Medical Pluralism and Global Health Policy

The integration of traditional medicine in health care systems

Brenda Joanne Foran

Doctor of Philosophy (Social Policy)

University of Western Sydney

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The Social Justice and Social Change Research Centre

Professor John Macdonald

Dr Betty Gill

Dr Danister Perera

Professor Lokendra Singh
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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Signature
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# ACRONYMS

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<tr>
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<th>Full Form</th>
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<tr>
<td>CAM</td>
<td>complementary and alternative medicine</td>
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<tr>
<td>CBD</td>
<td>Convention on Biological Diversity</td>
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<td>CITES</td>
<td>Convention on the International Trade of Endangered Species</td>
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<td>DALY</td>
<td>disability adjusted life years</td>
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<td>DAP</td>
<td>Drug Action Program</td>
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<td>GATT</td>
<td>General Agreement on Trade and Tariffs</td>
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<td>GEF</td>
<td>Global Environment Facility</td>
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<tr>
<td>GOBI</td>
<td>growth monitoring, oral rehydration, breastfeeding, immunization</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus, Acquired Immunodeficiency Virus</td>
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<tr>
<td>HFA</td>
<td>Health For All</td>
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<td>IK</td>
<td>Indigenous Knowledge</td>
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<td>IM</td>
<td>Indigenous Medicine</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>Intellectual Property Rights</td>
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<tr>
<td>NCCAM</td>
<td>National Center for Complementary and Alternative Medicine</td>
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<tr>
<td>NIH</td>
<td>National Institutes for Health</td>
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<tr>
<td>NIEO</td>
<td>New International Economic Order</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OPEC</td>
<td>Organisation of Petroleum Exporting Countries</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>SLMA</td>
<td>Sri Lankan Medical Association</td>
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<td>SLMC</td>
<td>Sri Lankan Medical Council</td>
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<td>TBA</td>
<td>Traditional birth attendant</td>
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<td>Traditional medicine</td>
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<td>UN</td>
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<td>UNDP</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>Acronym</td>
<td>Full Name</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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ABSTRACT

This research explores the international evolution of the policy of integration (formalisation) of traditional medicine in health care systems. This concept first arose on the policy agenda of the World Health Organisation in the 1970s and then re-emerged in 2002 (with alternative and complementary medicines). The history of this policy at the global level and its transfer to national levels over this period is analysed, via the content, scope and outcomes of policy and programme documents. This analysis emphasises the roles of context and stakeholders (specifically interest groups).

The context in terms of the economic, political and social environment surrounding the development of the policy is considered, and held to offer a potential explanation as to how and why the policy agenda on integration was set and the manner in which programmes were formulated and implemented. Interest group interaction (competition for resources) is concluded to play a key role in explaining the development of this policy on an international level, and its problematic transfer to national levels. A case study of Sri Lanka explores national level implementation in greater detail.

An analytical framework to analyse the development and implementation of this policy has been created, from a synthesis of anthropological and political science tools. The combination of several theories into an analytical framework allows this policy issue to be understood as an intrinsically political exercise that has been stimulated by global social and economic forces. The analytical framework developed offers another tool for the analysis and consequent understanding of the health policy process and thus may have relevance beyond the health policy issue of integration.
1. Introduction

1.1 Introduction

At the turn of the century, the impacts of globalisation on the development of health policy and provision of health services became a focus for researchers in the health field (Buse et al., 2002; Kickbusch & Buse, 2001; Lee, Buse, & Fustukian, 2002; McPake, 2002; Whiteford & Manderson, 2000). This new focus was the result of a growing realisation that globalisation was exerting complex impacts on public health, and health policy formulation and implementation. Researchers began questioning the extent that globalisation itself was a contributing factor to the worsening of global public health and the failure of global health initiatives. The regressive impacts of globalisation on public health were most obvious in developing nations (the South) where there has been a “slow, unstable and unequal pattern of growth, and stagnation in health indicators” (Cornia, 2001:79).

Worsening global public health was despite “one of the most extraordinary attempts to frame a global health agenda” in the 1970s, the commitment by member states of the World Health Organisation (WHO) to achieving “Health For All” (HFA) by the turn of the century (Kickbusch, 2002). The HFA goal (1978) was a bold, landmark initiative, spurred by the recognition that biomedical health care systems were not adequately meeting the needs of populations in the South (Djukanovic & Mach, 1975), and influenced by the optimistic movement for a more holistic approach to development of that time (Macdonald, 1992).

A new approach using local resources and knowledge was advocated. Under the WHO-endorsed policies, integration (formalisation) of traditional medicine (TRM) into health care systems was required in order to achieve optimal health care coverage (Stepan, 1983:307). However, implementation of this objective on national levels was hindered by a variety of factors, some of which were associated with globalisation. Despite consensus at the international level in the 1970s that such an approach was rational, practical, and offered social and economic benefits (WHO, 1978b), it proved difficult to realise over the following decades.

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1 Globalisation is defined as “… the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa” (Giddens in Albrecht et al. 2000:84).
As the policy for formalising the role of TRM in national health care systems seemed to lose momentum in the South in the 1980s, new trends emerged in developed countries (the North). Millions of people began seeking complementary/alternative (CAM) approaches to biomedical systems. TRM systems became subject to intense clinical and commercial interest. As will be argued later, this presented new threats and challenges to the integrity of TRM and its role in health care in the South. Although the profile of TRM had been raised, the lack of progress in policy formulation and implementation left it vulnerable to economic exploitation.

In 2002, the WHO announced a global TRM Strategy (WHO, 2002e). The TRM Strategy called for all member states to integrate and formalise the role of TRM/CAM in health care systems. In the 25 years since the WHO originally promoted the role of TRM, only 25 out of the 191 member states had developed an associated policy (WHO, 2002e:3). As this thesis will demonstrate, over that time demographic changes, growing medical pluralism and changing economic and social trends created a policy “convergence” in both the North and South. The applicability of TRM/CAM in health care had broadened and forced a range of policy issues onto the global agenda.

The WHO TRM Strategy (WHO, 2002e) can therefore be seen as an example of one of the trends in a globalising world – convergence, where a common policy solution is proposed for global application.² There has been an increasing emphasis on global models, where policies from one part of the world are transplanted elsewhere without due regard to context or objectives. Therefore, the global–local interface in terms of policy transfer, (Buse et al., 2002:271), the processes of policy transfer, and the role of international organisations in that process (Ogden, Walt, & Lush, 2003) are deemed worthy of further attention.

Exploring such questions requires comparative country case studies to establish the impact of policies and the roles of actors in making policy “coherent and feasible” (Buse et al., 2002:272). One important consideration that McPake notes is the variation of objectives that may exist in different settings despite common policy prescriptions (2002). Buse et al. caution against the widespread transfer and adoption of universal policy models that may be “conceived from predetermined ideological preferences and introduced through top-down

² Some health policy theorists have argued that there are global patterns emerging regarding the reform of health systems (see Field, 1989; Alridge & Sundarapandiyan, 1995). This concept has usually been applied to financial/economic factors, such as the application of market mechanisms (McPake, 2002). However, as far as the convergence theory argues that common policy solutions are emerging, it is applicable to the concept of integration of TRM/CAM. The reasons for convergence are still a matter of conjecture (Buse et al., 2002; McPake, 2002).
approaches” as this process usually precedes an adequate evaluation of whether such policies work, and under what conditions (2002:267).

1.2 Health policy

Considine (1994) determines that policy can be any or all of: clarification of public values and intentions; commitments of money and services; or the granting of rights and entitlements. He concludes that the standard definition is “a public policy is an action which employs governmental authority to commit resources in support of a preferred value” (1994:3). Therefore WHO policy statements and resolutions (while not committing government resources directly) can be analysed through the preferred values they support and their internal resource allocation.

Researchers and academics in the health policy and governance field have questioned the “rationality” of health policy formulation and implementation. Kickbusch asks “why in the course of globalisation, the primacy of economics overran all knowledge of what constitutes sound health policy?” She points out the paradox that, despite all the information available on determinants on health and means to address this, health policy is often very different than one would expect based on such information (Kickbusch, 2002). Some commentators think health policy should be rational because of this very fact – that the information on the problem and the solution is available, so implementation should therefore be straightforward. Policy is generally assumed rational when the problem is technical, the climate consensual and the process controlled (Gordon, Lewis, & Young, 1993:7).

However, as many commentators conclude and this thesis will demonstrate, health policy is far from “rational”. The notion of “rationality” in health policy is a very subjective and ambiguous concept that varies depending upon perspective – for example, economic, political or socially “rational” outcomes may vary widely. Accepting any premise of rationality where experts (such as economists or epidemiologists) make a logical plan which is then simply implemented will lead to very flawed assumptions (Zwi & Mills, 1995:315). As health policy is shaped by power relations (is inherently political) irrational outcomes and conflict in formulation and implementation will inevitably occur. A coherent and feasible policy needs to take into account the motivations and likely responses of various actors as well as constraints and contexts at national levels, and this thesis will explore those key factors.
Health is usually considered different from other policy fields not only because it is a public good, but also because the biomedical profession has a complicated role in shaping and constraining it; the inherent complexity of health care provision (such as balancing ethical, moral and social justice considerations with economic concerns); and the assumed inability of consumers to distinguish between quality of services and weigh up costs and benefits (Hancock, 1999; Palmer & Short, 2000:24). In making health policy, political and economic issues are therefore central, and the interests of the actors and stakeholders involved are an important factor (Walt, 1994). Berliner and Salmon (1980a:547) reflect this view when they note that the conflict between TRM/CAM and biomedicine in health paradigms and health policy is political – it is about power and control.

Therefore formulation and implementation of health policy will be very difficult, as it will result in a bargained outcome, the process will be impeded by “diversity and constraint” and the environment is one of conflict (Gordon, Lewis, & Young, 1993:8). If it is acknowledged that health policy formulation and implementation is political and the relationship between medical systems is also essentially political, understanding the motivation and behaviour of actors involved is crucial in order to understand the outcomes and impact of a proposed policy. If this behavioural aspect is overlooked, it will be difficult to understand and anticipate responses. Assuming that individuals, groups, or organisations behave rationally is an oversimplification (Jenkins, 1993:42), and this is compounded by an ambiguous and uncertain environment for implementation.

The relationship and interaction between medical systems has a long and complicated history. Integration of TRM into formal health care systems is a complex issue that touches on a range of significant topics. Many of these issues are within discrete disciplines accompanied by bodies of extensive literature, traversing fields as diverse as anthropology, sociology, health sciences, psychology, philosophy, law, economics, natural sciences and history. The scope of this research does not allow the exploration of this literature (and other related issues) in depth. Instead, this analysis aims to use a multi-disciplinary approach to illuminate global and local policy formulation and implementation in relation to integration of TRM in the latter part of the century.

This scrutinises TRM and its role in health care systems from a political science perspective, and could be located within the discipline of critical medical anthropology (see Morsy, 1990; Singer, 1986; 1989, 1990; Singer, Baer, & Lazarus, 1990). It places the concept of integration within its political, economic and social context in exploring why it emerged on the policy agenda in the 1970s, its global-local transfer in the intervening years and the
circumstances surrounding its re-emergence on the international agenda as a global WHO Strategy in 2002 (WHO, 2002e).

1.3 History and context

As the focus of this research is on the interaction of various medical systems, it is important to offer some background information on their history. Different systems of medicine and health care trace their roots to prehistoric sources of knowledge about the human body and its interaction with the environment. Over time, different schools of thought on health care have waxed and waned. Each sought to perfect methods to obtain well being, and defeat disease and death. Long before writing was invented, this revered knowledge was passed down from generation to generation; changing and developing as the social, economic, cultural and physical environment transformed over centuries. Arabic, Chinese, Egyptian, Indian, and Western civilisations all produced complex systems of healthcare, using different tools and concepts, and interacting with each other in various ways. There have been tens of thousands of different medical traditions practiced on Earth (Grossinger, 1990:47), some of which still survive and others which have been born or reborn in this generation.

With globalisation over the past century, the manner in which various systems of health care have developed and interacted within the modern state has become increasingly multifaceted. Focussing only on the recent past of the last few decades, changes in both health systems and the health status of populations has been profound and rapid.

“Globalisation” is not a new phenomenon, although it has increased in velocity during the course of the twentieth century and changed in nature (Chen & Berlinguer, 2001; Zielinski Gutierrez & Kendall, 2000). Whiteford and Manderson call it “merely an old book in a new cover” with the same purposes and outcomes as imperialism and colonialism (2000:3). They contend that globalisation facilitates and extends processes that commenced with colonisation, where “knowledge” and “authority” were exported and imposed on local behaviours, values and beliefs (2000:13).

This process is clearly evident in the provision of health care services, where Western biomedical models were transferred and entrenched worldwide. Some consider biomedicine to be “one of the best examples of globalisation” (van der Geest, Reynolds Whyte, & Hardon, 1996:155). The relationship between imported biomedical and existing indigenous or traditional systems of healing offers an interesting example of health systems development that has absorbed anthropologists and social scientists for decades.
1.3.1 Definitions and use of terms

All of the definitions and terms used for both biomedicine and TRM/CAM are plagued with controversy and difficulties. None of the terms (traditional, complementary, alternative, biomedical) are adequate and all are contested (for example, see Cassidy, 2002; Eskinazi & Mindes, 2001; Millet, 1999; Pigg, 1995). “Traditional medicine” (TRM) is difficult to define because of the diverse range of practices it encompasses. In addition, efforts to define TRM usually reflect particular values and cultural norms (Millet, 1999; Ranjan, 1998:52; Wolffers, 1990:5). Janes concludes that “there is no satisfactory term to refer to non-Western, indigenous medical systems” (1999:1803) and the WHO acknowledged that “at a global level, traditional medicine eludes precise definition or description” (WHO, 2002c:7).

The WHO has defined TRM as “ways to protect and restore health that existed before the arrival of modern medicine” (WHO, 1996b). However, WHO also notes that this distinction is arbitrary in that “all medicine is modern in so far as it is satisfactorily directed towards the common goal of providing health care, despite the setting in time, place and culture” (WHO, 1978b:9). The term traditional medicine includes “… diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain wellbeing, as well as to treat, diagnose or prevent illness” (WHO, 2002c:7).

Traditional medicine (TRM) and “complementary” or “alternative” medicines (CAM) share many similarities, and variations in terms mainly reflect historical, political, cultural, and geographic distinctions. Complementary and alternative medicines can be considered any therapeutic system based on a theory of health/disease or method of treatment other than that of biomedicine. As such, TRM can be considered a form of CAM, and the term CAM is used in those countries with no history of TRM (WHO, 2002c:1, 8). TRM is the term used in the South, and CAM in the North, referring generally to those systems of medicine and health that use natural remedies, spiritual and/or physical therapies. This distinction is used throughout this document, with TRM/CAM used when referring to these systems of health care in the global sense.

Biomedicine is defined as the system of medicine which is of western origin and based on the biological sciences (Janes, 1999:1803). Biomedicine is based on principles and values of western scientific knowledge and is also known as western, conventional, modern, orthodox, mainstream, cosmopolitan, scientific or allopathic medicine. All of the labels are “culturally loaded, inaccurate and no longer appropriate” (Cassidy, 2002:401), and words such as
“doctor” and “medicine” have become exclusively associated with biomedicine when they are general and neutral terms that can refer to a variety of medicine or a variety of doctors (Cassidy, 2002:401).

Aspects of these terms and definitions are contentious. For example, the term biomedicine implies a degree of scientific objectivity that is not correct (Janes, 1999:1803). Van der Geest considers the term TRM “misleading, embarrassing, and naïve” as it suggests homogeneity, is ethnocentric and disregards the fact that biomedicine is also traditional in the sense of being handed down over generations (1997:904). Wolffers highlights biomedical bias in some definitions of TRM (1990:5). Bodeker prefers the term “traditional systems of health care” as they provide “comprehensive approaches to prevention and treatment beyond the scope of medicine alone” (1994b:6).

Others have noted the tensions in defining “traditional” or different systems of medicine as other to the dominant biomedical discourse, which is implicitly considered the standard or norm – particularly evident in the term “alternative” (Ranjan, 1998:52). Koop (2002) and Easthope (2003) note that changes in the use of the terms “alternative” and “complementary” reflects shifts in usage trends. Initially, “alternative medicine” was the term used, reflecting disenchantment with biomedicine “as well as a cultural rebellion against the biomedical community” (Koop, 2002). More recently, “alternative” therapies have become more frequently referred to as “complementary” therapies, used not in opposition to biomedicine but as an adjunct to it.

Saks (1992a) argues that the term “alternative medicine” is preferable to terms such as “complementary”, “traditional” or “holistic” as this expression is more comprehensive. For example, “traditional medicine” does not encompass some of the more recently developed therapies such as chiropractic. The term “complementary medicine” excludes therapies with philosophies that fundamentally conflict with biomedical theory (such as homeopathy) (Saks, 1992a:3). Finally, “holistic medicine” does not include therapies based on mechanistic systems of disorders such as osteopathy.

According to Saks, using the concept of “alternative medicine” is not only more widely applicable but has “greater analytical utility” than other labels. Other terms are based on trying to identify common elements in an inherently heterogenous field. As Saks proposes that the main distinguishing feature of such therapies is their weaker socio-political position in the health care system (1992a:3), the term “alternative” encompasses the notion of their role outside formal health care systems. Despite that, most of these systems are “holistic” in
the sense of promoting health and preventing illness, in contrast to the biomedical mechanistic/engineering concept of intervention (Saks, 1992a:4). It could be argued, however, that the term “alternative medicine” is ethnocentric and fails to adequately take into account cultural contexts where biomedicine was not historically the main medical system.

The term “traditional medicine” is sometimes used in the North to refer to biomedical (conventional) systems (Benjamin et al., 1997; Rifaat, 1997). This is a reflection of the cultural relativity of the terms, where biomedical systems are considered the norm and thus the “traditional” system. The relativity of all terms is important to note. The definitions are not static across time or culture, and such terms are largely political (Astin et al., 1998:2309). Saks points out that “much of the alternative medicine … has links with mainstream health practices of centuries past and may well be on course to become part of the new orthodoxy of the future” (1992a:4).

Despite inadequacies and difficulties in definition, the term TRM is used in this thesis for consistency. Although “traditional systems of health care” may be a more representative term, the use of TRM is consistent with WHO documents. When the generic term is insufficient for the discussion, more specific descriptions of particular healing traditions will be used. Although TRM encompasses diverse practices, to enable analysis of this issue on a global level, it is considered as representative of one group with philosophies that differ from and oppose biomedicine.

Therefore, TRM/CAM systems and practitioners worldwide are grouped together as a cohesive interest group, even though they do not operate in this fashion or necessarily identify with each other. This is based on Saks’ concept that “the key distinguishing feature of such therapies is not their common content, but their socio-politically defined marginal standing in the health care system” (Saks, 1992a:3). Despite not sharing common content, these health care systems share broadly similar features – for example: the use of biological resources such as plants, physical therapies and specialised ritual/spiritual techniques.

While some may find the groupings of biomedicine and TRM/CAM crude or misleading, others would similarly reject the dichotomies of North and South. Just as the heterogenous

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3 It is acknowledged that this is a crude grouping, akin to “the lumping of human races into two categories: ‘caucasian’ and ‘other’” (Press, 1980:45). However, without such a generalisation, global (cross-cultural) analysis would not be possible. Some CAM practitioners would be surprised to be grouped with TRM, as they perceive inherent distinctions based on geography, history and philosophy rather than similarities based on socio-political position and health care resources used.
nature of the professional groupings has been acknowledged, it must also be acknowledged that the categories of North and South contain a large number of countries which differ widely. The North-South distinction could even be applied within countries, as wealth is stratified and polarised to varying degrees on national as well as global levels.

The categories of “developed” and “developing” is being replaced with other categories and the terms **North** to indicate developed, industrialised countries and **South** to indicate countries dependent upon development aid has been adopted by some (Kickbusch & Buse, 2001:703). These categories are not an effort to simplify by disregarding disparities; they are used only as abstractions. This permits macro-analysis, in order to consider larger scale processes and entities (government agencies, international bodies, professional groups, economic and environmental forces) and address questions of power, resource allocation and organisation (Janzen, 1978:121).

Finally, the term *integration* can have multiple meanings, and is difficult to define and describe (Adams, 2003). Firstly, it can refer to incorporation of TRM/CAM into the general or formal health care system. Secondly, the use of some TRM/CAM by biomedical doctors, or the practice of traditional or alternative medicines alongside biomedicine can also be a form of integration. Thirdly, it can refer to the synthesis of TRM and biomedicine into a new branch of medical science which incorporates elements of both (WHO, 2000d:16-17). In this thesis, *integration* is used to refer to incorporating TRM/CAM into the formal health care system. This can take different forms and is discussed further in the following section.

### 1.3.2 Structure and organisation of health care systems

The use of universal policy prescriptions regardless of context has a long tradition in relation to the organisation of formal health care systems. Commencing in the nineteenth century, the Western biomedical model was transferred globally with little effort to match services to local needs (Macdonald, 1992:17). While Unschuld notes that the cross-cultural transfer of medical resources has an extensive history, colonialism actively suppressed and rejected existing indigenous medical traditions on the assumption that medical resources imported from the West were sufficient to construct a complete health care delivery system (Unschuld, 1976b:5). This also served particular political and economic interests (Brown, 1978, 1979; 4

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4 Approximately 25% of modern medicines are derived from plants first used traditionally (WHO, 2002b). Some of these include resperine (from *Rauvolfia*) which is used to treat blood-pressure and central nervous system disorders; quinine (from *Cinchona*) to treat malaria; digitatin and digoxin (from *Digitalis*) to treat heart conditions; ephedrine (from *Ephedra*) as a decongestant, amongst many others (Srivastava, Lambert, & Vietmeyer, 1996:3-4).
The idea of transferring biomedical systems was related to the “modernisation” theory of social development, which assumed that as developing societies adopted western ideology, “indigenous healing would wither on the vine” and biomedicine would prove a superior substitution (Kleinman, 1984:139). It was then that the label “traditional medicine” was applied, to signify them as separate and distinct – an aspect of the tradition and history that biomedicine was to replace in its modernising mission. Before biomedicine arrived, there weren’t any “traditional” medicines, there was just medicine/health care. Though generally presented otherwise, biomedicine is itself only Western indigenous medicine in a new location, where it was the “alternative” medicine. On utilisation figures in the South, it remains the “alternative” system today (Bodeker, 1996:323).

The belief about modernisation and its inevitable replacement of existing health traditions was therefore proven false, as the use of TRM continued to flourish and sole reliance on biomedical infrastructure was found to be untenable (Djukanovic & Mach, 1975; Kavadi, 1991; Lee, 1997:29). Rather than demand for TRM decreasing with modernisation, some have contended that it actually increased – TRM practitioners can offer a therapeutic social relationship that may help people cope with rapid social and economic transformations, or the transition to urban life (“maladies of modernisation”) (DeJong, 1991:6; Good et al., 1979:146; Green, 1988:1128). The paradox of increasing demand for TRM with urbanisation has also been linked to affordability, efforts to preserve local heritage or a lack of independent access to plant sources for self-medication (Bodeker & Bichan, 1996:390).

In some countries TRM knowledge systems were embraced and promoted during the post-colonial period, as part of the restoration of national customs (Islam, 1994). The movement to utilise and recognise the value of TRM in national health care systems thus had a dual purpose. It was motivated by the need to provide basic health care services, and it was reinforced by the political aspiration of reviving the heritage of newly independent nations (George, 1991; Okoth-Owiro, 1994:39-40; Stepan, 1983:298). This was endorsed on the international level by the WHO in the 1970s, with an acknowledgment that TRM systems offered a feasible alternative in establishing and extending health care services. This was “revolutionary” for an organisation that until that point had strongly advocated and assisted
in the transfer of Western biomedical technology as the only appropriate method to deliver health care services (Lee, 1997; Turshen, 1993:987), in line with the UN objective of modernisation.

However, organising TRM in legal and policy frameworks presented a range of conceptual and structural difficulties (Green, 1988; Neumann & Lauro, 1982; Pillsbury, 1982). Biomedical systems continued to dominate formal health care delivery worldwide, which Unschuld argued was “more due to coercive factors … than to natural development and demands from the population” (Unschuld, 1975:303). Support for biomedicine from dominant global paradigms was augmented by its “nearly perfect” adaptation to bureaucratic organisation, which inflated its role in health care planning (Leslie, 1983:314).

For example, biomedicine continued to absorb up to 90% of resources invested by international agencies, while reaching only around 10% of populations (Bodeker, 2001a:390). Biomedical tertiary services were allocated the majority of resources, with little fiscal appropriation for primary health care (Zwi & Mills, 1995:309), and biomedical specialists/hospitals captured both the health budget and prestige in service delivery (Light, 1995:33). The domination of formal health care systems by biomedicine results in a dependency on pharmaceuticals and technology – the former often absorbing up to 30-50% of health care costs in the South (Chi, 1994:308).

Stepan (1983) described four main organisational relationships between biomedical and TRM systems in national health care (see table 1), a schema which has been used, with some variations, by others (Bannerman, Burton, & Wen-Chieh, 1983; Bodeker, 2001b; Last, 1990; Young, 1994). It should be noted that as the exclusive and tolerant systems either suppress or ignore TRM, the methods for actively using TRM in national health care systems are therefore the integrated and inclusive systems (Leslie, 1983:317).

The use of these categories, the countries grouped within them, and their practical meaning is not a matter on which there is universal consensus. Leslie considers it important to understand that these labels actually describe normative institutions and not the reality of how health systems operate. Integrated systems do not incorporate all aspects of TRM, only selected practices. Inclusive (parallel) systems may have separate institutions for biomedical and TRM education and delivery, but integration may occur at the consumer (or even practitioner) level. These systems form a “continuum” rather than two distinct frameworks (1983:316).
### Table 1: Organisation of health care systems

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
<th>Example (1983)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monopolistic (exclusive)</td>
<td>Only the practice of biomedicine is recognised as lawful</td>
<td>Most European countries and their colonies – 19th and first half of the 20th century</td>
</tr>
<tr>
<td>Tolerant</td>
<td>Does not officially recognise TRM, but does not prevent the practice of non-biomedical systems</td>
<td>Germany, United Kingdom, Australia</td>
</tr>
<tr>
<td>Inclusive (parallel)</td>
<td>Two (or possibly more) systems of health and medical care co-exist (separate formal recognition)</td>
<td>Sri Lanka, India</td>
</tr>
<tr>
<td>Integrated (integrative)</td>
<td>Biomedical and TRM are merged in medical education and service delivery - jointly practiced</td>
<td>China</td>
</tr>
</tbody>
</table>

Source: Adapted from Stepan (1983); Bodeker (1994b:7); WHO (2002)

According to the WHO, monopolistic systems no longer operated by 2002 and only three relationships between medical systems were recognised in the *TRM Strategy* (WHO, 2002e:8-9):

- **integrative** systems, where TRM/CAM is officially incorporated into health care provision, including drug policy, regulation and registration of practitioners and products, public and private provision of therapies, health insurance, and education

- **inclusive** systems recognise TRM/CAM but it is not fully integrated into all aspects of formal health care, whether at the delivery, education and training, or regulation levels

- **tolerant** models where the health care system is based entirely on biomedicine, but some TRM/CAM practices are tolerated.

The lack of recognition of monopolistic systems in the *TRM Strategy* (WHO, 2002e) reflects a shift that developed throughout the twentieth century. Most countries operating under monopolistic systems gradually moved to tolerant models (for example, many countries in Africa), and those with tolerant models moved towards the inclusive/parallel systems (for example, Germany and the United Kingdom were classified as tolerant in 1983 but inclusive in 2002). However, this trend has been further extrapolated by the WHO as indicating that monopolistic systems have ceased to exist and that “ultimately countries operating an inclusive [parallel] system can be expected to attain an integrative system” (WHO, 2002e:9).

However, as this thesis demonstrates, the development of an integrative system is not necessarily evolutionary as assumed by the WHO. The continuum of systems is not one that represents a progressive “improvement” on a scale, with parallel systems on one end and
integrative systems on the other. Rather, the position on this continuum represents a political relationship between different medical systems, mediated through the state. The state has a critical role in determining structural access to and distribution of health services, and the regulatory basis for practice in the formal sector. Countries that have achieved “fully” integrated systems are rare, and have socialist or communist backgrounds (China, Vietnam, and Democratic Republic of Korea). They rejected neo-liberal economic values, were shielded from global market forces and had a strongly espoused political commitment to equity in the provision of social services.

Further, where “integration” has been achieved, it has been questioned whether this “arranged marriage” is necessarily a “happy marriage” (Beyerstein & Sampson, 1997). As all organisational relationships between medical systems in formal health care networks are dominated by biomedicine, and integrated systems exclude many aspects of TRM (Leslie, 1983:316), there are inherent tensions and conflicts. Bodeker comments that in China, biomedical control over the process of integration resulted in the loss of aspects of TRM theory and practice (Bodeker, 2001b). In South Korea, conflict between practitioners of different systems of medicine was high throughout the 1990s, in the lead up to the goal of full integration by 2001 (Bodeker, 2001b; Cho, 2000b). In Japan, herbal medicine was “in serious danger of a complete demise through its ‘integration’ and adoption into biomedicine” (Lock, 1990:42). Young (1994:66) determines that, in this regard, monopolistic and integrative systems share much in common, and van der Geest (1985) alludes to integration as a “fatal embrace”.

The paradox of the policy of integration is that it has widespread support from a coalition of diverse interests, including governments, international bodies, pharmacologists, idealists, radicals and realists (Last, 1986:1), although genuine collaboration at the practitioner level is rare. Functional national policies have proven very difficult to articulate and implement. This is a peculiar situation, considering the practical benefits that could be obtained, the statements of support from stakeholders, and the length of time that integration has been advocated. Asking why this collaboration is easy to agree on and difficult to achieve may be a simple question, but there is no simple answer. Looking in more detail at key stakeholders provides some clues.

Unschuld concludes that very limited integration has taken place in China or anywhere else, and structured competition was more often the outcome (1976b:19).

Ambivalence, discord and resistance has also been documented in Nigeria (Offiong, 1999), South Africa (Kale, 1995), Zimbabwe (Freeman & Motsei, 1992), Uganda (Tabuti, Dhillion, & Lye, 2003), Ethiopia (Bishaw, 1991), Ghana (Warren et al., 1982) and Botswana (Barbee, 1986) – amongst other countries.
1.4 Stakeholders

Friction between stakeholders is a crucial issue in the formulation and implementation of a policy of integration. This friction is multi-faceted. For example, on a global level there may be divergences of objectives between non-state bodies; health care practitioners may have tensions related to securing economic and professional benefits; and national governments have to reconcile competing domestic demands while adopting internationally-driven agendas. Although improved access, outcomes, equity and quality in health care for consumers may be State goals, sectional interests and conflicting principles often overshadow these objectives. A brief description of some of the main stakeholders (international bodies, the state, medical systems, and citizens) and their roles is discussed below.

1.4.1 International bodies

Since its inception over 50 years ago, the WHO has been considered the principle body for guiding international health work and policy (Lucas, 2003). During the first 30 years of operation, it focused on mainly providing technical and scientific advice and setting international normative standards. However, in the late 1960s and during the 1970s, membership swelled with newly independent states, and decisions became “more political and less predictable” (Godlee, 1994a). The Health For All initiative in the 1970s (of which use of TRM was an aspect) was one scheme that marked the beginning of an advocacy role which some consider breached its mandate to provide technical advice (Lee et al., 1996). This goal was “extraordinarily ambitious” although “in tune with the times, espousing equality and social justice” (Godlee, 1994a).

