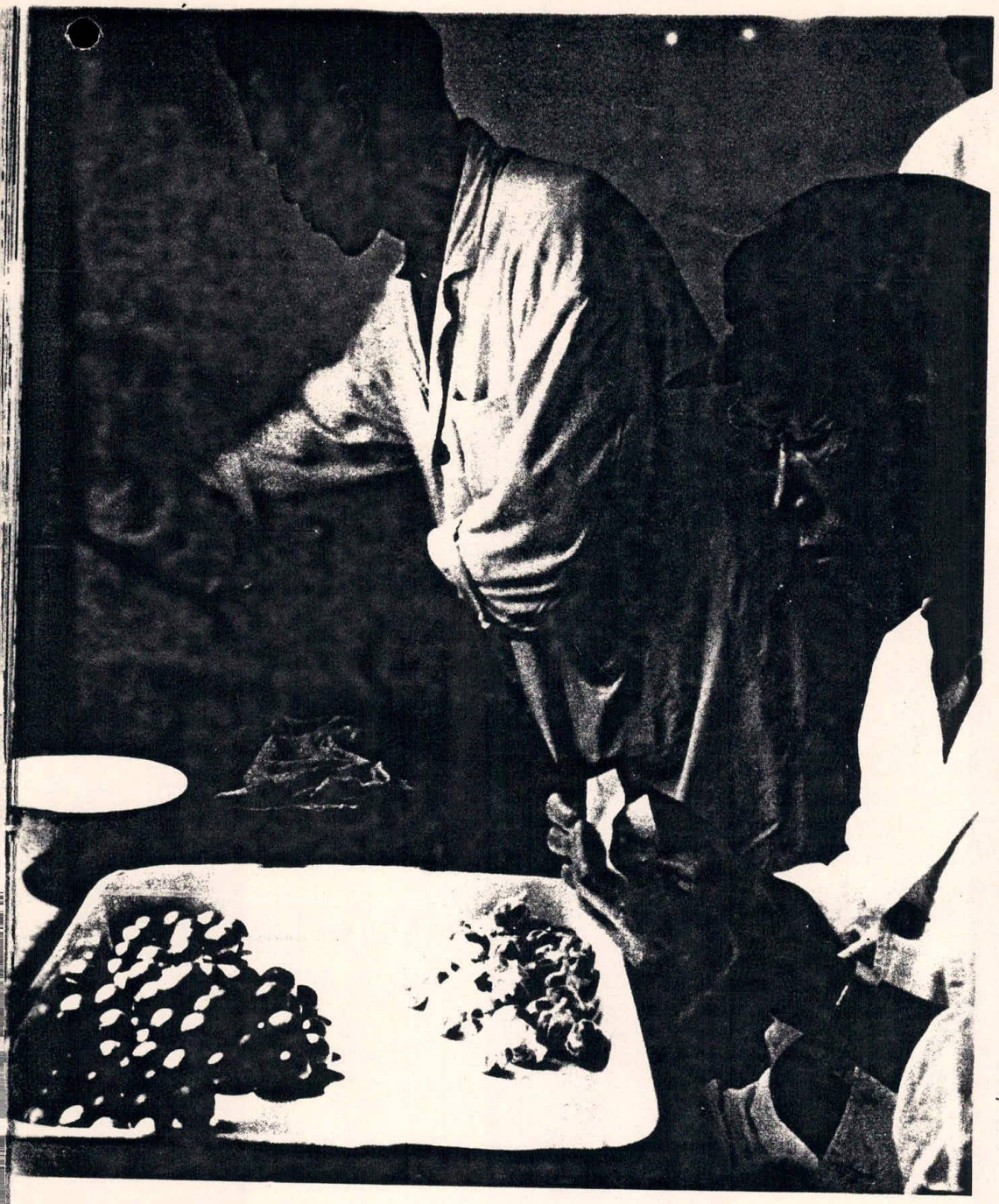
Rosa Raymundo, a traditional birth attendant, dons a plastic apron before bathing a newborn child, as she has been taught during special training. (Photo WHO/J. Abcede)

Traditional Birth Attendants

Still the greatest barrier to realizing the proper potential of traditional birth attendants (TBAs) today is the resistance of some professional health workers. But TBAs still deliver two-thirds of the babies in the world.

In Asia, Africa and Latin America they are accorded, for the most part, very high prestige in their villages. Several countries have already started on-going training programmes for these women, to ensure that they offer safe midwifery practices where they will be most effective. Other countries are beginning to encourage them and give them additional training so as to gain for them increasing involvement in primary health care activities.

Several countries have also tried to explore their full potential in family planning programmes. They have proved capable of making useful contributions to family planning communication activities in Indonesia (where they are known as *dukuns*), Malaysia (as *bidans*), Mexico (as *parteras*) and India (as *dais*). There is probably no reasonable alternative for government maternal health and family planning programmes but to join hands with TBAs. The findings and recommendations of various studies have repeatedly shown that they enjoy a relatively high degree of credibility in the eyes of villagers and the urban poor, while their potential for incorporation as partners in public health work is a very practical reality.



Left: *The simplest of equipment suffices to prepare traditional herbal medicaments and roll them into pellets. The pharmacopoeia of traditional Chinese medicine has long proved to be a great storehouse of knowledge.*

(Photo WHO/R. Bannerman)

Right: *Health students practising acupuncture techniques on each other. An acupuncture needle carefully planted above this girl's nose will act as a local anaesthetic. The application of acupuncture for local and general anaesthesia is well developed in China, and is used even for major abdominal operations.*

(Photo WHO/L. Ambrose)

We saw the highly successful treatment of extensive burns in the general wards by the application of only one set of surgical dressings medicated with medicinal herbs and without resort to specially equipped intensive care units; the management of fractures by employing small padded splints; and the care of patients with acute abdominal conditions such as perforated peptic ulcer, appendicitis and extra-uterine pregnancy – all of these by combined traditional Chinese and "Western" methods. All these could be readily replicated in many developing countries. The techniques for preparing medicinal herbs and plants as powders, tablets and liquid extracts using relatively simple locally manufactured equipment proved of great interest to us. What might perhaps be more difficult to emulate is the capacity for hard work, resourcefulness, motivation and discipline we encountered in every community we visited.

WH: *Is the famous barefoot doctor part of the traditional system or is he regarded as a totally modern phenomenon of Chinese public health?*

BANNERMAN: The well-known barefoot doctor is very much part of the traditional Chinese system. They used to be called "peasant doctors", but acquired the title "barefoot doctor" not because they walk barefoot but as a reminder of the fact that many of them spent a greater part of their time with other members of the community in the rice-paddy fields.

Barefoot doctors are trained in the first instance for six months, and those who show keen interest in health work and wish to follow it as a profession can become fully qualified doctors through further training in colleges. Work as a barefoot doctor has now become an important entry point to medical college and university. On the average, they spend about two-thirds of their time each year in agricultural work and industry and the rest in health work. They are very much a part of their community and are selected initially for health work by members of the community.

WH: *Your colleagues during the Study Tour came from all parts of the world. Do you feel that they had ideas to offer which China might find worthwhile taking up and adapting?*

BANNERMAN: We were asked this question in various forms during the tour. None of us could really make any con-

Left: *Hilot Asuncion Saginsin pays a prenatal visit to a patient. The Philippines' Government has introduced a teaching programme to make hilot practice safer for mothers and to encourage the traditional birth attendants to seek guidance from trained health personnel when needed.*

Right: *Nurse Felicitas Bautista graphically explains to a class of hilots-in-training the basic steps to be taken when attending deliveries.* *(Photos WHO/J. Abcede)*

This included some concessions to hilot practice in localities where the services of practising physicians or registered midwives were not available. Within this new policy frame, traditional birth attendants would receive such training and orientation on hygienic procedures and routine midwifery practices as would promote the safety of the mother and the newborn child; they would also be given health staff supervision and guidance in the course of their work.

In 1954, with WHO and UNICEF assistance, the Department of Health initiated the training of hilots as part of the country's midwifery training programme. Priority was given first to staff involved in teaching and supervision such as nurse-midwife supervisors at the central level, then at the regional and later at the provincial and local levels. This was followed by a teaching programme to make hilot practice safer for mothers and to encourage the birth attendants to seek guidance and assistance from the trained health personnel.

This training was first conducted by a provincial nurse supervisor who had herself undergone training under the midwifery training programme. Her understudy was a nurse or midwife of the rural health unit or puericulture (mother and child health) centre, who took over as instructor of subsequent hilot classes.

The classes are usually organized in groups of ten, and the course consists of 12 weekly or bi-weekly meetings each lasting three hours. Instruction is given in the local dialect. A hilot who satisfactorily completes a course is given a UNICEF midwifery kit and issued with a record book to insert the necessary information needed to register the birth of the child she has delivered or report any birth which has not yet been registered. After training, the birth attendants organize themselves into a local association which holds monthly follow-up meetings. At these meetings, the nurse or midwife of the rural health unit inspects their kits and evaluates reports of their activities.

Now that official recognition has been given to the trained hilots, and with the increasing acceptance of the health auxiliary or aide in providing health care, the hilot is being encouraged to get herself involved in a wider variety of community health activities. These include helping to notify communicable diseases, organizing mothers' classes, registering births, helping to arrange mother and child referrals to the health centre or hospital, participating in the housekeeping at the health centre, assisting in community immunization round-

and collaborating in the family planning programme by motivating mothers to following up those who accept the services. On the whole, hilot training and the broadening of her participation in community health work have forged stronger links between the traditional birth attendant and the local health staff. She has thus become an important service in the local health service even though she is still not a member of the health team. She receives neither compensation, honorarium nor daily wages for her services. The remuneration she receives from the mother may be in the form of a gift or sometimes in cash, but more often her services amount to simple acts of goodwill and good neighbourliness.

Government's goal of ultimately replacing the hilots with licensed midwives remains unchanged. But considering the limited resources and the magnitude of existing health problems, it will take some considerable time before the Government's goal can be achieved. Therefore the stop-gap arrangements for training the hilot and involving her in health services are proceeding with more active Government support as well as the endorsement of various sectors of the local community. Increasing attention is being given to the hilot as a potential health manpower resource capable of being trained and guided to respond to local community health demands, particularly for mother and child care.

With a view to obtaining more accurate information about the hilot manpower resources in the country, the Department of Health carried out a nationwide survey in 1974 with the help of a WHO grant. The objective was to obtain information on the number of traditional birth attendants in practice, where they live and other useful data which would enable central and local hilot registries to be drawn up. More than 31,000 hilots—both men and women—were identified. On the basis of the findings it was calculated that the total number who were in practice was between 38,000 and 40,000, or roughly a ratio of one hilot for every *barangay*—the smallest local administrative unit with an average population of 1,000 to 2,000. The registries that have since come into existence will help in identifying those birth attendants who need training and in locating their homes, and will thereby facilitate their supervision by the local health personnel. The registries will be kept constantly up-to-date and will furnish other useful information which will help in designing the hilot training courses in the coming years. ■

Study Tour in China

Community health specialists and senior health administrators from 29 developing countries c verged on Peking in August to begin a Study Tour on traditional Chinese medicine arran under the auspices of WHO and UNDP. Dr Bannerman of Ghana acted as Team Leader to group, and is also the Secretary of the Working Group on Traditional Medicine at WHO he arters. On his return to Geneva he was interviewed for this special issue of *World Hea*

WH: *Dr Bannerman, what was the objective of this Study Tour involving so many senior health officials from the developing countries?*

BANNERMAN: The main purpose was to give participants the opportunity to study how China has harnessed its precious legacy of traditional medicine to the needs of its vast rural populations, and has combined the traditional Chinese system with "Western" medicine. The group had the opportunity to study the training of health personnel including practitioners of traditional Chinese medicine and the barefoot doctors. We also learnt something about the use of medicinal herbs, the preparation and production of pharmaceuticals and the use of special methods such as acupuncture for treating various disorders and for anaesthesia. The study was in fact multisectoral, and we were exposed to agricultural and irrigation projects, housing schemes, rural development and so forth.

WH: *One gets the impression that the division which is very noticeable in the rest of the world between "orthodox" and "traditional" medicine is much less pronounced in China. Is this the case, and to what degree has the older system been integrated with more modern aspects of medicine?*

A veteran herb grower shows a team of medical workers how to distinguish medicinal herbs during a plant-gathering session on the slopes of Mount Huangshan, China.

Photo WHO/Chinese Ministry of Health)

BANNERMAN: As was emphasized by the late Chairman Mao, traditional Chinese medicine has a great storehouse of knowledge. Chinese pharmacology is therefore being integrated and various institutes and hospitals for the practice of Chinese medicine have been established.

At the first national health conference held in 1950, three principles were adopted: firstly, to serve the workers, peasants and soldiers; secondly, the prevention of disease; and thirdly, integration of traditional Chinese and "Western" medicine. In 1953, Premier Chou En-Lai endorsed the fourth principle: "to combine health work with mass movement". The people are educated to combat disease by themselves and not to rely exclusively on health workers.

The difference between "orthodox" and "traditional" medicine is therefore much less pronounced in China. Many of the orthodox-trained doctors receive orientation in traditional Chinese medicine and practise both systems. It has therefore become difficult to draw a definite line between the two. Their attempts at integration have evolved into what they now call the 'New' traditional Chinese medicine, which can be described as the application of modern scientific principles to the traditional Chinese system. The integration of traditional Chinese and modern medicine is now an established policy and is by no means an expedient. Veteran practitioners are involved in shaping the 'New' traditional Chinese medicine. Some teach in medical colleges and are often consulted in matters relating to medicinal herbs and plants.

In 1965, priority in health work was given to the rural areas where 80 per c of the population live. The doctors now community oriented and 70 per c of the graduate doctors work in ru areas. The "mass-movement" has b responsible for the virtual extinction the four pests—rats, flies, mosquitos a bed-bugs.

WH: *What did you see which might regarded as the kind of simple medi technology that might well be transfer to and adapted by other countries?*

BANNERMAN: Offhand, I would say t use of acupuncture for the treatment disease, the relief of pain and for pu poses of anaesthesia. About 70 diseas can be treated with acupuncture alo and some 200 when used in combinati with herbal medicines. Training in t use of acupuncture is essential, if t transfer of this technique is to be tru beneficial. The equipment is relative simple and, in essence, all that one nee is the acupuncture needle which can inserted into the appropriate point an rotated to and fro with the index fing and thumb. But recently an electric machine has been developed which intr duces regular electrical pulsations to t needle and thus produces the desire effect.

The application of acupuncture fo purposes of local and regional anaesth sia is well developed. Many procedur on the head and neck, such as dent extractions, and eye, ear, nose and thro operations were demonstrated. We als saw major abdominal operations lik total hysterectomy and prostatectomy- all under acupuncture anaesthesia.

suggestions. We have to remind ves that China has a population of estimated 850 million. The basic ecessities such as electricity, water supply, adequate sewerage and refuse disposal were available equally in both urban and rural areas. The people appeared well nourished and adequately : everybody was well clothed and wore rags or went barefoot. We old that there was total employment with generous pension schemes for omen at 55 years and men at 60, adequate educational facilities and, of ourse, total health care for all. There as no evidence whatsoever of the inflaonary trends that have recently gripped e of the world. In a situation like its could only marvel and wish a ter people greater success.

There could, however, be greater echanization especially in agriculture—provided that did not cause unemployment in any way. I personally considered the absence of private motor cars from the roads a great boon, and the use of bicycles contributory to good health.

WH: *It will no doubt take some time for the ideas exchanged during the Study Tour to be evaluated. What use is WHO going to make of its new view on traditional Chinese medicine?*

BANNERMAN: We prepared a questionnaire for the participants before the tour started and happily there was 100 per cent response. Every participant stated that the tour was truly worthwhile and should be repeated for other, smaller groups on a yearly or even twice-yearly basis. Many took the opportunity to re-examine their own priorities and decided that national priorities in several countries required urgent review. Health problems were never presented in isolation and the part played by agriculture, housing, jobs, water supply, and education (academic, technical and political) were all very obvious to the discerning eye. The developing countries certainly have a great deal to learn from China, and WHO could well make an in-depth study of the 'New' traditional Chinese system, particularly in terms of cost benefits and technical cooperation, with a view to adapting the system for use in various developing countries that might be interested.

The most attractive feature to us from the developing countries is the extent to which China has improved the quality of life of her people and achieved total health coverage within one generation. There is no such parallel in ancient or modern history. China is unique! ■

Plants that heal

Plant screening has often yielded poor results because traditional healers were not involved; but the advice of good healers ensures at least a 50/50 chance of success

BY OKU AMPOFO

When, some years ago, I started showing interest in African traditional medicine, like many other investigators in this field I doubted the efficacy of any of the claims made by our local healers. Time soon proved me wrong, and luck too came to my aid. It was not difficult to establish contact with two well-known herbalists in my district and they were most willing to pass on their age-long knowledge. They were both octogenarians with long years of practice behind them and were trusted and respected by their patients.

I also learned to respect them for their wide knowledge of plants and diseases, their frankness and wealth of human experience. Every other week I would go with one of them into the bush, collect plants and learn about their uses. These old herbalists were great botanists and knew something about every plant we saw in the bush. They each identified at least 200 plants with healing properties.

These traditional herbalists treated a wide variety of diseases and injuries, apart from offering maternal and child care. One day, one of our modern-trained district midwives was faced with a case of severe post-partum haemorrhage, and she later told me that she actually ran to find a taxi to carry the patient to my clinic. On her return she was surprised to see the patient washing her baby. Her bleeding had been arrested by one of the old herbalists who lived a few yards away. It was this incident which first put me in touch with this herbalist. I later learnt of some interesting cures from other local herbalists, found out about their methods and tried them out in my practice. As Director of the new Centre for Scientific Research into Plant Medicine in Ghana, I now have greater opportunity for doing clinical trials with traditional methods.

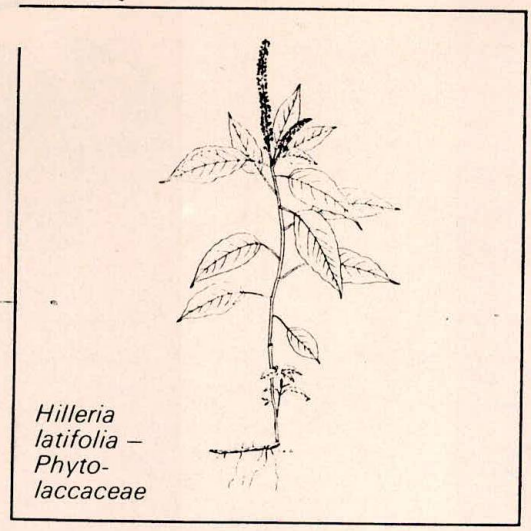
It is my contention that to achieve any success in the field of research into traditional medicine, we have first to acquire our knowledge from the traditional healer himself, try out his methods clinically and then, if successful, subject them to scientific analysis. Many plant screening programmes have not yielded any fruitful results because traditional healers have not been involved in these trials; but experience shows that with the advice of the good healers there is at least a 50/50 chance of success.

In our clinical trials with medicinal plants, our aim has not only been to find cures for diseases in which "Western" medicine is ineffective but also more particularly to find substitutes for i ported drugs. Here are two examples.

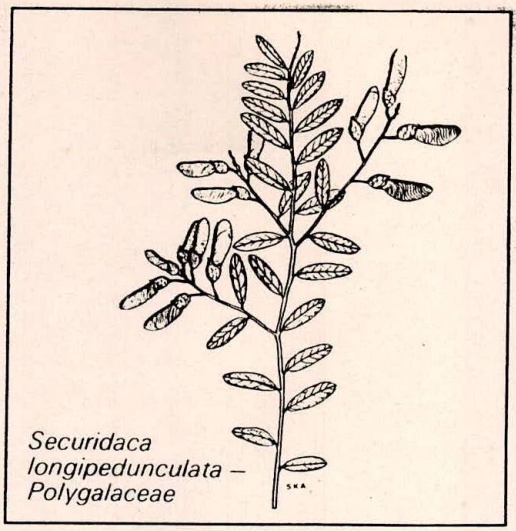
The Public Health Department of o Medical School recently asked us to h them to fight an epidemic of guine worm in three nearby villages. In p vious years, attempts had been made treat the yearly epidemic with a com nation of procaine penicillin and d ferent proprietary drugs. The 88 peo involved in this trial included 18 ch dren, 20 bed-ridden adults and 50 amb lant adults. These were divided into t groups of 44 people each. The first gro was put on a decoction of pieces of r of *Combretum mucronatum*, a kno worm-expeller, at a calculated dose .03 gm/kilo. The second group was gi a decoction of *Mitragyna stipulosa* wh looks like *Combretum mucronatum*; t calculated dose was .06 gm/kilo. Patie were examined twice weekly.

After one week, examination revea that there was complete extrusion of t worms in 43 out of 44 in the first gro (i.e. 97.7 per cent) and there was mark reduction in the inflammation arou

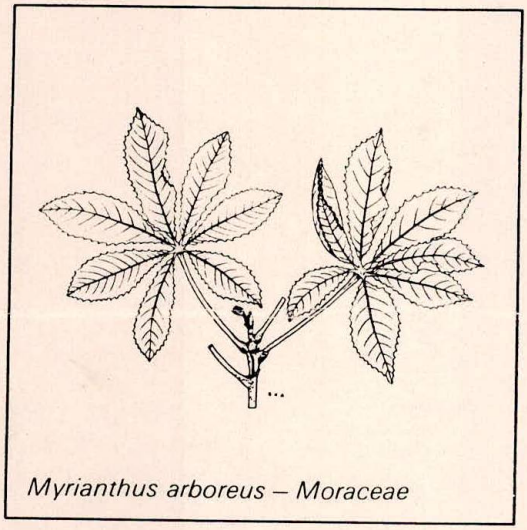
Herbalists at a centre for African traditio medicine learn how to prepare and proc roots so as to make the best of their hea properties. *(Photo WHO/R. da Si*



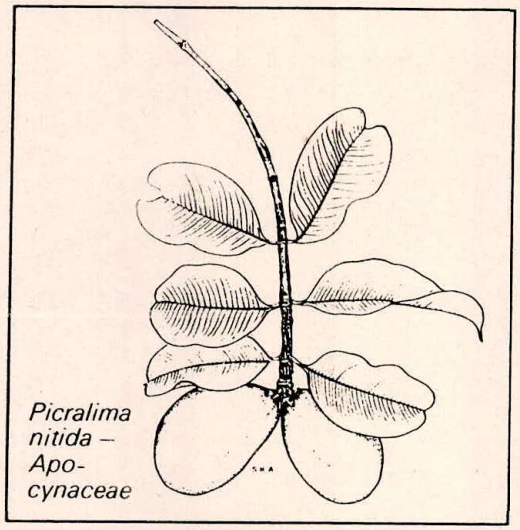
Hilleria latifolia – Phytolaccaceae



Securidaca longipedunculata – Polygalaceae



Myrianthus arboreus – Moraceae



Picralima nitida – Apocynaceae

Left: *Hilleria latifolia has been proved as a filaricide in cases of guinea-worm infection. The bark of Securidaca longipedunculata is useful in treating psoriasis and also has convulsive properties. Myrianthus arboreus decoction made from its bark appears effective against diabetes. When suitably prepared root of Picralima nitida can heal the disease herpes zoster in the space of weeks.*

Right: *This woman has come to consult healer at a centre for traditional medicine. Such healers are respected in their local communities for their wide knowledge of plants and diseases as well as for their understanding and wealth of human experience.*

(Photo WHO/R. da Silva)

the lesions. The wounds healed completely after two weeks with local application of sterile palm oil. In the second group, there was complete extrusion of worms in 23 out of the 44 cases (i.e. 52.2 per cent), with healing of the wounds after local application of palm oil in two weeks. Thus, it was proved that *Combretum mucronatum*—as the traditional herbalists claim—is indeed a true expellent of guinea-worm.