During the 1980s and 1990s, the WHO was subject to increasing criticism, which mounted as it became apparent the “Health For All by the Year 2000” goal had failed. A lack of funding, inability to implement policies, a narrow biomedical and technical focus, lack of co-ordination, and structural weaknesses combined to limit its effectiveness (Godlee, 1994a, 1994b, 1995b). At the same time, the World Bank began to take an active role in health matters, and by the 1990s was considered the “new 800 lb gorilla in world health care” (Abbasi, 1999a:866).

While the WHO is primarily an advisory body, it also funds and promotes some programmes although its budget has progressively decreased since the 1980s (Ogden, Walt, & Lush,
The World Bank offers loans, but these are often conditional and may be tied to policy prescriptions. It also has an increasing role in funding programmes directly and indirectly related to health since the 1980s (Abbasi, 1999a, 1999d). The World Bank quickly managed to eclipse the WHO in directing global health policy through the sheer volume of funding it provided. It also heavily influenced paradigms in global health policy, with the key 1993 World Development Report Investing in Health viewed as the epitome of applying economic rationalist principles to health care.

However, despite taking an increasingly active role in global health, critics considered the World Bank’s debt servicing requirements and structural adjustment programmes were acting as a powerful, negative counterforce to improving the health status of populations in the South (Bello, 1994; Werner, 1995, 1998). In the 1990s the World Bank began to take a direct interest in TRM from an economic and trade perspective rather than purely as a health issue, under the mandate of improving efficiency of health systems and guiding sustainable development (DeJong, 1991; Lambert, Srivastava, & Vietmeyer, 1997; Srivastava, Lambert, & Vietmeyer, 1996).

A fundamental difference between the WHO and the World Bank was their varying concepts of health and its role in development, which have changed over time. These bodies are not cohesive, neutral or static organisations; they are also subject to external trends and must mediate internal political interests. Promotion of policies and strategies by these two bodies is the outcome of the interaction of these interests, within the broader political and economic climate. At times their policies and programmes may mutually reinforce each other, and at times they may diverge. International bodies have been subject to criticism for both exceeding their mandates or not fulfilling them, and some consider that these bodies (like the UN itself) mirror and transmit (further perpetuating and reinforcing) the balance of world power and domination of North over South (Turshen, 1993:987).

1.4.2 The state

The state has a pivotal role in funding, structuring, co-ordinating and regulating the formal health care system (Walt, 1994:13-15). The political and economic decisions of the state affect the size, distribution, operation and quality of health services infrastructure. In determining the scope and nature of health care systems, factors such as access and

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7 For example, in 1996, lending amounted to $2350 million compared to $900 provided in grants by the WHO (Abbasi, 1999a:868).
affordability, social equity and social justice, longer term sustainability, economic efficiency, quality of care, and public interest and accountability may inform the policy making process (Hancock, 1999:7-10).

In addition to a direct role in providing and regulating health care services, the state has a broader role in the health status of populations, as many factors interplay in complicated ways and impinge on health outcomes (for example, housing, education, environmental and economic policies). Therefore, the role of the state in provision of health care and health care outcomes goes beyond the direct role it has in funding and structuring formal health care infrastructure. It also performs a key role in mediating and balancing the interests of other stakeholders in the health policy arena such as medical systems, citizens, corporate interests and international bodies.

1.4.3 Medical systems

Historically, there has been an uneasy and antagonistic relationship between TRM/CAM and biomedicine. The history of the biomedical profession in the North has been described as one of consolidating a monopoly of power and stamping out competition from alternative health care systems (Berliner & Salmon, 1980a; Green, 1988:1129; Kaptchuk & Miller, 2005; Saks, 2003a; Starr, 1982). At various times, biomedical groups have tried to eliminate chiropractors, acupuncturists, homeopaths and naturopaths, amongst others (Boozang, 1998:218; Freund, McGuire, & Podhurst, 2003). This also occurred more overtly and aggressively in colonised countries in the South, as mentioned, and conflict between practitioners of differing systems is still evident (Bodeker, 2001a; editorial, 2002b; Wolffers, 1990).

In the development of national health programs based on Western medicine official attitudes toward traditional healers have ranged from neglect to outright opposition: they have been looked upon by most medical doctors as undesirable competitors, if not outright enemies to be vanquished (Foster, 1977:533).

These tensions can be attributed to differences in paradigms; diagnostic and treatment methods; conceptions of illness, disease and health; and values and interests. The various systems of health and medicine “may be likened to different languages” (Jobst, 1996:319). The conceptual gulf between biomedicine and TRM systems has been widely noted, and

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8 The first endeavour of the American Medical Association after formation in 1847 was to ban referrals to non-biomedical doctors and healers (Berliner & Salmon, 1980a:544).
McKinlay considers that they are based on ultimately irreconcilable presuppositions that evolve from divergent social philosophies (1998:5).

Biomedicine is a relatively recent medical system, having emerged from “shamanistic roots” in only the last 150-200 years (Cunningham & Andrews, 1997:7; Glasser, 1988:1461). Biomedicine began diverging from other systems of medicine and health care in the first half of the nineteenth century following the industrial revolution, when it aligned itself with the “new enlightenment ideology of science” (acquiring the language of science) and began to professionalise (Saks, 2003a:143). It differentiated itself from competitors and obtained a privileged position in that process, forming a legal monopoly on formal health care provision and market domination (Freund, McGuire, & Podhurst, 2003:214; Kelner et al., 2004:917; Lee, 1982; Saks, 1998, 2003a; Waldram, 2000).

Biomedicine has historically maintained structural power through alliances with corporate interests and professional elites and has a symbiotic relationship with the pharmaceutical industry (Moran & Alexander, 1997; Unschuld, 1976b:9), sometimes referred to as “the medico-industrial complex” (Light, 1995; Navarro, 1993). Biomedical and pharmaceutical corporate interests can be linked together as an interest group, as they are usually considered “allies”, and form a structurally dominant coalition in modern health care systems (Light, 1995:36). While the multi-national pharmaceutical industry plays a crucial role in health policy as a key stakeholder in its own right, it is beyond the scope of this research to consider it as a separate interest group. It has therefore been grouped with biomedical interests, although it is acknowledged that a more detailed analysis of the role of the pharmaceutical industry is a pre-requisite for a comprehensive inquiry into integration. Practitioner groups instead form the main focus of this thesis.

In general, biomedicine is based on a mechanistic or reductionist view that focuses on physical biology, illness and specific etiology, with a conception of health as being the absence of disease. This is a “downstream”, curative or tertiary focus (pathogenic). In contrast, TRM/CAM (while embracing diverse practices) tends to be based on an holistic view of health where achieving and maintaining equilibrium is the goal – an “upstream”, preventative or primary focus (salutogenic) (Macdonald, 2005:52-56, 58-70). Health is more broadly considered as internal and external balance, incorporating emotional, psychological and social factors.9

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9 See also (Gerke & Jacobson, 1996; Islam & Wiltshire, 1994; Kaptchuk, 1983; Leslie, 1976; Leslie & Young, 1993; Shanker, 1991) for further discussion on differences between biomedicine and traditional medicine. For historical overviews of the development of, relationship and differences between, biomedicine and CAM see Saks (1992a)
The concept of health espoused by TRM/CAM is ironically very similar to the definition of health used by the WHO – complete physical, mental and social well being (van der Geest, 1997:905). Van Der Geest lists four salient characteristics of TRM as their social character, religious dimension, orientation to prevention, and comprehensive concepts of illness incorporating entire environment and general well being (1997:904-905). Food is central, with “food therapy” or an emphasis on diet a main aspect. Some TRM practitioners believe that nothing should be used as a medicine that cannot also be used as food (Trawick, 1987:1034).

The difference in focus can be illustrated with an example of payment for services – in some TRM systems, payment is only made when an individual is well (Scrimshaw, 2001:63), reflecting the goal to prevent rather than treat disease. Another reflection of the different focus is in the use of metaphors to describe the human body. Biomedicine considers the human a “machine” regulated by laws of physics and science which can be taken apart and reassembled by a doctor, or have parts replaced when they break down (Lupton, 1994:59-61; Macdonald, 1992:37-39). This engineering model is premised on a doctrine of a singular cause and process of disease (specific aetiology) which is universal, and can be isolated, removed or treated according to common methods (Freund, McGuire, & Podhurst, 2003:6-7, 221-223).

Modern Ayurvedic (Indian TRM) texts use the metaphor of the body being like a car which needs good fuel, removal of toxic build-up and regular maintenance of parts to keep operating smoothly (Chauhan, 2000; Sharma & Clark, 1998:109). More emphasis is consequently on food, diet, and physical therapies as lifestyle practices to maintain balance in physical health. Although they have very sophisticated remedies to treat disease, they focus on maintaining health (preventing the “car” breaking down). Ancient Egyptian medicine used a metaphor of a river and Chinese tradition is based on the balance of elemental forces (Freund, McGuire, & Podhurst, 2003:7). Biomedicine and TRM/CAM therefore visualise the body and concepts of health and treatment differently.

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(Great Britain); (Baer, 2001) (United States) and Berliner and Salmon (1980a) (United States and Europe). For a description of social and historical foundation of biomedicine (Davis & George, 1993), and the relationship between biomedicine, technology, power (Moran & Alexander, 1997). Unschuld (1987; 1993) proposes that the differences between Western and Chinese medicine have been over-simplified and exaggerated, and it is acknowledged that the differences, as presented here, are generalisations.

10 Ayurveda did use surgical techniques, and invented both procedures and surgical tools that are still widely used today in biomedicine (e.g. rhinoplasty, and glaucoma operations) (Chauhan, 2000).
Peabody et al. describe the main differences as being that biomedicine focuses on drugs and drug therapy, and TRM on diet, lifestyle, herbal treatments, physical exercises, religious practices and psychological support (1999:126-127). A biomedical doctor “treats the disease” while a TRM doctor “treats the person (who happens to be ill)” (Neumann & Lauro, 1982:1818). In addition to differing techniques and conceptions of health and disease, TRM may have a central foundation built on spirituality, religion and belief (Adams, 2003; Eskinazi & Mindes, 2001:20). Some forms of TRM make no distinction between healing and religion (Barbee, 1986:77; Koumare, 1983). The vital role of the mind is also recognised, and is considered supremely important in both governing health maximising behaviour, interaction with the physical environment, and regulation of emotions. Peace of mind is one criteria for well being in Ayurveda, and if you are not happy you are not considered healthy regardless of physical condition (Chauhan, 2000).

This interlinking of religion and the mind within conceptual foundations of TRM is the antithesis of Cartesian scientific materialism upon which biomedical systems are based. TRM systems view a person as more than the sum of their biological parts, with intangible aspects such as the “soul”, the “subtle body” or “life force” (prana, chi) playing a significant role in quality of life and general health. Diseases may have supernatural or emotional/psychological origins, and causative factors and treatments may not be able to be reduced to strictly biological terms (Berliner & Salmon, 1980b:142). In contrast, scientific materialism and positivism reduces the body to a cluster of cells which are dealt with in isolation, and any non-visible parts (mind and soul) are split from the body (Macdonald, 1992:38-39) and relegated to the realm of superstition or myth (or at least beyond therapeutic boundaries: the observable).

While TRM is often criticised for a lack of scientific foundation, practitioners of these systems argue that this is an ethnocentric bias that fails to appreciate “alternatives in science” (Shanker, 1991:5) or the sophistication of TRM theory (Sharma & Clark, 1998). Some TRM systems have complex, internally coherent and logical theoretical bases, with elaborate concepts of disease, pharmacology, physiology, diet and nutrition. This is the case with medical systems of Asia such as Ayurveda, Unani and Chinese medicine (Leslie & Young, 1993:5). If science is considered a systematic body of knowledge, these medical schools of thought clearly have a scientific (although culturally specific) foundation. Scientific method is not confined only to biomedicine (Alderete, 1996:383; Lantum, 1982:17; Ramprasad, 1994:135). The literal translation of Ayurveda is “the science of life” and Sorig-pa (Tibetan medicine) is “the science of healing”.

Science can be seen to represent a struggle between rival ideologies (Trawick, 1987:1032). The common dismissal of TRM systems by biomedicine on account of a lack of sufficient clinical evidence derives from the viewpoint of Western scientific rationalism, which is considered by many to be impartial and therefore universally applicable. The global dominance of this paradigm means the legitimacy of TRM/CAM has to be derived from conforming to the parameters of biomedicine (Quah, 2003; Shanker, 1991). However, it has been noted that many biomedical treatments lack evidence as to their pharmacology or exactly how they work – aspirin is one example (Airhihenbuwa, 1995:57; Dalen, 1998; Unschuld, 1976b:7). In addition, many aspects of TRM are considered beyond the realm of scientific measurement and are “theoretically inexplicable within the domain of scientific discourse” (Berliner & Salmon, 1980a:543).

Unschuld concludes that dismissing TRM on account of its “non-scientific” basis is motivated by ideological and political factors, and that if biomedicine abandoned all drugs and techniques that were not understood “not very much would remain” (1976b:7), a position with which Berliner and Salmon concur (1980b:142). Although these observations were made some time ago, contemporary commentators continue to assert that biomedicine is usually less scientific than it appears, and the scientific validity distinction between biomedicine and TRM is “more apparent than real”:

… the clinical basis for many Western and TRM therapies is observational and empirical without strong scientific support. Thus, both types of medicine need to be subjected to more scientific scrutiny, and there may be no compelling reason in many situations to favour one style of treatment over another (Peabody et al., 1999:127).

Both biomedical and TRM systems have strengths and weaknesses, advantages and disadvantages, costs and benefits (Jonas & Levin, 1999:4). Both types of medicine and health care have treatment modalities that exhibit ambiguity of efficacy (Elling, 1981b). In addition, all systems of health and medicine are the products of their social, cultural and historical contexts, and thus reflect particular values and practices that are embedded within those origins. Accordingly, biomedicine is only one form of “ethnomedicine” (Amarasigham Rhodes, 1990; Maclean & Bannerman, 1982).

Biomedicine, despite being culturally constructed, has somehow detached itself from its socio-cultural origins and achieved an entrenched global penetration, a “monolithic orthodoxy” associated with its ideology of “science”. The history of this diffusion indicates

11 Smith (1991) assessed that only 15% of biomedical treatments have a “scientific basis” or have clearly demonstrated effectiveness.
that its success as a competitive social and cultural institution has been far greater than efficacy alone explains (Riley, 1977:557). There is no rival, coherent system of medicine which has managed to successfully challenge this ideological supremacy (Frankenberg, 1981:115).

[Biomedicine] is inherently assumed to have an internally coherent, self-evident, and objective validity. This assumed validity … is so taken for granted in western society that suggestions that other systems of medicine may also have validity are often rejected out of hand. Western superiority in economic, technological, and military spheres has perpetuated the assumption that scientific medicine is likewise far superior to its predecessors and competitors. Even the referent of “scientific” exemplifies having reached a pinnacle of achievement, implying that other systems of medicine are non-scientific, being based upon lesser foundations (Salmon, 1984:3).

Unschuld determines that the major difference between traditional Chinese medicine and biomedicine is in their conceptions of “truth” – biomedicine has a foundation that is built on an assumed single, dominant paradigm; an “either or mentality”; a universal truth that can be isolated and determined by logic; “Western civilization [is] a culture searching for and believing in, the existence of one single truth … it is reflected in a continuous attempt to build one coherent scientific paradigm, free from internal inconsistencies or contradictions” (Unschuld, 1993:57-58). The application of this scientific paradigm creates “biomedical artefacts masquerading as universal truths” (Waldrum, 2000:619). In contrast, Unschuld proposes that traditional Chinese medicine accepts a “patterned knowledge” – the existence of multiple, even antagonistic “truths”.

Biomedical and TRM practitioners are not homogenous groups, forming unified, discrete blocs that are rigidly demarcated. Some TRM practitioners use aspects of biomedicine, such as prescribing antibiotics and analgesics, or using stethoscopes, white coats and blood pressure cuffs (Bhatia et al., 1975; Kleinman, 1984:148; Taylor, 1976; van der Geest & Reynolds Whyte, 1989). Conversely, some biomedical doctors in the North have found it lucrative to practice what has been termed “integrative” or “integrated” medicine, which selectively incorporates aspects of TRM/CAM alongside biomedical diagnosis and treatment (Cowley, Underwood, & Braiker, 2002; Rees & Weil, 2001; Weil, 2001).

TRM systems and practitioners vary widely in scope. There are herbalists, traditional birth attendants, bone-setters, dentists, faith healers and diviners, amongst others (Oppong, 1989). It is the heterogeneous nature of TRM that presents one of the obstacles to formally using it

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12 The union between science and a single, resilient “truth” was originally threatened by Kuhn (1970), who proposed that such truths are replaced by new paradigms, new “truths” that displace the previous ones as they are falsified (Gillett, 1994:1125). Kuhn countered the concept that there were universal rules of evidence for making scientific judgements and that science is a neutral activity (Saks, 1998:201).
in health care systems (Bannerman, 1983:320). There is a particular divergence between Asian and African systems of TRM, with the former based on systematised knowledge that has been recorded and is taught in state recognised institutions (DeJong, 1991:1; Last, 1986:12). This may be one reason for the comparison noted by Zwi and Mills (1995:301) - Asian systems of medicine have proven “more resilient in their clash” with biomedicine. It is claimed that TCM and Ayurveda (both Asian systems) are used by approximately half of the world’s population, with published clinical research worldwide (McIntyre, 2001:10).

The degree of sophistication of Asian TRM systems (Ayurveda, Unani and Chinese medicine) means they may share more similarities with biomedicine than with other TRM systems of health (Young, 1983:1205). However, even these more formalised TRM systems are not cohesive, consisting of an overlapping diversity of sub-systems (Nordstrom, 1988; Unschuld, 1975). Lock (1990:41) notes that biomedicine also varies widely in beliefs and practices, with many specialities, and differences between regions. Despite greater “ideological coherence”, biomedicine consists of an increasingly complex division of labour (Saks, 1998:205) and is culturally reinterpreted in local settings (Finkler, 2004).

The fundamental differences in philosophies, heterogeneity of TRM systems and practitioners, and asymmetric power relationships, lead some to conclude that genuine integration may be impossible or even undesirable. A policy to combine two systems of medicine where there is power disequilibrium usually results in the domination of one over the other (Islam, 1994; van der Geest, 1985:12). So, the question remains, nearly three decades after integration was proposed: “How can the collision of such seemingly irreconcilable medical cultures be managed so as to yield mutual benefits?” (Gerke & Jacobson, 1996). While this question is beyond the scope of the research, it indicates the complexity of issues the policy of integration raises, and practical difficulties of implementation.

1.4.4 Citizens (consumers)

The main benefit of formalising the role of TRM/CAM in health systems should flow to citizens. Consumers often have the weakest voice in the formulation of health policy, exercising influence through patronage and consumption. The survival of TRM in the South, in the face of strong competition from biomedicine and monopolistic health systems, was due to continuing support from citizens. Although figures vary between countries, the WHO estimates that between 60% and 90% of populations in the South use TRM to meet health care needs (WHO, 2002e). In these countries, TRM has the advantage of usually being more
acceptable, accessible and affordable than biomedicine (Airhihenbuwa, 1995:47; Asuni, 1979a; Green, 1986:121; Sofowora, 1996:366).\footnote{Some have questioned these assumptions (Anyinam, 1987).}

Studies have found that citizens in the South exercise relatively sophisticated forms of medical pluralism. There appears to be a preference for TRM to treat some conditions (chronic), while biomedical treatment is sought for others (infectious/acute), and this pattern has been observed across diverse cultures; from Nepal and Tibet to Bolivia, Mexico, Swaziland and Zaire (Adhikari, 1997; Crandon-Malamud, 1991:202; DeJong, 1991:5; Green & Makhubu, 1984:1073; Janes, 1999:279; Kennedy & Olsson, 1996:44; Lee, 1982:639; Peabody et al., 1999:252; Tamang & Dixit, 1992:43; Yoder, 1982:1855). These types of health care are not regarded as substitutes for one another, but fulfil specific health requirements (DeJong, 1991:7). This pattern of dual utilisation has created a “defacto division of labour” between the medical systems (Green & Makhubu, 1984:1073), although the same patterns of use is not apparent in all societies (Caldwell et al., 1989:371).

This broadly parallels attitudes in the North, which began to emerge in the 1960s and 1970s but was only recognised as an established trend in the 1990s. In the US, by 1990 visits to CAM practitioners outnumbered visits to biomedical practitioners (Tataryn, 2002:877). The turning point for the recognition of this trend was a study by Eisenberg in 1993, which found that 34% of American adults had used therapies other than biomedicine (CAM). The use of CAM increased by another 25% between 1990 and 1997; the percentage of Americans taking herbs nearly quadrupled (Cowley, Underwood, & Braiker, 2002); and sales of herbal supplements increased by 101% between 1996 and 1998 (WHO, 2002e:12).

It became clear that the use of TRM/CAM was not based only on tradition or necessity, but was also a choice that those with higher educations and incomes were exercising in greater numbers (Astin, 1998; Lupton, 1997). The use of TRM has been interpreted as a personal counter-hegemonic commentary on the failure of modernisation, urbanisation and development which biomedicine symbolises (Wayland, 2004). The personal mixing of biomedical and TRM/CAM can be considered pragmatic, as well as a form of “cultural politics” in which identity, control and power can be expressed (Whyte et.al. 2002 in Craig, 2000; Crandon-Malamud, 1991; Wayland, 2004:2411).

In the global WHO TRM Strategy 2002-2005 (WHO, 2002e), the potential efficacy of TRM to treat chronic, lifestyle-related conditions unresponsive to biomedicine was mentioned.
However, the rapidly growing market in the North raised new policy issues. In 2002 the WHO estimated that the global trade for remedies based on TRM was US$60 billion.\textsuperscript{14} In some countries, consumer’s annual spending on TRM/CAM outstripped that on biomedicine (WHO, 2002e:12). Once the use of TRM moved beyond local or national boundaries and into the global sphere, a host of public health and regulatory matters needed resolution (Bodeker & Kronenberg, 2002; Deng, 2002).

\textbf{1.5 Aim and scope of research}

As the foregoing history and context demonstrates, the global policy of integrating TRM into health care systems has had a long gestation internationally and uneven implementation nationally. This “rational” policy goal has proven extremely difficult to execute on national levels, despite apparent international consensus and support and practical grounds for its utility. Why integration is so problematic to implement, and why this issue reappeared on the global agenda (with CAM) in 2002, is the main focus of this research. This addresses the question: “Why did the issue of integration arise on the international policy agenda in the 1970s, become submerged in the following decades with minimal national level adoption, and then reappear in 2002?”

Examination of these questions as a case study in health policy development and implementation also aims to illuminate some of the broader questions raised by researchers in relation to global health policy. How appropriate are universal policy models that are driven by “top-down” approaches?\textsuperscript{15} What are some of the forces behind convergence of policy proposals? What are the requirements for successful transfers of global health sector reform policies? What is the impact of international initiatives at country levels and what are the practical implications of these initiatives (such as cost burdens)? Is there “lesson drawing” on what works and for what reasons in health policy development? Are certain values promoted and transmitted globally through international organisations? (Buse et al., 2002; Justice, 2000; McPake, 2002; Navarro, 1984; Whiteford & Manderson, 2000).

The research does not attempt to provide definitive “answers” to these questions, but rather to explore their relevance and application in relation to the issue of integration. The detailed

\textsuperscript{14} If improvements in people’s health and capacities are factored in, the total economic value in the United States in 1996 alone was at the very least US$68 billion annually. The country reaps a financial dividend about six times the market value of the plant products themselves (Srivastava, Lambert, & Vietmeyer, 1996:4).

\textsuperscript{15} “Top down” approaches can refer to within an organisation, at national levels or at a global level from international bodies. This research looks at the latter forms of “top down” approaches - international bodies driving policy directions at national levels, or national level processes.
analysis of integration as a case study of global health policy aims to offer some insight into these issues, and provide information which may assist other researchers in the health field to clarify such broader questions.

In exploring such questions, the global–local interface in terms of policy transfer (Buse et al., 2002:271), the processes of this policy transfer, and the role of international organisations in that process are deemed worthy of further attention. Therefore, the focus of this research is on the history of a specific global health policy (integration of TRM), its development within an international organisation (WHO), and how readily it was transferred to local/national levels. The aims are twofold:

1. To identify, develop or synthesise a theoretical model or framework which will adequately explain why the policy goal of integration has proven extremely difficult to execute on national levels, despite apparent international consensus and support

2. To contribute to the understanding of the policy processes within the complex, contradictory and contested health field

In the following chapter, theories to analyse health policy are described and assessed. A framework to explore the evolution of the global policy of integration is proposed, which will then be tested in the main body of the thesis. This framework offers a new, alternative approach to current theories used to analyse health policy. The structure of the thesis is also outlined, and the methodology used to gather data elaborated upon.
2. Methodology

2.1 The search for an explanatory model

To systematically explore the questions arising from the evolution of the global policy of integration of TRM, and its global-local transfer, requires an analytical framework. This framework or model needs to take into account key factors mentioned in the introduction, including the role and behaviour of actors (such as organisations and interest groups). The search for such an explanatory model has necessitated the consideration of how health policy is currently analysed and what methods other researchers in the health field have used to explore health policy questions. This chapter describes a potential explanatory model, building on the strengths of existing frameworks.

Ham (1993) outlines three main approaches to considering power distribution and the dynamics of policy making in health services – Marxist (class relations within a capitalist system), pluralist (compromises between interest groups), and Alford’s structuralist model. The structuralist framework divides groups competing for health resources into three, rival “structural interests”. These are firstly, the “professional monopoly” (dominant structural interests), comprising biomedical professions and other health occupations. They are served by the social, political and economic institutions. Secondly, the “corporate rationalisers” (challenging structural interests) consist of public health agencies, insurance companies and planners and administrators. Finally, the community (repressed structural interests) usually lack the organisation to promote their interests.

While pluralism emphasises the dispersion of power amongst interest groups, structural approaches conceive of power as being unequally spread and concentrated in a few groups or an elite (Davis, 2002:942). Although Ham concedes that each has weaknesses, the structuralist framework as espoused by Alford (1975) is considered to offer the most analytical promise as it incorporates the strengths of pluralist theory with the insights of Marxist analysis (Ham, 1993:190).

Alford’s structuralist theory has proven a popular approach to examining health policy and health services, primarily in the North. However, it may not offer the same value in considering health policy issues in the South, where the “professional monopoly” group is more complex in organisation. Increasingly, its validity in the North may also be
questionable as the biomedical monopoly’s authority is reduced and new medical traditions (CAM) threaten its sovereignty in health systems. Cho (2000b) is one of the few analysts to apply the Alfordian framework outside of Western democracies. The context was health policy in South Korea, in order to explore the prolonged and intense conflict between biomedical (pharmacists) and traditional (oriental) professionals.

Cho (2000b) concluded that while the structuralist approach “can be useful” in the analysis of health policy in South Korea, it also raised some difficulties. The cleavage within the professional monopoly group (biomedical/TRM) diverged from the standard inter-professional conflict as contended by Alford, in several respects. For example, the rivalry was between radically different medical systems (not within one system), and the extent and nature of the competition far exceeded normal inter-professional friction. The thesis that heterogenous interests within the professional monopoly will act together when their autonomy is threatened, as predicted by Alford, was not demonstrated in the South Korean case. Instead, the “united collective front of professional monopolist seemed to have completely collapsed” which was “a significant departure from the main thrust of Alford’s analysis” (Cho, 2000b). Professional activity in pluralistic medical systems appears more complex than Alford’s theory allows for, with Cho resorting to identifying it as a “bipartite” professional monopoly in order to fit within the framework.

Cho contends that Alford’s theory still offers a more plausible explanation of this conflict than conventional pluralistic theories. However, the findings illustrate that Alford’s model does not effectively account for a “duopoly” – for example, where one medical system is structurally and politically dominant (biomedicine) and another socially and culturally dominant (TRM). Instead, social, political and economic institutions are expected to serve only one medical profession or system (within which there is a hierarchy of “sub-professions”), ultimately unifying under pressure due to a common identity and interests.

More recently, the Alford framework of structural interests was applied in a Canadian study of biomedicine and CAM (Kelner et al., 2004). However, in this analysis, CAM was placed in the community (repressed) category rather than professional monopoly (dominant biomedicine) category. This perspective allowed for two separate health profession stakeholders to compete with each other for power and resources in the health system. However, it presented some problems in distinguishing which health professionals should be placed within each group. For example, nurses and other allied professionals, such as chiropractors and naturopaths, are members of the dominant group but are also repressed by them (Kelner et al., 2004:918).
The analytical perspective used by Kelner et al. (2004) (which placed CAM in the community group) was also a significant modification of Alford’s structural theory which undermined its main premise – that of one health professional group in interplay with two other stakeholders with distinct interests (the community, the government/health agencies); not another health profession group with directly competing interests. In addition, the community (repressed) group is defined by Alford as lacking organisation, which is not a characteristic of CAM despite its weaker status in formal health care systems.

The application of Alford’s structural theory to analyse health policy where medical pluralism exists has therefore demonstrable weaknesses. Despite it offering the most analytical promise according to Ham (1993:190), it falls short of accommodating actors that play a role in health policy but are categorised outside of the three rival interests (professional monopoly, corporate, community). While these rival interests still exist, the contemporary health policy landscape has become more complicated and different interests have entered the domain in ways that may not have been envisaged when Alford developed his framework in 1975.

2.2 An alternative approach

According to Ham, while all three approaches (Marxist, pluralist and structuralist) have merit, none offers a complete account independently (1993:183). He proposes that, rather than seeking to develop one overarching theory that could provide an explanation of health policy in its own right, searching for links between different theories could prove more fruitful. This would produce “mediating frameworks to connect macro-theory with specific policy issues” (Dunleavy 1981:4 in Ham, 1993:183). Similarly, the use of macro-micro models to explore medical pluralism, that take into account broader political and economic contexts, has been encouraged by medical anthropologists (Janzen, 1978; Singer, 1986, 1990).

Walt and Gilson (1994) also call for new approaches, and lament the lack of policy analysis applied to issues of the South, and to health questions in particular. They argue that rather than focusing totally on the content of reform, the actors (at international, national, sub-national levels), processes contingent upon developing and implementing change and the context within which the policy is developed all need to be considered (1994:358). Other analysts began to look beyond conventional theories of power and change in the health
policy domain, such as the roles of networks and coalitions, or political parties (Geva-May & Maslove, 2000; Lee & Goodman, 2002; Peterson, 1993).

Walt and Gilson (1994) consider their model (a triangulation of context, content and process with actors located inside) to have greater explanatory power than classic, landmark policy-making theories such as the incremental model (Lindblom, 1959) and the rational model (Simon, 1957). The model is classified with political economy approaches – that is, it considers the interaction between political, economic and social factors. Walt’s book (1994) on health policy was also an effort to inject a greater emphasis on process and power in health policy discussion and debate. The framework proposed by Walt and Gilson (1994) shares similarities to that developed by Kingdon (1984), which Walt discusses in her book on health policy processes (1994).

Walt used Kingdon’s framework to explore issues of health policy transfer between international and national levels, and found it particularly apt (Ogden, Walt, & Lush, 2003). The issue analysed was the global transfer of tuberculosis control policy, also over a thirty year period. Kingdon (1984) based his model on another classic theory in policy literature – the “garbage-can model of organisational choice” (Cohen, March, & Olsen, 1972). These approaches counter theories that describe policy in incremental, rational or hierarchical terms. The policy process is instead presented as more anarchic and fluid, with various problems and solutions mingling in an ambiguous policy environment. While it is commonly agreed that policy making usually follows a “process” of setting an agenda, specifying alternatives, making choices, followed by implementation (and usually evaluation); what is open to contested interpretation is how the agenda is set, and why certain alternatives are chosen.

2.2.1 Kingdon’s multiple streams model

Kingdon attempts to conceptualise the policy process in order to take into account these variables. The policy environment (*context*) is likened to a “primeval soup” within which various policy communities (*actors*) move. The development of policy proposals (*content*) is “evolutionary” in a process that is considered “akin to biological natural selection”. Various ideas and issues are “floated, translated into proposals, discussed, revised and honed and floated again” (1984:226), flowing on and off the agenda. Kingdon is more concerned with what makes particular ideas popular, than with where the idea originated, and considers the “critical thing to understand is not where the seed comes from, but what makes the soil fertile” (1984:77). In other words, like Walt and Gilson (1994), he stresses *context*. 
Kingdon’s model manages to systematise what otherwise may appear to be random processes. He identifies three separate *streams* which operate largely independently of each other and run through decision-making units (organisations, governments). These “process streams” are *politics* (ideology, public opinion, interest groups, officials, political parties); *policies* (generation of ideas within communities such as academics, bureaucrats, interest groups); and *problems* (problem recognition).

The key to understanding when and why certain policies are adopted, or the agenda changes, is the *coupling* (linking) of these *streams*. “A problem is recognized, a solution is available, the political climate makes the time right for change” (1984:86). This coupling occurs when an opportunity arises through a window opening in the *political* or *problem streams*. When a window opens (for example, new administration, personnel changes), a proposal or alternative is pulled out of the *policy stream*. It therefore becomes elevated on the agenda because it is seen as a solution to a “pressing problem” or “sponsorship is expedient” (1984:172). The combination of all three streams dramatically enhances the chances that an issue will seriously receive attention (Zahariadis, 1999:76). Kingdon places importance on the role of specific people in the policy process (*policy entrepreneurs*), and specific issues (*catalysts*) that open windows. These key actors seize and exploit opening windows to push a favoured policy onto the agenda.

Kingdon’s model offers a useful way to consider the policy issue of integrating TRM into health care systems as it enables questions like: “Why did the issue of integration arise on the international health policy agenda in the 1970s, become submerged in the following decades, only to reappear (with CAM) in 2002?” While the issue of integration remained alive in the *policy stream*, being propounded, re-assessed and debated within the policy community, the broader environment was not fertile for implementation. During the 1990s, the conditions developed to allow the window to open again, and in 2002 the streams coupled and the strategy was endorsed on a global level. However, as this analysis will demonstrate, the scope of the problem had changed, and the reasons for sponsorship differed.

The selection and analysis of documents and other data which forms the empirical research in this thesis will therefore be guided by the mediating framework offered by Kingdon (1984). As noted by Walt and Gilson (1994), analysing the interaction between political, social and economic factors is basically a political economy approach. However, using Kingdon’s model allows the policy issue to be contextualised further, by linking the *politics*, *problems*, and *policy streams*. The practical application of the framework offered by
Kingdon, in addition to an explanatory model for the behaviour of interest groups, is the subject of the main body of the thesis.

### 2.2.2 Unschuld’s theory of medico-cultural conflict

Within the *politics* stream, an analytical tool will be used to consider the relationship between interest groups. If emphasis is placed on resource allocation, the policy of integration can be viewed as the outcome of contested resources, mainly between two stakeholders in the health system – biomedical and traditional practitioners. Conflicts and tension in formulating and implementing this policy can be perceived as a struggle to control resources by competing interest groups, who manipulate the policy process. Unschuld (1975; 1976b) offers a theory which is a useful way to characterise the political relationship between these two groups.

Unschuld proposes that “medical [health] systems represent a momentary stage in the continuous competition of various groups for medical resources” (Unschuld, 1975:304). According to Unschuld, conflict between these groups is an outcome of competition for primary and secondary resources. *Primary* resources are medical knowledge and skills, drugs or remedies, technology, techniques, equipment and facilities. *Secondary* resources are material or non-material rewards (status, prestige, authority) for medical practice. Dominating primary resources controls access to the secondary resources (1975:304). Therefore, different systems of medicine compete for access to the available secondary resources (material and non-material rewards) through controlling and promoting their primary resource base (remedies, techniques, knowledge). It is important to note that manpower itself is not classified as a resource, as it remains a competitor for available secondary resources.\(^{16}\)

In order to gain more control over particular resources related to their occupation, the groups embark on a process of professionalisation.\(^{17}\) MacCormack (1986) describes this process as

\(^{16}\) Drugs, techniques, manpower and concepts are considered *dimensions* of medical systems, which offer areas suitable for "structured co-existence" with other systems – in order of increasing difficulty (Unschuld, 1976b:7). Pederson and Baruffati (1989), analysing asymmetrical power relationships between biomedical and TRM systems, produced a very similar classification (technologies, practitioners, ideological substratum), although lacking the detail and dynamics of interaction offered by Unschuld. Chi (1994) considers medical technology and knowledge, personnel, and other resources (drugs, equipment) as the main distinguishing factors between different medical systems.

\(^{17}\) Professionalisation and its processes, purposes and outcomes in the health field have preoccupied many academics. It is beyond the scope of this research to consider the vast literature and theoretical approaches to professionalisation in the health care sphere. For the purposes of this analysis, the perspective of Unschuld is employed - which considers professionalisation only as a method to maintain occupational power and control, although not all commentators agree that this is necessarily the case. Unschuld’s view on professionalisation varies from other theorists in that it is not concerned with processes and hierarchies, but is related to an “ideal” continuum
moving from “traditional legitimacy” to “rational-legal legitimacy”, using Weber’s (1947) categorisation. Professionalisation only needs to be seen as a method for exerting or expressing group power, and as a technique to control, protect and promote their primary resources. It involves identifying and claiming their respective primary resources, and determining who has access to the secondary resources that accrue from their use (economic and social benefits).

While Unschuld’s analysis related to Asia, Last (1986) also developed a similar conclusion regarding professionalisation in reference to Africa. He proposes that the process of professionalisation for TRM practitioners which has occurred there is an aspect of decolonisation, and developed in response to increasing competition from an expanding biomedical profession (1986:10). This had already occurred in China and India in the 19th century when biomedicine became a competitor in those regions. Ayurveda and traditional Chinese medicine only began to professionalise with the import of biomedicine, directly in response to the new encroachment (Unschuld, 1976b:18).

Unschuld hypothesises that competing medical systems will never voluntarily exchange or share primary resources, without obtaining secondary resources (economic benefits, status) in return. “[W]here two or more groups compete for possession of, or control over, certain resources it is extremely difficult to have these different groups work together and share the resources available, except under coercion and close government supervision” (Unschuld, 1976b:8, emphasis added). Therefore, in the absence of coercion and supervision, the rejection or adoption of particular primary resources by interest groups is dependant upon the incentives offered in the form of secondary resources. Shifting primary resources from one group to another is easier, once it is “recognised that these resources will be of use in gaining access to more secondary resources” (Unschuld, 1976b:8).

Although Unschuld does not explicitly state or discuss the origin of secondary resources, it can be inferred that they are provided by citizens (consumers), the state, and agencies such as insurance companies and donor bodies – through using, sanctioning or subsidising particular primary resources. Citizens, communities, the government and administrative/regulative bodies therefore have a key role in supplying secondary resources, through their use and legitimisation of primary resources. Medical systems can thus increase their share of

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according to 1) who generates the knowledge the occupational activities are based on 2) who determines when it is appropriate or permitted to apply that knowledge and 3) who defines the secondary resources attached to that application of knowledge. Therefore, biomedicine itself has not obtained full professional status as it is dependant upon state and corporate players (e.g. insurance companies) in the determination of 2 and 3 (Unschuld 2004, personal communication).
secondary resources through enlarging their primary resource base; minimising their competitor’s primary resource base; or appealing for support and legitimation from providers of secondary resources.

Several anthropologists have made passing reference to Unschuld’s theory of medico-cultural conflict, as a method to conceptualise pluralistic medical systems (Janes, 2002; Janzen & Feierman, 1979; Leslie, 1980; Press, 1980). Crandon-Malamud (1991) uses a variant of the theory in a study of Bolivia, and argues that medical pluralism provides communities with secondary resources that permit social mobility (Crandon-Malamud, 1991:ix). This analysis is from the perspective of the patient or community, and argues that they choose to use different medical systems (primary resources) to seek a cure but also for social, economic, and/or political ends (secondary resources). This variation extrapolates beyond the “ownership” or control of the health/medical resources by practitioners, to the use of those resources by the community and what they gain from such patterns of use. Secondary resources that flow from primary resources may therefore be obtained by consumers as well as practitioners, although the secondary resources vary.

The “resource model” which is primarily based on an adaptation of Unschuld’s theory of medico-cultural conflict, but also incorporates Crandon-Malamud’s (1991) extension and other themes from the literature, is displayed in Table 2. Health systems represent distribution patterns of medical resources, with different medical systems simply “primary resource aggregates” conceptualised differently from other primary resources (Unschuld, 1976b:16). Biomedicine can be considered resource aggregate 1 and TRM/CAM resource aggregate 2. The five-fold division of stakeholders in health systems parallels that noted by Light (1995), who identified various countervailing powers in the health domain: the biomedical profession (with an optional additional alternate healing modalities), the state, the medical-industrial complex, and patient groups. Each has different goals that are in tension with each other (in Kelner et al., 2004:917).

State and corporate agencies are placed above citizens, to reflect their authoritative role in filtering and structuring the resources that are available to the community in the formal health care sector and the market. Citizens can also operate outside of the formal health care system. Variables affecting use in the citizen category may include income, age, gender, ethnicity, education, religion, location and health condition (disease or illness) (see Barrett, 2003:418). These factors influence access to, selection, and experience of primary resources. Citizens “oscillate” between the resource aggregates to cope with their health problems (Fabrega in Unschuld, 1976b:6).
### Table 2: Resource Model

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Primary Resources (tools &amp; methods)</th>
<th>Secondary Resources (benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. RESOURCE AGGREGATE 1</strong></td>
<td>Pharmaceuticals, antibiotics, biomedical diagnostic tools (stethoscope, pathology, x-rays); vaccinations, surgery, chemotherapy, hospitals</td>
<td>Status, Prestige, Authority/power, State allocations, Material rewards, Emotional rewards</td>
</tr>
<tr>
<td><strong>Discourse:</strong> science</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Authority:</strong> rational-legal</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Focus:</strong> curative</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness:</strong> infectious/acute</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strength:</strong> structural (state, corporate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. RESOURCE AGGREGATE 2</strong></td>
<td>Food/diet, plants, herbs, minerals, intangible ritual and spiritual techniques, meditation, physical therapies, exercise, relaxation, counselling</td>
<td></td>
</tr>
<tr>
<td><strong>Discourse:</strong> holism, vitalism</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Authority:</strong> traditional/charismatic</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Focus:</strong> preventative and palliative</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness:</strong> chronic/psycho-social</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strength:</strong> functional (citizens)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. State &amp; public health agencies</strong></td>
<td>Sanction, subsidise, regulate, provide</td>
<td>Therefore providing</td>
</tr>
<tr>
<td><strong>health = investment, cost, service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Corporate, industry</strong></td>
<td>Manufacture, distribute, provide/supply</td>
<td>And also gaining</td>
</tr>
<tr>
<td><strong>health = consumption item, commodity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Citizen (family, communities)</strong></td>
<td>Buy, use, consume</td>
<td></td>
</tr>
<tr>
<td><strong>health = right, necessity, capacity</strong></td>
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</tbody>
</table>

This resource model (table 2) could be viewed as a more flexible and detailed variation of Alford’s structural interest theory. It separates out stakeholders from within the dominant, challenging and repressed categories, allows for medical pluralism and multiplies the potential configuration of relationships. Each stakeholder has different interests, rationales, varying power/control and arenas for exerting that, and can form alliances and networks that fluctuate historically according to context (economic, political, social conditions). Alford’s theory which is considered applicable worldwide can be viewed as the specific configuration or network of relationships in the United States in the mid-1970s, one of the momentary stages in the struggle for resources. The struggle for resources varies and has different outcomes according to location, culture or points in time (Unschuld, 1975:304).

Boundaries between primary resources are constructed by the professions (groups) themselves, and this is what they struggle over. The stratifications of professions/occupations within each resource aggregate may also engage in these struggles between themselves. So, for example – biomedicine may splinter into more specialised professions or occupations,
each claiming different primary resources (or creating a new one). The struggle over resources can therefore manifest within as well as between the groups, and also on community, regional or national levels. The struggles over primary resources are driven by the need/desire to secure secondary resources and prevent competing groups from gaining them.

As discussed in the body of the thesis, some challenges are presented by the TRM/CAM primary resource base in relation to integrating (formalising) their role in public health care systems, particularly but not confined to the religious or spiritual dimensions (Bibeau, 1982, 1985; Maclean, 1986; Pearce, 1986). These systems have historically operated in informal, private spheres and may be “invisible” from the perspective of the state. TRM/CAM may even be banned, repressed, or formally ignored (as happened during colonisation), although they may be still highly respected and used extensively on community levels. Therefore, the role and regulation of TRM/CAM primary resources in the formal health care sphere may be problematic, and use in the private sphere is often where practitioners obtain their secondary resources (status, prestige, authority, economic benefits).

The main tenet of Unschuld’s explanatory theory on the relationship between medical systems centres on contested resources. However, the definition of “resources” moves beyond that typically used, so that not only fiscal appropriations from the state are contestable. A variety of health care and medical resources exist (primary resources), the control of which has been staked out by various groups who claim exclusive access to their use and the benefits that accrue from that use (secondary resources). Both TRM/CAM and biomedical practitioners have different primary resource bases, and different ways to guard access to these resources. If access to the other’s primary resources cannot be acquired, “they may simply be downplayed in their importance and subsequently neglected” (1975:311). Unschuld offers the example of acupuncture to illustrate this point. Another example of this tactic is the homoeopathic rejection of vaccinations and publicity campaigns to discredit immunization (Cant & Sharma, 1996:585).

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18 The observations upon which Unschuld based his theory have also been noted as a distinct pattern by others: “Initially, orthodox groups either ignore these practices or attempt to undermine and suppress them by making them hard to access, by labelling them as quackery or pseudo-science, and by disciplining those who use them … Later, if the influence of these practices grows, the mainstream community begins to examine them … and selectively adopt practices into conventional medicine that easily fit …” (Jonas & Levin, 1999:3). Armstrong (1987) notes that orthodoxy … manages to control the threat from the unorthodox by a strategy of either marginalization or incorporation” (in Lock 1990:45). Baer (2001) comments that alternatives to biomedicine are co-opted by biomedicine if they cannot be dismissed as ineffective (in Janes, 2002). See also Leslie (1980), Baer (1981), Saks (1995b; 1998).
Unschuld’s hypothesis evolved in the same era as the anthropological “adversarial school”, prominent in the 1970s. This school of thought considered that traditional and biomedical health care practitioners were rivals. For example, traditional healers needed to resist or adapt to the intruding biomedical system (Landy, 1974), or each system was fighting to obtain or preserve the loyalty of the community (Foster, 1977). Coreil explains that this approach to analysing health services was supplanted when it became clear that consumer behaviour was complex, and both TRM and biomedicine were used in diverse ways (1990:9-12). Anthropologists began to determine that medical pluralism operated in many different contexts. One medical system did not necessarily displace the other in modern societies – they operated in “harmony”.

The focus shifted from conflict, adversarial behaviour and contested resources at the practitioner (group) level, to the citizen (individual) and their activities, patterns of resort to health care services and the socio-cultural constructions of health issues. The issue of potential discord between practitioners of various systems was minimised, as this was not evident in utilisation of services. For example, Justice notes that Nepalese “willingly used both traditional and modern medicine. It often appeared that only planners and government health practitioners perceived conflict between different medical systems” (1986:95). Waxler (1984) similarly proposed there was no conflict based on observations in Sri Lanka. The harmony (oscillation) between primary resource aggregates, at the citizen or community level, has also been noted by other authors and mentioned in the introductory chapter.

This may explain why Unschuld’s theory has been neglected as an analytical tool. Unschuld thinks it may have been too “cynical” for medical anthropologists to accept (Unschuld 2004, personal communication), and any discussion of adversarial behaviour may have been incongruous in the 1980s. However, this overlooks the nature of the actor, and the operation of interest groups. A focus of this research is on the behaviour and motivation of groups (practitioners, professionals), and their role in the policy process. As this thesis demonstrates, the formulation and implementation of a policy on using TRM/CAM in formal health care systems brings to a head conflict in demarcating resource boundaries – what primary resources are used in formal health care systems, who is allowed to use them, and how secondary resources are allocated (money/authority/status/prestige). This is primarily a question of politics – who gets what, when, and how (Lasswell, 1958).

When Unschuld developed his theory, the increasing popularity of CAM in the North was not envisaged. It is this development that allows his theory to be applied on a global level, rather than just in Asian settings. The issue of “new resources brought to the society from outside, or discovered in the society itself” intensifies conflict, as it ignites a battle for
control over these imported or newly discovered primary resources (Unschuld, 1975:311). For example, while the biomedical profession disparaged acupuncture in the 1970s, by the turn of the century it had become a lucrative field and biomedical practitioners increasingly administered it. In Belgium today, 74% of acupuncture treatment is provided by biomedical doctors (WHO, 2002e:12). In his analysis of the relationship between acupuncture and biomedicine in Britain, Saks concludes that professional self-interest motivated both the initial rejection of acupuncture, and the later adoption of it by the biomedical profession (Saks, 1992b, 1995a).

The focus on conflict over resources between practitioner groups aims to address an insufficiently documented aspect of efforts to integrate biomedical and TRM systems – that of “economic and prestige competition between the two sectors” (Green, 1988:1126). Interest group competition based on preserving and controlling primary and secondary resources may be “irrational” in outcomes in terms of health system development, if it requires co-operation (sharing resources) to improve delivery or supply. As mentioned earlier, according to Unschuld’s theory of medico-cultural conflict, these two groups require close government supervision or coercion to co-operate, unless they gain an advantage (secondary resource) from doing so.19

The “blurring boundaries” between systems mentioned previously (some TRM practitioners adopting biomedical equipment, and some biomedical doctors practising “integrative medicine” using CAM) can therefore be viewed as efforts to encroach on each other’s primary resource base. Their behaviour is rational in the sense of preserving and extending their professional group economic and/or social benefits (secondary resources). However, the result of this competition is:

In reality, the two systems are everywhere complementary from the point of view of those who experience them; yet nowhere does this complementarity seem to develop into effective co-operation, integrated into a structure that acknowledges the fundamental legitimacy of both systems (Kikhela, Bibeau, & Corin, 1981:96).

19 This may account for the success of integrating biomedical and TRM systems in socialist and communist countries. McDonald notes they “refuse to allow the battles of professionals over the carving up of the medical arena to interfere with the delivery of health” (1981:106). The biomedical profession has far less power and autonomy in socialist countries (Maclean, 1986:16). Elling (1981) has explored links between socialist and capitalist countries, and the mixing of TRM and biomedical systems, and hypothesised it was related to economic resources available. However, his theory was not strictly borne out by developments in the 1990s (for example, in capitalist-oriented societies, TRM/CAM was not used more by the working class). Availability and distribution of economic resources is, however, an important factor as demonstrated by Elling in an analysis of relationships of power, status, wealth, and health care (see also 1978). He concludes that the actual configuration of medical systems is less relevant to the health status of populations than the control and distribution of resources in that society.
Difficult and conflicted policy areas, like health systems development and planning, may therefore demonstrate competition between interest groups and subsequent “irrational” outcomes on social or economic levels. While all stakeholders engage in the policy formulation process, this research focuses specifically on two interest groups – TRM/CAM and biomedical practitioners, because they have a critical relationship in the policy formulation and implementation phase. These competing medical systems perpetually manoeuvre to simultaneously preserve and/or extend their primary and secondary resource bases, and one strategy for this is professionalisation.

The multiple tensions and trade-offs in taking up strategies such as professionalisation are explicitly described in the case of homoeopathy by Cant and Sharma (1995; 1996). According to Unschuld, how much of the stimulus that drives medical/health system development is ultimately related to this need for increased control over and utilisation of resources for the benefit of the professional groups members rather than humanitarian goals is questionable (1975:310).

2.2.3 Lee’s conceptual model for comparative studies of health care systems

While Unschuld’s theory offers an interesting method to conceptualise the interaction of medical systems, it neglects explaining or taking into account power differentials. Lee (1982) also analysed the dynamics between different medical systems, and his findings correlate with, and extend, Unschuld’s theory. The conclusions drawn by Lee also articulate recurrent themes subsequently established in medical anthropology and health policy literature, and this material has been incorporated into an adaptation of Lee’s model.

Lee considered the universal pattern of “hierarchical pluralism” which characterises the organisation of medical systems. He concluded that dominance had two dimensions – “structural superiority” (control over health affairs, economic resources, power, status) and “functional strength” (use and distribution in society) (Lee, 1982:630). For example, whereas biomedicine may be structurally dominant, TRM may be functionally superior. Lee was interested specifically in how and why the functional and structural strengths of medical systems varied between societies and throughout history.

An important component in the varying strengths of medical systems was the role of professional organisations, which help to legitimate medical knowledge and contribute to gaining political and economic power (Lee, 1982:636). However, Lee noted that although TRM/CAM practitioners had recently begun to form professional associations, they had not
managed to gain the same structural status as biomedicine (1982:37). Therefore, the context of modernisation and the role of scientific discourse in this process were considered important (Lee, 1982:637).

The central role accorded to scientific discourse in shaping power relations corresponds with the concepts of power and knowledge developed by Foucault. Gieryn (1983) has described the use of science in constructing boundaries between professions (securing primary resources), and how this demarcation provides professional benefits (secondary resources). This is also important to notions of modernisation where the role of expert systems of knowledge often based on science assume greater importance, and there is an ascendance of secular, materialist and rationalist values (Saks, 1998:199-200).

Lee argues that Western science emerged as the dominant ideology in the process of modernisation, and biomedicine attained credibility and status aligned with this (“legal–rational authority”). In that process, biomedicine achieved a legalised structural monopoly on formal health care (Kelner et al., 2004; Saks, 1998, 2003a) and was considered the only legitimate health care provider, or the “official supplier … a role it protects with diligence” (Waldram, 2000:618). This intimate relationship between science (technology), biomedicine, modernisation and the industrial capitalist state (Moran & Alexander, 1997) may have assisted what Kleinman observed as biomedicine outstripping its own professional autonomy and achieving a status that is inseparable from the modern state (1995:39).

Lee contends that modernisation via science and technology facilitates the absorption of TRM into biomedicine, and that TRM systems have tended to embrace rather than resist this trend through professionalising and adopting scientific methods and ideology (Lee, 1982:639). These two factors of professionalisation and use of scientific discourse (which form themes in the literature) therefore appear to play central roles in determining the structural strengths of different medical systems. The processes of professionalisation and adoption or application of scientific discourse can be seen to have key roles in power and authority between competing medical systems. The approach of professionalising and adopting or applying scientific discourse to seek and maintain structural strength (state recognition) can be interpreted as methods to secure primary resources, in order to access or preserve secondary resources (economic benefits, prestige).

In summary, the concepts proposed by Unschuld (1975; 1976b) and Lee (1982) offer tools to conceptualise the interaction of medical systems. Different medical systems (primary resource aggregates) are in competition and conflict with each other to obtain secondary
resources (wealth, power, status). Techniques used in this competition may include professionalisation (for example, formalised associations, standardised training, codified knowledge) and the application of scientific discourse.

Use of the dual techniques of professionalisation and adoption of scientific discourse has been noted in osteopathy (Baer, 1981; Berliner & Salmon, 1980a:544), homoeopathy (Cant & Sharma, 1995, 1996; Lee, 1982; Taylor, 1979a:83), chiropractic (Coburn & Biggs, 1986), acupuncture (Baer et al., 1998) and naturopathy (Gort & Coburn, 1988). However, this process appears to create unintended outcomes. Namely, the presumed benefits (secondary resources) may not be fully obtained by the TRM/CAM group, autonomy and scope of their primary resources are threatened, and ultimate absorption and subordination within biomedicine can occur. This allows biomedicine to continue strengthening its structural status.

Struggles between competing groups for structural strength (secondary resources) therefore seems to manifest in recourse to professionalisation and the use of scientific discourse, which serve to maintain and strengthen existing power relations in formal health care systems. A form of “hierarchical pluralism” is perpetuated, and they do not “blend into a unified system of health care, despite the fact they claim to perform similar functions (i.e. dealing with health and illness) for the society” (Lee, 1982:629). According to Lee, TRM/CAM adopting the processes of professionalisation and scientific ideology will simply facilitate biomedical absorption unless scientific discourse can be accommodated within their own theoretical frameworks, and state support obtained in the formation of a centralised professional organisation (1982:640). He considers that the WHO promoting TRM could also accelerate this absorption process (Lee, 1982:639), therefore serving to amplify biomedical structural strength.

Although Lee made reference to other articles authored by Unschuld, he appeared to be working in isolation from Unschuld’s theory of medico-cultural conflict. These theories are complementary and can be synthesised. The relationship and “jockeying for power and legitimation” between medical systems has been a subject explored by many medical anthropologists (Lock, 1990:41). However, it does not appear that common principles and conclusions between various theories and observations have been established or linked (such

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20 An example is osteopathy, which adopted scientific discourse and subsequently received state support and was integrated into mainstream health care in the United States (Berliner & Salmon, 1980a:544). Homeopathy was also absorbed by a “significant extent” into biomedicine after reforming theories, techniques and organisation (Lee, 1982). Taylor notes that the “progressive upgrading” of osteopathy and homeopathy led to a “spontaneous synthesis” with biomedicine (1979a:83). See also Baer (1981).
as professionalisation and application of scientific discourse as techniques in the competition for resources), and tested in policy and programme analysis on an international and national level. The framework developed from consolidating these theories and themes intends to address this gap in the literature.

2.3 Linking the theories to explore the policy of integration

An analytical framework to explore the evolution and implementation of the policy of integration of medical systems in formal health care has been created, in this thesis, from a synthesis of anthropological and political science tools. The framework simplifies and generalises in order to try to clarify an otherwise bewildering topic of enormous scope. This is necessary in order to have any chance of understanding complex processes or situations, and is based on the premise that a smaller set of critical relationships underlies such phenomena (Sabatier, 1999:4-5). It is proposed that interest group interaction (competition for resources) may partially explain the peculiar 25-year life-cycle of this policy on an international level, and its problematic transfer to national levels.

Kingdon’s “multiple stream” theory allows the economic, political and social environment surrounding the policy of integration to be explored, and offers a potential explanation as to how and why the policy agenda on integration was set. It provides a framework to consider how health issues are defined (problems), and how the solutions proposed to address them (policies), are influenced by the surrounding context (politics). These streams coupled (linked) twice, when the issue of integrating TRM into national health systems arose on the global health agenda – in 1978 and in 2002. Examining the policy documents at those points in time, and tracing the history of this policy and programme development in the intervening years allows boundaries of debate, paradigm and power shifts to be explored, and the roles and motives of various actors and interest groups to be assessed.

The politics (such as shifts in ideology, public opinion, interest group activity); and problems (problem recognition and identification) surrounding this policy at an international level will be analysed. Emphasis is given to the politics stream (specifically interest group activity) using Unschuld’s (1975, 1976) theory of medico-cultural conflict combined with Lee’s conceptual model for the comparative study of health care systems (Lee, 1982). The combination of the theories and frameworks mentioned allows this policy issue to be considered as an intrinsically political exercise that has been stimulated by global social and economic forces.
A critical relationship is focused on in this assessment – biomedical and TRM practitioner groups, who operate as interest groups within both the politics and policy streams. These groups are motivated by a desire to maintain and increase access to primary and secondary resources, apart from their common goal of providing health care to the community. Tactics to preserve and increase access to resources include professionalisation and the use of scientific discourse. This synthesised framework for analysis illuminates the conflict and competition for primary and secondary resources between medical systems (interest groups), and how this is reflected in policy content and programme formulation and implementation. For example, in the identification of problems, definition of health resources, methods proposed for integration, and allocation of financial resources.

Key policy and programme documents and activities in relation to integration can therefore be interpreted with the application of the “resource model” (reflecting interest group motives to secure resources motivated by professional self-interest). If this hypothesis is correct, policy content and programme development regarding integration will reveal the manoeuvring and strategies of interest groups to influence the definition, legitimation and allocation of primary resources (knowledge, skills, techniques, drugs, technology, equipment and facilities) in order to preserve or extend access to secondary resources (material and non-material rewards). In doing so, the interest groups take advantage of surrounding economic and social contexts to promote their political and professional interests on the health care agenda.

The concept of integration requires sharing economic and political power (Chi, 1994:308), and a level of mutual respect between practitioners of diverse systems. However, if as Unschuld hypothesises, biomedical and traditional practitioners (groups) compete to preserve exclusive access to and the integrity of their primary resources, and increase secondary resources (money, status and prestige) then the process will be extremely problematic and highly contested. As this thesis demonstrates, the health policy of integration of TRM into health care systems is therefore not technical but political, and the outcomes can be interpreted to reflect power relations of interest groups at organisational (e.g. WHO) or national levels.