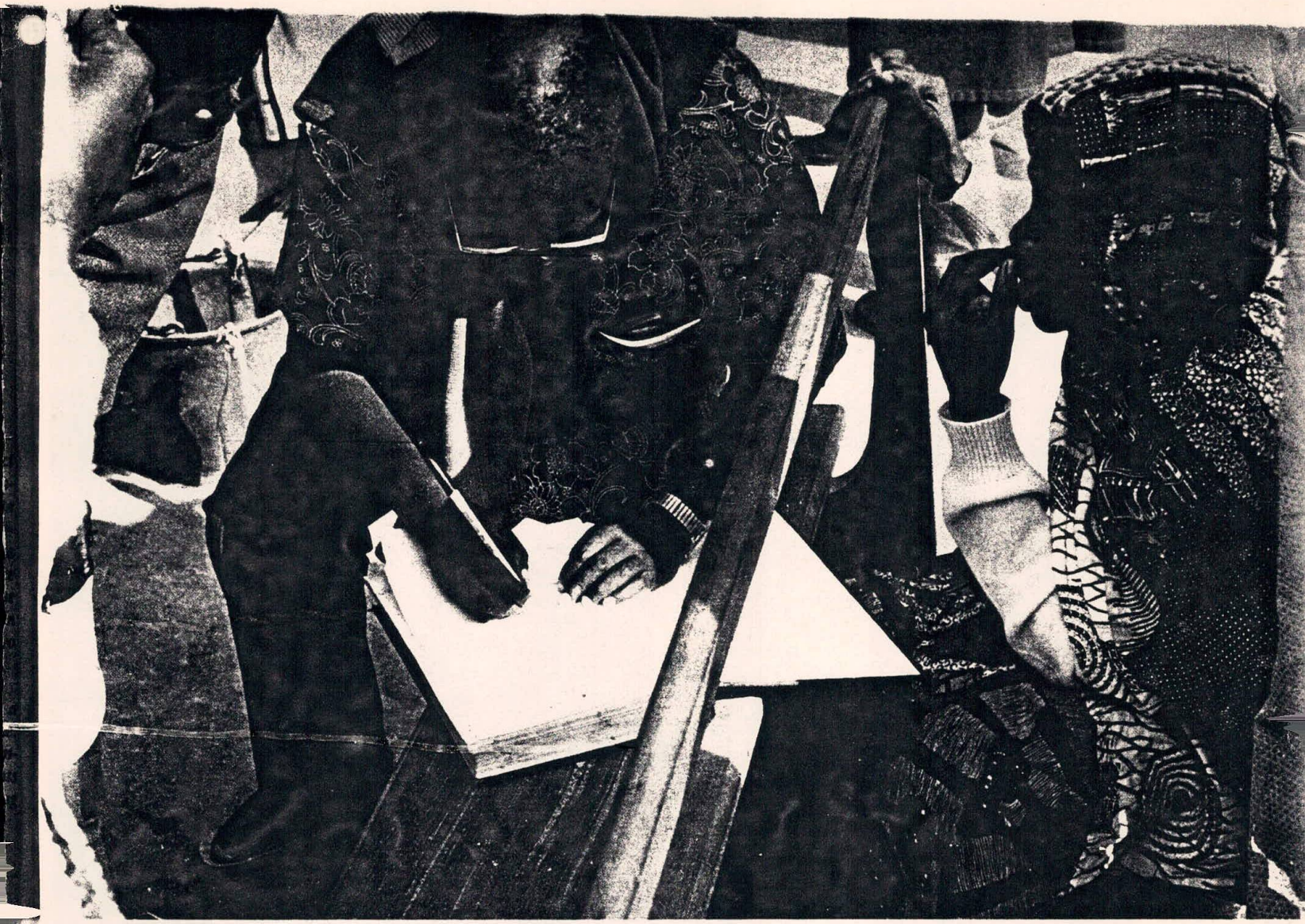
We were also able to prove that the leaves of *Elaeophorbia drupifera* and *Hilleria latifolia*, taken in combination in a palm soup preparation, act as a filaricide in guinea-worm infestation.

Skin diseases have particularly engaged our attention and we have had success in the treatment of coccal infections, epidermophytons, allergy and herpes zoster. Four traditional treatments of herpes zoster are particularly interesting. The local application of the flowers of *Hoslundia opposita* and red cola nut, chewed together and sprayed on the lesion twice a day, often heals it within a fortnight. The local application of guava leaves, ground into paste with kaolin or white clay and *Piper guineense* twice a day, heals the infection in about ten days. Alternatively, the root of *Picralima nitida* is charred with *Piper guineense* and ground into fine powder, mixed with kernel oil and applied to the infected area with cotton wool twice daily; for internal application, the black powder is mixed in alcohol and taken, one dessertspoonful thrice daily, to allay pains; this treatment is very effective and healing takes place in 10-14 days. But perhaps the most dramatic form of treatment is the use of the root bark of *Balanites aegyptiaca*, ground into fine powder, then made into a paste with water and applied to the infected area morning and night; healing occurs from five to seven days. A similar result is obtained with *Securidaca longipedunculata* root bark, which is also useful in treating psoriasis and possesses anti-convulsive properties.

Guinea-worm and herpes zoster are some of the diseases for which modern medicine has so far no effective remedy. Traditional African medicine appears to be more effective.

Two other diseases for which tra[di]tional African medicine appears to [be] more effective and less risky than mo[d]ern medicine are diabetes mellitus a[nd] bronchial asthma. For some years no[w] we have been studying the work of he[r]balists who treat diabetes mellitus, so[me] of whose remedies come mainly fro[m] herbal preparations. In particular, th[e] anti-diabetic activity of herbs of t[he] *Loganiaceae* family has been confirm[ed] by our University of Science and Te[ch]nology. One teacher herbalist claims [a] high as 75 per cent of "cures" among hi[s] diabetic patients treated with the *Log[a]niaceae* family. He has successfully trea[t]ed a patient who developed gangrene a[nd] ketosis even though he was on insul[in] injections. A thorough investigation int[o] the anti-diabetic property of the *Lo[g]niaceae* seems to be called for.

The combination of *Canthium* [sp.] *Myrianthus* bark as decoction or alcoh[o]ic "bitters" also appears effective. [A] patient had his diabetes mellitus arre[st]ed when he was treated with this extract [for] two months. His fasting blood sugar [has] been normal since. Another colle[ague]



who practises dentistry in England persuaded a physician friend to try the alcoholic extract on two English patients with juvenile diabetes five years ago. After two months treatment, it made no impression on one case but the second improved considerably and her fasting blood sugar has remained normal ever since. They were both on insulin. *Costus schlechteri* is another plant claimed by some herbalists to be effective against diabetes mellitus, and our observation is that this plant is effective in some early cases.

I am in the use of *Bridelia ferruginea* for controlling diabetes mellitus that I have required more experience and hope for the treatment of diabetes. Of the 12 cases under treatment, I have selected three as showing typical reactions to the plant.

Patient M. A., a woman aged 49 years, reported in May 1976 and had been receiving insulin injections, 44 units daily for the last two years. Her fasting blood sugar was 242 mgm/100 ml. The patient looked worried, did not want any more insulin and preferred herbal treatment. She was put on one dessertspoonful of powdered *Sclerocarya birrea* leaves twice daily but at the end of the third week, her fasting blood sugar had risen to 340 mgm/100 ml. Treatment was discontinued and the patient was put on a chlorpropamide preparation, 250 mg twice daily for ten weeks. There was mild improvement but the patient wanted to try another herbal treatment. In August 1976, she was put on *Costus schlechteri* as recommended by a herbalist. Her fasting blood sugar rose to 250 mgm% and it was decided to try *Bridelia ferruginea*—ten leaves boiled with one pint of water, one teacupful to be taken three times daily as recommended by a herbalist. There was a steady lowering of the fasting blood sugar till it became normal after 12 weeks, and it has since remained normal.

Patient L.B., a woman aged 45 years, reported for treatment of her hypertension. Routine examination revealed that she had diabetes mellitus with fasting blood sugar of 370 mgm%. We decided not to give her any "Western" drugs and put her straight on *Bridelia ferruginea*—20 leaves boiled in a pint of water, one teacupful being taken three times daily. After one week the fasting blood sugar came down by 120 mgm% and continued to fall till it became normal after 11 weeks. It has since remained normal. Incidentally, no treatment was given for her hypertension which also automatically fell from 180/90 to 140/90.

Mrs T.O., aged 59 years, is another typical case. She has been a diabetic since 1969, and first reported to us in April 1975 for a prescription for more of the proprietary tablets which she had been taking daily. Her fasting blood sugar was 252 mgm% and it ranged between 190 mg and 285 mg for 16 months until October 1976 when we decided to put her on *Bridelia* leaves. There was no significant change for three months and the dosage was increased by 50 per cent. After another two months, the dose was doubled as the fasting blood sugar continued to rise. There was still no significant change for two months and the patient was put back on her tablets. It was then discovered that the patient had been secretly taking both *Bridelia* and the tablets together and we concluded that

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Watched by two village women, a herbalist explains the contents of a pot of mixed herbs and roots to a visiting official (in white suit).

(Photo WHO/R. da Silva)

this may have accounted for the ineffectiveness of the former. It would appear that the traditional drug and the modern one acted as antagonists here. This is true of other patients who are over-anxious to get well and take both drugs, while patients who take alcohol during *Bridelia* treatment also show no improvement.

My own experience in the prophylactic use of plants for bronchial asthma will be supported by Professor Marian Addy, who has used the same materials in experimental animals. Drugs used for bronchial asthma in modern medicine are mainly applied during attacks whereas medicinal plants can be used prophylactically until attacks are well reduced or completely eliminated. Of the many plants available for bronchial asthma the following have been most widely used at our Centre: *Desmodium adscendens—Papilionaceae*, *Thonningia sanguinea—Balanophoraceae*, and *Deinbollia pinnata—Sapindaceae*.

The leaves of *Desmodium adscendens* can be given in the form of dry powder, one to two teaspoonfuls, according to age, in warm water in three divided doses per day, or it can be made into alcoholic extract. *Thonningia sanguinea* root is pulverized and dried. Two dessertspoonfuls of the powder are mixed thoroughly in ten ounces of honey and given in doses of one teaspoonful to one tablespoonful thrice daily. This too can also be prepared in the form of alcoholic extract. Dry, powdered *Deinbollia pinnata* root bark is used differently: one to two teaspoonfuls of the powder may be taken according to age in palm soup every other day for two to three weeks, and it can also be taken in soda water.

Each of these preparations is capable of deferring bronchial asthma attacks or even stopping them, especially in children. But the best result we have obtained at our Centre is the administration of a combination of *Desmodium adscendens* and either *Thonningia* or *Deinbollia*.

We undertook a "double blind" clinical trial during which 12 randomly selected patients were treated with placebo herbs, that is, drugs having no therapeutic value, for three months and then for a second period of three months with combinations of *Desmodium*, *Deinbollia* and *Thonningia*. The results were quite clear. All the patients continued to have asthmatic attacks during placebo treatment, but eight of them had no attacks during the herbal therapy. Some of the remaining four had decreased attacks, but the response to the combined herbs was judged less than satisfactory. From our point of view there is no question that *Desmodium* and the other herbal preparation produced a satisfactory response in 75 per cent of the patients. ■

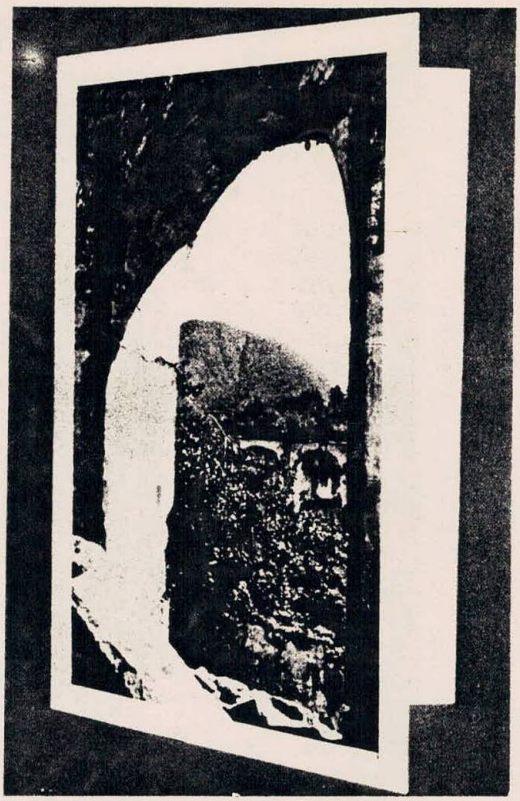
NEWS PAGE

PORTUGAL AND WHO WORK TOGETHER

Portugal's health authorities first invited environmental health experts from WHO to visit the country in 1974, following a sudden outbreak of cholera. In October 1976, at the government's request, a joint WHO/World Bank team carried out an extensive country-wide sector study of the water supply and waste disposal conditions. This study provided Portugal with an overall picture of the existing situation, indicated the constraints that were then limiting the development of this vital sector, and suggested an action programme for immediate and long-term improvements.