Table 3 offers an overview of how the synthesised “resource model” based primarily on Kingdon (1984) and Unschuld (1975; 1976b), but also drawing on Lee (1982), will be applied and tested to the policy issue of integration on a global level. It does not include broader social and economic trends, and ideological shifts, that also influenced policy
development and implementation. The framework outlined in table 3 is a generalised illustration to enable the policy issue and progress in its implementation to be conceptualised. The table demonstrates how a window of opportunity opens in the problem and/or politics streams for a policy to be elevated on the agenda. It also demonstrates how the problem identified can change in nature, while the policy solution proposed remains the same. In addition, the politics stream (specifically interest groups) can modify their position based on external circumstances – such as the development of economic incentives for co-operation, or the rise of new public health problems. By 2002, public health and economic issues in the North also became relevant to the matter of integration, and all parties had a direct interest in resolving the formal role of TRM/CAM.
### Table 3: Application of the theoretical framework to policy of integrating TRM to illustrate coupling" of problem and politics streams on global level

<table>
<thead>
<tr>
<th></th>
<th>SOUTH</th>
<th>Policy</th>
<th>NORTH</th>
<th>Problem</th>
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<tbody>
<tr>
<td>SOUTH</td>
<td>Politics (TRM)</td>
<td>Policy</td>
<td>Politics (Biomedicine)</td>
<td>Problem</td>
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<tr>
<td><strong>1970s (ch. 3)</strong></td>
<td>Biomedicine resource intensive (not feasible to extend coverage 100%), does not meet needs and has not replaced TRM; maternal and child mortality; communicable diseases</td>
<td>Achieves formal recognition and therefore potential to acquire more resources (redistribution of secondary resources, formal recognition of their primary resource base)</td>
<td>Integration of TRM via PHC to provide the South with basic health care services; linked to HFA goal (window opened in South) technical advantage in co-operation</td>
<td>Not threatened as TRM sphere restricted to PHC and “scientifically valid” practices; TRM seen as a method to extend the reach of limited biomedical services</td>
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<tr>
<td><strong>1980s (ch. 4)</strong></td>
<td>Continued lack of biomedical manpower, drugs and infrastructure; AIDS, environmental degradation (need for preservation of primary resource base)</td>
<td>Limited role in PHC means less status (biomedical auxiliaries), no increase in remuneration (secondary resources); rise in formation of professional bodies and professional activities (e.g. conferences, publications)</td>
<td>PHC concept falters in implementation phase; biomedical/vertical approaches continue to dominate delivery (window closed) competition to secure resources</td>
<td>TRM/CAM practices disparaged and criticised, dismissed as having no clinical validity. Actively limit role of TRM practitioners in delivery (except TBAs), unwilling to relinquish power and authority (secondary resources)</td>
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<td><strong>1990s (ch. 5)</strong></td>
<td>Supply of essential drugs; fragmented health care systems; decimation of population from preventable conditions, AIDS, malaria; concern over preservation of primary resources (biodiversity, sustainability)</td>
<td>Increased secondary resources through growth of global market for TRM/CAM; agitation over appropriation of TRM knowledge by biomedicine (IPR/TRIPS); many accept “scientific validity” agenda to secure access to markets and increase status</td>
<td>Continued statements of support for integration of TRM in the South; delayed integration of TRM in South and rapid informal integration of CAM in North (window opens in North) economic advantage in co-operation</td>
<td>TRM/CAM primary resources appropriated to increase secondary resources; domination via “safety and efficacy” agenda; efforts to consolidate monopoly by selectively absorbing TRM/CAM into mainstream care (“integrative medicine”)</td>
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<td><strong>2002 (ch. 6)</strong></td>
<td>Merging of politics and problem streams from the North and South on global level allows common solution (integration of TRM/CAM) to be proposed; meeting different objectives (different problems) – an attempt to protect and enhance access to resources by both biomedical and TRM practitioners - 2002 WHO Global Strategy on TRM</td>
<td></td>
<td></td>
<td>Recognition of cost and equity issues in biomedical service delivery</td>
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</table>

AIDS = acquired immuno deficiency syndrome; CAM = complementary and alternative medicine; HFA = Health For All; IPR = Intellectual Property Rights; PHC = primary health care; TBAs = traditional birth attendants; TRM = traditional medicine; TRIPS = Trade Related Intellectual Property Rights; WHO = World Health Organisation
2.4 Structure and overview of thesis

The plan to incorporate TRM into formal health care systems is a case study to explore and offer insight into some of the issues raised by global “top-down” health policy formulation and implementation. These issues were mentioned in the introduction and include questions regarding the requirements for successful transfers of health sector reform policies, the impact of international initiatives at country levels, the practical implications of these initiatives, and whether there is “lesson drawing” on what works and for what reasons in health policy development.

In addition to considering these general policy questions, the case study on the history and evolution of integration of TRM allows the development and testing of a potential explanatory framework, the application of which forms the body of this thesis. This framework incorporates a macro (international) and micro (national) approach, and proposes that interest group activity is crucial in understanding the outcomes observed. The interest group activity is “rational” as a form of group behaviour but serves to produce “irrational” health policy outcomes in relation to the integration (formalisation in health care systems) of TRM, and obstacles in the national level implementation of such a policy.

The *politics* (shifts in ideology, public opinion, interest group activity, administrative changes); and *problems* (problem recognition and identification) surrounding this policy are investigated. Within this analysis, specific emphasis is given to evidence of professionalisation and the use of scientific discourse, to assess whether and how these techniques (as proposed by Unschuld and Lee) are employed by interest groups in the competition for primary and secondary resources, and the extent and method of their application. Policy and programme documents are therefore examined from the perspective of revealing underlying unarticulated values and ideologies (Hancock, 1999:47) that reflect power relations and conflict between competing medical systems.

Shifts in the *politics* and *problems* streams (such as the influence of health transitions and new public health concerns, and changing or emerging economic and social factors) and how this affected the role of TRM on the policy agenda, and the nature of interaction between interest groups, will be considered. This is because such shifts may influence the preferences or validity of primary resources used, and the generation or allocation of secondary resources. For example, the increasing use of CAM in the North and concurrent export of TRM from the South (“new resources brought to the society from outside, or discovered in
the society itself”) is anticipated to result in intensified competition and conflict between interest groups, as control and authority over these imported or newly discovered resources is contested (Unschuld, 1975:311).

The role of international organisations in the integration policy process is important in terms of both the broader questions raised by global health policy (such as global – local policy transfer, the promotion and transmission of certain values, and the formulation and implementation of universal policy prescriptions) and also specifically in relation to the relationship between TRM and biomedicine. Lee hypothesised that the WHO promoting TRM would accelerate the absorption process (Lee, 1982:639) therefore serving to augment and intensify biomedical structural strength. Whether this has occurred over the approximately 30 year period analysed, and how the WHO mediated and guided health system integration policy and programme development, is considered.

The thesis does not follow a conventional format, such as presenting a literature review followed by methodology, data presentation and research analysis and findings. This is partly due to the volume of material, and also the inability to separate out the literature from the research findings. Part of the literature review has already been presented in the introduction and methodology chapters, and the literature is used throughout the body of the thesis to interpret and assess interest group interaction. In this way, the literature review and research analysis and findings are inevitably bound together.

Each of the following chapters presents the results of assessment of the literature, using the methodology already outlined to construct the findings. This synthesised framework is used as the “prism” through which the data is presented, in order to illustrate its application to the policy issue. The policy and programme documentation and data is analysed and structured in terms of how it relates to, defines or restricts the primary and secondary resources of biomedicine and TRM. This is indicated where necessary to provide guidance on the application of the theories, and the terminology of primary/secondary resources is used throughout. The thesis is divided into two parts. The first part explores the global evolution of the policy on integration (chapters 3-6), and the second part explores the transfer and application of this policy on a national level (chapter 7). The conclusion is contained in chapter 8.
2.4.1 Part 1: global level

The first part of the thesis is a chronological narrative of the development and progress of the WHO policy on TRM between the 1970s and 2002. This aims to illustrate and explain how the WHO policy on TRM (content and application) was influenced by the surrounding political, economic and health policy environment. The changing nature and agenda of actors (WHO, World Bank, interest groups) is traced; shifting influences of power and boundaries of health policy debate considered; and broader social and economic factors that form the backdrop to these changes are discussed. This investigation offers insights into the issues that influence agenda setting and policy currency in the health arena on an international level.

Journal articles, books, reports and resolutions of the WHO, and conference proceedings are the main sources of information. A timeline was constructed of all identified WHO activity in relation to TRM, listing resolutions, reports, documents and conferences or meetings. This list is contained in appendix 1 (page 348). The two key documents were identified as the initial WHO technical report on TRM (WHO, 1978b) and the WHO global strategy on traditional medicine (WHO, 2002e). As the policy directives from the WHO headquarters in relation to TRM, these two documents loosely delineated the research boundaries.

The international level analysis is divided into decade sections (one chapter for each decade), although it is acknowledged that these sections are “artificial” in the sense that there is often no discrete demarcations delineating trends and ideological shifts. However, prominent themes and issues that emerged in those decades are discussed in relation to their influence and role on the policy of integration of TRM.

Chapter 3: 1970s – *international recognition of TRM*: an upsurge of nationalistic sentiment and biomedical primary resource pressures in the South combined to give impetus to TRM on the international health agenda. With China providing an inspiring model, the goal of “Health For All” (as advocated by the WHO) was to be achieved using TRM primary resources.

Chapter 4: 1980s – *difficulty transferring policy to national levels*: a neo-liberal economic environment and global recession led to a contraction of health services and hindered the implementation of new public health initiatives. Integration of TRM floundered in national level adoption, and was submerged internationally in a policy vacuum.
Chapter 5: 1990s – conducive conditions develop for pushing TRM back onto the global agenda, as TRM was exported worldwide and became a multi-billion dollar industry. This generation of secondary resources (economic benefits, growing status and prestige) led to stakeholders competing to secure resource bases and a renewed policy interest in TRM.

Each chapter is structured in a similar manner. Firstly, the broader policy context is described, both generally and then specifically in relation to the health field. The activities of the WHO and World Bank are then explored, in relation to TRM. The last section considers responses in the policy stream (actors such as academics, policy and programme advisors, interest groups) and national level activity. The chapter structure is therefore layered from the broader and more general policy context to the specific micro level policy context:

Section 1. General global events and policy trends; health policy trends
Section 2. International agencies - WHO, World Bank
Section 3. Responses in policy stream to integration of TRM (academics, interest groups); national level implementation and policy in relation to TRM

This structure aims to demonstrate how broader policy trends affect the scope of health field debate, which influences agencies responsible for health policy articulation and implementation (WHO, World Bank). These influences are also discernible in discussion, debate and activity in the policy stream on national levels. How problems are framed, and how actors (both international bodies and interest groups on national levels) respond to those problems must therefore be placed in the context of broader policy trends. There is a complex inter-relationship between these levels of policy activity, and the threads which link them can be illustrated through looking in detail at one policy field – in this case, integration of TRM. Underlying this is a competition for resources between health professions, who must operate within the fluctuating policy context to secure their place (role in the health care system) on the agenda.

While much of the material from the broader policy context and international agencies will be familiar to those with a background in health policy and medical sociology, it is presented here in an effort to recast the perspective on the relationship between medical/health care systems and more clearly establish the context within which they are interacting. While they are providers of health care, in this research they are focussed on as agents (interest groups; competing discourses) operating within the broader political, economic and social milieu to secure resources. In that sense, the issue has been framed from a political science/policy
theory perspective, rather than as a technical “health care” provision question or anthropological issue per se.

The final chapter on the global level (chapter 6) specifically analyses the **TRM Strategy 2002-2005** (WHO, 2002e). This milestone document is considered in a separate chapter due to its significance in articulating the WHO stance on TRM, and as the final outcome of the policy process over several decades. It is also enables the previous chapters to be structured in a similar manner, and kept within their chronological boundaries.

### 2.4.2 Part 2: national level

In the second part of the thesis a national level study of Sri Lanka, using the same theoretical framework, is undertaken to consider transfer of the concept of integration from the global to a national level. This aims to demonstrate that the framework can be applied on global or national levels, and to explore the issues raised by global policy formulation and transfer in detail.

The national level study focuses on the implementation of “integration” through exploring the current situation and relationship between TRM and biomedical systems in Sri Lanka. Legislation, resource allocation, programme development, professional organisations, education, and current patterns of usage will be assessed. This analyses the impact that the international consensus on integration has had on a national level, and how it has been implemented and interpreted by the government and interest groups.

**Chapter 7: Sri Lanka**: The role of Ayurvedic medicine in the health care system will be the focus. This is a form of traditional medicine that originated in India and has been used in Sri Lanka (with some local variations) for thousands of years. Sri Lanka was chosen as a case study as it has a strong history and tradition of TRM use, was considered in the initial WHO technical report on TRM (WHO, 1978b), and because previous research on TRM undertaken in India and Nepal enabled an understanding of local TRM systems used (specifically Ayurveda). Sri Lanka is considered an “interesting laboratory” to examine pluralistic medical systems, as Ayurveda and biomedicine formally coexist (Waxler-Morrison, 1988:531). Field work was undertaken in March and April (2003) and October, November and December (2004). The empirical data used in the national case study analysis consisted of primary and secondary resources as detailed below.
a) Primary sources consist of semi-structured interviews and material gathered from conferences and seminars. Two main groups of people were interviewed. The first are bureaucrats and government employees working in an administrative role (such as programme and policy officers) in the relevant government departments. The focus of the interviews related to programme development and implementation (such as general history, constraints and obstacles, resource allocation, focus of activity, catalysts for expansion or contraction of programmes, roles of external agencies).

The second group are practitioners of traditional medicine and biomedicine, and the focus is the relationship between these groups (such as professional collaboration and referral patterns, attitudes to and extent of interaction between medical systems, education and training, response to government initiatives). These participants were met at conferences or at seminars (detailed below) or recruited via snowball sampling. Data was analysed for the identification of any themes and issues related to the theoretical framework.

The process for identifying and locating people for interviews was extremely difficult and time consuming. Initially, people in government departments or agencies, or practitioners in private practice, were approached via “cold calling”. A fortuitous breakthrough in this process came when a key informant was located, a TRM practitioner who held a senior government policy position and was also active in programme development – Dr. Danister Perera. Dr. Perera was interviewed multiple times and enabled access to be gained to other senior bureaucrats. He also helped gather policy and programme documents in English, and served as a reliable source for checking facts.

A total of twenty formal interviews were conducted, with the aim of obtaining an equal and balanced sample from both biomedical and TRM systems, as well as representatives from government agencies, professional bodies and educational institutions. A list of the people interviewed and their positions is at appendix 2 (page 354). The interviews were semi-structured and open ended and were not taped. This was because taping the interviews appeared to formalise the process to the extent that people being interviewed may have felt inhibited, and also because of the political sensitivity of some of the issues discussed. Detailed notes were taken, based on questions that were framed to explore those issues mentioned above – the extent and nature of interaction between medical systems and how this was expressed in policy and programme development.

The interviews were tailored according to the position of the person, their English proficiency and time available. Common themes were used as prompts, such as the level and
appropriateness of government support for TRM, whether there were divergences between policy statements and actual programme implementation, the role of TRM in the formal health care system, difficulties in integration, attitudes and referral patterns between practitioners, WHO activities, and if national policy activity was changing with increasing foreign interest in TRM. The interviews were allowed to spontaneously develop rather than being rigidly pre-determined to allow for the potential of previously unknown or unrecognised issues to emerge, and to prevent possible bias in the structure of interviews skewing data collection.

While it would have been preferable to conduct more interviews of both practitioners and bureaucrats (or to conduct multiple interviews), time limitations of participants and the difficulties in locating suitable informants constrained the sample size. However, the specialised nature of the issue meant that relevant people to interview (the “policy community”) was also naturally restricted. At the end of the field work, no noticeable new themes were emerging from the interviews. It may have also been interesting to conduct interviews with a broader sample (for example, with students of these medical systems, or with patients) but this was not strictly necessary for the purposes of this research.

Various conferences and seminars were attended, which were chosen according to their relevance to the research issue. These were identified through newspaper publicity or by invitation by Dr. Danister Perera (to those events that were not public). The English language paper was read daily to source relevant articles, as well as to locate any activities such as seminars or conferences that offered opportunities to gather information or identify people to interview. The activities attended were very valuable in obtaining an understanding of the current climate in the relationship between medical systems, difficulties and tensions in the interaction of these medical systems in formal health care delivery, and the operation of programmes. The specific meetings and conferences attended were:

- Sri Lanka Association for the Advancement of Science Meeting; Hon. Bernard Soysa Memorial Oration – Dr. ROB Wijesekera *Traditional Pharmacopoeias and Modern Therapy*, 25 March 2003
- Sri Lanka Medical Association Conference; 116th Anniversary Academic Sessions *Spiritual Health – A New Dimension in Health*, 26-29 March 2003
- Training session for community health workers, National Institute for Traditional Medicine; 24 October 2004
- Medicina Alternativa *Congress on Integrated Medicine*, 27-30 Nov 2004
• Workshop on the formulation of national policy on indigenous medicine, National Institute for Traditional Medicine, 9 December 2004
• Registration of TRM practitioners, Pallekele Ayurvedic Hospital, Kandy, 13-14 December 2004

b) Secondary sources include policy and programme documents from the Sri Lankan Government, the World Bank and the WHO. Government policy statements, programme information, health plans, legislation, newspaper and journal articles, conference and seminar papers, and books were collected. Some of these documents were unpublished or confidential (“grey literature”) that were obtained from interview participants. Permission was obtained to access the WHO and the Sri Lankan Medical Association libraries in Colombo. Physical searches of these libraries were undertaken to assess the representation of literature on TRM, and to obtain general information on the health policy domain in the Sri Lankan context. All major bookshops in Colombo were also canvassed for relevant material.

To explore the relationship between biomedicine and TRM, journals from the biomedical and Ayurvedic profession were analysed. These journals offered an insight into professional attitudes and extent and history of interaction between medical systems. The *Ceylon Medical Journal* (the local version of the *British Medical Journal*, published in English) represents the biomedical profession, and all issues from 1990-2004 were manually assessed for articles of relevance, and any reference to indigenous medicine. Hundreds of articles were available from this source, but only a few of these articles made specific reference to traditional medicine.

The corresponding journal for the Ayurvedic profession is *Ayurveda Sameekshawa*, and all issues from inception (1983) to 2004 were similarly assessed. Unfortunately, only articles in English could be considered which reduced the available material from *Ayurveda Sameekshawa*. The parameters for collecting the information from professional journals were therefore imposed by physical constraints – all issues that could be accessed of the *Ceylon Medical Journal* were, these were shelved in the Sri Lankan Medical Association Library and no copies prior to 1990 were available. Similarly, the index of all issues of *Ayurveda Sameekshawa* from its inception in 1983 revealed about 100 articles in English, but many of these were about specific TRM remedies and treatments. Only about a dozen articles over that time frame specifically related to the relationship or interaction between biomedicine and TRM, or the role of TRM in health care.
While locating documentation in English was problematic, the paucity of data on integration and the formal role of TRM in the health care system was revealing in itself. It should be noted that the lack of available data related to health care policy and planning in general and not exclusively in relation to TRM. The gathering of literature and data thus only stopped when avenues for locating secondary sources appeared to have been exhausted. Over the course of the field work, a comprehensive selection of material was obtained from a wide variety of sources and this information enabled consideration of the issues in detail at the national level. The findings of this research are contained in the case study of Sri Lanka (chapter 7).

2.4.3 Conclusion

The final chapter of the body of the thesis (chapter 8) contains the conclusions. Conclusions are drawn about various aspects of the field of inquiry, firstly drawing findings about the main research question of why this issue first arose on the international policy agenda in the 1970s, why it seemed to languish and prove very difficult to implement on national levels in the 1980s, and why it was regenerated in the 1990s to reappear on the global health policy agenda in 2002. The appropriateness and utility of the explanatory model in answering this question is summarised and discussed.

Conclusions about the supplementary global health policy questions are also considered. These are the broader questions raised by researchers in relation to health policy and globalisation, mentioned in the introductory chapter. The questions include the appropriateness of universal policy models that are driven by “top-down” approaches, the forces behind convergence of policy proposals, the processes and outcomes of the transfer of global health sector reform policies, whether there is “lesson drawing” on what works and for what reasons in health policy development, and whether certain values are promoted and transmitted globally through international organisations. Finally, implications for theory, implications for policy and practise, and implications for future research are covered.
3. 1970s: International recognition of traditional medicine

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?

(Mahler, 1977) Director-General of WHO

In the 1970s, fertile ground developed for elevating TRM on the policy agenda. This decade can be viewed as one where TRM systems of health exploited opportunities to challenge the authority of biomedicine and its pre-eminent position in health care. The primary resource base of TRM was asserted, contesting the status of biomedicine and its sole claim to secondary resources (material and non-material rewards). This chapter outlines how the policy environment on an international level became favourable to the concept of TRM, and how this was mediated by the WHO. Despite both TRM and biomedicine sharing the common goal of improving health, they are perceived as professional competitors motivated by the need to secure and maintain access to resources.

During the 1970s, the WHO formally recognised the valuable role that traditional medicine played in health care services, and the potential to employ it in a more systematic way. The TRM Programme was established in 1978, following a series of related resolutions. TRM was also a component of other progressive schemes, launched around the same time. These were the essential drugs list (1977), and the ambitious global health goal – Health for All by the Year 2000 (1975), to be achieved using Primary Health Care (1978).

The values of the Health For All goal (HFA), and the Primary Health Care (PHC) approach, were clearly stated in the joint WHO/UNICEF declaration made in Alma Ata, in 1978. It was revolutionary in both its language and implications. It called for “urgent action by all governments” to address the “existing gross inequality in the health status of the people [that] is politically, socially and economically unacceptable”. The means to achieve this included more effectively utilising all resources available, such as reallocating money currently spent on armaments and military conflicts.

This approach was a contentious departure for the WHO, which had previously restricted its activities to technical, disease specific (vertical) interventions. Despite the far-reaching concepts it endorsed, 60 international organisations and 138 member nations represented at
the conference unanimously approved it. Very few concepts or proposals in the health care arena have attained the same level of collective approval (Mull, 1990:32). These countries and organisations had diverse backgrounds, with widely divergent political and economic conditions, yet found accord on what could be considered a very radical proposal.

The ideas and language contained in the HFA resolution and the PHC commitment (known as the Alma Ata Declaration), reflect economic, political and social trends prominent in that era. Today, the utopian concepts it endorses seem overly idealistic and it has become a renowned landmark in the history of the WHO. The commitment to achieving this humanitarian goal, and even the understanding by signatories of the concept, has been questioned (Macdonald, 1992:55; Werner, 1995). Officially sanctioning and encouraging the use of traditional medicine was not met with the same approval as the PHC concept (Bichmann, 1979:177), and was considered by some a “mistake”, and the result of “emotional self-indulgence” (Velimirovic, 1984b:74).

While the goal of HFA was laudable, the proposed methods to achieve it (PHC, Essential Drugs and using TRM) have been hotly contested and achieved variable degrees of success in implementation. Viewed in the broader context of popular sentiments and ideological shifts of the decade, they appear logical solutions to the serious inequities in health status. Nevertheless, as will be demonstrated, they are not simply technical and administrative concepts but have inherently political and economic consequences. The environment that produced the Alma Ata Declaration and the associated schemes is initially considered, followed by more specific trends in the health field. The content of resolutions, programs and policy documents of the WHO in relation to TRM are then assessed, in the context of revealing a battle for control over and access to resources. This battle took place against the backdrop of the broader policy context.

Section 1: policy context

3.1 The broader policy context

In the 1970s, the optimism of the prosperous “development decade” that preceded it was replaced with a critical assessment of the current global social and economic situation, and a reappraisal of what boded for the future. Assumptions underlying development discourses were questioned, with the sobering realisations that poverty, ill-health and lack of access to basic services remained and even increased, despite economic growth. The benefits of
The supposed panacea of economic growth and modernisation as a solution to many social problems was replaced with a more critical examination of institutions, entrenched interests and the distribution of resources within historical and social frameworks. Whether economic growth as an end in itself was desirable, and how to balance this with social needs was also questioned (Schumacher, 1973; Seers & Joy, 1971). This was undertaken in an environment where the limits to resources available became an over-riding concern. It was recognised there were limits to economic growth, to the benefits of such growth and the resources available to support continued expansion.

3.1.1 Limited resources

The oil shock in 1973 was a catalyst for the recognition of the finite existence of natural resources. The Organisation of Petroleum Exporting Countries (OPEC) quadrupled the price of oil, which again doubled in price before the decade was out. The 500% increase in the price of a commodity (that did not have substitutes) ended the inexpensive access to energy that had fuelled rapid industrialisation, and the confident belief that such growth would be unimpeded. The oil crisis meant that governments and international agencies realised that continued growth relied upon natural resource management (Sachs, 1993:9). It also had flow on social and economic effects, such as inflation and price increases for imported goods as well as basic commodities.

Rapid population growth and the subsequent demand on resources remained a cause for concern, continuing a trend that had gained international attention in the 1960s. It seemed that the questionable progress made with development could not keep pace with population
growth, which threatened to outstrip the supply of goods and services, including basic necessities like food and water. India and China introduced draconian measures to curtail the population explosion – forced sterilisation (1975-76) and one-child policies (1978) respectively. Food shortages magnified the crisis scenario that was developing. In the early 1970s, poor harvests and drought in Africa resulted in famine and widespread malnutrition.

There was a growing sense of scarcity, environmental fragility, economic vulnerability and a need to seek alternatives to meet the basic needs of humanity. A convention on the international trade of endangered species (CITES) was agreed and became operational in 1975. A series of international UN sponsored conferences reflect the prominent concerns with resources and the environment: human environment (1972), food, population, as well as a special session of the General Assembly to discuss resource issues (1974), water, and desertification (1977). All these conferences reflect the themes of limited resources, population growth and resource balance and meeting basic needs.

3.1.2 Human rights and equal opportunity

Throughout the decade, the rights of minority groups to access services, and be recognised as contributing to and benefiting from development efforts also came to the fore. The economic and social exploitation of women, ethnic groups, the poor or less educated was exposed and their rights championed, building on and institutionalising an impetus that had commenced in the 1960s. Rawls (1971) produced an influential account of social justice; and racism, sexism and human rights became a matter of civil concern, both on national and international levels.

The UN held conferences on women (1975), followed by a Convention on the Elimination of Discrimination Against Women (1979) and declared an International Decade to Combat Racism and Racial Discrimination. The Helsinki Accords of 1972 and 1975 were an international recognition of and commitment to human rights issues. This atmosphere established the scene for health as a basic human right, and the need to improve the dire health status of those in the South (the less privileged), to be affirmed in Alma Ata in 1978.

At the same time, there was growing public disquiet about involvement in armed conflicts and the arms race, with calls for restraint on both humanitarian and economic grounds. A turning point was the 1973 withdrawal of US forces from Vietnam, after a long and costly engagement. This war, the longest the US had fought and first it had lost, seemed to symbolise the futility of conflict, limits to Western technology, and the unlimited resources
war could absorb (see Lake, 1993). Using resources more constructively for positive ends (such as health and education) became a moral concern, as expressed in the Alma Ata declaration. According to Bello (1994:9), the decisive victory of Vietnam over the United States and OPEC success in oil price control (discussed below) meant that the South felt on the threshold of a new political and economic era.

3.1.3 Shifting economic and political power

On a global level, newly independent countries began to flex political and economic muscle. Asserting their power after decades of colonisation, and buoyed by the success of OPEC reclaiming price control over its natural resources, these countries demanded a new international economic order (NIEO). OPEC was significant in that it represented many previously politically and economically “powerless” countries. Uniting allowed them to control the agenda of an important global issue and increase their national share of economic benefits (in direct opposition to Western oil corporations and their monopoly on prices). Other developing nations tried to follow suit, and create price control on minerals and agricultural commodities (Bello, 1994:9).

Following from the example of OPEC, at the UN special session of the General Assembly in 1974 developing countries grouped together to present their demands, which became known as the new international economic order (NIEO). In general, the developing nations sought special recognition of their circumstances in economic affairs, to provide them with access to markets and an increase in resource transfers. This was a highly symbolic and important event, although did not succeed for a variety of reasons and became considered a “classic illustration of failed international reform” (Rothstein, 1993:629). This economic movement corresponded with a surge in membership of United Nations bodies including the WHO, which shifted the balance of power in the Organisation to the South and allowed it to influence the agenda of the World Health Assembly and refocus priorities away from the industrialised nations.

The HFA and PHC movements of the same era could also be grouped with the failed NIEO initiative. They sought a “new health order”, and a redistribution of resources to meet the needs of the poorest and least powerful segments of society. While the NIEO sought North-South economic redistribution, the HFA and PHC (basic needs) initiatives sought national redistribution from tertiary (curative) to primary (preventative) health. The NIEO, HFA and PHC initiatives all reflected concern over resources and access to resources, and sought
concessions in the name of human rights, social justice and equity (see Cohen & Purcal, 1989:8).

These idealistic international commitments were features of a global wave of moral concern, leading to the establishment of goals that were noble but not pragmatic. While the member states of the WHO pledged in 1975 to achieve health for all by the year 2000, the United Nations Conference on Human Settlements (1976) pledged to have safe water for all by 1990, and the 1974 World Food conference assured that “within a decade no child would go to bed hungry, that no family would fear for its next days bread, and that no human being’s future capabilities would be stunted by malnutrition.” While achieving consensus on these ideals was not difficult, translating the rhetoric into reality proved far more problematic.

3.2 Trends in the health field

The broader trends and concerns of the tumultuous 1970s are reflected in the content and scope of WHO initiatives, as well as in specific ideological developments within the health field. Issues such as the limits to biomedical technology and its resource intensive nature; inequitable service delivery; and the failings of the western biomedical models emerged. These growing concerns worked to undermine the authority of the biomedical primary resource base (drugs, techniques, knowledge) and question the previously uncontested power and authority of the biomedical profession within the health care system.

The stark North-South disparities in health status, and continued health inequities even within wealthier nations, pointed to structural faults in existing systems that had failed to meet their promises. Health as a basic human right was re-asserted, with the conditions required in achieving and maintaining it considered an associated prerequisite. The need to reassess and reorient previous strategies to find alternative ways to meet the basic health needs of populations became paramount.

21 Two books offer a comprehensive collection of major authors, articles and concerns that emerged in the 1970s: “Health and Disease – A Reader” (Black et al., 1984) and “The Cultural Crisis of Modern Medicine” (Ehrenreich, 1978).
3.2.1 Limits to biomedicine

Major contributors to the shift in the perception of the role of biomedicine in public health were Cochrane (1972), Illich (1975) and McKeown (1976; 1979). They built on the crucial assessments and themes raised by Dubos (1959). Cochrane critically considered the assumption that biomedicine was necessarily effective or efficient. He worked to eliminate bias in assessing its validity, and promoted the rational use of resources by using the most effective treatment at lowest cost. His work was the result of caring for prisoners of war where he successfully treated many people despite having almost no biomedical pharmaceuticals (Black et al., 1984:104).

McKeown questioned the significance of the biomedical contribution to improvements in population health. He demonstrated that other factors such as improved nutrition, water, sanitation and smaller family size were more important to the progress made in health indices that had occurred throughout the century. The assumption that hospitals and pharmacies, vaccinations and development of biomedical theory and education caused the rapid decline in mortality was exposed as erroneous. This false conclusion was the result of the “failure to distinguish clearly between the interests of the doctor and the interests of the patient” which he considered “a common error in the interpretation of medical history” (McKeown, 1984:107, emphasis added).

Unlike Cochrane and McKeown, Illich was not a biomedical doctor and was even more critical in his approach, arguing that the medical profession itself and medical technology were threats to health (iatrogenesis). *Medical Nemesis – the Expropriation of Health* (Illich, 1975) was a landmark critique broadly condemning industrial society and its impact on health and well being, as well as the biomedical monopoly that removed the power from individuals to treat and heal themselves. According to this perception, “medicine has become a source of harm and oppression rather than a vehicle of relief and liberation” (Navarro, 1976:xi). Illich proposed the “de-professionalisation” of biomedicine – removing and reducing the control of experts over medical knowledge (primary resources) and increasing the autonomy of the individual to choose and manage their health care.

Illich (1975) raised many issues that were formative in the development of critical discourses on biomedicine and health care services, such as the ineffectiveness of biomedical treatments, the inordinate cost of biomedical equipment, the commodification of health care and “medicalisation” of society. The role of the environment, including food, housing, and working conditions were stressed as important in determining health status. His presentation
was persuasive, although his conclusions were extreme; criticised even by other radical commentators (Doyal, 1979:17-20; Navarro, 1976:104-128).

The themes of limits to, and dangers of an uncrirical acceptance of biomedicine (science and technology), are reflected in many other texts of that period. For example, in books with titles such as *The Cultural Crisis of Modern Medicine* (Ehrenreich, 1978), *The Magic Bullet: Social Implications and Limitations of Modern Medicine, an Environmental Approach* (Diesendorf, 1976), *The Drugging of the Americas* (Silverman, 1976) and *Medicine out of Control: Anatomy of a Malignant Technology* (Taylor, 1979b). Addictions to and dependency on drugs, the side effects and implications of commonly prescribed biomedical treatments, and the benefits of this approach for the individual and society were considered. In 1978, the Office of Technology Assessment in the United States reviewed the safety and efficacy of biomedical technologies, and concluded that evidence of their benefits was often minimal. It quoted research findings that only 10-20% of all procedures used in biomedical practice had been clinically proven as beneficial (OTA, 1978:94), a sobering conclusion also recognised by others (Berliner & Salmon, 1980b; Elling, 1981b; Unschuld, 1976b).

### 3.1.2 Biomedicine, equity and social justice

The links between biomedical, economic and social systems, and the ways that these perpetuated and reinforced inequalities, were explored by many scholars throughout the decade, such as Navarro (1976), Doyal (1979), Fanon (1967; 1978) and Paul (1978). The political economy approach linked capitalism, colonialism and imperialism with an unequal distribution of biomedical health resources, and a profit-orientation that denied access to the poor and marginalised. The nature of capitalism itself played a role in the poor health of segments of the population, and the relationship between the pharmaceutical industry, the biomedical profession and the growing commodification of health were critiqued.

The health system was inherently skewed in distribution as biomedical professionals gravitated to urban areas where their access to secondary resources (material and non-material rewards) was greatest (Maynard, 1977). Likewise, in the South, trained health care professionals immigrated to the North to secure professional benefits (Gish & Godfrey, 1979). This problem of inadequate biomedical manpower and in rural or poorer areas could not be addressed by simply increasing the number of doctors or the number of government positions, as this did not modify the preferences of doctors who were motivated by financial gain and status (secondary resources) (Good et al., 1979:147; Sathyamala, Sundharam, & Bhanot, 1986:26). In 1975 it was estimated that in the South, less than 15% of rural and
underprivileged populations had access to biomedical health services (McDonald, 1981:101). Freidson critically explored biomedical professional monopoly and dominance, and health care systems skewed to provider self interests (Freidson, 1970a, 1970b).

Beyond the distribution and effectiveness of biomedical services, social and cultural critiques analysed biomedicine as a form of social control. The nature and impact of biomedical discourse in areas such as mental health, obstetrics and gynaecology, race, and class were explored (Ehrenreich & Ehrenreich, 1978; Zola, 1978). The expanding sphere of biomedical control through “medicalisation” and its perpetuation of racist, sexist and oppressive ideologies were analysed, in contrast to biomedicine being perceived as a benign, altruistic and objective profession. The issues of equity and justice, and structural faults of biomedical models of health care became the focus of a journal launched by Navarro in 1971, *The International Journal of Health Services*.

A body of work developed by Foucault (1973; 1975; 1977; 1979) informed this process. Foucault emphasised that discourse and knowledge operates within institutional and social environments, and was a medium through which power, domination and control could be expressed. Foucault demonstrated that biomedicine's assumed linear evolution of a greater objectivity and understanding through the application of science and technology was misleading. Instead the “medical gaze” constructs and transforms perceptions of disease and illness according to subjective criteria, and serves to maintain the hierarchical authority of the biomedical profession.

### 3.1.3 Shifting emphasis of health care

The growing awareness that health status and distribution of disease were related to complex socio-economic factors meant that technical, curative interventions were increasingly considered ineffective and insufficient to meet the needs of populations. In the North, the burden of disease was shifting to chronic conditions (cancer, heart disease, stroke) that biomedicine was unable to cure or prevent (Jones & Moon, 1987:19-20). In the South, infectious and preventable conditions (diarrhoea, malnutrition, malaria) were still causing

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22 In contrast, TRM practitioners outnumbered biomedical health professionals by many hundreds or even thousands to one. For example, in a table on health manpower in Nepal, if the scale was kept constant, the bar representing faith healers would be nearly 20 feet long while that for biomedical doctors would be less than 1 cm (Shrestha & Lediard, 1980:7). In sub-saharan Africa, TRM practitioners outnumber biomedical practitioners by 100:1 and in Tanzania, Uganda and Zambia the ratio of practitioners to population is 1:200-1:400 for TRM, and 1:20 000 or less for biomedicine (WHO, 2002e:12).

23 This perspective supports Lee's (1982) contention that scientific discourse is an important factor in maintaining biomedical structural status in health systems, and has been combined with Unschuld's theory (1975) as an explanatory tool (as described in the theory and methodology section).
high mortality rates; conditions that did not require expensive biomedical technology to treat. Prevention, education and public health measures were increasingly viewed as having more important roles to play.

The increasing acknowledgement of the limits to biomedical effectiveness highlighted the excessive financial resources it absorbed, and the limited health benefits obtained relative to cost. Morley expressed this discrepancy as “three quarters of the deaths are caused by conditions that can be prevented at low cost, but three quarters of the medical budget is spent on curative services” (in Good et al., 1979:147). Just as the “Green Revolution” had failed to achieve food self-sufficiency, because it was a technical solution to essentially socio-economic problems (Doyal, 1979:130); the merits of the biomedical model of health care were being questioned on the same grounds. The biomedical paradigm itself, based on physical reductionism, prevented consideration of social, emotional and economic factors that influenced health and the effective treatment of complex, chronic illnesses. The biomedical model of health presented an inherent obstacle to inclusive health care (Macdonald, 1992:30-53), a factor noted by Engel in his promotion of a bio-psycho-social model of health care (Engel, 1977).

Throughout this decade, some countries experimented with implementing comprehensive and basic health services, rather than attempting to expand tertiary biomedical infrastructure. These efforts were made partly on cost considerations, and partly due to recognition that biomedical primary resources were inadequate to meet the health needs of populations. This was combined with a commitment to equity and meeting basic needs. Kenya, Indonesia, the Philippines, Tanzania, Vietnam, Cuba, Nicaragua and China all provided examples of shifting the emphasis of health care from curative to preventative services, established at community levels. Good et al (1979:152) considered that “the dualistic and dichotomized health care systems of the developing world seem ripe for modification and mutual adjustment, especially given the dire scarcity of economic resources” and that continuing to ignore TRM in health planning would be a disservice to those populations. Within this environment, the WHO was also undergoing fundamental transformations and TRM emerged as a viable health care resource.
Section 2: international bodies

3.3 The WHO activities

Under the leadership of Mahler (1973-1988), the WHO spearheaded the advocacy of a radical new direction in health services. Dr Mahler personified the sentiments of the era. He was a biomedical doctor who had worked in India so had been exposed the poverty, inequality and failings of delivery systems. Mahler was vocal in his criticism of biomedical services and what they had delivered to public health, notably calling hospitals “disease palaces” (Elling, 1981a:87; Mull, 1990:28) and questioning biomedical dominance in health services:

Thirty years ago modern health technology had just awakened and was full of promise. Since then its expansion has surpassed all dreams, only to become a nightmare. For it has become over sophisticated and over costly. It is dictating our health policies unwisely; and what is useful is being applied to too few. Based on these technologies, a huge medical industry has grown up with powerful vested interests of its own. (Mahler addressing the World Health Assembly 1978, in Mamdani, 1992:1)

To Dr. Mahler, Health for All was not just a slogan, but an international obligation that could be achieved with co-operation and a more rational and objective resource allocation. He was acutely aware that the WHO had failed to facilitate effective service delivery, to enable the level of health that it had committed itself to. Mahler saw it as “a bad joke when set against the realities of the health scene today” (in Elling, 1981b:90). A keynote address he gave to the International Health Conference (1974) clearly exemplifies his passion, and graphically reflected many of the prominent concerns of the time (see appendix 3 for an excerpt of this speech; page 355). The distortions in biomedical delivery systems, geographic inequities (North-South, urban-rural), limits of modern technology, exorbitant and growing costs, and the moral/ethical dimension to distributing health care resources were all raised. He pithily summed up the current situation as “serving champagne to the few while many do not get their daily bread.”

Mahler shifted the focus of WHO from a narrow disease orientation (vertical interventions) to broader socioeconomic factors and their role in health status. He managed to galvanise the organisation, and infuse it with the courage and commitment to tackle the complexities of improving global health status. He was described as a “visionary”, a “charismatic leader”, and “almost like a priest” according to one of his staff – “Health for all was an impossible concept, but he said it and everyone believed him” (Godlee, 1994a). Mahler made it clear
that “unorthodox solutions” must be sought to meet this ambitious goal, as it was “beyond the scope of the present health care system and personnel trained in modern medicine” - even if resorting to TRM was “disagreeable to some policy makers” (Mahler, 1977).

In Dr. Mahler, traditional medicine had found a natural ally and advocate. This administrative support was reinforced by the Director of the Psychiatric Division and later Deputy Director-General, Dr Adeoye Lambo. Lambo was a psychiatrist who had been involved in projects in Nigeria establishing “therapeutic villages” to treat mental illness, using traditional practitioners (Lambo, 1967, 1973). Therefore, he was familiar with the primary resources of TRM and had a belief in their efficacy and value, specifically in a field where biomedical resources were considered inadequate.

Under their guidance, the international health community made an abrupt about face. In the 1950’s and 1960s, “primitive” TRM systems were seen as an obstacle by the WHO to populations in the South adopting new health practices.

The struggle against disease, ignorance and poverty has been retarded by the persistence of superstitious beliefs and practices … the path from magic to medicine has often been slow and difficult … Adjustment to the machine age is a long process of social education (WHO First Report on the World Health Situation 1954-1956 in Lee, 1997).

TRM was considered a cultural and social barrier to the unreserved acceptance of biomedicine and an expression of the “backwardness” that modernisation efforts were to eliminate. Most countries in the South (with some notable exceptions such as China and India) had a policy of “eradicating” TRM (Riley, 1977:554) and replacing it with the primary resources of biomedicine. However, in the late 1970s, TRM systems were formally endorsed and their role in health care systems promoted. Whether these pronouncements could overcome decades of entrenched structural superiority of biomedicine on national and international levels remained to be seen (discussed in the following chapter).

3.3.1 Changing composition and focus

By the 1970s, the WHO had changed greatly in membership and focus than that of its first decades of operation from inception in 1948 (Lee, 1997; Walt, 1993). In the 1960s, there was an influx of newly independent member states from former colonies. Membership nearly doubled and became weighted to countries from the South, who could control the agenda for the first time by forming the two-thirds majority required for World Health Assembly decisions (Godlee, 1994a). This membership broadened the agenda, although the new focus
politicised the organisation and made decisions more contentious (Godlee, 1994a; Walt, 1994:138). The changes in administration (a new Director-General and Deputy) and membership fostered an environment receptive to TRM, as a majority of member-states were facing health crises equipped only with inadequate biomedical infrastructure, and a lack of required resources to feasibly expand it.

One new WHO member made a spectacular impact on the international public health community. In 1972, Nixon visited China in an effort to forge closer relations between it and the United States, and stimulated international interest in the previously isolated country. In the following years, China re-established diplomatic relations with the North and in 1973 joined the WHO. Much interest was generated in the health system as it had evolved under a Communist government, and the impressive health gains attained (Lee, 1997; Sidel & Sidel, 1975). Attention was focussed on the progress made in controlling infectious diseases, decreasing infant mortality, improving nutrition and successfully extending basic health services. Over thirty years (1952-1982), China’s average life expectancy increased from 35 to 68 years, infant mortality was reduced from 250 to 40 deaths per 1000 live births and the prevalence of malaria decreased from 5.5% to 0.3% of the population (Hsiao, 1995:1047).

These rapid improvements were considered all the more remarkable in light of the large population and low per capita income, lack of professionally trained health personnel and limited biomedical infrastructure. Their successes were a result of organisation and distribution of limited resources, rather than of increasing expenditure (Cox, 1989:44). A country with around one fifth of the world’s population had constructed an outstanding health care system not based on biomedical professionals or biomedical primary resources and with no assistance from the WHO (Lee, 1997:33). It presented an “intriguing paradox” in that it was classified as a developing country, yet had achieved health indices and mortality statistics that rivalled that of industrialised Western countries (Blendon, 1979). How this had been done, and whether other countries could mimic the methods used, became a pertinent question (Good et al., 1979:152; Leslie, 1980:192; Pang, 1976:129). It was considered a blueprint worthy of emulation and became a prototype for both the WHO and World Bank (Doyal, 1979:288). Chinese health policy was lavishly praised by commentators of the time (Doyal, 1979:349) and in the United States, China became a “cause celebre”

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24 In the 1960s, the growing confidence and assertiveness of the South had even led to the Sri Lankan government to propose to China to establish an Asian Health Organisation, which would have corresponded with the WHO but instead of being staffed and dominated by biomedical professionals, it would be staffed by practitioners of Ayurveda, Traditional Chinese Medicine and other Asian systems (Leslie, 1989:25).
among health professionals, reflected by an increase in journal articles and research activity focused on this issue (McQueen, 1985). Some even asked whether its pluralistic system should become a model for US health care delivery, and not just the South (Berliner & Salmon, 1980a:547).

A main area of interest was in the unique approach of using a new form of health worker - “barefoot doctors” to deliver basic services, and the related aspect of combining traditional and biomedical knowledge systems. The traditional Chinese system of medicine (TCM) received great attention in these assessments, and became subject to increasing curiosity in the West (Walt, 1993:134), which was a society “disillusioned with the growing perception of the limitations and harmfulness of Western science” and now fascinated with exotic and esoteric philosophies (Taylor, 2004:104). In international health planning, the interest was related to the significant role TRM had in the development of a more equitable, economical and efficient health system, and the novelty of its treatments and theories of which Horn (1971), Sidel and Sidel (1975; 1974) and Crozier (1965; 1968; 1976) amongst others, circulated and popularised. Western journalists who accompanied Nixon, and later medical delegations, were “intensively courted by the TCM establishment” who emphasised acupuncture as a treatment modality (Beyerstein & Sampson, 1997:3).

In 1977, a WHO delegation visited China, and was heavily influenced by the paradigm of community health workers and merging old and new medical systems (see appendix 4 for detail on integration of TRM in China; page 356). “Where China was putting her best foot forward and displaying the achievements of her latest policy on the integration of Chinese and Western medicines, the West saw the ‘long awaited panacea from the Orient’” (Taylor, 2004:105). The health improvements experienced in China and successful changes in health care delivery systems were significant contributory factors to the WHO endorsement of the PHC approach and Health For All goal (Gish, 1979:204; Janes, 1999:1811; Macdonald, 1992:18; Purcal, 1989:34). This new perception increased the visibility and profile of TRM. The proponents of TRM managed to enmesh it within this new approach to health service delivery, and other key projects.

As long as the promotion of health was envisaged as an affair of medical technology, and the necessity of very specialized medical personnel was insisted upon, the medicine practiced by the [TRM] healers totally escaped notice in all the public health plans, and it remained a marginal reality, which in the eyes of many, had nothing to even do with medicine per se (Bibeau, 1979:183).

This receptiveness to new approaches was also facilitated by the failure of vertical approaches to address disease. For two decades prior to the mid-1970s, the WHO had based
its strategy on targeted interventions to eliminate specific diseases, such as malaria, leprosy, trachoma and schistomiasis. However, despite success eradicating smallpox, this narrow disease focus was becoming problematic. For example, the malaria programme faced DDT resistance and a lack of health infrastructure in the South for detection and treatment (Godlee, 1994a; Walt, 1993:133-134; Walt, 2001). After a decade, malaria rates were unchanged or even higher in the majority of countries where it had been implemented – severely denting the WHO’s credibility (Mull, 1990:31-32).

The failure of the malaria eradication programme is attributed to an ideological shift within the organisation. Drugs, vaccines, and medical technologies (biomedical primary resources) were failing to make lasting improvements to population health or meet programme objectives. These frustrating failures were the crucible within the organisation to reconsider health planning and endorse a new approach – PHC (Mull, 1990:28; Newell, 1988:903; Walt, 1994). While China provided the inspiration for TRM, the Soviet Union prompted the Alma Ata Declaration (Lee, 1997:25; Litsios, 2002). Communist ideals of comprehensive community based health care were being devised and successfully implemented in some countries (besides China, such as Indonesia, the Philippines, Vietnam, Cuba, Nicaragua), which demonstrated that alternatives to vertical interventions were feasible.

The *politics stream* (administration, membership) within WHO was therefore amenable to new approaches, the *problem* (lack of resources, failure of vertical approaches) was clearly established throughout the decade and the solution (integration of TRM) was present within the *policy stream*. China entering the WHO and failure of malaria eradication could be considered *catalysts* for a change in approach to the delivery of health care services on the policy agenda (see Lee, 1997; Walt, 1993 for more detail on the environment of the WHO).

### 3.3.2 Formalising the role of TRM in health care

Many accounts of the WHO involvement with TRM commence with the mid-1970s and the resolutions of the World Health Assemblies of 1976 or 1977 (Akerele, 1987; Chi, 1994; Green, 1988; Pillsbury, 1982). However, traditional medicine was mentioned in 1969 (resolution WHA 22.54), which concerned the establishment of pharmaceutical production in developing countries. The World Health Assembly “being aware of the differences in the development of therapeutic practices” expressed concern about the “hazards and economic

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25 This same environment was not conducive for other policy initiatives within WHO that proposed continuing vertical, disease specific interventions such as tuberculosis control (Ogden, Walt, & Lush, 2003).
wastage connected with the empirical use of [traditional medicines] as long as their efficacy and safety have not been established.” However, this was with the awareness that “scientific research in this field may yield valuable pharmaceutical products.”

It was an ambiguous beginning to the formal recognition of TRM, and stopped short of positively endorsing it. TRM was not necessarily safe or effective (and could even be dangerous and wasteful), but with scientific research, may provide some useful products. It was an aspect of local culture that needed to be rationalised with the establishment of domestic pharmaceutical industries. This resolution may be seen as a vestige of the modernisation push, as it reflected the ideology that the use of TRM was unfounded and hindered development. TRM was viewed as not a legitimate therapeutic practice in itself, but its primary resources could possibly contribute to the superior, biomedical pharmaceutical armory.

Throughout the 1970s, TRM received rapidly increasing attention on the international agenda. This culminated in 1978 with a WHO technical report regarding its promotion and further development, the establishment of a programme under the auspices of the WHO, and the inclusion of TRM in other major initiatives. The specific activities of the WHO in relation to TRM during the 1970s are considered in the following three sections, which are roughly chronological in sequence and also categorise activities into discrete areas that developed incrementally. Activity initially commenced with 1) traditional birth attendants (1970-1975), then moved onto making 2) resolutions (1976-78), which provided a foundation for 3) programme development and promotion (1976-1979). Programme development is sub-divided into the separate activities that involved TRM: a) technical report on TRM; b) traditional medicine programme; c) essential drugs and d) primary health care.

### 3.3.2:1) Traditional birth attendants

In the early 1970s, the first forays of the WHO into TRM were in the area of traditional birth attendants (TBAs). TBAs are considered one subset of TRM practitioners, with a focus on pregnancy and obstetrics. Activity in this area also occurred prior to the 1970s, but was not co-ordinated or systematic. The increasing WHO interest in TBAs and their role in maternal and child health care was a natural outcome of many of the concerns of the day: population control (family planning), community based approaches, using existing local resources, and reaching areas not served by biomedical infrastructure. These concerns merged neatly into the focal point of the TBA, of which there was usually at least one in every village and who
attended up to 90% of births.\textsuperscript{26} They represented an easily identified access point to an audience that health care agencies were keen to reach – mothers and children. This was particularly the case as high infant mortality rates were a stark indicator of poor health status, and could be reduced with improved care during birth and infancy.

The motivations behind seeking alternative approaches to meeting basic health care needs was affirmed in a TBA training guide (1979b). Modernisation assumptions were discredited, economic growth will not necessarily improve the quality of life of the poor, and “health development is both a means to and a product of social and economic development ...” Due to this, and the imbalance between health needs and resources available, approaches “that depend neither on the building of costly hospitals nor on the provision of sophisticated services by personnel trained at exorbitant cost” were required.

Evidence of the successful blending of traditional and modern medicine, such as has occurred in China, for example, and the findings of numerous anthropological and other studies of traditional healers have raised questions in the minds of many as to whether scientific health services are the only way to health (WHO, 1979b:7, emphasis added).

In 1972, the WHO undertook an international survey of 20 countries and their use of TBAs. This was followed by a consultation on The role of the TBA in maternal and child health and family planning in 1973, and two Interregional Seminars in Chile and the Philippines in 1974. At the consultation in 1973, a list of existing practices of the TBA was compiled, divided into sections according to whether they were harmful (to be abandoned), harmless (ignored) and safe or beneficial (reinforced). The harmful practices were discussed, and modifications to be made to those practices proposed. This provoked a heated debate, with some “vigorously opposed to the list of modifications, arguing that the prescriptions were totally unrealistic” (WHO, 1979b:26). This task would inspire debate as it involves redefining the scope of primary resource base (techniques) of the TBA.

The outcomes of these exercises were reported on in 1975 (Verderese & Turnbull, 1975). This report was undertaken with financial assistance from the UN Fund for Population Activities. The results of the international survey of TBAs (1972) were presented in annex 3 (Verderese & Turnbull, 1975:98) and reveals the scope of the programmes. Basic subjects were broadly offered, such as preparation and care of equipment and materials, hygiene, and management of labour. More “complex” subjects, traditionally the domain of biomedical

\textsuperscript{26} An average of 67% of births in developing countries were attended by “others” (a grouping that includes TBAs) (Verderese & Turnbull, 1975:93).
professionals, were offered less often – e.g. physical examination, urine testing, recognition and handling of complications in the newborn. However, instruction on when to seek the help of, or refer to the biomedical profession, was more popular. The strict demarcation of roles was more explicitly stated in some countries. These restrictions reflect the establishment of boundaries to protect the primary resource base (knowledge, techniques, equipment) of the biomedical profession.

The “lack of emphasis” on family planning, and the fact that only five countries included it in their programs was specifically noted by the authors of the report (Verderese & Turnbull, 1975). The strong link between family planning and the TBA training programs was exemplified by the fact that in some countries, the teachers were members of the family planning board. It was implicit that a main role expected of the TBA was in family planning as well as maternal and child health, both delegated, routine tasks from the biomedical sphere.

The limited autonomy of the TBA, and their auxiliary role to the biomedical service is apparent in annex v (Verderese & Turnbull, 1975:106-110). This is an extensive list of the “suggested tasks of the trained traditional birth attendant working in collaboration with the health establishment”. The list itself is five pages long, and reflects not only a poor appreciation of socio-economic conditions but also an unrealistic expectation of what the TBA could reasonably do, and their cultural role and social function. In effect, the tasks specified simultaneously expected the TBA to be a menial assistant while having detailed knowledge of biomedical concepts. The subservient role of the TBA to biomedical professionals was reinforced through repeated reference to her role in collaboration with, under supervision of and with instruction from the “health establishment”.

27 “Several programmes specified actions not to be taken … such as: ‘not to render midwifery services in the presence of loss of blood or haemorrhage during pregnancy; when the arm is delivered first’, etc. Some of the don’ts … also include: ‘not to introduce the fingers or any instruments or objects in the birth canal of the mother with the purpose of performing examination or any other reasons, not to give injections in the birth canal’, etc” (1975:99, emphasis in original)

28 See Manderson (1989) for a discussion on the surveillance of traditional mid-wives and their use as an extension of state control over reproduction.

29 In terms of family planning, specific tasks included informing women of common side effects of contraception (“of no significance, but which require reassurance”), distributing non-clinical contraceptives, providing family planning guidance, and to “counteract and/or inform the staff of the health establishment of any unfavourable rumour that might undermine family planning”. The Orwellian overtones extended to requesting that the TBA “inform the staff of the health establishment of her activities” and attend meetings arranged by the “health establishment”.

30 For example: care to be provided during child birth included putting on an apron, giving an enema, cleaning the mother, changing her clothes, offering food/drink, wrapping the baby in a pre-warmed cloth and informing the “health establishment” of the delivery. Post-partum care involved observing the breasts and advising on swellings, fissures, colostrum and presence of maternal milk; recognising signs of puerperal infection, delayed haemorrhage, urinary retention and urinary tract infection.
An unpublished **evaluation** undertaken of the experience of TBAs in using midwifery kits provided by UNICEF in 1976-77 (WHO, 1979b:100), was revealing. Of the 38 TBAs questioned, six of them had not even used their kits. Only two found all 18 items in the kit easy to handle, and five had forgotten how to use nearly half of them. Some of the confusion was due to the sheer number of items and apparent duplication of use. Despite that, the results were not interpreted as an indication of a need to simplify the kit. One conclusion that could be drawn is that the kit contained items that were superfluous to the requirements of the TBA, and perhaps discouraged the use of the kit itself. Reducing the number of items would be a cost saving, and shorten training. In addition, some of the items in the kit were not compatible with WHO training at regional levels – for example, for the TBA not to insert instruments (Verderese & Turnbull, 1975:99).

However, when assessing this information, the WHO drew two main conclusions. The first was that there was a need to be aware of the contradictions between what the TBAs “assert” by word and what they do in practice”. For example, all of them had agreed that the kits were useful, although some had never used them. Others insisted that they did not know how to use certain items as these had not been demonstrated in training. Therefore, it was concluded that TBAs may not always tell the truth. The other main conclusion drawn was that repeated practical training in the use of each item in the kit was required (WHO, 1979b:39). The weakness of this programme was not in the kit itself, nor the training methods used. Rather, the focus of the failure was placed on the inability of the TBA to absorb the primary resource base (knowledge, techniques, instruments) of biomedicine rather than pointing to the potential inappropriateness (or even rejection) of the resources themselves.

The discussion on **incentives** to encourage co-operation of TBAs (Verderese & Turnbull, 1975:31) is interesting in that it elucidates the operation of Unschuld’s theory of medico-cultural conflict (1975; 1976b). In Unshuld’s terminology, the TBA already had access to the secondary resources of status and prestige – they often exercise considerable power and authority in the community sphere and may be the wife or mother of the village chief (Verderese & Turnbull, 1975:11). The authors were therefore aware of the need to provide incentives and “symbols of prestige” (material rewards or secondary resources) for co-operation. They advised that in deciding the most suitable incentive scheme, community leaders should be asked to choose from a range of alternatives. However, caution was given
regarding direct cash incentives – TBAs “may become motivated by money” and it could “cause jealousy and mistrust” as well as criticism of bribery.\(^{31}\)

The TBA was being asked to transfer her existing secondary resources (status and prestige) to the “health establishment”, and accept limited material rewards as compensation. In addition, her traditional primary resource base (skills and techniques) were downplayed in importance and considered outmoded or inadequate, to be replaced with the biomedical primary resource base. This was still under the control of the “health establishment”, who had to train her in its use and retained responsibility for its ownership. She was an “attendant” (auxiliary, assistant), not a professional in her own right with access to a distinct resource base. Shifting primary resources from one group to another is easier, once the second group (in this case, TBAs) “has recognised that these resources will be of use in gaining access to more secondary resources (economic benefits)” (Unschuld, 1976b:8).

Later, the issue of paying TBAs was clarified and retention by the TBA of their original role and identity was considered important from a remuneration perspective (WHO, 1979b). Rather than assuming responsibility for tasks previously performed by biomedical practitioners, the TBA was only to “perform more safely those tasks they generally perform on the basis of the principles of mutual self-help and humanitarianism” (WHO, 1979b:8, emphasis added). If the TBA partially acquired the primary resources of biomedicine, then the avenue for claiming secondary resources was open. However, by just “upgrading” their skills within their traditional roles, the TBA would also continue to be unpaid for her services.

The reluctance of many health professionals to “take advantage of improvements that can follow from a more effective collaboration” was also noted, and considered to arise “from the lack of knowledge about traditional systems of health care” (Verderese & Turnbull, 1975:84), rather than due to a lack of incentives and threats to their secondary resources (economic benefits, status, prestige) that may arise from sharing responsibilities. Education and training on both sides therefore seemed necessary; however the emphasis was on the education and training of the TBA. This was in order for her to accept “modern” concepts and therefore become the agent to “modernising” community attitudes to hygiene, nutrition

\(^{31}\) These items were grouped as material or social goods. However, the material goods (water, housing, agricultural supplies) seemed to offer what should be classified as “social benefits” and some of the social benefits category (television and radio sets) appeared to be material goods. The “social benefits” group was defined by what behavioural change they may inspire (i.e. “modernisation” along western lines), which is assumed would ultimately benefit the community. It is ironic that the water supply is a reward upon compliance, but not installed as a requirement to fulfil the prescribed duties. Education, agricultural supplies and clothing were “symbols of prestige” rather than necessities.
and family planning, as well as channelling the community to recognise and use biomedical services (the “health establishment”).

What this approach failed to recognise was the integrity of TRM systems, and the fact that manpower and techniques were dimensions of that system rather than simply primary resources that could be readily absorbed within biomedicine. As TBAs were not professionalised in the Western sense \(^{32}\) and had localised rather than centralised power, they appeared to enable more ready adaptation to and absorption within biomedical systems. However, tension and conflict rather than co-operation soon manifested: “…on the whole, professional health workers have been hostile to them … [and] criticize them endlessly with stories to prove their ignorance, superstition, unsanitary habits and uneducatability” (Leslie, 1980:192). Thorne and Montague (1977) noted “…massive reluctance on the part of both trained medical personnel and traditional midwives to open a dialogue” (in Leslie, 1980:192).

### 3.3.2:2) Resolutions

The resolutions on TRM were stimulated by increasing activity in TRM at regional levels. For example, in 1976, Regional Committees in Africa and South East Asia discussed the official use of traditional healers by governments, and a board of experts was formed to propose modes of co-operation between modern and traditional medicines (Brazzaville, Africa). In the following year in Sri Lanka, the regional committee considered the development of a programme in TRM and recommended that governments in the region make policy decisions to recognise, promote, and rehabilitate TRM. The activity at regional levels and increasing co-ordination of TRM interests would have been a factor in World Health Assembly recognition. The growing importance and recognition of TRM is reflected in the dedication of an issue of the WHO publication *World Health* to it in 1977, with a foreword by the Director-General, Mahler (Mahler, 1977).

#### 3.3.2:2a) Resolution WHA29.72 (1976)

The recognition and utilisation of TRM continued with a spate of resolutions in the mid-1970s. In 1976, the World Health Assembly, in light of the “absolute and relative shortage of

\(^{32}\) The first step to professionalisation is acceptance of remuneration for services, which was not common for TBAs. However, TBAs did have some aspects of professionalisation as identified by Unschuld, including monopoly, autonomy and status. TBAs derived their professional identity from ‘traditional legitimacy’ rather than ‘rational-legal legitimacy’.
health manpower and the often inadequate and irrelevant training of such manpower” made brief reference to TRM. One of the seven requests was “to encourage the development of health teams trained to meet the health needs of populations, including health workers for primary health care, and taking into account, where appropriate, the man power reserve constituted by those practising traditional medicine” (WHA29.72). TRM practitioners represented a ready reserve of labour for other health care activities, in much the same way as TBAs had. The focus broadened out from a subset of TRM practitioners, to TRM practitioners more generally.