One result of the activities that followed was the convening of a seminar on "project preparation and evaluation" organized by WHO and held in Lisbon last July. Thirty-five Portuguese engineers participated in the seminar, which gave them an opportunity to acquaint themselves with new trends in planning, design, and economic and financial evaluation.

One project of assistance to the basic sanitation sector, with backing from WHO and the UN Development Programme (UNDP), has just started, at an estimated cost of US $2 000. The project will last for two and a half years and WHO has been designated as Executing Agency. A further result of the 1976 sector study was the identification of such investment projects as water supply and sewerage for Lisbon and Oporto, the second-largest city. The World Bank is expected to assist in financing these schemes, and in the first instance a loan is being considered for the improvement of Lisbon's water supply.



GREETING CARDS

WHO's new programme of Appropriate Technology for Health was given the task of designing this season's greetings cards for the Organization. In full colour and with the theme "Through to a better world", the cards may be ordered from: The WHO Staff Association, WHO, 1211 Geneva 27, Switzerland, or from any of WHO's Regional Offices in Alexandria, Brazzaville, Copenhagen, Manila, New Delhi and Washington. The price is US $3 or 8 Swiss francs per packet of ten, and each card is within the airmail limit. Any profits from the sale of the cards will go to WHO's Voluntary Fund for Health Promotion.

In the next issue

The December issue of *World Health* will be concerned with Mental Health, and will show how certain countries are dealing with this problem within the framework of their health services.

Authors of the month

Dr H. MAHLER is Director-General of the World Health Organization.

Mr J. DAUTH, formerly Press Officer at the Embassy of the Federal Republic of Germany in Malaysia, is now working as a journalist in Malaysia.

Dr X. LOZOYA is the Co-ordinator of the Mexican Institute for the Study of Medicinal Plants (IMEPLAM) in Mexico City.

Dr P.N.V. KURUP is Adviser to the Government of India for Indigenous Systems of Medicine.

Dr K. N. UDUPA is Professor of Surgery and Director of the Institute of Medical Sciences at Banaras Hindu University, Varanasi, India.

Dr R. H. BANNERMAN is Secretary of the Working Group on Traditional Medicine at WHO headquarters in Geneva.

Dr A. MANGAY-ANGARA is Chief of the Division of Maternal and Child Health, Department of Health, Philippines.

Dr O. AMPOFO is Director of the Centre for Scientific Research into Plant Medicine at Mampong-Akwapim, Ghana.

The leaves of Bridelia ferruginea have proved an effective treatment for diabetes. *(see Page 26)*

Soc. Sci. Med. Vol. 15B, pp. 87 to 92, 1981

0160-7987/81/020087-06$02.00/0

PROFESSIONAL ASSOCIATIONS, ETHICS AND DISCIPLINE AMONG YORUBA TRADITIONAL HEALERS OF NIGERIA

D. D. O. OYEBOLA

Department of Physiology, University of Ibadan, Ibadan, Nigeria

Abstract—Four Yoruba traditional healers were interviewed on their professional associations and the objectives of such association. A semi-structured questionnaire was administered to 165 traditional healers on the ethics of traditional medicine and the discipline of erring members. Photographs were made of sign-posts related to the practice of traditional medicine found in strategic locations in and around Ibadan city. The results of the study showed a proliferation of Yoruba herbalist associations. These associations serve as meeting points for healers for social purposes, and to share their professional experiences. There are rules and regulations (mostly unwritten) that guide the practice of traditional healers. Disciplinary bodies also exist to deal with offending members. The misleading nature of one herbalist's sign post is highlighted. The disadvantage of not having a central professional body to control its activities, and the dangers of unsubstantiated claim of proficiency in the treatment of certain diseases by herbalists is emphasized.

The invited comments on this paper have stressed the growing interest in traditional medicine and have touched on some of the problems confronting researchers and health planners in matters relating to traditional healers. The author is in agreement with many of these comments and has attempted giving answers to some of the questions raised by the discussants.

INTRODUCTION

In Nigeria and many developing countries, scientific medicine and traditional medicine co-exist and the two systems are well-patronized by health consumers. The practice of scientific medicine in Africa is along the lines found in Europe and America, although available facilities in terms of human and material resources for practice is less adequate in the developing countries. The practice of scientific medicine is controlled by accredited professional associations in all countries. Such associations keep a register of members of the profession, and claim to ensure that medical ethics are adhered to by all practitioners by the associations' punishment in cases of professional misconduct. For each country, there is usually a parent professional body, with regional or state branches. Activities of such professional associations are documented through notices/preceedings of meetings, and the publication of articles on medical science in various journals.

The traditional healers are often the only source from which 80–90% of the population of many developing countries can receive health care [1]. Their importance in health care delivery in Nigeria had been stressed [2–5]. In spite of this high utilization of traditional healers, there has been no account in the literature about the professional body/bodies controlling the practice of traditional medicine. At the preliminary stage of a recent study of Yoruba traditional healers in Nigeria [6], I found that the traditional healers also have professional associations. Indeed, the support of one of the main professional associations facilitated the study. The ethics which guide the practice of the Nigerian traditional healers have not been previously reported. Information on whether they have ways of protecting the interest of the public by way of punishment and/or other forms of deterrent for infamous acts amongst their members should be of interest. The present communication is on professional associations, ethics and discipline among Yoruba traditional healers.

MATERIALS AND METHODS

The study was carried out in three parts. The first part was on professional associations. Four traditional healers were interviewed. Two of them could read and write the vernacular (Yoruba) and two were illiterate. The four healers were asked the names of Yoruba herbalist associations known to them, the year of formation of each association, and to indicate whether the associations were still functioning. The healers were requested to give a brief historical background of the associations, if this was known, and to outline their objectives. The two literate herbalists were allowed to refer to the scanty written records available from a few traditional healers.

The second part involved 165 traditional healers randomly selected from 31 towns and villages in the Yoruba speaking areas of Nigeria. A semi-structured questionnaire was administered to these healers. The scope of the questionnaire is reflected in Tables 2 and 3. The details of the selection of towns and villages for study, the selection of herbalists interviewed, the preparation, pretesting and administration of the questionnaire as well as the analysis of results were published in an earlier communication [7].

The third part of the research involved taking photographs of sign-posts related to the professional life of the traditional healers (Figs 1–5). The practitioner whose sign-post is shown in Fig. 2 was interviewed about how he diagnoses hypertension, a symptomless condition, and the drugs he uses for treating it. A sample of the drug for gonorrhoea advertised in

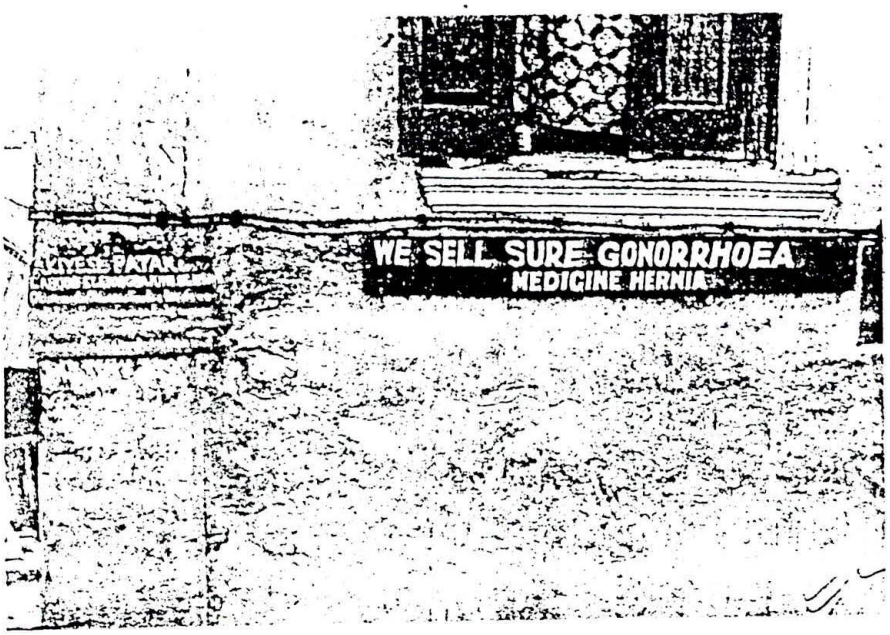
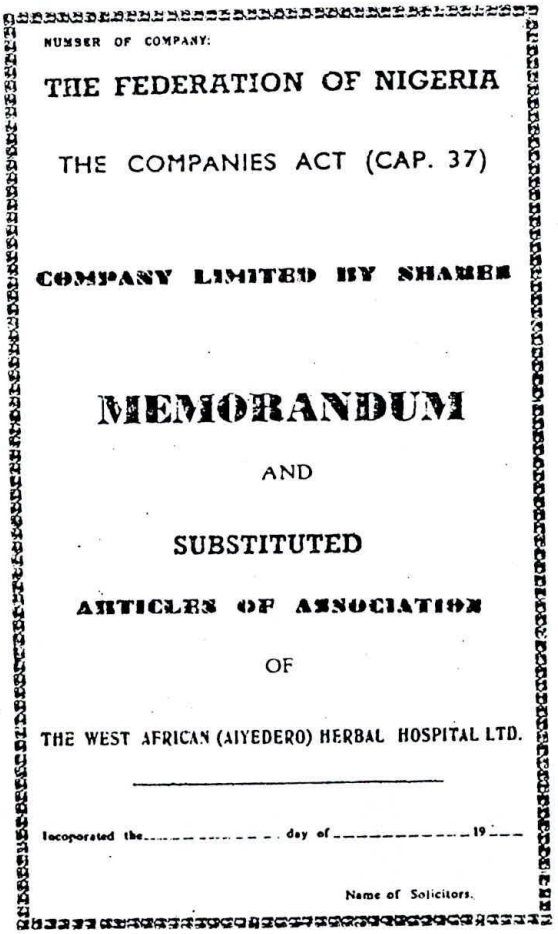


Fig. 3. Advertisement sign on the wall of the house of a traditional healer. This sign-post is meant to advertise the availability of medicine for "gonorrhoea and hernia". Note the "Important notice" ("akiyesi pataki") on the left corner. Its title is "LABODE ELEMU GBAJUMO OGUN", that is, "LABODE ELEMU, the renowned medicine-man".


NUMBER OF COMPANY:

THE FEDERATION OF NIGERIA

THE COMPANIES ACT (CAP. 37)

COMPANY LIMITED BY SHARES

MEMORANDUM

AND

SUBSTITUTED

ARTICLES OF ASSOCIATION

OF

THE WEST AFRICAN (AIYEDERO) HERBAL HOSPITAL LTD.

Incorporated the ..... day of ..... 19...

Name of Solicitors.

Fig. 4. An attempt at founding a herbal hospital. This is the cover of the hospital's constitution (the venture failed).

Fig. 3 was purchased and tested *in vitro* for effects on isolated cultures of Neisseria gonorrhoea organisms.

Of the 165 herbalists involved in the questionnaire aspect of the study, only 156 filled the questionnaire sufficiently well to be included in the analysis of results. The results of the study are shown below and in Tables 1, 2 and 3 and Figs 1–5.

RESULTS

Professional associations

Herbalist or traditional healers' associations have existed among Yoruba since the 19th century. In the early stages, such associations were confined to individual communities. The "Oloriawo" or "Babasegun", "the head of those who keep secrets" or "father of the healers", was the designation for the head of such associations. Since most of the people are illiterates, very scanty records of their activities are available. Towards the end of the 19th century the herbalists became aware of the need to form regional associations. Hence, about 1886 (Table 1) the Ekiti-parapo Herbalist Association and the Beje Medical Herbalists Association were formed in Ekiti and Ijebu-Igbo areas. Although these associations served primarily the interests of communities in their areas, herbalists from other towns and villages in the Yoruba speaking areas subscribed to them. Other associations were later formed. The objectives of these associations in those early days were:

(a) To afford herbalists the opportunity of meeting and knowing themselves;

(b) To provide a forum for members to cooperate in their practice by identifying specialists in specific problems and referring relevant difficult cases to such persons;

Fig. 5. A certificate issued to registered members of a herbalist association.

Table 1. Herbalist associations among the Yoruba

Name of association	Probable year of formation*	Comments
Akoko United Herbalist Association	1945	Functioning
Association of Nigeria Medical Herbalists	1908	Functioning
Beje Medical Herbalists Association, Ijebu	1886	Functioning
Egbe Aiyegunle Herbalist Association	1950	Defunct
Ekiti-parapo Herbalist Association	1886	Functioning
Ewedaiyepo Nigeria Herbalist Association	?	Functioning
Federation of Herbal Indigenous Practitioners	1945	Functioning
Gbegbesele Aiyelola Herbalist Association	1930	Functioning
General African Medical Herbal Organisation of Nigeria (GAMHON; also called Amalgamation of Nigeria Medical Herbalists)	1945	Functioning
Ijebu-Mure Herbalists Association	1888	Functioning
Ijunmun-parapo Herbalists Association	1930	Defunct
Lagos African School of Herbalist Association	1935	Defunct
Nig. Herbalist Research Association	1950	Defunct
Ogo-Oluwa Herbalist Association	1955	Functioning
Taiyese Herbalist Association	1950	Defunct
Union of Nig. Medical Herbalists	1930	Functioning
United Nig. Medical Herbalist	1950	Defunct
Western Herbalists College	1950	Defunct

* These dates were those given by my informants and were not authenticated since there were no written records in most cases.

Table 2. Professional ethics of the traditional healers/midwives

No.	Questions	Possible options	Number of respondents
(a)	Is public advertisement allowed	Yes	74
		No	78
		No response	4
(b)	Can a herbalist/traditional midwife actively canvass for patients?	Yes	29
		No	115
		No response	12
(c)	Can a herbalist/traditional midwife be intimate with a patient who is of the opposite sex?	Yes	—
		No	148
		No response	8
(d)	Is there any disciplinary body for cases of misconduct?	Yes	135
		No	15
		No response	6

(c) To provide a forum for the continuous improvement in the knowledge of the herbalists through exchange of ideas on herbal remedies.

(d) To preserve and ensure the growth of traditional medicine.

With the passage of time, the herbalists became politically conscious and a few of their associations were registered along the lines laid down by the government for trade unions. Among other functions, these associations became media for agitation for government recognition and support. Table 1 shows the more important regional herbalist associations among the Yoruba.

Apart from achieving the above aims, these associations were charged with the responsibility of drawing-up guidelines and codes of conduct to discipline erring members. Many of these associations published pamphlets containing their constitution (Fig. 4). Abortive attempts were also made to establish herbal hospitals. It was also the duty of herbalist associations to assess the quality of the knowledge of herbalists who wished to become their member through interviews. Certificates of proficiency were issued by some associations to successful applicants. Figure 5 shows the certificate issued by one of the herbalist associations.

Professional ethics, cupable acts and discipline

All 156 herbalists in the second part of the study belonged to one or more professional associations. The response pattern to the questionnaire are shown in Tables 2 and 3. Disciplinary actions against

Table 3. Offences for which herbalists can be disciplined

Type of offences	Number of respondents*
Being intimate with a female patient	79
Procuring abortion	34
Seducing or committing adultery with the wife of a professional colleague	30
Fraud	19
Preparing harmful medicines	17
A male herbalist using his penis as applicator to push a drug into a female patient's vagina ("atidiki")	
Stealing	15
Failure to attend association's meetings	13
Receiving money from patients under false pretence	13
Seducing or marrying a patient	11
Social misconduct	10
Giving a useless medicine to patients	9
Practising without joining the professional association	9
Treating a married female patient who is not accompanied by her husband or relation	8
Aiding a thief by giving him medicinal charms	7
Snatching a colleague's patient	5
False advertisements by the healer about his competence	5
Leaking secrets	5
No idea	2
No response	4
	8

* Several herbalists named two or more offences.

members could take the form of fines, suspension or dismissal from the association, or handing over to the police for prosecution if a criminal offense had been committed. The type of disciplinary action taken would depend on the gravity of the offense committed. The associations set up disciplinary bodies from among their members.

Figures 1–5 depict various features on matters related to advertisements, professional associations and the practice of traditional medicine. The healer whose sign-post is in Fig. 2, who claims to treat hypertension and cardiovascular diseases, does not know how to measure blood pressure! He claimed to treat "hypertension" with herbal concoctions whose components were not disclosed. The drug advertised for treating gonorrhoea in Fig. 3 showed no pharmacological activity in *in vitro* tests on cultures of *Neisseria gonorrhoea*.

DISCUSSION

There are several herbalist associations among Yoruba traditional healers. Efforts to make them form one professional body have so far been unsuccessful although some of the associations have combined to form G.A.M.H.O.M. (Table 1). However, the latter is not an all-embracing association of Yoruba traditional healers. This proliferation of professional associations makes a central control of the practice of traditional healers difficult and weakens their bargaining power with the government. Table 1 also shows that the herbalists have felt the need and have attempted to establish a herbal college and a herbal research unit. Figure 1 butresses the latter and Fig. 4 the former.

The herbalists, like Western-trained doctors, have tried to protect the interest of the society they serve by having ethics that bound the practice of their profession (Table 3). From Table 2, it will be noted that apart from public advertisement on which opinion is divided, most of the herbalists agreed that it is unprofessional to canvas for patients, have intimate relationship with a patient and it is possible to discipline erring members. Some of the culpable acts in Table 3 are similar to what would constitute an infamous act if committed by the present-day practitioners of scientific medicine. It is difficult to imagine how the healer whose sign-post is in Fig. 2 could treat hypertension without a proper method of diagnosis of the disease. This casts serious doubts about his claim. His practice may be mere deceit of a gullible clientelle. It is important to protect the public from this type of practitioner. Also, the much advertised gonorrhoea medicine (Fig. 3) had no effect on plates of *Neisseria* organisms cultured *in vitro*. Although *in vitro* tests were not done, the effects of anti-biotics can usually be demonstrated *in vitro*. The absence of activity in *in vitro* tests puts the efficacy of this medicine in doubt. Again, the dangers of patients with gonorrhoea infection purchasing a worthless medicine for treating their condition cannot be over-emphasized.

In the course of the larger study [6], it was discovered that the professional associations wield tremendous influence over their members. Their co-operation and support will be needed if proposals to utilize traditional healers for health care delivery in the developing countries is to be successful. They are also indispensable in research ventures into traditional medical systems. It is important that further studies be carried out to identify the herbalist associations in the major ethnic groups in Nigeria and other African countries. The Western-trained doctors and government health policy makers should liaison with such associations to ensure success if and when the proposal of the W.H.O. [1, 8] that traditional healers in Africa should be integrated or at least, should cooperate with scientific doctors in the delivery of health care is implemented.

Acknowledgements—I am grateful to Prince A. Adegboyega and all the other herbalists who participated in this study. The herbalists kindly gave permission to publish the photographs. Miss Monica Ikekhua gave secretarial assistance.

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Soc. Sci. Med. Vol. 15B, pp. 93 to 102, 1981
Printed in Great Britain

0160-7987/81/020093-10$02.00/0
Pergamon Press Ltd

PROFESSIONAL ASSOCIATIONS, ETHICS AND DISCIPLINE AMONG YORUBA TRADITIONAL HEALERS OF NIGERIA

by D. D. O. Oyebola

DISCUSSION

by

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Gilles Bibeau
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Gabriel B. Fosu
Kris Heggenhougen
Una Maclean
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This study relates to traditional medicine amongst the Yorubas—a major ethnic group in Western Nigeria comprising some 14 million of the total population of 70 million in Nigeria. The first section of the report was published in *Soc. Sci. Med.* 14A, 23–29.

Readers would be well advised to read the first article in order to gain better appreciation of this report. Although the study relates to a particular ethnic group—the Yorubas, there are many aspects common to tropical African Communities in general, and the statements that scientific or western and traditional systems of medicine co-exist effectively and that 80–90% of the populations depend almost exclusively on traditional healers especially for primary health care are statements of fact. There is no vacuum anywhere and each community over the years has developed its own health care system in rational response to the perceived causes of illness.

The often quoted statement that "some 80% of the people in the developing countries have no health care system at all" is therefore totally erroneous and misleading. These people depend on their traditional and indigenous health care systems and their healers, practitioners of traditional medicine and traditional birth attendants or so-called native midwives are indeed their primary health care workers.

The belief that illness arises from supernatural causes and indicates the displeasure of ancestral gods and evil spirits, or is the effect of black magic is still held by many communities in the Third World countries, and to some extent, this is also true of the industrialized countries. It is therefore wrong to attribute magical, irrational and superstitious ideas to any group of countries or levels of industrial or educational development. Naturalistic causes of illness are favoured in the industrialized countries, but the evidence is that the two approaches to health care are complementary and that with the swing of the pendulum greater attention should be paid to the traditional, indigenous or alternative systems which bring comfort to very large numbers of people everywhere.

Recently, some health administrators in the developing countries have recommended the inclusion of traditional healers in primary health care services on the grounds that traditional medicine is holistic and the healers know the socio-cultural background of their patients, and are highly respected and experienced in their work. Economic factors, distance, time, traditional beliefs and shortage of health professionals, particularly in rural areas, have also influenced the above recommendation. Training and orientation programmes have already been developed in several countries for suitable healers and traditional birth attendants especially. Provided they are willing, such traditional health workers can, at a very moderate expense, be trained to the level where they can provide adequate acceptable health care.

Certain governments are already encouraging the development of the type of professional associations described in this study, with the enactment of appropriate legislation for licensure and registration. The more enlightened laws aim at enabling the healers to assume some doctor-functions and with adequate legal protection in the performance of those tasks. They also provide assurance to patients that the persons undertaking the health care have been properly trained.

The type of professionalism regarding quality control, more ethical and rational development of traditional medical practice will no doubt assist in the achievement of better collaboration and possible integration of the various health care systems.

Present health care systems place most of the developing countries in a dilemma. Either we continue to aim at a type of medical care which cannot, in the foreseeable future, be extended to cover all needs; or we revise our ideas on types of medical care and delivery systems. Dr Oyebola's study report is therefore timely and there is little doubt that the time is now opportune for clearly defined policy decisions at the highest governmental level and the enactment of realistic legislation for the recognition, control and development of traditional and indigenous systems of

health care. Happily, these initial steps have already been taken by certain third world countries.

Finally, we must remind ourselves that much of modern medicine has stemmed from traditional medicine. Should the health professions acknowledge the healers and traditional birth attendants? Or is it wiser to leave things as they are? What is regarded as unorthodox today may well become highly Orthodox before the close of this decade.

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It is quite usual among non-specialists to think that traditional healers are individualistically-minded peoples, refusing any collaboration with colleagues, because this would mean sharing of personal "secret" knowledge. Through a short historical approach, Dr Oyebola has demonstrated, on the contrary, how deep are the roots of solidarity and communication between healers: the foundation of the profession on initiation and the public acknowledgement of their social status by a formal appellation have indeed always situated healers within a corporate body. Among ritualists and priest-healers, this solidarity has even taken in the remote past, in the form of formal associations with regular meetings, control over individual practice by elders in the initiation, and collective therapy in few occasions. I would suggest that Dr Oyebola makes a distinction between individual herbalists and healers working at a shrine or within a ritual, because these two categories of healers were not traditionally in the same position, regarding relations with initiators and colleagues. Their proximity to modern associations is therefore evidently different.