3.3.2:2b) Resolution WHA30.49 (1977)

The resolution of 1977 (WHA30.49), is usually considered the official commencement of WHO endorsement of TRM, and related to the promotion and development of training and research. This resolution made reference to the fact that health care in developing countries had not reached the majority of the population, and the importance of using local health resources. The community acceptance of TRM and the important role it played was also noted: “… immediate, practical and effective measures to utilize traditional systems of medicine fully are necessary and highly desirable.”

This resolution encouraged more attention be paid to TRM, and requested organisation of training and research activities. This included awarding fellowships “for training in research techniques, for studies of health care systems and for investigating the technological procedures related to traditional/indigenous systems of medicine.” Unlike the resolutions preceding and following it, this agreement considered TRM systems as a whole, including their “technological procedures”. Technology was no longer solely the preserve of biomedicine, TRM also used techniques that were acknowledged as technology in their own right. However, Pillsbury notes that this resolution followed heavy debate and was still heavily qualified and cautiously worded (1982:1826).

3.3.2:2c) Resolution WHA31.33 (1978)

In 1978, a resolution was passed (WHA31.33) which focussed specifically on the use of medicinal plants. This recognised the importance of medicinal plants in health care systems in developing countries, the “increasing awareness of governments and the scientific and medical communities of this matter” and that the use of such plants was likely to continue. However, it considered that while these plants “contain substances which may be of therapeutic value [they] may also possibly show potential toxicity when improperly used”.

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Therefore, compiling inventories and therapeutic classifications, reviewing the scientific data of efficacy; developing and applying “scientific criteria and methods for proof of safety and efficacy”; and developing international standards for “identity, purity and strength … and manufacturing practices” was deemed necessary. Establishing “methods for the safe and effective use of medicinal plant products … including labelling containing adequate directions for use, and criteria for use or prescription by various levels of health workers” was also required.

This carefully worded resolution was peculiar, although more accommodating than the resolution of 1969. It encapsulated the “double-edged sword” dilemma of political recognition of TRM systems. While it recognised the importance of medicinal plants and acknowledged that their use was likely to continue, it also stressed “potential toxicity” and the application of scientific values to validate and standardise them. The safety and efficacy agenda reflected a concern with only one dimension of TRM systems (phytotherapy or plant remedies), and emphasised issues removed from their local sphere of practice. It encouraged the “modernisation” and universal application of TRM through adoption of biomedical concepts.

The broader use of TRM remedies in health care systems raised new issues from the scientific community, as reflected in this resolution (labelling, directions for use, and criteria for use or prescription by others). However, developing international standards for “identity, purity and strength” revealed a perspective that failed to appreciate divergences within and between TRM systems, even in such basic aspects such as the names of plants, their preparation and therapeutic use. For example, even within one TRM system such as Ayurveda, there are localised differences in plant names and uses. This takes into account geographical variations in vegetation and climate. Strength or potency varies according to locale, soil, season, time picked and other factors including the type of vessel the remedy is prepared in, what it is mixed with, temperature and preparation processes. This local knowledge of bioactive fluctuations and interactions has been clinically verified (Bannerman, 1982:10; Barsh, 1997:31-32).

The majority of TRM plant based remedies were still prepared in local clinics or pharmacies and the home, not mass-produced industrially. While in some countries (e.g. India, China, Sri Lanka, and Bangladesh) small scale commercial enterprises had been established, producing “general” traditional remedies (using formulae that were thousands of years old); this did not totally displace production at the local and household level. The fact that these remedies had been used safely and effectively for thousands of years was usually considered
a sufficient evidence base by practitioners. This was determined from observation and practical use, rather than from clinical experimental methods.

The focus of TRM is on the patient as an individual, with a unique aetiology of illness. According to TRM, no two people are alike, and no two people will share the same diagnosis and prescription. Therefore, the practitioner (or an assistant) may blend a specific remedy immediately after the consultation, to treat the manifestation of the illness in that person (but not in another, who may even show identical symptoms). Age, weight, sex are all taken into account (Lock, 1990:43). A verbal explanation of how to use the remedy is provided at dispensation, as this again varies. The highly specialised and individualised nature of the preparation of remedies extends to harvesting particular parts of plants at specific times of the day or season, lunar phase (Jagtenberg & Evans, 2003), planetary activity, compass direction, altitude, signs or signals from animals or birds in the environment, and state of mind of the person gathering the plants (Gerke & Jacobson, 1996).

In addition, some uses, identification and preparation of plants remained secret, passed down verbally for generations. This not only protected secondary resources, but was considered a key factor in efficacy – if the secrecy is compromised, the efficacy or potency of the remedy is deemed to be diminished (Perara, 1985:95; van der Geest, 1997:905). Such information was not always in the public domain, but orally transferred from father to son, guru to disciple, master to apprentice or from a “divine source” to a specific person (Airhihenbuwa, 1995:59; Ramprasad, 1994:134). The recipient of such knowledge usually had to demonstrate particular character traits, signifying worthiness as a beneficiary (Chauhan, 2000; Gerke & Jacobson, 1996). For example, that they would utilise the knowledge in a positive and humane way, and not for personal material gain. In many TRM systems, access to primary resources was therefore given if this knowledge and techniques were not exploited to gain economic secondary resources. It was an act of service to gain merit (Perara, 1985:97).

To impose international standardisation on factors like plant names, uses and labelling removes an aspect of localised cultural expression, and overlooks some important features of TRM systems, such as knowledge transmission and remedy formulation. The procedures for

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33 Individual preparation is considered a significant aspect of the therapeutic process and a part of the healer-patient relationship. For example, an Ayurvedic doctor may chant mantras to instil the remedy with particular potency. In some cases, even the number of times the mixture is stirred or the direction it is stirred in is specified. This aids natural/supernatural forces that infuse the remedy with healing power. In Tibetan medicine, consecration of raw materials and blessings are seen as essential contributions to the remedy (Gerke & Jacobson, 1996). The therapeutic effectiveness of some remedies therefore cannot be reduced to strictly biological terms. This is also a major feature of African TRM (Koumare, 1983:26).
this assessment of TRM were determined and supervised by biomedical interests – an unambiguous expression of structural power and authority. The very act of naming things and bestowing meanings is a source of power (Wolf 1982:388 in Finkler, 2004:8). Categorisation and demarcation of TRM primary resources is not simply an analytical exercise. A characteristic Gieryn noted of scientists more broadly can be paraphrased and applied to biomedical practitioners: “… because of the considerable material opportunities and professional advantages available only to “scientists” [doctors], it is no mere academic matter to decide who is doing science [medicine or health care] and who is not” (Gieryn, 1983:781).

The intrinsic biomedical reductionist stance and pharmacological concepts are evident in the language and focus of this resolution: for example; that plants may contain substances of therapeutic value. This notion exemplifies the belief that there is a single therapeutic agent that can be identified, and that isolating this molecule verifies clinical validity and efficacy. In contrast, TRM belief systems often use the whole plant or more than one plant, and process them in complicated ways to produce a compound that operates synergistically. Biological catalysts used in herbal remedies may have obscure biochemical mechanisms that are difficult to clinically isolate or identify (Barsh, 1997:32). The plant or plant parts in their natural form are also considered important, and extracting certain molecules from them may reduce ultimate effectiveness (Bodeker, 1994b:11-12; Scarpa, 1981).34 In reducing plants and remedies to purely physical and biological interpretations, the social and cultural context was removed from the therapeutic encounter.

This resolution on medicinal plants (WHA31.33) appears to promote TRM, but exposes fundamental conceptual clashes between biomedical and TRM systems. While biomedicine is based on a single cause/single cure for disease, and therefore presents no difficulties in mass production or international standardisation (and even demands it), the situation is markedly different in TRM where treatment is unique, consultation itself forms part of the therapeutic process and the plants in their natural source and as part of complicated amalgams are valued. In addition, while biomedical doctors would undoubtedly be disturbed by the concept of allowing prescription of pharmaceutical products by “various levels of health workers”, this resolution requests that in relation to herbal medicines. The biomedical community was asking for their standards and norms of measurement, efficacy and so on, to

34 Two examples illustrate this point: The natural source of quinine (cinchona bark) is more effective than the synthetic anti-malarials modelled on it, to which resistance has developed (Bodeker, 1994b:12). The active ingredient of digitalis (digitalin) is extracted and used to treat heart conditions. This accumulates in the body and cannot be used indefinitely. However, TRM systems use this plant in entirety and it has been found that besides the active principle, other substances in the plant prevent the toxic accumulation of digitalin (Scarpa, 1981:319).
be imposed on TRM; and for TRM practitioners to provide access to their primary resource base for scientific scrutiny and lay distribution. If TRM systems sought political recognition, it required accepting the hegemonic “scientific-rationalist” framework, in violation of some of their core principles.

3.3.2:3) Programme development and promotion

In 1975, the WHO in conjunction with UNICEF, began to explore methods, other than those based on biomedical models, to improve health care delivery (Djukanovic & Mach, 1975; WHO, 1975). *Alternative approaches to meeting basic health needs in developing countries* (Djukanovic & Mach, 1975) criticised the emphasis on specific diseases (vertical interventions) which was considered to have hindered the development of basic health services. A new approach was needed because “the strategy adopted … by many developing countries has been modelled on that of the industrialised countries, but as a strategy it has been a failure” (Djukanovic & Mach 1975:7). The assumption that biomedical systems would organically expand to cover entire populations as resources allowed, was exposed as a fallacy:

… the enthusiastic application of new knowledge and technology has not always achieved the results expected, and some of the consequences have been untoward … history and experience show that conventional health services, organised along ‘Western’ or other centralized lines, are unlikely to expand to meet the basic health needs of all people” (Djukanovic & Mach 1975:7).

A more permanent, equitable and sustainable system using local resources was required. Case studies were undertaken exploring how to achieve this, and the results were considered “sufficiently promising to warrant a major change in policy … enabling such programmes to be fostered, extended, adapted and used as examples for a large scale global programme” (Djukanovic & Mach, 1975:104). It was acknowledged, however, that this alternative approach would require a “virtual revolution in most health service systems” (1975:103), as it involved a major reallocation of funds, decentralisation of administration, community involvement, and integration and co-ordination. “It will bring about changes in the distribution of power, in the pattern of political decision-making … and in people’s awareness of what they are entitled to” (1975:104). This report was an explicit official recognition that sole reliance on biomedical primary resources was unsatisfactory, and a major reorientation of health care was required. It also acknowledged the political dimension of health care.
Despite the radical implications, incorporating TRM as part of a basic health service was considered the best way forward, and one that the WHO seemed willing to consider more seriously. In 1975, a taskforce was formed to examine the use of indigenous plants for fertility regulation – again reflecting a preoccupation with population growth as had been already clear with TBA initiatives. This group used a meticulous approach to screening plants for potential contraceptive use. The scientific methodology was directed from Geneva, guiding six research centres (WHO, 1978b:34). Of all the known species used in TRM for contraception, which numbered in the thousands, 250 were eventually chosen (according to specific criteria) for investigation. The criteria included that it could be orally administered, cheap and non-toxic and act as an anti-implantation agent (Wijesekera, 2003).

Each team was assigned 50-75 plant species to investigate, and each followed the same strict protocols and communicated findings to each other. This program was still operating in 1977, but the outcomes are uncertain as any reports produced were not made public. However, the teams managed to isolate eight plant species with potential to fulfil all criteria, of which two demonstrated definite clinical use as fertility regulating agents. According to a scientist who worked in this program, these two options were not pursued due to pharmaceutical industry interests, and the difficulty in competing against the market for steroid based contraceptives that had been established (Wijesekera, 2003). In this case, the primary resource base of TRM (despite meeting scientific criteria), was opposed by the primary resource base of biomedicine and the powerful commercial incentives that sustained it.

In 1976, a WHO research project reviewed the scientific literature available on the safety and efficacy of TRM remedies. The results of this project also remained unpublished. In the same year, an “expert consultation group” was convened by the Deputy Director General, Lambo. This group included anthropologists such as Unschuld, Leslie and Singer and aimed to “give prominence, by the quality of [the] expert deliberations, to traditional medicine” (Singer, 1988:9). A Working Group on TRM was also established at the headquarters, under the leadership of a biomedical doctor from Ghana, Dr Bannerman. The “Headquarters Working Group on Traditional Medicine” convened a meeting on the promotion and development of traditional medicine, held in 1977. This was a direct result of the growing

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35 In 1952, WHO decided not to undertake population programmes due to the religious and political implications; in the 1960s it agreed to give technical advice on family planning on request (Godlee, 1994a). A new UN organisation (UNFPA) was established in 1969 specifically to deal with population because both the WHO and UNICEF refused to enter into this politically sensitive field (Lee et al., 1996). In the 1970s the WHO was straying into this arena via TRM (TBAs and this programme – the WHO Special Programme of Research, Development and Research Training in Human Reproduction) which may partially explain the lack of publicity given to the fertility regulation programme and its outcomes.
interest in TRM, the resolution of the same year to give more priority to research and training, and “subsequent requests by Member States for technical collaboration” (WHO, 1978b).

The seven members of the meeting were all from the South, apart from an expert in Asian science and medicine from the United States. They represented diverse TRM systems as well as backgrounds in psychology, physiology, community health, and medicinal plants. The Secretariat and WHO working group present at the meeting were all biomedical doctors, and outnumbered the members by nearly two to one. The report of this meeting, *The Promotion and Development of Traditional Medicine* (WHO, 1978b), was a qualified endorsement of TRM, representing the need to balance competing biomedical and TRM interests over the recognition and legitimation of TRM primary resources (drugs, techniques, knowledge).

### 3.3.2.3a Technical Report 622: The Promotion and Development of TRM

The technical report (WHO, 1978b) was not universally welcomed, and was criticised as being unlike other technical reports in that it “neglects scientific and objective dealing in favour of emotional advocacy of integrating traditional medicine into the health services” (Velimirovic, 1984b:61). The report does differ from previous reports in the technical series, in that it deals with health systems issues, promotes a particular strategy and clearly suggests integration as a means to address failings of current health services infrastructure.

It is clear from the outset (including the title of the report) that TRM was viewed favourably and the inquiry would focus on supportive measures to endorse it. For example, the main **objective** was to consider the “effective collaboration of different practitioners and their integration into an overall national health care delivery system” (1978b:7). The members were particularly impressed with the example offered by China, which demonstrated the extent to which integration “could contribute to and even revolutionize health care” (WHO, 1978b:41). Two films on the developments of TRM in China during the previous decade were viewed during deliberations, China was a case-study for research promotion and development (WHO, 1978b:30), and it was referred to throughout the report:

> 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 … (WHO, 1978b:17) … If China could succeed within one generation, then the whole world could likewise achieve some success in providing the entire population with adequate health care services (WHO, 1978b:29).
Other countries and their history of TRM use were also considered by the working group. Providing details of various countries experiences of TRM (Sri Lanka, Sudan, Egypt, Ghana, India, Cameroon, Mexico, Nigeria) was intended to emphasise the broadness of TRM scope, which had been narrowed in focus to only one dimension (medicinal plants) by contemporary research. “…it was stressed that this tendency must not be allowed to continue to give the impression that traditional medicine was limited to medicinal plants exclusively in the health-giving process” (WHO, 1978b:10). The entire primary resource base of TRM was to be recognised (knowledge, skills, drugs, techniques) not just selected dimensions. A reductionist stance to TRM, focusing on medicinal plants, had already been recognised and deemed undesirable.

The advantages of integration, apart from the “intrinsic utility” of TRM, included that such systems of medicine have “certain advantages over imported systems of medicine in any setting” due to cultural relevance. However, “the most cogent reason for the radical development and promotion of traditional medicine is that it is one of the surest means to achieve total health care coverage of the world population, using acceptable, safe, and economically feasible methods, by the year 2000” (WHO, 1978b:14). Integration was considered beneficial because it offers mutual gains to each system, improves health care knowledge and coverage, enhances quality and number of practitioners, promotes information distribution related to PHC, and was the best way to achieve health care for the entire population by the year 2000 (WHO, 1978b:18).

The repeated references to achieving cost effective health care coverage by the year 2000 were related to the WHO Health for All Goal (HFA), which had been endorsed in 1975. The main reason for integration was therefore that the primary resource base of biomedicine was inadequate to meet the HFA 2000 objective, and needed to be supplemented with TRM. The promotion of TRM was thus strongly tied to a prominent and popular objective of the organisation, and presented as the only feasible method to achieve it. This was a shrewd political manoeuvre on behalf of the advocates for TRM which emphasised the practical benefits of integration.

Despite integration being considered easy to achieve with a cautious approach based on research and education, anticipated obstacles or fundamental problems of integration ironically made this goal very difficult or even impossible to achieve (WHO, 1978b:17-18). These obstacles included prominence given to the “cultural formulation” of TRM; economic and commercial factors which favoured particular types of health care measures; unfeasibility of integrating aspects of some TRM systems based on spiritual or moral
principles; and conceptual gulf between various philosophies. The greatest problem to be
overcome was considered to be “administrative intransigence”, and thus persuading the
government and bureaucracy of the need for this approach was important. This is an implicit
recognition of the dominant structural status of biomedicine in health services.

Even in situations where the policy on integration was “favourable”, other potential
limitations were recognised. These were more practical obstacles to the implementation of
this policy, rather than difficulties in formulating a policy itself. Included in the list was
“payment of lip-service”; apprehension about possible harmful effects of TRM; uncertainty
about the position of those who received integrated training in current social and professional
hierarchies; opposition by “intransigent advocates of one or another system” and “fear of
litigation, since the legal apparatus tends to protect only the entrenched system, to encourage
monopoly, and to even proscribe other systems” (WHO, 1978b:18-19). These perceived
obstacles express concern about the consequences of a redistribution of primary and
secondary resources within bureaucratic and legal frameworks favourable to biomedicine,
and resistance to that process of redistribution.

In the professional area, dialogue and collaboration would assist in addressing some of these
anticipated obstacles, as well as “replacement of existing council or board members with
more receptive people who would appreciate the need for change to meet present–day
exigencies” (WHO, 1978b:20). This appears to be a reference to biomedical professional
bodies, which may resist the recognition and acceptance of TRM primary resources, and be
reluctant to share secondary resources. Replacing senior members of biomedical professional
bodies would prevent entrenched resistance and weaken lobbying efforts to counter
integration, but would be contentious. In the community sphere, using “integrated health
teams in basic health services” was recommended, although it was unclear whether this
referred to teams consisting of biomedical and TRM practitioners or personnel trained in
both systems.

China was held to be the example of effective integration, defined as a synthesis of
traditional and biomedicine “through the application of modern scientific knowledge and
techniques” (WHO, 1978b:16). The superiority and hegemony of biomedicine was inherent
in this definition, which had perhaps been influenced by the members viewing of two films
on the Chinese methods for integration. A number of points were noted following these films
on acupuncture and medicinal herbs, including “the importance of applying modern science
and technology in research on traditional medicine” (WHO, 1978b:41). China had relied
heavily on scientific verification of TRM in their integration strategy (discussed in more
detail in appendix 4; page 356), which now enhanced the status of traditional Chinese medicine in Committee deliberations.

The parallel situation in India and Sri Lanka was noted, where traditional medicine had been officially recognised and developed separately from biomedicine. This led to a problematic situation where “the practitioners … ‘borrow’ freely from one another when the health situation indicated that such a practice would be advantageous” (WHO, 1978b:17). Parallel systems allowed the primary resource base (drugs, techniques) of the other to be co-opted according to circumstance. The solution to this situation was considered to be integration in the form of synthesis of medical systems (merging of primary resource bases). This form of integration was considered to have advantages over parallel systems and was therefore recommended for “wider implementation” (WHO, 1978b:17). Rather than restricting the recommendation to formalisation of traditional medicine (whether parallel or integrative systems) the report clearly advocated a form of integration, specifically modelled on the Chinese experience.

**Processes** and procedures to utilise TRM and ultimately integrate it into public health care provision included promoting research, information gathering and dissemination. Research into traditional medicine was the initial step, “with a view to assessing its claims and validating them on a scientific basis” (WHO, 1978b:17). In order to “shorten the duration of the public education process [there is] the need for an educational revolution …” involving major reforms in curricular and training (WHO, 1978b:14). In addition, it was considered necessary to educate “the community to believe that the provision of traditional remedies is not second rate medicine” (WHO, 1978b:15). The primary resources of TRM were to be viewed as valuable assets, and not inferior in status to biomedical primary resources – an attitude promoted and entrenched during colonisation.

In order to assist the integration process, guidance was provided on some pre-requisites (WHO, 1978b:19), such as generating information to educate administrators, practitioners and the community. This information would consist of “data validated on modern scientific principles” and strategies such as development of a common pharmacology to serve as a “bridge” between the systems. Obviously, it was also considered necessary to gain legal recognition and “socio-political acceptability” in order to secure financial support. Dialogue

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36 This situation had been noted with some concern by medical anthropologists. This usually was in reference to TRM practitioners (misusing antibiotics, penicillin, syringes and other biomedical primary resources (Bhatia et al., 1975:17; Taylor, 1976:288). As Unschuld’s theory suggests, “borrowing” primary resources serves to increase access to secondary resources (status, income). Bhatia et al note that TRM practitioners who used biomedical drugs had larger clientele and greater incomes (1975:18).
between practitioners and the “demystification of several aspects of medicine” were also criteria required to ensure eventual success. These strategies aimed to give appreciation of the merits of each system, which would then allow public education and assimilation of the practitioners trained within an integrated system into the public service (implicitly, those trained in a merged education system) (WHO, 1978b:19).

**Manpower development** (WHO, 1978b:20-28) was focussed on as the main process to achieve integration. Implicitly, this dealt with using TRM practitioners as biomedical auxiliaries:

In general it was considered desirable to mobilize the existing manpower categories for maximum utilization, since these workers have justified their existence by the fulfilment of health care needs in their respective communities. The problem then would be one of orientation to modern concepts of health care delivery systems, validation of their professional claims, further development of their skills and efficiency, and their integration into public health systems, especially in primary health care. In this respect retraining was considered essential (WHO, 1978b:21, emphasis added).

The creation of a new category of personnel trained in both systems to fill newly created roles in an expanded PHC sphere was acknowledged as offering potential, but it was decided to focus on the development of the existing manpower categories. This differed significantly from the Chinese approach of creating a new manpower category (barefoot doctors) that was trained in basic aspects of both systems. Oddly, training in Ayurveda, Siddha, Unani and Yoga; and training in Chinese traditional medicine including acupuncture, were also facets of the development strategy (WHO, 1978b:21). It was not stated who the intended recipients of this training were, but it appeared to sanction and legitimise specific forms of TRM for wider global diffusion. These systems, indigenous to India and China, were the structurally and functionally strongest in the hierarchy of TRM systems. Both enjoyed state support in their respective nations, had extensive recorded histories and were institutionalised and formalised to a high degree.

The manpower strategy seemed to be based mainly on using TRM practitioners and TBAs as PHC workers. The models for development considered were the training of TRM practitioners as PHC workers in Cameroon, and the use of TBAs. It was noted that changing existing attitudes of both TBAs and biomedical professionals, the change in status of TBAs and demand for higher remuneration may present problems (WHO, 1978b:25). The guidelines proposed that “judicious selection of tasks that could effectively be delegated to TBAs” was required. Therefore, careful consideration of which aspects of the biomedical primary resource base to relinquish was needed, with awareness that this may lead to
increased claims by the TBA on secondary resources (material rewards, status, and authority).  

The TBA is presented as a passive, less knowledgeable beneficiary of biomedical wisdom. Although it was noted that “some TBAs have [a] very high level of skills … and knowledge [and] have much to contribute, even to modern obstetrical care” (WHO, 1978b:23), the flow of training and education was established as one way: from biomedical to TBA. The distinction between the inferred unskilled and untrained TBA, and the biomedical sphere was emphasised with reference to “professional health workers” as synonymous with biomedical practitioners. This negated the TBA as part of a specialist profession in her own right. The diagram on the process of integration of TBAs (WHO, 1978b:24) overlooked any consultation with TBAs in formulation of policy. Instead, they first entered the process at the level of “gaining acceptance of basic policy decision”.

The sixth part of the report dealt with research promotion and development (WHO, 1978b:29-35). As priorities would vary between countries, case-studies of different approaches taken by three countries (Mexico, Nigeria and China) were considered. The significant common feature of all these approaches was the role accorded to science to validate or invalidate the primary resource base of TRM. This was emphasised, and practical methods that had been used to do so were outlined. Scientific research on pharmacological compounds was a priority, and scientific transfer of techniques necessary. Use of scientific methods and adoption of scientific discourse was deemed to give weight to TRM in the health field.

Research into literature, and scientific studies (guided by teams of scientific experts) was advocated as imperative, and the principles of future development of TRM. This was despite the fact that the socio-cultural basis of TRM had been noted (WHO, 1978b:30). It was considered that the lack of use of science and technology had led to the stagnation of TRM in some countries (WHO, 1978b:9). The final section of the technical report was a list of recommendations (WHO, 1978b:36-40). This list was quite detailed and aimed to promote use of TRM in national health systems. The WHO was urged to give this high priority and allocate substantial resources to ensuring the development of schemes using TRM.

Unschuld’s theory proposes that control of primary resources (knowledge, techniques, drugs, facilities) allows access to the secondary resources (status, prestige, authority, income). Therefore, providing biomedical knowledge and equipment to TBAs would automatically authorise access to secondary resources.
Several themes were consistent throughout the TRM strategy: scientific authority in determining what aspects of TRM to incorporate; a one way process of education/training (from biomedical to TRM); a limited and subordinate role for TRM in basic services (PHC) and the use of only two dimensions of TRM systems – manpower (specifically TBAs) and herbal medicines. Therefore, the hierarchical superiority of biomedicine in health systems was embedded throughout the report. Two aspects of this policy document were commented on by Reissland and Burghart (1989). The planners acted as “agents of modern medicine” and they “rigidly circumscribed the terms of integration”:

Certain features of traditional healing, such as the use of native drugs, were thought to be of benefit but only after their efficacy had been proven by the methods of science. The integration of traditional healers and birth attendants into the lower echelons of the state medical system was advocated, but only after the healers had been properly trained in medically approved procedures. In the former case, traditional medicine works, but only modern medicine knows why. In the latter case traditional healers are useful as medical auxiliaries, but only after modern medicine has rendered them in key respects scientific and in all other respects harmless (Reissland & Burghart, 1989:43, emphasis added).

In Unschuld’s terminology, the primary resource base of TRM (drugs, techniques, knowledge, concepts) was subjugated to the primary resource base of biomedicine. Biomedical scientific knowledge was the criteria advocated for assessing TRM primary resources, which allowed biomedical experts to maintain authority. In effect, this allowed the biomedical profession to control the primary resources of TRM, in terms of what was officially recognised. The manpower dimension of TRM was to be co-opted to extend basic biomedical services, and only scientifically acceptable remedies or therapies were to be incorporated into health care delivery (or synthesised into the biomedical primary resource base).

3.3.2.3b) Traditional Medicine Programme

The Headquarters Working Group on TRM, perhaps recognising the magnitude of some of the issues to be resolved, proposed a programme be established in TRM, which was approved by the Executive Board in 1977. The TRM Programme can be considered the operative body to implement the findings of the technical report (WHO, 1978b), in terms of the identified WHO role. The Director of this programme later explained that it came into being due to minimal resources available to extend health services, and the exercise of political power by newly independent countries which reflected broader trends in the policy arena (self-determination, use of local resources): “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 utilisation of all available resources” (Akerele, 1983). Unschuld proposed that attaching TRM to nationalistic agendas was simply a method used to “disguise the fight for resources” and that arguments based on cultural heritage and nationalism prevented the loss of their primary resource base (1976b:18). Therefore, while there was a practical and rational concern with a lack of biomedical resources, the proposal to extend the medical resource base by recognising TRM was also a political strategy by those groups to gain official recognition of TRM primary resources, and thus potentially extend access to secondary resources (state financial support, status).

The WHO states the motive for the establishment of the TRM programme as: “the reason why the WHO initiated the Traditional Medicine Programme some years ago, [was] to help Member States to make a critical examination of their traditional medicine systems and practices and to see what should be retained and adapted to today’s needs and what should be discarded as useless or patently harmful.” This objective is a common theme in documents related to traditional medicine (WHO, 1978b:26; WHO, 1979b:26; WHO, 1986a). However, in the earlier documents the objective is not expressed simply as retaining those practices deemed “useful” and discarding the rest. There is often a third approach included, which is to disregard those practices which are harmless, or of unknown impact (see, for example WHO, 1978b; WHO, 1979b). By 1985, the objective had been simplified, as expressed by Mahler in the introduction to the document on PHC and China (WHO, 1986a:2).

This is a controversial mission – who decides what should be retained, and according to what criteria? How and why are these to be adapted? Why should the “useless” be discarded? Some practices perform cultural and social roles, and have a therapeutic benefit in themselves despite appearing to have no clinical validity. Others may not yet be fully assessed with current knowledge, or treat culturally specific and not universally (biomedically) recognised conditions. The underlying objective appeared to be the rationalisation and modernisation of TRM according to biomedical concepts.

Scrimshaw (2001:55-56) discusses the difficulties of determining which practices are harmful, which are beneficial and which are merely peculiar. To illustrate the complexity, she cites an example from Bolivia, where villagers were discouraged by health workers from

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consuming a mixture of fine clay. Later, these communities began to show signs of calcium
deficiency and increased prevalence of dental caries. It was realised that the clay had actually
been a key source of calcium. Scrimshaw notes that clay is also used in biomedicine, but is
coloured, flavoured and packaged. The cultural relativism used in judgements about
beneficial or non-beneficial practices is clear in this case.

The WHO (1978b:26) itself notes the problems surrounding the preservation of cultural
heritage, expressed in particular practices when they are judged against western biomedical
standards. For example; in Mexico, traditional birth attendants were discouraged by
biomedical practitioners from dressing umbilical cords with spiders’ webs as it was
considered dirty and harmful. It was later discovered that the saliva of spiders and their
cobwebs had antibiotic properties. Caution was therefore advocated and the cultural context
fully taken into account when determining which practices are grouped within these
categories (WHO, 1978b:26).

The political motivations for the establishment of this programme were questioned by Singer
(1988:9) and Velimirovic (1992). Singer alleges that the promotion of TRM and the
establishment of the programme itself was a personal vehicle by the then Deputy Director
General (Lambo) to promote his candidacy for the position of Director General. As one of
the experts participating in the “consultation group” on TRM, convened by Lambo in 1976,
Singer perhaps had more insight into the programmes genesis and objectives than other
commentators. He asserts that in personal conversations with Lambo and other WHO staff,
“it became clear that at least part of the motivation for the [TRM] Program included the hope
that by appealing to the national pride and traditional cultural identity of the Third World
Health Assembly delegates, he could promote his own candidacy” (1988:9).

Velimirovic also makes reference to political motivations in the formation of the TRM
Programme, and was also intimately familiar with internal WHO operations, as he held
positions as Director of the Communicable Diseases Unit in the WHO Regional Office for
Europe, and worked in various capacities with the WHO in different regions.

The heavy political influence of some Chinese authorities is obvious. One has to remember
that it was the Chinese Assistant Director of WHO who pressed for [its establishment], which
he obtained as a concession in the period of political rapprochement with his country
(Velimirovic, 1992:76).

Lambo did take an active role in the TRM activities of the WHO – he was a member of the
Headquarters Working Group, and also took part in the meeting that produced Technical
of any personal motives that may have been attached to the agenda of promoting TRM, Lambo and/or the Chinese Assistant Director appear to have played the role that Kingdon (1984) describes as policy entrepreneur. The mission of the entrepreneur is to exploit openings in the problem or politics streams to push their favoured policy onto the agenda. In the 1970s, both streams presented opportunities to raise the profile of TRM on the health care agenda.

In January 1979, the Director-General provided a report to the Executive Board on the progress of the TRM Programme. The Board, “conscious of the need for practical and effective measures to promote and develop research” in TRM and acknowledging that the success of this programme relied upon the active involvement of the member states, requested that efforts be intensified to promote the participation of countries in the implementation of the programme. The Board also requested that assistance be given to governments to develop “more realistic and flexible approaches” to TRM and that financial and other resources be allocated to the programme (EB63.124). This resolution seemed to indicate that interest in the programme on national levels was weak, and perhaps overambitious in those countries that were already committed to the concept. However the wording (as with other resolutions), was ambiguous and open to various interpretations.

3.3.2:3c) Essential Drugs Scheme

The formulation of the essential drugs list (WHO, 1977) was a “bombshell” and is considered one of the most important documents ever published by the WHO (Chowdary, 1995:40-41; see also Kanji et al., 1992). The publication of this technical report was highly controversial, despite the apparently benign objective. It aimed to guide the rational selection of necessary drugs, and encourage domestic production. It recognised that although the number of pharmaceutical products had grown rapidly, there had not been a proportionate improvement in population health. The marketing and promotional activities of pharmaceutical companies was criticised, and the large proportions of health budgets spent on such products (up to 40%) noted (WHO, 1977:9).

The meeting concluded that a list of about 220 “essential drugs” were sufficient to deal with the vast majority of health problems, in contrast to the thousands marketed and used in health care systems. In the guidelines for establishing the list, cost was a major selection criterion. When assessing this, the cost of “non-pharmaceutical therapeutic modalities” should be taken into account (WHO, 1977:12). Attention was drawn to the fact that “for treatment of certain conditions, non-pharmaceutical forms of therapy, or no therapy at all,
may be preferable” (1977:13). Under research and development, to “hasten self reliance”, one aspect in the clinical area was to carry out therapeutic trials to assess “the benefits and safety of traditional medicines, including medicinal plants” (1977:18).

The essential drugs scheme was a formal recognition that an important aspect of the primary resource base of biomedicine (drugs) had inflated beyond what was necessary, and was absorbing more secondary resources than warranted. The scheme itself threatened to reduce access to secondary resources for biomedical practitioners (including the pharmaceutical industry) and restrict the scope of their primary resource base. The recognition of the potential value of primary resources from TRM also indicated that an alternative primary resource base may be more suitable in some circumstances. Mahler was sure that “[w]hatever the outcome of … 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” (Mahler, 1977). The promotion and development of herbal medicines could therefore help achieve the essential drugs programmes goals by providing cheaper local alternatives (Le Grand & Wondergem, 1989:19).

This report was “bitterly criticised by the US Pharmaceutical Manufacturers Association (PMA) which stated on 10 April 1978 ‘[The] medical and economic arguments presented by WHO as justification for an essential drugs list are fallacious and … the adoption of this recommendation could result in suboptimal medical care and might reduce health standards already attained.” They argued that an essential drugs list would discourage the pharmaceutical industry from investing in research (Chowdary, 1995:42). After intensive lobbying from the pharmaceutical industry, which included employing the Chair of the 1977 WHO Expert Committee on Essential Drugs, (who remained on the panel); the subsequent revised report (WHO, 1979a) was reduced in scope and content. No reference was made to traditional medicine. However, subsequent reports only revised the list of essential drugs rather than modifying the policy foundation detailed in the initial report. The counter-offensive by the biomedical lobby re-asserted the value of biomedical primary resources (drugs) and their role in health care, which was being brought into question and from which secondary resources (status, financial support) were being withdrawn.

3.3.2:3d) Primary Health Care

The Primary Health Care (WHO, 1978a) approach drew together and reinforced some of the disparate initiatives and principles already advocated in other programs and resolutions, such
as the essential drugs scheme and TRM Programme. The Alma Ata Declaration articulated how Health for All by 2000 could be achieved; with a new form of health services – primary health care (PHC). The Declaration and recommendations flowing from it reinforced and endorsed the trends that had been established throughout the 1970s: the maximum utilisation of locally available resources, self-reliance, cost effective extension of delivery systems and basic services to meet basic needs.

PHC was defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford in the spirit of self-reliance and determination” (WHO, 1978a). The PHC movement was designed to shift the health care focus from sophisticated tertiary curative services, to prevention and promotion as part of a comprehensive coverage, to enable better quality of life. This scheme aligned itself with wider social and economic social justice movements, and was premised on the development of the “New International Economic Order”. It recognised that health improvements were reliant on broader social and economic conditions.

The Alma-Ata Declaration specifically recognised traditional medical practitioners, including TBAs, as potentially important allies in achieving health for all through primary health care (1978a:63). The report of the meeting recommended that traditional medical practitioners could be selected as community health workers (1978a:26) and that the list of essential drugs for primary health care should include “proved” traditional remedies (1978a:29). Despite this apparent approval of the use of two dimensions of TRM systems (manpower, drugs), there was uncertainty expressed about the overall contribution of traditional systems of medicine which was deemed to require further research (1978a:16). PHC relied upon health workers including traditional practitioners, but only as needed or where applicable.

The principles of PHC as defined by the WHO are embraced by TRM systems: TRM is practical, socially acceptable, universally accessible and encourages self-reliance. However, there is one caveat – it is not “scientifically sound” in the Western sense. Despite that, in practise, PHC was considered by some to be tantamount to TRM: “For the majority of people in the developing countries, traditional medicine in fact remains the main or only source of care. For such patients ‘primary health care’ is therefore necessarily synonymous with traditional medicine” (Maclean & Bannerman, 1982:1815). PHC appeared to offer the promise of being the most suitable method for the implementation of TRM strategies.
The emphasis on community participation and self-determination, with a simultaneous demand that PHC be scientifically sound, can be considered an inherent contradiction within the PHC model (Welsch, 1986). This calls for the “bottom-up” development of health services, yet is structured as a “top-down” approach (the experts at the top of the administrative hierarchy overseeing and guiding the uninformed communities). That the Alma Ata declaration was able to combine these two conflicting philosophies so skillfully demonstrated the WHO’s capacity to reconcile various and often divergent political and scientific interests (Welsch, 1986:105). This contradiction between local autonomy and biomedical authority can be seen for example in the definition of “appropriate technology” – “appropriate means that besides being scientifically sound the technology is also acceptable to those who apply it and for those for whom it is used” (WHO 1978a:59). That is, scientific soundness is paramount to community acceptability and is the default criteria for selection of primary resources.

The “scientific soundness” filter was an effective control over the full acceptance of the TRM primary resource base. As mentioned, without this caveat, TRM systems met the definition of PHC. However, with this biomedical limit established it implicitly gave control to the biomedical profession to determine what was considered appropriate, rather than the communities themselves. Welsch notes that “scientific soundness” as an essential feature of the PHC model ensured the professional legitimacy and authority of biomedicine (1986:105). This correlates with the implications of the WHO policy on TRM as expressed in the technical report (WHO, 1978b), which Reissland and Burghart call an “ideological boundary, created and defended by modern medicine … Movement across that boundary was to be controlled by the agents of modern medicine” (1989:43). Again, what appeared to be an endorsement of TRM was ambiguous and qualified, and subordinated TRM systems of health to biomedical primary resources (knowledge, techniques).

The ambiguous and ambivalent endorsements of TRM, and confusion or contradictions in the use of central terms and concepts, were evident in other WHO documents. By the end of the decade, some of the practical implications of integration were becoming apparent. In 1979, the introduction to Traditional Birth Attendants – A field guide to their training, evaluation, and articulation with health services (1979b), a movement away from some of the earlier positions could be detected. The introduction made specific reference to two problematic issues: integration and remuneration (secondary resources) (see appendix 5 for an excerpt of this introduction; page 359).
It was clear there was some confusion as to what “integration” actually meant, and how to apply it. There was no clear definition of it or framework to implement it. In this document, it was stated that integration in the “true sense of the term should be avoided at all costs” (WHO, 1979b:8). This was perceived to be a merging with the biomedical delivery system to the extent that the TBAs identity as traditional practitioners was lost. It directly contradicted the technical report (WHO, 1978b) published in the previous year, where integration was explicitly endorsed, especially at TBA level.

Integration might cause conflict between traditional and biomedical practitioners, as well as alienating them from their communities. Only informal links between TBAs and the formal health system were therefore advocated. Rather than “integrating” the TBA into health care, “integrating” within them the principles of biomedical and traditional practices was promoted. “Articulation” was the preferred term, as it implies “organization in which each part fits into another …so built that it functions as a whole yet without any loss of flexibility or distinctness in any of its component units or without any conflict between them” (WHO, 1979b:8).

3.4 World Bank activities

While the World Bank did not make loans for health sector activities until the 1980s, it began taking a serious interest in health issues in the 1970s. In 1975, a policy paper on health correlated with sentiments expressed by the WHO. To correct the distorted distribution of resources that had resulted in an emphasis on tertiary biomedical infrastructure in urban areas, the World Bank recommended extending PHC coverage, increasing the responsiveness of existing biomedical infrastructure to the PHC worker and “planning the extension of primary care with the aim of supplementing the role played by traditional healers in village society” (in Doyal, 1979:286). The World Bank interest in health, education, housing and other social services was stimulated by the recognition that these factors were related to economic productivity and development. Prior to this, health expenditure was classified as a non-productive, consumption item (Bichmann, 1979:179).
Section 3: Activity at national levels

3.5 Debate and activity in the policy stream

Academics (primarily medical anthropologists), debated the theoretical and practical implications of integrating TRM into health care systems. The increasing interest in medical pluralism, trans-cultural perspectives on health and the incorporation of TRM was reflected in journal articles. In the late 1970s, *Social Science and Medicine* devoted several special issues to it (vol. 12B no2; Vol 13B No 2, 3, 4), and there were a variety of conferences and symposiums.

Foster (1977), proposed that except for the use of TBAs and mental illness specialists, approaches to harness TRM practitioners would fail as most TRM systems would gradually diminish and eventually cease to exist. Therefore, integration was a “moot question”. Foster felt the evidence clearly demonstrated that where people have had access to biomedicine for a generation or more “the battle has usually been won, and scientific medicine is the victor” (1977:533). Taylor also proposed that TRM would eventually be absorbed within biomedicine (1976:298) and both felt integration was only a transitional step to deal with biomedical manpower shortages (Foster, 1977:534; Taylor, 1976:298).

These beliefs were based on the premise that the primary resource base of biomedicine would inevitably supplant that of TRM, once delivery systems were sufficiently developed. Yoder believes that this naïve assumption that the use of TRM would naturally diminish as biomedical services expanded was the reason that official recognition of TRM was delayed until the 1970s (1982:1851), when modernisation theories based on the superiority of biomedicine were finally discredited and TRM systems experienced a revival.

Insights into the current situation were provided by Good et.al. (1979), who noted that the once euphoric expectations attached to the potential of the biomedical model had recently subsided in light of many apparent limitations, but the demand for biomedicine was voracious. The ambivalence of both national governments and biomedical practitioners led to a non-recognition of TRM, which biomedicine “rationalizes through its own cult of science and professionalism” (Good et al., 1979:146). They questioned whether this laissez-faire stance would continue, concentrating all resources on biomedical services despite it demonstrating a class and urban bias that segregated it from the broader population.
A limited (informal) fusion of techniques and drugs of the biomedical and TRM systems occurred at their interface, and TRM practitioners were aware of the disregard they were accorded. While they were receptive to the idea of collaboration with biomedicine, they lacked prestige and influence in upper echelons of political decision making. A conceptualisation of integration was offered – it would represent a “diffusion downwards of [biomedical] care and a diffusion upwards of [TRM]” (Good et al., 1979). In other words, this would entail a democratisation of biomedicine and an empowerment of TRM; or a de-professionalisation of biomedicine and professionalisation of TRM to obtain an equitable status. The pursuit and adoption of simplistic models in this process was warned against (Good et al., 1979:152).

Kleinman (1978) offered a detailed consideration of the issue of integration based on research from Taiwan. He commented that promoting the integration of indigenous practitioners into orthodox medical systems might be acclaimed as an accomplishment for ethnomedicine in international health planning, but its merit may actually be questionable (1978:82). He considered that the motives and responses of the groups of practitioners would vary. While most practitioners using traditional Chinese medicine (professionalised, licensed) viewed integration positively, if it meant equality with biomedical practitioners (1978:84) those from the folk healing traditions (unlicensed, not professionalised) were not so enthusiastic.

Kleinman concluded that for the practitioners of Chinese origin medicine, the proposal was not markedly divergent from their present position in the health system, which was sanctioned and autonomous. However, as biomedicine was of higher status and its practitioners enjoyed greater income and more patients (more secondary resources), the TRM practitioners “have some specific gains they wish to achieve from integration” (1978:83). That is, increased access to secondary resources on par with the biomedical practitioners. The only practitioners from this group who were unfavourable towards integration were those who already enjoyed a high income, status and large clientele. They had little to gain from such change (1978:83) as they already enjoyed maximum access to secondary resources (material rewards, status, prestige).

The majority of practitioners from less professionalised traditions were resistant to the concept of integration as they suspected they would not be given equal status to biomedical practitioners, it would reduce their patients and income (secondary resources), and would lead to taxation: “integration would mean they would be controlled by competitors whose interest lay in putting them out of business” (Kleinman, 1978:84). Therefore, the less
professionalised groups felt their secondary resources were threatened by integration. However, in some African nations (e.g. Nigeria) traditional practitioners pushed for state recognition in the form of licensing, in order to secure economic benefits (secondary resources) by limiting entry into their field and allowing them to compete more effectively with biomedical practitioners (Dunlop, 1975:585).  

It appeared that level of professionalisation may be a factor in TRM practitioners’ response to integration, as this is related to the degree of control they exert over their primary resources. The less professionally organised have less control (and subsequently only tenuous access to secondary resources) and therefore more to fear from state regulation. However, partially professionalised groups may enhance their access to secondary resources through integration. Ironically, the highly professionalised groups (both TRM and biomedical) were also resistant to integration, as this would mean sharing access to their existing secondary resources (financial rewards, status). Economic and professional competition may therefore be a factor in the antagonism reported to training TBAs (Leslie, 1980:192), and did not bode well for the pre-requisite of goodwill on both sides for successful inclusion of TRM in formal health care (Mahler, 1977).

Regardless of any tension between practitioners, international endorsement of the concept of integration meant that the practicalities of implementation also needed to be addressed. Cost-benefit analysis, assessment of efficacy, and identification of the groups from the heterogeneous field of TRM that were to be integrated were required before programs and plans could be formulated (Kleinman, 1978:82-83). Cost-benefit analysis of using TRM and various strategies for incorporation were analysed by Dunlop. He concluded, based on his economic assessment and experiences of some African nations, that the most effective policy position may be informal recognition as it offered the most benefits at least cost (1975:585).

Kleinman also felt that some forms of TRM may function more effectively outside of formal treatment settings and “bureaucratization and professionalization may not only contribute little to biomedical care but undermine” specific forms of alternative healing (Kleinman, 1978:85). So, while some groups were enthusiastic, others were more cautious and dubious (Asuni, 1979a:37; Unschuld, 1980:15; WHO, 1979b:8). The difference in responses may be

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39 Monopoly and license is one of the latter stages of professionalisation (Unschuld, 1975:307).
40 This correlates with Asuni’s observation that “The traditional healer may feel uneasy about the co-operation, or may feel his status enhanced by the co-operation, depending on the level of expertise and confidence [professionalisation]... There is no doubt they feel a sense of competition ...” (1979b:180-181). Taylor also noted that in India, TRM practitioners not doing well financially were eager to co-operate, while those with already active practises “could not be bothered” (Taylor, 1979a).
related to who would win and who would lose from such a process, and how the shifting power and control in health planning and policy would affect vested interests and the boundaries of primary and secondary resources.

3.5.1 Lesson drawing from China?

Doyal (1979) was one of the few early voices questioning what was later termed as “lesson drawing” (Rose, 1991) – that is, what policies and programmes work and for what reasons, specifically whether what had been achieved in one country (China) could easily be transferred elsewhere. Doyal proposed that what China had successfully implemented arose out of revolutionary change and was not divisible from that: “the health policies simply cannot be transferred from one social, economic and political context to another” (1979:288). Blendon (1979) also argued that the health system in China was a direct result of their unique economic policies and could not be transplanted in isolation of them, and Good et.al. considered it an “open question” as to how much of their experience was transferable (1979:152). In 1975, Geiger commented:

Great social experiments, like new species which have adapted precisely to a particular ecological niche, are rarely if ever directly transplantable from one society (or environment) to another. When technological change is intimately and deliberately interrelated with social, political and economic change as in the health care system elaborated over the past 24 years [in China] the limits of direct transplantability are narrowed even more drastically (in McQueen, 1985:934).

Doyal illustrated her argument with comparative data on community rural health workers from Iran, India and Tanzania (1979:288-290). There, as experienced elsewhere in the South, programs modelled on the barefoot doctor scheme had been failures. A major factor in the lack of success was resistance from the biomedical profession to the training of auxiliaries with biomedical responsibilities, even where there were serious shortages of doctors. In addition, workers trained in such schemes identified with the more prestigious and powerful biomedical profession and were driven by goals of personal advancement.

In terms of conflict over resources, biomedical doctors strongly opposed sharing their primary resource base, which would allow access to secondary resources for those peripheral to their professional hierarchy. In contrast, the community health workers were eager to acquire access to biomedical primary resources and aspired to the secondary resources this ensured, but such motivations alienated them from the communities they were meant to serve. This situation experienced with community health workers appears to parallel the
concerns expressed by WHO about TBAs potentially identifying with the biomedical profession, changing in status and seeking commensurate secondary resources (WHO, 1978b:25; WHO, 1979b:8).

In contrast, in China, one of the most commented on and distinctive attributes of the barefoot doctor scheme was the “ideological zeal” and altruistic devotion they displayed to their communities health, “without thought of any personal material gain” (secondary resources) (Ronaghy & Solter 1974:1331 in Doyal, 1979:288). This factor appeared crucial to the success of the scheme, as they did not threaten the biomedical profession and remained respected within their villages. Barefoot doctors retained their original occupations and received no remuneration for their services. Therefore, they made minimal claims on the primary resources of both biomedicine and TCM (receiving only basic training and restricted drugs/techniques) and no claims on secondary resources.

A significant achievement of this scheme was “the unbiased integration of valuable primary medical resources from both subsystems within the practice of one manpower category” (Unschuld, 1976b:15). That is, the medical systems were not synthesised and existing practitioners compelled to share resources, but certain dimensions of their primary resource bases (drugs, techniques) were instead allocated to a new manpower category. Their manual was based on biomedical concepts, although it used traditional terminology. This program was carried out under close government supervision with a high level of political support. Frankenberg describes the Chinese approach as bypassing all medical ideologies and reconstructing them (1981:115).

Despite the unique political, cultural and economic environment in China, it was perhaps inevitable in that the international community looked to it in the mid-1970s. China provided both an inspiration and one of the few models in using TRM in health care systems. The conditions and objectives of the international community correlated with what China faced several decades previously – expanding health services to underserved populations, in an environment of resource constraint. The dual concerns of limited health resources and heightened nationalistic sentiments (along with social justice concerns) converged to provide a supportive policy environment for the promotion of TRM. Many countries including Nigeria, Zaire, Tanzania, Congo, Guinea, Kenya, the United Republic of Cameroon, and

41 For example, Ademuwagun comments in reference to Nigeria: “All the problems mentioned in connection with health care delivery systems and methods in China in the 1950s are with us in Nigeria today.” These were shortage of manpower, mal-distribution of resources, and patterns of utilization (availability, accessibility, acceptability) (Ademuwagun, 1979 [1975]:159).
Malawi (Lee, 1997; Okoth-Owiro, 1994:40) legally recognised TRM and began to define a role for it in their health care systems.

The model eventually proposed by the WHO for integration of TRM was considered by some to be a replication of the Chinese system (Bibeau, 1985:943), although this is considered a simplistic assessment by others (Frankenberg, 1981:117). However, it is clear that the technical report (WHO, 1978b) clearly favoured China’s strategies. One crucial difference was that rather than training a new category of workers for PHC, the WHO emphasis appeared to be on extending the responsibilities of existing categories of TRM manpower (e.g. TBAs).

This support for the unique paradigm developed by China came despite the doubts expressed about transferability of policy models; the evidence of failure in other countries adopting community health worker schemes; and ironically at a time when the Chinese government itself appeared to have abandoned such an integration strategy. Singer notes that in the post-Mao period (after 1976) “the Ministry of Health and the China Medical Association were shovelling the traditional medicine camel out of the health tent” (1988:9).

While this may be overstating the case, evidence suggests that TCM was being relegated to an ancillary position in formal health care at the same time the international community seized on it as an innovation. By the 1960s, although integration was still advocated, it appeared that TCM had been relegated to a “supplementary and … inferior position” (Croizier, 1976:350). Similarly, the commune system central to the organisation of PHC was dismantled in 1978, ironically the same year that PHC was endorsed on an international level (Huang 1988 in Macdonald, 1992:19). The enthusiasm and support for the concept of integration as an ideal may have been greater internationally than at country level in the South:

Most of the vocal and strong proponents of the idea of integrating traditional healing practice into the health care delivery are foreigners to the situation. The knowledgeable and sincere indigenes of the developing countries are usually cautious in advocating such integration … (Asuni, 1979a:33).

Why did the WHO enthusiastically promote a particular form of integration of TRM as a promising method to achieve HFA by 2000? Singer (1988) argues that the WHO uncritically accepted the propaganda presented by China during the Cultural Revolution, and that it was a misguided strategy pushed by Lambo as part of his efforts to secure the post of Director-General. Velimirovic also mentions personal political ambitions within the WHO as a
driving force behind the endorsement of the concept, and the politically motivated promotion by China (Velimirovic, 1992:76).

According to Elling (1981a:87), quoting a 1973 WHO study, the WHO seemed to want to believe or hope that the relationship between political conditions and organisation of health systems was remote: “this link between health service and political structure is not so intimate that the health services cannot change separately and independently within most socio-political systems.” As will be explored in the next chapter, this naivety, optimism or lack of knowledge had consequences in implementation of the policy in the following decade – when it became obvious that transferring the PHC concept (and related goal of integration of TRM) to national levels, was fraught with obstacles.

3.6 Conclusion

During the 1970s, an international consensus appeared to develop that the universal policy model exported during colonial expansion based on biomedical primary resources (drugs, techniques, facilities, knowledge) was ineffective and costly. In the South, it was not meeting basic health needs and even in the North, its failings were becoming evident. This new perspective was expressed in the Alma Ata declaration, PHC, and the recognition of TRM. These commitments aimed to reorientate health care from a technologically intensive, tertiary focus to community based health care programmes. Improving access to and equity of health care services was crucial to achieve the humanitarian global commitment to “health for all by the year 2000”.

These new directions in health policy mirrored broader social, economic and political trends in the politics and problems streams. They were an aspect of the re-evaluation of the values and outcomes of the “modernisation” campaign, and reflected the new awareness of resource constraints. The continuing expansion of biomedical delivery systems and their appropriateness in meeting health care needs of populations in the South was critically examined in this light, and new solutions were sought. The new orientation also reflected the rising demand for self determination and independence amongst previously colonised countries, which embraced and promoted their own heritages and called for greater control over national matters.

These broader trends permeated the WHO, which greatly changed in character during the course of the decade. From the mid-late 1960s, countries from the South were able to
influence the agenda of the World Health Assembly. “… newly independent states joined the Organisation … (and) grew more confident in drawing issues of concern to them, and to publicising their own solutions” (Walt, 1993:127). The WHO was being exposed to new concerns and new ways of dealing with them – particular attention was drawn to innovative models and low cost community health programmes like the “barefoot doctor” scheme developed in China. This concept was inspiring to other countries in the South, who had few resources and major public health issues to deal with. China offered a compelling success story, a practical example of what could be achieved when local resources were mobilised and an inventive approach taken to delivering basic health care services.

The policy of promoting and developing TRM therefore simultaneously addressed several issues that had become prominent on the health care agenda in the 1970s. Integrating TRM into health care systems appeared to offer a practical solution to a host of important health policy problems. These problems included extending the delivery of basic health care services in a cost effective manner, addressing maternal/child health issues, family planning and communicable diseases, using local resources, and achieving the new goal of “Health For All” by the year 2000. In Kingdon’s theoretical perspective, the policy of integrating TRM therefore arose on the agenda as it offered a feasible solution to identified problems and the political context was conducive to endorsing such an approach. Therefore, integration as a solution was pulled from the policy stream – the politics, problems and policy streams merged.

However, the new universal policy models that were promoted (PHC), and the integration of TRM based on the example offered by China, may have been flawed in definition and based prototypes that were difficult or even impossible to replicate. Kleinman notes that anthropologists are aware that health policies and programmes are often hindered by the very political, economic, social and cultural realities they wish to change (Rifkin in Kleinman, 1978:72). Plans may carry within them inherent impediments to the realization of their goal, often the very impediments that the programme seeks to overcome (Foster in Kleinman, 1978:72).

It could be argued that this was the case with PHC and the integration of TRM, which were intended to re-orient health care away from a biomedical, curative focus yet in definition and design maintained the pre-eminent position and authority of the biomedical profession. This was most obvious with the emphasis placed on “scientific validity” and the supervisory role accorded to the biomedical profession. The use of scientific method (application of scientific discourse) can therefore be perceived as an effective method to assert control over
integration and PHC by the biomedical profession (Reissland & Burghart, 1989; Welsch, 1986). While such details of policy and programme content may appear to be only semantic, they have practical outcomes in implementation phases.

The policy activity during the decade in relation to TRM, as described in this chapter, can be seen as efforts by the interest groups to promote their own, and restrict their competitor’s primary resource base. Initially, biomedical primary resources were criticised and their validity in some settings questioned. These criticisms even came from eminent practitioners, academics and administrators within the biomedical profession itself (e.g. Cochrane, McKeown, Engel, Mahler, and Lambo). The TRM primary resource base was then promoted as more acceptable, accessible and affordable. The very failings of the biomedical infrastructure could be addressed by TRM systems. The problem stream (lack of manpower, expensive drugs, incapacity to extend the biomedical infrastructure, high mortality from preventable diseases) all reinforced the perceived inadequacies of biomedical primary resources and presented an opportune moment for TRM to seize the agenda.

While the recognition of the TRM resource base was politically significant, biomedicine was unwilling to relinquish power or authority. Therefore, only certain aspects of TRM primary resources were recognised, and those were to be assessed and validated by biomedical professions using scientific ideology. In effect, this selective legitimation allowed the biomedical profession to control what was officially recognised as the primary resource base (knowledge, techniques, practices) of TRM. In addition, the manpower dimension of TRM was accepted, but only to delegate to them limited and routine biomedical functions. Therefore, they were to act as subordinate agents to extend the biomedical infrastructure and channel populations more effectively to existing biomedical facilities.

With official recognition of their primary resource base, TRM practitioners had the prospect to increase access to secondary resources (wealth, status). However, the biomedical profession risked losing secondary resources and needed to effectively guard their existing resource base. TRM was a significant threat to the biomedical grip on status, prestige and financial rewards, but this threat could be minimised by maintaining structural control – as evidenced in the PHC and TRM policies. The use of scientific discourse in this process appeared to be pivotal. The fluid battle for control of resources during the 1970s had seen TRM practitioners appear to win some ground by obtaining a place on the policy agenda, but biomedical practitioners managed to maintain structural dominance and control in formal health care service delivery. How this battle for resources progressed in the following decade is the subject of the next chapter.
4. 1980s: Difficulties transferring policy concept

*The [Chinese] model was a myth from the beginning, and the international medical profession has never seriously attempted to utilize indigenous medical systems to improve state systems of health care, but something has been happening that we would all be better off if we understood.*

(Leslie, 1985a:921)

While the concept for integration of TRM was developed in a favourable environment, the seed fell on barren ground in the 1980s. As outlined in the preceding chapter, in the 1970s, windows opened in both the *politics* and *problems streams* to elevate the issue of TRM on the international health care agenda, but in the 1980s the policy floundered in implementation. By the mid 1980s, many anthropologists were questioning the slow progress made; whether the concept was even feasible; and the commitment of the WHO to the notion (Bibeau, 1985; Maclean, 1986; Pillsbury, 1982; Singer, 1988; Velimirovic, 1984b). What appeared to be a promising solution to service delivery problems was extremely difficult to transfer and translate into workable policies.

Lack of tangible activity on national levels was compounded by an absence of clear guidance on the international stage. The ambivalence exhibited by WHO to the use of TRM was reflected in both programmes (Werner & Sanders, 1997) and publications (Wolffers, 1990:3). PHC, the primary vehicle for the implementation of an integration policy, also struggled in formulation and implementation. Many of the problems confronting these policies (PHC, and the use of TRM) were shared – such as lack of resources, ambiguous definitions, confusion about central concepts, and the scale of change required in the face of administrative and health system inertia.

Macdonald comments that the response to the sentiments expressed in the Alma Ata Declaration as one “not of deafening silence, but of deafness” (1992:10) while Maclean similarly notes that the idea of integrating TRM into health care systems had fallen on deaf ears (1986:31). The broader *policy* context, and activity in the *politics stream* (such as shifts in ideology, interest group activity, administrative changes) provide a backdrop for understanding the apparent resistance to implementing on national levels what had been advocated internationally.
When Leslie (1985a) questions what exactly has been occurring, the broader policy context and the nature of professional conflict and competition between medical systems provides some clues. Throughout this decade, there were unfavourable economic and political conditions for implementation of policies that would divert resources and structural control from the biomedical profession. These conditions allowed the biomedical profession to reassert authority over their primary resource base (drugs, techniques, knowledge, facilities) and deflect the efforts of policies and programmes that would dilute their power and exclusive access to secondary resources (status, prestige, economic benefits). The activity (or lack of activity) around the policy of integration can be interpreted as efforts by TRM practitioners to expand and legitimize their resource base, and a counter-offensive by the biomedical coalition to protect their professional interests and role in the health care system.

The revival of TRM in opposition to the dominant biomedical profession can be considered an example of what Foucault termed “the insurrection of subjugated knowledges” against “the centralising powers which are linked to the institution and functioning of an organized scientific discourse ...” (Foucault 1980:81, 84 in Cohen, 1989:169). This insurrection of local, marginalised beliefs and knowledge systems against the hegemonic biomedical discourse, and the conflict and ambivalence generated, is clearly expressed in international and national policy and programme development on TRM throughout the 1980s.