Colonial administration and bureaucracy in independent countries have more recently pushed healers to use new legal forms of solidarity expressed in numerous modern associations. These new administrative structures can surely be considered as a continuation of former solidarities, but Dr Oyebola has not stressed enough, according to me, the rupture with the tradition. Any comparative study of constitutions and statutes regulating these associations reveals a tremendous abuse of legal terms which mean very little to healers, and researchers must evidently read, behind explicit aims of the associations, what they really want. It is not enough to note that associations have assigned themselves as main objectives, census and registration of healers, enforcement of ethical code with fines for malpractice, defence of profession, etc.; in fact, these associations have multiplied in African cities, since the Independence mainly, for two more fundamental reasons that Dr Oyebola has not explicitly stated: first, healers try to define themselves and their therapeutic activities within modern society, in proposing a new space to occupy; second, formal associations intend to force governments to make decisions regarding legal status of traditional medicine and individual licences for practice. Healers have attained a new visibility in modern Africa, not only as individuals but above all as corporate bodies, exertin pressure on Ministries of Health and health officials. had sometimes the impression, in reading Dr Oyebo that healers are waiting for recognition by WHO an local governments without active participation in th debate: in fact, they took the initiative and they a still protagonists in the process.

I disagree with the position advocated by Dr Oy bola concerning his sociological description of th healers' professional associations. My close work wi healers' associations in Zaire has convinced me th national associations cannot exist for the time bein and this, for the benefit of healers, because vario territorial regions, different categories of healers a more easily represented through many parallel asso ations. This pluralism must be stimulated and on the coexistence of associations can really maintai democratic participation of individual healers. I a not against federation, concertation and cooperatio between associations, but my feeling is that effor must be preferably, at this stage, directed at develo ing strong local, regional, limited associations; t national healers' associations I am aware of, in man African countries, appear to me as purely legal emp forms without any power of mobilization. Sociolog cal characteristics of efficient healers' associations c be reduced everywhere to the two following trait first, they are rooted in a geographical area, or in particular form of therapy (herbalists, ritual pries healers, spiritualists, ...); second, they are highly pe sonalized, in the sense that leadership is assumed b a healer of great fame in the area. Only associatio with these two characteristics have shown th capacity for "bargaining power". As a second ste national-level associations will slowly evolve from t incentive given to the formation of local associatio but governments must be careful in their promotio of such an unrealistic national administrative stru ture. To guide this process towards a national asso ation, I think it necessary to provide a permane minimal structure: for example, regular meetin between local leaders associations.

The Health Ministry, in any African State, m rely very much on local healers' associations for a action taken within the realm of traditional medici These associations constitute, according to me, t only channel allowing continuous contacts wi healers of any level and in any area of the coun Many responsibilities must be delegated to the boa of local leaders associations: for example, only pe review can really lead to decision concerning "who a healer", and new services of inspection crea within few African Health Ministries, with the aim delivering individual licences, would take advant to document their certification on the techni advice given by local associations. In my opinion, t first stage towards recognition of traditional medici goes with the necessity for anybody who consid himself as a healer to seek his membership within local association. Health Ministries must entrust th associations and rely on decisions taken by heale colleagues, in many areas of concern: census, regist tion, evaluation leading to individual licences, cod cation of professional rules, etc. In our proposal t the Zairian government after a three-years resear on healers, we constituted healers' associations a

center of gravity for the new health national policy regarding formal utilization of traditional healers in the official health delivery system (see Bibeau, Corin, Mulinda and Alii (1979). Abridged Report published (English version) by International Development Research Center, Box 8500, Ottawa K1G 3H9, Canada).

Dr Oyebola has discussed extensively the relations between associations and codes of ethics. Professional ethics have always existed among healers, and its writing down is conjectural, having become a necessity within the modern Africal context. Examination of written deontological codes enables me to say that the first concern for healers is to adapt former regulations to modernity without betraying them. Articles developed in these codes are dedicated to such problems as use of traditional solvents (oil, water, alcohol) for drug preparations, prices for consultations, disposal of devices which served during therapy, use of etiological categories for interpretation of disease (for example, sanction put on healers referring too often to witchcraft in their interpretation), minimal facilities to hospitalize patients, community-context for individual treatment, etc. Most healers still recognize that they are obliged to perform their therapeutic activities according to regulations, and these regulations are still, in their majority, very clear. What has dramatically changed is the contextual setting of the practice, and healer associations have the duty to guide their members in this difficult work of adapting former rules to modernity. Deontological codes represent substantial efforts made by healers in this direction. They are not existing, first of all, as a prevention against quacks, or a locus for disciplinary actions against erring members.

My last comment relates to the two sign-posts on hypertension and gonorrhoea treatments. I do not know why Dr Oyebola has limited his investigation to two negative cases, when researchers have stressed positive outcomes in many other disease situations. This limitation can be interpreted as a refusal of the science dimension within traditional medicine and I would like to know Dr Oyebola's exact position on this problem. I question the method followed to study treatments efficacy: it is not because a healer does not use apparatus to measure hypertension that he is unable to "cure" it. And what does "curing" hypertension mean?

The problems raised by Dr Oyebola regarding professionalization among traditional healers are important, but authors should approach these problems with tools developed by medical sociology, which would provide relevant interpretation. I understand that it is not always possible for biologists, physiologists and physicians to have a parallel formal training in sociology or anthropology, but when they study multidimensional problems, it would be very helpful for them to work within a team research.

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Dr Oyebola's report on the professional associations of traditional Yoruba healers in Nigeria comes at a time of growing recognition of the continuing importance of traditional medicine in its many forms throughout the world; of the complexity and diversity of these traditions, even within supposedly culturally homogeneous settings; and of the extent to which each of these traditions is regulated and sanctioned, officially and/or unofficially, within its own social context.

The demonstration—as in this paper and other recent contributions—that such institutions exist will not surprise many social scientists. Reports of this sort should help, however, to increase awareness, understanding, and acceptance of traditional healers by those of the cosmopolitan medical profession. In many countries cosmopolitan practitioners complete their training with little, if any, exposure to the alternative (i.e. non-cosmopolitan, non-"scientific", non-"Western") forms of medical care that may be available within their country or region. Even now few medical school curricula include required instruction in this area. Elective instruction in comparative medical systems does not meet the need. Optional courses generally attract students who are already aware of, interested in, and receptive to the possibilities for interaction between or among diverse "systems" of medical care. In my view an introduction to comparative medical systems (to include study of reports such as the present one) should be a part of the core curriculum of any school in the health sciences.

The only point in Dr Oyebola's paper that I would question is his statement (from his informants) that Yoruba associations have existed (only) since the 19th century. It may not be possible to prove it in this particular case, but I should guess that the origins of these Nigerian associations are ancient indeed. I suggest, in other words, that some form of healer's association, however local and small in scale, can be found in any society that supports traditional healers—that is to say in any society, past or present.

I should also like to expand the author's opening point about the co-existence and patronization of medical systems. It is not only in many developing countries that such conditions exist. The state of national development may influence the relative "importance" of various systems of care but some degree of medical pluralism is surely universal.

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In spite of the numerous studies on traditional healers, Dr Oyebola's lucidly written and thought-provoking article is probably the first attempt to address the central issue of professional associations in traditional medicine.

As the author rightly points out, the existence of traditional healers associations is not a new phenomenon. However, they were mainly organized at the community level and served useful social and professional purposes (e.g. referral and consultation). They had a network of communication channels (eaves-dropping, gossip, etc.) through which they

gathered information to help them in their practice. As noted by the author, attempts to organize them at the national level are recent. Such efforts have not always been successful for several reasons, notably internal strife for leadership positions and difficulties in legitimation and integration into the national health care system. Nevertheless, with the support of the government some progress has been made in some areas, a good example being the formation of the Institute for Herbal and Plant Medicine in Ghana.

The advantages of having accredited traditional healers associations are many. The author aptly points out "Their cooperation and support will be needed if proposal to utilize traditional healers for health care delivery in developing countries is to be successful. They are also indispensable in research ventures into traditional medical systems". These are plausible reasons, and they bring into a sharp focus some of the basic issues that should be tackled before any meaningful integration becomes possible. Some of these issues have been raised by Dr Oyebola, and I would like to comment on them.

The ease with which new professionals are accepted into the health care delivery system depends very much on the attitudes of physicians. They usually make the decision as to when and how to use the new professionals. Their decision is based on whether the services of the new professionals are perceived as role-elevating or role-threatening to them [1]. However, instead of coming to grips with this basic reality in the case of traditional healers, the reason often given for keeping them away is that they are untrainable because they hold superstitious beliefs, and because their practice is secret it is difficult to evaluate. Also, they are regarded as quacks because they claim to cure disease which they can't cure. Oyebola echoes these apprehensions when he states "The healer whose sign-post is in Fig. 2, who claims to treat hypertension and cardiovascular diseases, does not know how to measure blood pressure. He claimed to treat "hypertension" with herbal concoctions whose components were not disclosed. The drug advertised for treating gonorrhoea in Fig. 3 showed no pharmacological activity *in vitro* tests on cultures of *Neisseria gonorrhoea*".

I believe that not knowing how to measure blood pressure should not be taken as sufficient evidence to cast doubt on the efficacy of traditional medicine. The observation of Oyebola is based on only one person and is not statistically valid. On the other hand, if the traditional healer is the only one specializing in the treatment of hypertension and cardiovascular diseases in the area under investigation, then it might be worthwhile to subject hypertensive patients (diagnosed by scientific methods) to treatment by this herbalist under controlled conditions to enable us to make a better assessment.

Another important aspect that has been stated repeatedly is that traditional healers have a different method of diagnosis and treatment [2]. Thus the investigator should have posed questions to find out how native doctors diagnose hypertension and cardiovascular diseases which do not have to conform to western standards. Their claim to contact some supernatural beings and good ancestral spirits in their treatment should not be dismissed as superstitious. I think that until an independent observer can confirm or disprove the reality of these paranormal phenomena, it will be difficult to make such statements as Dr Oyebola makes above Obviously, Dr Oyebola and many others seem to be influenced by their mode of training in "scientific" approaches to diagnosis. Some doubts about traditional medicine, I believe, may be removed if physicians would "condescend" to undergo the type of training available to traditional healers (minimum of 3 years for fetish priests in Ghana). Then with the added advantage of the scientific analytical mind help to settle the issues. The case of acupuncture is relevant here.

This is not to argue that everything traditional healers do is beneficial. There are frauds everywhere. It is not inconceivable that some native healers may be phonies. Generally speaking, however, unlike itinerant drug hawkers they are genuine and well meaning people. They treat many patients who get well and are never seen by Western trained physicians [3]. I agree with Dr Oyebola that there is a need to separate quacks from genuine practitioners, and one way to do this is to organize them under accredited professional bodies.

The second point is that it is not uncommon, even in scientific medicine, to come across cases where a drug may have potent *in vivo* effect but without *in vitro* action. Diethylcarbamazine, trade name banocide, is a good example. Its efficacy as an antifilaricide is only realized *in vivo* [4]. It is possible that a metabolite of some compound(s) in the concoction is responsible for the therapeutic efficacy. It is, however, difficult to subject such a concoction, which may be crude, and, therefore, contain many substances, to careful scientific investigation. One can only go about this by trying to isolate an active principle(s) from the concoction and test for its effectiveness *in vitro* and *in vivo*.

Undoubtedly, Dr Oyebola has done an excellent job by bringing into focus a central but hitherto neglected issue for health professionals in developing countries who are being encouraged to work with traditional healers. Traditional healers are willing to talk on many aspects of their practice if the investigations are made in good faith and from a genuine desire to learn and help. I hope that Dr Oyebola's insightful discussion will stimulate further research in this important area.

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Dr Oyebola's discussion of professional associations for traditional healers points to some of the central issues in the current resurgence of interest in traditional medicine, and is most timely in view of the deliberations which are now taking place about the advisability, feasibility and consequences of a closer official relationship between traditional healers and the cosmopolitan medical system.

The recent call for "Health for all by the year 2000" has placed a renewed emphasis on primary health care, particularly in rural areas. Tied to this emphasis is a recognition that the goal cannot be reached if reliance is made on cosmopolitan medicine alone. Not even with concerted training and employment of Nurse Practitioners, Hospital Assistants, "Barefoot Doctors" and other types of village health workers, in combination with physicians, would this goal appear realizable. The feeling is that traditional practitioners must be officially brought into the picture, especially since "indigenous health practitioners are there already" [1]. Dr Oyebola is not alone in stating that such healers are the main source of health care for more than 80% of rural populations in many countries. A resurgence of interest in, and promotion for an official reliance on, traditional medicine can now be noted throughout the world.

This interest has in part been legitimized by the WHO, which has made repeated recommendations for member nations to integrate traditional healers into the national health care systems, or at least establish a cooperative relationship with them, whenever possible. This was again reiterated within the 1978 "Declaration of Alma Ata" [2], the same year in which the WHO also published the report on "The promotion and development of traditional medicine" [3]. The WHO Traditional Medicine Group which has been functioning for several years and serves as a clearing house on issues related to traditional medicine is currently preparing a handbook on traditional medicine for health administrators which should be available in early 1981 and would presumably offer guidelines for collaboration.

Physicians in control of national health care systems and especially those within the hierarchy of national (cosmopolitan) medical associations, however, still seem to be quite skeptical about integration and even about collaboration. One can, of course, point to numerous cases, in "developed" and "developing" countries, where collaboration between cosmopolitan and traditional healers have taken place, but to establish a national policy for such collaboration seems to be quite another matter. The, by now, almost fashionable criticism of physicians which relates the reluctance to collaborate with a desire for medical monopoly, defense of status and maintenance of superior income possibilities should not blind us to the fact that some of the hesitancy in wanting to deal with traditional healers is often motivated by a direct concern for the welfare of patients. There are valid reasons for skepticism of certain traditional healing practices. One should be careful, however, in too easily pointing to some of the detrimental results of traditional treatments as it is by no means certain that their damage equals (or surpasses) that of the estimated 20% of all illnesses which are due to (cosmopolitan medical) iatrogenic causes. Faults can be found on both sides. Surveillance, censure, guidance, training and examination should be required for all practitioners, and one mechanism for this could be professional associations.

The hesitancy to collaborate is often caused by neither self-serving nor by validly skeptical reasons but is rather a consequence of ignorance about traditional healers and about their capabilities. This is particularly the case in relation to so-called "folk" practitioners within local medical "systems" [4] and many of the "popular medicine" practitioners [5] who are quite individualistic, have little standardized training and go through no uniform final exam or centrally monitored period of intern-, or preceptor-ship. In most countries it is the folk healers, the herbalists, bone setters, spiritualists, spirit mediums (and the "popular" injection doctors) and others including the more uniformly definable midwives, who make up the majority, if not all, traditional healers.

Professional associations for herbalists and other folk healers could presumably overcome this lack of knowledge by generating information about the healers they represent. Through such associations it is presumed that an overview of the training and capabilities of healers, and the types of treatment modalities used, will be revealed more easily and will be better understood by physicians and others. Such associations are also expected to have a certain amount of control over the members by having established mechanisms for ascertaining professional competency and ethical conduct. Dr Oyebola points to the importance of this as well as to the problems new associations face in assuring such competency and ethical conduct (i.e. mention of the questionable claims made by members of an association about their ability to treat hypertension and gonorrhoea).

National and international research and study groups, which are working with traditional healers and their professional associations, where these exist, have been established in many countries and serve to overcome the information gap. The Division for the Documentation of Traditional Medicine at the National Museum in Kuala Lumpur and the Traditional Medicine Research Unit at the University of Dar es Salaam are but two of numerous examples. A further example is the International Association for the Study of Traditional Asian Medicine which was formed after a week-long conference in Canberra in September, 1979, where practitioners and students of different traditional Asian, and cosmopolitan, medicine met. Papers from such collaborative research groups and meetings are increasingly appearing in the medical and health care literature with whole issues of certain journals being devoted to the subject (e.g. *UNESCO Courier* July, 1979 [6]; *Hemisphere* July/Aug., 1979 [7]. *Social Science and Medicine*, of course, has long been in the forefront in providing such information.

The question of whether or not traditional healers should be licenced or registered before being officially

recognized is central to the issue being discussed. It has been argued, however, that one result of such licensing could be the creation of a subservient role for traditional healers and a (possibly drastic) change in their healing practices. This is one of the reasons why, as a first step, the WHO [8] and others have suggested professional associations of traditional practioners should be established.

In a number of countries where traditional medicine associations are being formed, not all practitioners are eager to join; the majority of individualistic and proud folk healers are often skeptical of the benefit they will gain from such associations, a skepticism which does not necessarily arise out of incompetence or from a wish to be secretive. Healers are aware that initiators of such associations are sometimes motivated by special interest, political or self-serving considerations rather than by the potential benefit to the healers and their patients. However, if official recognition is to be predicated on membership in a professional association, and it is likely that this will be a minimum requirement imposed by many ministries of health, then membership in such associations can only increase.

It should also be pointed out that, contrary to what is generally believed, the folk healers with whom I have spoken in Southeast Asia express the desire for their practice to come under government scrutiny and to be "scientifically" evaluated since, as they are confident in their knowledge and capabilities, they feel such evaluation would provide official recognition and legitimation. It may be possible that such investigations could be carried out by the professional associations themselves through special committees which could function in collaboration with cosmopolitan practitioners and others. Many associations have already helped outside researchers carry out studies of their members and their therapies, as Dr. Oyebola indicates was his own experience, and has been mine as well. It may be worth promoting the establishment of a separate research committee for all such newly established associations;.Dr Oyebola sees the associations; as "indispensable in research ventures into traditional medical systems" and also points to the fact that the Yoruba herbalists have called for the establishment of a herbal research unit.

In Asia the situation is somewhat different from Africa, as mentioned by Dr Oyebola, and might be more conducive to collaboration. This is due to the existence of regional, learned, medical systems, chief of which are the Ayurvedic, Unani and Chinese, with long established and standardized courses of training, examinations *and* professional associations governing both the capabilities as well as the conduct of their members. The contemporary interest in traditional medicine is in fact largely due to information about intersystem collaboration said to be taking place in China. Thus in many Asian countries there is substantial official recognition of, or at least a relatively respectful coexistence with, such traditional medical practices even if there is not always collaboration.

As elsewhere, in Asia there are also a multitude of other folk and popular healers, including traditional medicine sellers promoting a wide variety of wares; medical pluralism fluorishes, patients go back and forth between cosmopolitan and traditional healers seeking a solution to their problems [9, 10]. So, naturally, questions arise: "With whom does one collaborate?" "Who are to be integrated?" "Who does one include in an official health care service policy?" and "What do these healers do, anyway?" These are questions asked by physicians who might recognize "some good" done by traditional healers, but who fear that any kind of official recognition would open a Pandora's box and would set a precedent for the eventual approval and promotion of every conceivable type of healer and healing therapy. This would hold true even if professional traditional medicine associations existed, and especially if one association represented all traditional healers in a country. Is Dr Oyebola advocating the creation of such all-encompassing associations?

The situation in Malaysia may serve to add to Dr Oyebola's discussion. The Malaysian Association of Traditional Malay Medicine was formed in 1977. It still has relatively few members, probably less than 200 as of 1979, but is designed to represent what is estimated to be more than 2000 full-time and 20,000 part-time folk healers, or *bomohs*, in the country [11]. It is most likely that as time goes on a substantial number of these bomohs will join the Association. The Association was established mainly through the initiation of the chief anti-drug addiction officer of the major political party, who is now the president of the association although he himself is not a healer [12, 13]. He has long urged the government to recognize the Malay healers for their capabilities in treating and rehabilitating heroin addicts. The formation of the Association is no doubt seen as one mechanism along the road to such a recognition. This may be a valid interpretation, and the motivation is no doubt humanitarian, but the creation of an all-encompassing association could also complicate the official recognition of those healers treating addicts.

Recent research is beginning to indicate that certain bomohs may have certain, possibly substantial, capabilities in addiction treatment and rehabilitation [14, 15] and ministry officials and physicians may be prone to give official recognition to some of the "drug bomohs". Despite this potentially positive inclination toward collaboration with the "drug bomohs", or at least toward some recognition of their capabilities, Malaysian physicians are still hesitant in recognizing these bomohs. The fear is that even if recognition is restricted to those treating addicts, all bomohs, who are a very mixed group indeed, could feel that they are being recognized. This fear is propelled by the existence of the new Association in which all bomohs are grouped together. It is still too early to tell whether this Association will soon be able to present an overview of its membership or have any specific gate-keeping mechanisms to ensure a desired level of therapeutic capability on the part of its different members. It is also too early to know whether separate or sub-groups of bomohs, herbalists, bone setters and the like, will be created.

A slightly older, and somewhat different association, exists in Malaysia, namely the Malaysian Association of Malay Medicine Sellers (PUBRA) which was formed in 1974 and claims to have about 400 members, some of whom are also bomohs. The association cannot yet present a particularly accurate

iew of its members nor of their wares. This is ecause such information is felt to be unnecess- ut because a number of circumstances make it ılt for the association to obtain such infor- n. The PUBRA leadership facilitated a recent [16] which indicated that these vendors sell ranging from a variety of roots and herps to t medicines, with herbal "body strengthener" aphrodisiac" mixtures being particularly popu- he membership included people knowledgeable traditional Chinese, as well as Malay, herbal ines, those who had a number of quite compli- recipes at their fingertips and could easily ize and name numerous medicinal plants, and who sold ready-mixed preparations and did not any particular "medical" or "healing" knowl- Although the association is less than 7 years old, embership list was found to be quite out of date, t least 25% of those listed having moved, died longer selling medicine. All of these problems ndable in view of lack of money for organ- rposes and because of the character of the ership itself which makes communication diffi- ut they point out that the problems faced by ssociations are not necessarily similar to those associations being formed for other "professio- roups.

ttempting to gain recognition for folk healers in sia joint meetings, including an elaborate 2 day ence, have been held between the new "bomoh" ation and the more established Malaysian se Association and the Malaysian Homeo-Ayur- iddha Physicians' Association. As mentioned, embers of these latter associations belong to al medical systems and enjoy more of a positive nship with cosmopolitan practitioners than do is. By linking itself with these associations and couraging the formation of a Federation of sian Associations of Traditional Medicine, it e presumed that not only traditional medicine is to be promoted but that it is hoped that the ers of the "bomoh" association, who are the ikely to be recognized, will gain recognition ch a linkage. The situation in Malaysia is, se, quite complex, as it is in most countries, may well be that there are certain political erations which motivate the more established tions to join ranks with the new "bomoh" as- n, so that both sides have something to gain. ly a federation representing all the traditional in Malaysia could have considerable influence. e is no doubt a great deal of truth to Dr Oye- statement that the "proliferation of professional tions [in Nigeria] makes a central control of actice of traditional healers difficult and s their bargaining power with the govern- An association which could claim to represent traditional (Yoruba) healers in Nigeria, or the an 20,000 bomohs in Malaysia, would wield rable political power which could bring about le reactions to the association's members. But e also other factors than mere size which e the reaction to traditional healers. We must mind that not all herbalists, let alone all tra- folk healers in a country, are the same and a variety of reasons, certain types of healers are more readily "acceptable" to ministries of health and cosmopolitan medical practitioners than others.

Traditional midwives/birth-attendants, who are often classified as belonging within the rubric of "traditional medicine", are a sub-group of "traditional practitioners" which has already gained wide acceptance throughout the world. Traditional mid-wives have been "integrated" into national health service schemes in many countries. If such midwives were members of an all encompassing central association of traditional medicine this would not necessarily mean that such an association could enforce a greater acceptance for them than they already have, nor that it could bring about greater acceptance for all its members because one sub-group of its membership had been integrated. In fact, as in the case of Malaysia, any suggestion that all members of an association should be officially recognized because a group of its members receive a favorable reaction could cause a restrain in the reaction to such a sub-group as well.

As Dr Oyebola indicates, it is most probable that the "cooperation and support [of professional associations] will be needed if proposals to utilize traditional healers for health care delivery in developing countries is to be successful". But it would seem that if a central association did exist it would serve its membership best, and use the political power it did have most appropriately, if it made a clear distinction between the different categories of folk healers, developed guidelines for ascertaining the competency of the members separately for each sub-group, although mechanisms for maintaining ethical conduct could be instituted universally, and made it quite clear that it was not assumed that all traditional healers were the same nor that the collaboration with certain traditional healers necessarily presumed the approval of others.

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Associations involving traditional healers are undoubtedly very common in Nigeria among the Yoruba. Out of a sample of 100 such healers studied in the city of Ibadan in the mid-sixties it was found that 89 belonged to some kind of club. 25 different associations were quoted by name, many of them being in the nature of local herbal guilds rather than professional organizations. The latter term implies responsibility for organizing a long process of systematic training and, whereas such healers do study for years, it does not take place under the aegis of the association.

The Ibadan healers we interviewed had begun to pick up their knowledge at about the age of 8 or 9. 20% of them came from families in which healing was an art or craft, handed down through many generations. The remainder had been trained by individual medical or priestly experts. Taken on whilst very young, they first worked under the guidance of an older man, carrying out a variety of menial tasks before being gradually entrusted with more important ones. The length of this medieval type of apprenticeship varied, averaging 8 or 9 years. But some healers had studied for over 15 years and 6 declared that they were still learning. The herbalists built up a knowledge of many different herbs and naturally occurring substances and their utilization in the manufacture of different kinds of medicines. There was never any suggestion of organized group training, however, the young boys were essentially assistants or acolytes.

Many of the herbalists in town advertised their activities by means of sign boards, in exactly the same way as sellers of bicycle parts or gramophone records might do. But some of the Babalawo (diviner priests) expressed a positive dislike of secular associations. One declared that if a healer's skills were sufficient they would soon become known without any necessity for public advertisements or special pressure to attract people to him.

What has not yet been definitely established is whether the associations of herbalists that do exist have sprung up simply in response to recent competition from scientific medicine or whether at least a proportion of them are manifestations of the tendency of the urban Yoruba to join clubs which represent to their occupational or social functions in the community. This is a feature of Yoruba society which has been remarked upon by Peter Lloyd.

I entirely agree with Dr Oyebola, however, that the proliferation of existing associations makes it exceedingly difficult to establish any kind of formal link between them and the representatives of scientific medicine. But this whole topic of syncretism is an enormously complicated one. It cannot be approached merely on the basis of two confronting groups of experts or specialists, scientific medical doctors on the one hand and the totality of Yoruba healers on the other. There are subdivisions and suspicions on both sides.

Nor should the activities of African healers be regarded simply in terms of their utilization of substances which may be pharmacologically active. Many observers have remarked on the relative insignificance of the pharmacological element, at least in so far as the operations of the Babalawo or diviner priests are concerned. This point was, for instance, expressly made by Michael Warren and his colleagues in a monograph on Yoruba medicines published by the institute of African Studies in Legon (1973).

I believe that much sifting and sorting has to be done and that a clear distinction needs to be drawn between the kinds of conditions which traditional practitioners are able to ameliorate and those in which their advice and operations may be positively disadvantageous to the patient. To take one example, the treatment of young children by local herbalists is almost invariably harmful. The presence of traditional healers should not be made an excuse by Governments who wish to avoid responsibilities in the field of maternal and child care or who will not expend adequate resources upon the public health side of medicine by preventing those communicable diseases which are known to cause the most childhood morbidity and mortality.

Secondly, it is a mistake to analyse the activities of the most revered healers purely in terms of a medical model. Although some practitioners are primarily herbalists, or bone setters, or circumcisors, there is a large group who deal with the social and psychological disturbances in the lives of their clients. It is better to regard these individuals as sources of spiritual or religious support than to look upon them as purveyors of esoteric physical treatments. Indeed there is an interesting example of a degree of syncretism already having been achieved between the therapeutic approaches of this type of priestly Yoruba healer and those of a different religion. The prophets of the separist, Aladura Churches continue to wield the charisma of their pagan counterparts and offer help for psychiatrically disturbed patients whilst specifically rejecting the use of any drugs whatsoever. They use "the power of the Word" plus sanctified oil and water and Christian symbols.

However, there is so little published material about the activities of different kinds of African healers and the way in which they go about their work, organize treatments and relate to one another and to other types of counsellors and practitioners that a paper like Dr Oyebola's is immensely useful. Doctors and medical anthropologists throughout the continent should be encouraged to make detailed notes on the nature of traditional practice within their own locality.

it is only in this way that we can begin to build up a picture of the real diversity and worth of African medicine and escape from the over-simplification of misleading stereotypes.

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Le court article du Dr Oyebola lève un gros lièvre devant tous ceux qui s'interrogent sur les modalités de l'intégration des praticiens traditionnels dans les systèmes nationaux de soins des pays africains. Je soulignerai d'abord qu'il nous apporte des informations peu diffusées et donc précieuses sur l'ancienneté et sur le degré de professionnalisation à ma connaissance exceptionnels—en Afrique Occidentai des guérisseurs yoruba. Que les 156 "herboristes" de son échantillon (on aurait souhaité une définition plus précise de cette population) appartiennent tous à une ou à plusieurs associations professionnelles réunies autour des objectifs libéraux énumérés dans l'article, soucieuses de contrôler la compétence de leurs membres et régies par des codes de conduite susceptibles de servir de support à des sanctions, appliquées le cas échéant par l'organe disciplinaire de l'association... tout ceci modifie nos idées reçues sur la faiblesse panafricaine de la professionnalisation médicale en comparaison notamment avec les médecines asistiques.

Les deux cas épinglés par le Dr Oyebola, les questions générales qu'il soulève et celles que nous sommes en droit de lui poser en prennent d'autant plus de relief. A vrai dire, il ne nous dit pas clairement dans ce texte si les deux guérisseurs incriminés appartiennent ou non à une de ces associations professionnelles et quelles sortes de sanctions pourraient-ils encourir si l'inefficacité de leurs traitements—notamment dans le ces de la blennorrgie—était miss en evidence par leurs pairs: en somme, il ne précise pas dans quelle mesure et éventuellement par quels moyens les associations médicales yoruba exercent un contrôle effectif sur *l'efficacité* des soins dispensés par leurs membres lorsque ceux-ci se disent spécialistes de maladies dont l'évolution est *contrôlable* sans le concours des outils de la médecine cosmopolite. Il me répondre peut-être que sa question est précisément là. Mais alors en quoi consiste, "évaluation de la connaissance" du candidat par les membres des associations et quelle place tient le contrôle du charlatanisme—entendu au sens yoruba—dans leurs codes déontologiques? Le lecteur reste sur sa faim quant à ce point important.

Par ailleurs, les deux ces examinés se caractérisent par la publicité donnée au traitement de deux affections désignées en tormes espruntés au vocabulaire biomédical. Nous observons des phénomènes similaires dans beaucoup de villes et de marchés de brousse ouest-africains. Ils ont un autre caractère "trompeur" que j'aurais, pour me part, souligné. A la différence du Dr Oyebola, les clients des guérisseurs incriminés—pas plus que leurs "thérapeutes"—ne disposent pas de moyens scientifiques pour mesurer l'hypertension ou pour identifier et pour suivre l'évolution de la blen-noraggie. Ils peuvent se croire affectés par ces maux sans l'être au sens bio-médical. C'est un fait d'observation courant que la diffusion de la terminologie "cosmopolite" engendre en Afrique, comme aillaurs, de singuliers *contrats de langage* entre les prétendus spécialistes et les soi-disant malades. L'auto-diagnostic du "paludisme" et l'application extrêmement libérale de ce label médical (aux maux de ventre, aux nausée aux fièvres de toutes sortes, aux affections hépatiques...) en est l'exemple le plus banal. Sans se faire l'avocat du diable, l'on peut supposer que les deux "charlatans" mis en cause —comme du reste leurs collègues plus discrets et prudents—bénéficient de la résolution spontanée de certaines conditions pathologiques présentées par leurs clients (soux le dénominations d' "hypertension" ou de "blennorragie"), voire qu'ils offrant à ceux-ci des remèdes efficaces dans d'autres registres que ceux qu'ils affichant sur leurs panneaux publicitaires. Je veux dire seulement par là que les critères objectifs retenus par le Dr Oyebola (le test *in vitro* et l'absence de mesure de l'hypertension) ne suffisent pas pour prouver l'inefficacité thérapeutique globale des deux guérisseurs épinglés.

Mais, l'essentiel du propos n'est pas là. Le Dr Oyebola aborde de façon tranchante et je dirais par le bout le plus facile—mais comment lui en tenir riqueur?—plusieurs questions centrales pour l'avenir des médecines africaines. La diversité et la dispersion ethnique considérables des traditions médicales africaines et de leurs praticiens semblent un obstacle majour—objectif, éthique, politique—à leur intègration dans les systèmes nationaux de soins. Est-ce que les associations professionnelles de guérisseurs, lè où elles existent ou celles que les initiatives des intéressés eux-mêmes pourraient susciter, là où elles n'existent pas, sont à même de s'organiser en quelque structure institutionnelle multi-ethnique (fédérative?) capable de *péoocier* leur reconnaissance officielle face aux représentants de la médecine cosmopolite? A supposer qu'une telle évolution soit concevable et souhaitable, quel les garanties de compétence, quel système d'admission et de sanctions, quels codes déontologiques pourraient-elles proposer en contrepartie de cette légalisation d'une sorte d' "ordre des médecine traditionnels"? Et surtout à qui? L'on sait que le corps médical occidental façonné par l'éthique hippocratique tend à récuser les interventions de la justice dans ses affaires internes et fonctionne bien souvent comme un *corps juridique* autonome. Compte tenu des rapports de force actuels, est-il imaginable qu'un état africain puisse légaliser des institutions médicales issues de la tradition sans leur imposer du même coup la *juridiction propre*—et l'éthique—de la médecine cosmopolite?

Les exemples choisis par le Dr Oyebola sont parlants à cet égard: ils appartiennent au registre des démarches médicales *objectivement* efficaces (ou ineffiçaces selon les critères énoncés par la médecine occidentale. L'idée sous—jacente—que je n'attribue pas à l'auteur—est claire: s'il convient de protéger le public contre les pratiques objectivement inefficaces, l'on pourrait éventuellement légaliser celles dont l'efficacité aura été objectivement vérifiée par la science médicale? Autrement dit, choisisso parmi ces démarches celles qui satisfont aux exigences de nos

tests scientifiques et appuyons-nous sur les organisations professionnelles de ceux qui les pratiquent pour redéfinir et pour maîtriser le charlatanisme. Malheureusement,—et le Dr Oyebola ne l'ignore certainement pas—l'écrasante majorité des démarches médicales proprement africaines ne se prêtent pas à de telles procédures de vérification expérimentales. Les ressorts de leur efficacité sont *à rechercher* dans l'interaction des variables biophysiques et symboliques, psychologiques et sociales que nos connaissance actuelles ne permettent pas d'abstraire du *contexte sémantique* où elles exercent leurs effets. Le guérisseur, ses concepts, son statut professionnel, ses outils thérapeutiques, sa déontologie ... sont partie intégrants de ce contexte et de cette interaction qui requiert généralement la recherche d'un consensus social, plus ou moins large, autour de l'action médicale entreprise. La professionnalisation et l'officialisation des médecines africaines sous la tutalle scientifique et éthique de la médecine cosmopolite modifierait considérablement les conditions d'exercice et par conséquent l'efficacité de ces médecines. Assurément, le Dr Oyebola a raison de demander des comptes aux guérisseurs yoruba qui s'aventurent dans le champ sémantique de la médecine occidentale. Mais, la direction dans laquelle sa recherche nous oriente me semble récéler aussi le danger de la méconnaissance des arts de guérison africains et le risque de leur assujettisement professionel et éthique à la médecine dominante. Quitte à être le cas échéant heurtés par leurs démarches ou par leur déontologie, nous avons *à découvrir*, et non à superviser, les arts de guérison en question. Les efforts d'intégration des guérisseurs africains dans les systèmes nationaux de soins risquent de manquer leur but tant que l'anthropologie médicale n'aura mis en évidence les mécanismes originaux qui différencient ces arts de la médecine positiviste de l'Occident et qui permettront d'établir les bases juridiques de leur autonomie.

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