**Section 1: Policy context**

**4.1 The broader policy context**

While grand schemes like PHC and “Health For All” were conceived in the idealistic 1970s, they were “implemented in the resource-constrained 1980s, a period dominated by neo-liberal political and economic thinking” (Walt, 2001:684). During this decade, severe economic constraints were experienced world wide – recession, high levels of unemployment and an international debt crisis. The global recession caused interest rate rises, and countries in the South were saddled with impossibly high interest repayments on loans from the World Bank. In the 1970s, many of these countries had borrowed heavily to finance industrialisation efforts, and were now faced with mounting debts. Mexico defaulted on interest payments in 1982, and throughout the remainder of the decade, much of Latin America and Africa were caught up in spiralling inflation, recession and political conflict (Krieger, 1993:438-439).
4.1.1 Global recession

Widespread economic difficulties created conditions that enabled neo-liberal economic theory to gain ground. The most prominent proponents of this “new right” agenda were Thatcher (1979-1990) in the United Kingdom, and Reagan (1981-1989) in the United States. This approach focussed on stimulating economic growth through policies of economic liberalisation, including deregulation. The social democratic commitment to a welfare state was questioned – whether the government should or could provide services as efficiently and effectively as the market was the main issue raised by proponents of economic rationalist thought.

The effort to halt economic decline and encourage market forces led to an agenda that was based on the reduction of public spending; the privatisation of state owned enterprises; contracting out of public services for private sector management and introduction of cost recovery methods such as “user pays” for services including education and health. This ideology had considerable significance in Western democracies, and amongst central and eastern European nations where state planning systems had collapsed throughout the decade. In China, central planning was relaxed, the market opened to foreign investment and trade and various other economic reforms implemented.

4.1.2 Environmental awareness

During the 1980s, environmental issues came to the fore. The environmental consequences of unregulated growth and development became a higher priority, carrying over from an awareness that developed in the 1970s. Pollution, ozone depletion and habitat destruction were greater concerns. In 1983 a World Commission on Environment and Development was established to investigate development-environment connections, and it produced *Our Common Future* in 1987 (also known as the Brundtland Commission Report). This introduced the concept of sustainable development – economic growth moderated by management of the environment.

Environmental degradation and the consequences of man-made substances and activity were emphasised by massive and dramatic environmental catastrophes. In 1984, a gas leak at a pesticide plant in Bhopal (India) killed 6300 people. In 1986, 30 tonnes of agricultural chemical was spilled into the Rhine River and killed 500 000 fish, in the same year there was a nuclear reactor disaster in Chernobyl. The health and environmental costs of that incident
are still difficult to calculate, but it directly affected over 600,000 people and has cost billions of dollars to date. In 1989, the Exxon Valdez polluted 2400 km of coast line after an oil spill.

All these events and the dramatic images of their impacts created a surge of concern for the environment, an appreciation of the fragility of ecosystems (Gelinas, 2003:143), and a questioning of the safety and consequences of modern developments (e.g. nuclear power, deforestation). This growing environmental awareness later filtered into both the WHO and World Bank activities and agendas. The *problem stream* became tinged with environmental concerns and its relationship to health and development, and more weight was given to environmental issues in the *politics stream*. Many of the policies that gained precedence on the international agenda were therefore tied to or reflected environmental concerns.

### 4.2 Trends in the health field

The main trends present in the health field during the 1980s reflect the themes of the broader policy context (described above) – a constriction of resources which created an emphasis on the effectiveness and efficiency of existing health services as well as methods for future financing; and a developing movement away from dependence on biomedical primary resources and an interest in “natural”, less technologically centred forms of health care.

#### 4.2.1 Financing and Effectiveness/Efficiency

Gwatkin (2002:1791) provides an overview of trends throughout this time in relation to health policy and health inequalities. During the 1970s and early 1980s, distributional issues were the main concerns in international health. Concern was focussed on the health status of different socio-economic groups within society, with the equity of health status being a major problem to address. However, this concern was overshadowed throughout the mid to late 1980s as attention moved from equity to efficiency. By the mid-1980s, it became obvious in the current economic climate that universal provision of free basic health services (as promoted in the Alma Ata Declaration, as the PHC approach) was not feasible.

In addition, Gwatkin proposes that the economic and political changes in Eastern Europe and China (where socialist and communist ideologies were being replaced or modified with free market and private enterprise philosophies) raised doubts and undermined confidence in state-led development approaches. This filtered into the health field with a questioning of the
appropriateness of the central role accorded to government in the provision of health care services. “Health sector reform” therefore became paramount, with the health status of disadvantaged groups less prominent and the financial sustainability of health services taking over as higher priority on the agenda. More activity on health financing, and a push towards efficiency and cost-effectiveness of services was evident in policy and programme activity (Gwatkin, 2002:1791).

The development of health economics as a field was stimulated by the lack of economic resources available. With limited resources to distribute, “objective” and “rational” techniques to allocate them became more important. Economic philosophies and concepts such as opportunity cost, demand, elasticity and externalities were applied to the health field. This was an effort to guide resource allocation so that efficiency and cost-effectiveness were maximised (see for example Lee, 1983).

4.2.2 Complementary and Alternative Medicine

A trend that had started in the 1960s and 1970s gained momentum in the 1980s. More people in the North began to use “alternative medicines” often based on natural and holistic systems of health care. The use of complementary and alternative systems of health care increased rapidly in popularity throughout the decade – in the United Kingdom, consultations increased at a rate of 10-15% annually and estimates regarding practitioners and consultations indicated CAM was developing at a pace five times more rapidly than biomedicine (West, 1984:343).

Some considered that the re-emergence of holistic health was related to the broader economic crisis that confronted biomedicine, as well as the inability of the biomedical paradigm to address health problems of advanced societies (Berliner & Salmon, 1980b:134). The growth in use of CAM was conjectured to relate to a variety of factors – such as concerns with the hazards or side effects of biomedicine, the appeal of individualistic therapeutic encounters, different ways of interpreting the illness experiences, a rejection of reductionist or mechanistic philosophies of biomedicine, and changing ways of viewing the body (Cant & Sharma, 2000; Sharma, 1992; Taylor, 1984; West, 1984).

Alternative medicine is witnessing a scene that a few years ago it would not have dreamed of. It has the favour of the media, the public voting for it with its feet, and the medical profession taking note of its existence. It is even gaining enough of a voice to begin to ask questions about taking up its rightful place within the country’s health care system (West, 1984:341).
As the popularity of complementary and alternative forms of health care grew rapidly, faith in and reliance biomedical doctors and consultations was decreasing. This could be viewed as undermining, or challenging, biomedical professional power and dominance (Cant & Sharma, 2000; Saks, 1994; Sharma, 1992). The popularity of alternative therapies was called a “forthright rebellion against the philosophical and clinical orientation of scientific medicine” (Berliner & Salmon, 1980a:535), although it was still uncertain whether this trend was a fad or more permanent social movement (Schiller & Levin, 1983; Velimirovic, 1984a). By the end of the decade, the rising phenomenon of using alternatives to biomedicine was considered more than a passing fashion (Alster, 1989:3).

The attitude within the biomedical profession to this trend was sceptical and critical, that it was “a flight from science” that left some “… wondering if this is because that group stands to lose the most by a change in the status quo of health care” (Alster, 1989:4). In addition to meeting emerging needs of populations that were not being addressed by the existing curative focussed, tertiary based health care systems, CAM also offered an option for reducing health care expenditures. Alternative healing treatments may offer less expensive treatment options than biomedical interventions, and therefore their role in health care systems offered an economic advantage if they could demonstrate efficacy (Berliner & Salmon, 1980a:538). Effectiveness and efficiency assumed importance as paramount principles guiding state support for health care, including TRM/CAM modalities.

Section 2: International bodies

4.3 WHO activities

During the 1980s, the WHO was besieged by financial, political and administrative pressures. The most pressing dilemma was its budgetary position. The budget was frozen in real terms by the World Health Assembly in 1982; member contributions were not paid and some withheld payments in protest of controversial schemes such as Essential Drugs. By the end of decade, funding from extra-budgetary funds exceeded the regular budget (countries were circumventing generals funding and instead donating directly to programmes they supported). A new Director in 1987 signalled a new direction for the organisation. Mahler was replaced by Nakajima who was considered a “consensus” leader. He steered the WHO out of political controversies by focussing on biomedical and technical issues (Walt, 1993:138-139).
The WHO remained dominated by the biomedical profession, with almost all senior positions filled with biomedical doctors, and it did not recruit sociologists or anthropologists (Foster, 1987; Godlee, 1994a:711; Walt, 1993:138, 139). “Consequently, the perspectives, objectives and interests, not to mention the unquestioned assumptions of the medical profession, structure the organization’s approach to health problems and to the decisions as to what are appropriate policies, programs and projects” (Foster, 1987:711). The WHO as an organisation was therefore aligned in perception, interests and operation with the biomedical profession. In spite of the growth of third world membership in the previous decade, the North continued to dominate the policy process, partly from a shift in balance between extra-budgetary and regular budgets (Walt, 1993:130-131).

The politics stream (administration, membership) within WHO was therefore biomedically dominated, the problem stream (issues for the agenda) shifted focus to internal management and programme concerns focussed on budgetary constraints, and the solutions (policy) favoured technical, vertical interventions and not those that were costly, time consuming, difficult to implement or evaluate, and politically controversial. In addition, the senior leadership change meant that a powerful advocate for the radical reform of health systems and programmes (Mahler) no longer existed within the organisation, and politically contentious or controversial policy and programme issues were less likely to gain prominence on the agenda.

4.3.1 Progress on TRM policy & programme implementation

Despite international endorsement, various resolutions and encouragement from the WHO, member states were slow to respond to calls to integrate TRM into formal health care systems. Appropriate policies and legislation had not been developed in most countries, and practicing TRM was still illegal in some nations. Aside from notable exceptions such as India, China and Sri Lanka, TRM largely remained outside the ambit of the official health care system and beyond organisational scope. Without any legal recognition or institutional basis, formally utilising TRM in health care remained unattainable. The promise it seemed to offer in improving health care delivery remained to be realised.

Although TRM was in vogue in international circles in the 1970s, it did not necessarily receive the same priority on the agenda in many countries in the South during the 1980s. The nature of this policy issue and the nature of the WHO itself offer partial explanations to the fate of TRM on the health care agenda. Firstly, TRM and its use in formal health care systems raised a cluster of complicated issues that were not readily resolved. Although it
appeared simple in theory and was easily agreed upon; in reality it raised a variety of practical, political and economic problems which had to be addressed at the national level. For example, who and what exactly was to be integrated, where and how was this to be done, and how was it to be financed? (Heggenhougan, 1981:98; Kleinman, 1984:156; Maclean, 1986:34, 35, 36; Neumann & Lauro, 1982:1823; Wolffers, 1990:9).

Secondly, as with essential drugs and the infant formula debate, the WHO had strayed into a contentious and challenging zone that contradicted its assumed role of a purely politically neutral, technical agency. It advocated the use of TRM, but could not compel member states to act. It depended upon the goodwill of national governments and other agencies to implement its advice. In the case of TRM, the advice was murky and burdened the member states with an exceptionally difficult task. Each country has a distinctive TRM heritage, and must forge a distinctive path to utilising it in health care. Beyond the fact that political commitment and investment of resources was required (both of which appeared to be mostly absent in the majority of countries), few generalisations about integration could be drawn. There was no common language to share amongst the TRM systems. The WHO noted the unusually slow progress made on national levels, and also the need to carefully adapt such a policy to individual circumstances; backing away from any blanket endorsement or direct advocacy:

Recognition of the value of traditional medicine is still slow. The support given by governments and institutions and associations of modern medicine is not enough. Traditional medicine should not be integrated into health care systems just because it is fashionable to do so or because other countries have adopted it. It has to be integrated into a country’s health system in the light of each country’s unique circumstances. Inaugural address by Nakajima (Director of the Western Pacific Regional Office) at the Second Meeting of the Directors of Collaborating Centres (WHO, 1988:6).

Aside from paltry results on national levels (discussed in section 4.5), the WHO internal programme and policy development on TRM appeared lacklustre. The lack of progress in programme and policy development by the WHO was criticised by commentators and academics (actors in the policy stream). For example, Maclean noted that the TRM Programme Director was still calling for research and information about implementation in 1984 (1986:20). Most activity had been directed to the periphery of investigating active ingredients of herbal remedies (Maclean, 1986:30). There had been very little action in other areas. The WHO still placed most emphasis on technical, biomedical interventions and the TRM Programme was not a high priority initiative within the organisation (Singer, 1988).

It was asserted that the technical report advocating TRM (WHO, 1978b) “contains recommendations that can only be described as involving interference in the internal affairs of sovereign nations” (Velimirovic, 1990:55).
While the WHO criticised some countries for paying lip-service to the principle (Akerele, 1987:177), commentators criticised the WHO for paying lip-service as well, and considered the policy more “rhetorical than real” (van der Geest, 1985:9, 10).

The role of TRM in health care was given a significant boost later in the decade by growing environmental awareness. In 1988, an international consultation was held on the Conservation of Medicinal Plants. This was jointly sponsored by the WHO, World Conservation Union (IUCN) and World Wide Fund for Nature (WWF). This meeting brought together health professionals, scientists and conservationists for the first time in one forum (IUCN, 1993:5). They reaffirmed their commitment to “Health for All by the Year 2000” through a primary health care approach that was aligned with the principles of conservation and sustainable development, as outlined in the World Conservation Strategy. The proceedings of the conference were later published (Akerele, Heywood, & Synge, 1991) and guidelines produced (IUCN, 1993).

An official statement was released from this meeting, which became known as the Chiang Mai Declaration. This declaration stated that medicinal plants are essential in PHC both in terms of self-medication and national health services, and that the rapid loss of plant diversity was alarming. It viewed with concern the fact that many of the plant species that provided both biomedical and traditional drugs were threatened and called on the United Nations, its agencies and member states to view medicinal plants as vitally important in health care. Plant resources were considered critically important, both economically and therapeutically. All people were urged to commit themselves to Save the Plants that Save Lives (see appendix 6 for the text of the Chiang Mai Declaration; page 360).

In this way, TRM became attached to and entwined with a popular new issue on the agenda – environmental conservation. The general fear about habitat destruction was translated into a specific concern related to TRM – that medicinal plants may be eradicated, along with the indigenous cultures that carried the oral knowledge of their identification and uses. This new support for TRM promoted it on intrinsic environmental grounds. TRM systems (primary resources) were also presented as a potential “bounty” of medicinal wealth that may help the broader global community.

While the main programme attached to the TRM promotion strategy (PHC) seemed to run out of steam in the latter part of the decade, a new one developed that could be harnessed to maintain TRMs position on the agenda (environmental conservation). In addition, a new public health threat (HIV/AIDS), also presented an opportunity for TRM to keep a profile
amongst policy and programme priorities. Throughout this decade, the policy entrepreneurs and proponents of TRM responsible for guiding it through the political and economic milieu managed to skilfully attach it to emerging issues in the problem stream. Although the reception to integrating it into health care systems had been mixed at national levels, this manoeuvre managed to revive and maintain the issue of TRM on the international level. This is described below, along with specific developments throughout the decade in the related areas of WHO activities, namely: 1) traditional birth attendants, 2) resolutions and 3) programme development (a. TRM Programme, b. essential drugs scheme and c. primary health care).

4.3.1:1) Traditional birth attendants

Some TRM practitioners and practices were easier to incorporate than others, and traditional birth attendants (TBAs) (while still very heterogenous in skills and status) were cited as one example. Pillsbury notes that programmes based on TBAs were far more numerous than those using TRM practitioners more broadly, and estimates that the ratio may have been more than 20:1 (Pillsbury, 1982:1827). Green attributes the greater popularity of these programs as due to the narrow and strictly defined role of the TBA, which presented little threat to biomedical practitioner’s status and power (secondary resources) (Green, 1986:118-119). They usually received no cash payments (minimal secondary resources) and had a tightly restricted function (limited primary resources) (Green, 1988:1126). Others also observed that they acted within a small sphere of activity and their interventions were not “alien” to the biomedical profession, unlike other TRM practitioners whose primary resources are perceived as distinctly foreign and difficult to comprehend (Neumann & Lauro, 1982:1820; Pillsbury, 1982:1827).43

However, even the acceptance of TBAs was not universal. Velmirovic reports that some governments rejected the plan altogether as they did not wish to encourage any kind of traditional health practitioner (1982:25). Some critics felt such programmes were simply diversionary tactics, adopted by countries that lacked the “political power or will” to more radically reorganize their health systems (Velimirovic, 1982:25). Using TBAs implemented the directives made in resolutions and the Alma Ata declaration (to use local resources including TRM), but it was the least controversial and easiest to formalise. Nevertheless, even where small projects were implemented using TBAs, they usually did not lead to their

43 The relatively neutral status of TBAs in health systems (as opposed to other types of TRM practitioners) is illustrated by an example from Nigeria – Yoruba herbalists and healers participating in training schemes for family planning were identified as TBAs rather than TRM healers (Green, 1988:1128).
formal incorporation into health care systems. For example, out of 44 countries where projects training TBAs had been implemented, less than half of those went on to use them in family planning programmes or health care delivery (Pillsbury, 1982:1828).

In 1986, the WHO commissioned a report on *The potential of the traditional birth attendant* (Mangay Maglacas & Simons, 1986). The title indicated the formal use of TBAs in health services was still considered only a latent possibility. This report defined TBAs as a health manpower resource, and reiterated the sentiment that TBAs “constitute an important resource that could be mobilized to help achieve the social goal of health for all” (1986:6, emphasis added). It consisted of evaluations of trained TBAs, and the implementation of various programmes. The report found various constraints on utilising TBAs (such as illiteracy and supervision), and that outcomes and impacts of such schemes were unclear and difficult to quantify (for example, whether the incidence of neonatal tetanus was reduced) (Mangay Maglacas & Simons, 1986:18).

This overview found that it was still rare for TBAs to be included as an integral part of a health strategy, even in those countries where they attended the majority of births. The reasons offered for this included the logistical difficulty of mounting large scale programs for training; fragile infrastructures; and high recurrent costs which strained scarce resources - especially in times of global recession (Mangay Maglacas & Simons, 1986:6). The authors concluded that using TBAs as a health resource was most difficult to implement in just those countries where it would offer the most advantages. There was also evidence in some countries of conflict over responsibilities (primary and secondary resources) between TBAs and biomedical practitioners.

For example, in Malaysia, activities had to be strictly demarcated, with TBAs performing more social/support functions while biomedical practitioners undertook the more technical procedures such as cutting the umbilical cord (Mangay Maglacas & Simons, 1986:100). In Ghana, some TBAs requested salaries (increased secondary resources) after training, and they were encouraged to increase their fees instead (Neumann & Lauro, 1982:1822). In Zambia, trained TBAs were sometimes refused payment as clients assumed they were now part of the formal health care service and were renumerated by the government (Mangay Maglacas & Simons, 1986:96). The training of TBAs therefore blurred the boundaries between the formal and informal health care systems and presented issues regarding allocation of both primary and secondary resources.
Training TBAs was considered an intermediary step in replacing them with a type of paramedical auxiliary to perform maternal and child health care duties. This implicit objective was articulated by Bannerman, the Director of the WHO Traditional Medicine Programme: “Ideally, traditional midwives should be phased out of service by fully trained professional midwives working in close collaboration with obstetricians, but owing to several socio-cultural and economic factors, any such hope will remain futile for many decades” (Bannerman, 1982:13). Clearly, TBAs were still generally considered inferior substitutes for biomedically trained midwives, and their use only transitional (Velimirovic, 1982:25). The inferior status of TBAs was reflected in this imposed label (“attendant” or “auxiliary”); a categorization rejected by a Kenyan representative as derogatory and inappropriate (WHO, 1990c:41).

4.3.1:2) Resolutions

Several resolutions in relation to traditional medicine were made in the 1980s. In 1988 a specific resolution was made regarding conservation of medicinal plants. In 1987 and 1989, the World Health Assembly passed resolutions which reaffirmed the previous resolutions on TRM and urged member states to intensify activities. Both of these restated the original requests made in previous resolutions throughout the 1970s. They reflect the lack of progress made on national levels, as well as insufficient funds allocated by countries, agencies and the WHO itself to adequately implement the resolutions that had been agreed to in principle by all member States. A decade after the original resolutions requesting member states to incorporate TRM systems into health care delivery, the same resolutions were being made. Little had been done in that time beyond the rhetoric of asserting their value and asking for official support.

The resolutions of the 1980s were less ambiguous than those passed in the 1970s. Pillsbury argues that the qualified wording and cautious endorsements of the previous decade’s resolutions was one of the reasons for lack of national policy activity in the 1980s. For example, the resolutions were heavily qualified with terms such as “as or where applicable”, “as needed”, or “where appropriate”. These qualifiers were necessary to reach World Health Assembly agreement and allowed considerable liberty in interpretation. It also meant that at the implementation phase TRM could be overlooked unless planners and administrators felt otherwise inclined (Pillsbury, 1982:1826). In contrast, the resolutions made in the 1980s lacked qualifiers and were more direct in their requests to member states.
4.3.1:2a) Resolution WHA29.72 (1987)

This resolution restated the important role that TRM systems play in health care and noted that “there exists a vast reservoir of practitioners of traditional systems of medicine and an almost untapped wealth of medicinal flora”. It encouraged member states to make optimal use of TRM practitioners and remedies, and to develop programmes to cultivate and conserve medicinal plants. The Director-General was also requested to mobilise extra-budgetary funds to assist in the implementation of these activities, and inter-country seminars were encouraged.

4.3.1:2b) Resolution WHA41.19 (1988)

In 1988, resolution WHA41.19 was passed which almost duplicated the Chiang Mai Declaration (see appendix 6; page 360). This resolution made specific reference to that Declaration, and called on member states to take measures to conserve their medicinal plants and encourage sustainable utilisation. Underlying these calls to preserve and make inventories of plants was the fear that rapid habitat destruction may cause the extinction of medicinal plants (primary resources) before they had been assessed for potential biomedical application. Ironically, the continuing global diffusion of biomedicine was displacing the very traditions that may be sources of immeasurable medical and health wisdom (Zielinski Gutierrez & Kendall, 2000:95).

4.3.1:2c) Resolution WHA42.43 (1989)

The resolution of 1989 again reiterated the previous resolutions of the 1970s and 1980s and called for a substantial increase in funding if any progress was to be made. It called on the TRM programme to be strengthened and requested member states to evaluate their TRM systems; make inventories and assessments of their medicinal plants; explore methods for incorporating TRM practitioners into the extension of PHC; and collaborate in the scientific appraisal of TRM treatments and their application in biomedical health care systems. The resolution was premised on the awareness that “plants used in traditional medicine hold great but still largely unexplored potential for the development of new drugs against major diseases for which effective treatment is not yet available” (WHA42.43). It was clear that the primary resource base of TRM was viewed only as offering potential supplementation to the biomedical pharmaceutical armoury.
The resolutions of the 1980s appealed to biomedical professional interests – TRM may offer remedies that can be used in the biomedical primary resource base (new drugs), providing greater secondary resources (economic benefits, status in treating previously incurable diseases). Farnsworth and Soejarto (1985) exemplified this stance by estimating the value of a single plant species, should it become extinct, with respect to its potential for drug use. They calculated the value of a single species of plant to be US$203 million, and the total value of plant species that may become extinct by the year 2000 at US$3.248 billion (1985:231). The value of medicinal plants was thus presented in economic terms (secondary resources) and as a potential loss to the biomedical community, as well as threatening the future availability of prescription drugs (biomedical primary resources). It was an economic rationalist perspective on plants and herbs, and completely compatible with the broader neo-liberal health care policy environment and dominant biomedical paradigm.

These resolutions also reflected new trends on the agenda – conservation, sustainable use of resources and environmental awareness. The problem that the policy of using TRM was meant to address was being reframed; from a specific concern with the development of low-cost health services evident in the 1970s to an additional problem of conservation of medicinal plants. The cultivation and cataloguing of medicinal plants was therefore intended to aid their conservation, especially in light of the fact that they may offer sources of drugs for the North and not simply as a cost effective form of health care for the South. The policy on using TRM was evolving in light of the broader context, and maintaining a place on the agenda by attaching itself to current concerns as well as appealing to a wider range of interests. This strategy of maintaining a place on the policy agenda in the face of competing priorities and scarce resources was also clearly articulated and advocated by Akerele, TRM Programme Director.

44 Farnsworth was the Director (and Soejarto an employee) of one of the WHO Collaborating Centres in TRM; at the College of Pharmacy in the University of Chicago. This collaborating centre oversaw the development and maintenance of NAPRALERT – a database on the chemistry and pharmacology of natural products, citations and review articles. Information from this service was provided on a fee-for-service basis. NAPRALERT was considered one of the main activities of the WHO TRM programme (Akerele, 1984:79; Farnsworth, 1983).

45 “Pragmatism should be encouraged and opportunities for linkages with other interests must be seized. Where agriculture and forestry departments are developing national resource maps, medicinal plants can be added to them. Where universities and research and development institutions are involved in the study of the environment and ecology, a place can be found for medicinal plants … Where emphasis is placed on the development of small local industries, the industrial potential of medicinal plants can be given priority. Where ministries of education are seeking innovative approaches for teaching natural sciences or for promoting knowledge of traditional values, the use of local medicinal plants can be incorporated into school curricula” (Akerele, 1988:358).
4.3.1:3) Programme development and promotion

Throughout the decade, the three main programmes associated with TRM varied in their progress. The TRM Programme, which was dedicated to promoting and co-ordinating the role of TRM in health care systems, suffered from lack of funds and poor organisation. The essential drugs and primary health care programmes also ran into difficulties exacerbated by adverse political and economic realities. Mahler was fighting bigger battles in protecting the higher profile primary health care and essential drugs schemes, amongst other contentious issues such as breast milk substitutes (Godlee, 1994a; Walt, 1993).

The two main activities related to TRM in headquarters were the publication of a book on traditional medicine and health care coverage, co-edited by the Director of the TRM Programme (Bannerman, Burton, & Wen-Chieh, 1983) and an international consultation on approaches for policy development for TRM practitioners, held in India (WHO, 1985). Activity at the regional levels continued with seminars, workshops and conferences; although the level of interest and output varied geographically.

The Western Pacific Region (of which China is a member) was particularly dynamic; organising a working group on the integration of TRM in PHC in 1983, and conducting workshops on the same issue in Fiji, Papua New Guinea, the Republic of Korea and Vietnam in 1984 and 1985. In 1986, a meeting was held in Tokyo to discuss herbal medicine research, and a workshop on training in TRM was held in Manila. Meetings were also held on standardising acupuncture nomenclature (Manila-1982, Tokyo-1984, Hong Kong-1985 and Seoul-1987). Publications on standard acupuncture nomenclature (WHO, 1984), and medicinal plants used in China and Vietnam (WHO, 1989a, 1990a) were produced by this regional office. The prodigious activity of the Western Pacific regional office may have been why it was the only region selected to present a report to the meeting of the Directors of the Collaborating Centres on Traditional Medicine (WHO, 1988:39-43).

4.3.1:3a) Traditional Medicine Programme

In the early 1980s, Bannerman was replaced as Programme Director with Akerele, a biomedical doctor from Zimbabwe. This was considered an opportune time by Akerele to “stand back and evaluate [it]” as the programme was at “an historical crossroads” (Akerele, 1983). The endorsement by WHO of TRM had encouraged and stimulated interest and 

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46 The report of this consultation was published the same year, but a copy cannot be located.
awareness, and the WHO now needed to more clearly define its role and intentions. According to Akerele, the WHO could become a passive observer and reporter of developments or take a more vital leadership function. He considered the latter course of action preferable, but by the end of the decade the former role seemed to have been assumed. In the early 1980s, the programme had “stalled” and by 1988, it was described as an “operational failure” (Singer, 1988:9).

Regarding the need to more strictly define and delineate the scope of the Programme, Akerele made reference to the fundamental problem mentioned in the 1978 technical report – that of integrating aspects of TRM relating to spiritual, moral or supernatural principles (Akerele, 1983). While rational-legal frameworks can reasonably regulate the herbal dimension of TRM, aspects related to ritual or magico-religious beliefs represent more challenging problems (Green, 1986:118). For example, sorcery, fetishism, divination, or psychic powers are deemed superstition, delusion or fantasy and therefore beyond the scope of rational institutional activity. Bibeau (1982; 1985) explored this dilemma in relation to institutionalising TRM in Africa. He concluded that “…Western legal codes are unable … to assume and incorporate the African etiological systems and ritual therapy which expresses them” (Bibeau, 1982:1846).

Bibeau (1982; 1985) argued that magico-religious beliefs were essential concepts underlying African TRM systems, which could not be simply hived off to accommodate TRM in legal frameworks. However, in viewing TRM as analogous to biomedicine in order to translate it to modern legal codes, certain fundamental aspects about the nature and functioning of TRM have to be disregarded. This position seemed to be the one adopted by the WHO Programme, in order to limit the field of activities and also avoid controversy. The main focus of the WHO regarding TRM was its use in PHC, specifically as inexpensive providers of basic health services (manpower) and also as a possible source of inexpensive drugs. The TRM Programme therefore concentrated on cataloguing, standardising (names, dosages), and evaluating medicinal plants and training TRM practitioners in aspects of PHC (Bannerman, 1977, 1983; WHO, 1991e:2).

Studying herbs is easier as they are “tangible, visible, measurable and manageable” unlike spiritual or psychotherapeutic dimensions (Maclean, 1986:32). Similarly, projects utilising TRM practitioners (apart from TBAs) focused on herbalists and related specialists such as

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47 A strong tendency to secularise medical resources and constrict magico-religious aspects is associated with modernisation (Unschuld, 1975:306).
compounders, and excluded religious, shamanistic or spiritual healers (Pillsbury, 1982:1828). Coreil believes that conflicts about medical authority and power (secondary resources) generated the reluctance of the biomedical establishment to give official recognition to traditional healers, especially those of the magico-religious type (Coreil, 1990:19). Ignoring and excluding this dimension of TRM by the WHO was illustrated in a discussion on the application of TRM to PHC, when Akerele stated in response to mention of psychic and spiritual healers and faith healing:

The kind of objective and scientific approach to traditional medicine that WHO advocates has, of course, nothing to do with the occult, nothing to do with witchcraft, but aims at the critical examination by modern methods of knowledge handed down to us by the past (WHO, 1986a:62) … Being compelled to limit the field of activity, we have decided to concentrate on the study and application of those aspects of the subject that can be explained at the present time. And so, there is much that must be left for another day (WHO, 1986a:66).

Later, Akerele more explicitly excluded healers using supernatural or spiritual techniques as “their methods and beliefs are so diverse as to preclude their incorporation in any formal system” (Akerele, 1986:9). The foundation of the TRM Programme reveals that modern rational-legal frameworks (within which policy and programmes must be structured) were unable to absorb specific dimensions of TRM systems. As Unshuld (1976b) identified, medical systems have four dimensions (drugs, techniques, manpower and concepts), which could be structured to co-exist with each other, in order of increasing difficulty.

Of these dimensions, not all are easily or readily reconciled. They offer opportunities for cooperation in order of increasing difficulty, with “drugs” being easiest to assimilate and “concepts” the hardest. This difficulty, and the resulting varied acceptance of certain dimensions between medical systems, seems apparent in the scope of WHO Programme activities. While drugs (herbal remedies), techniques (acupuncture, moxibustion, yoga), and manpower (TBAs, herbalists) were dimensions that were readily accepted as offering potential to health care; concepts based on spiritual, supernatural, or ritual belief systems were disregarded.

Therefore, the effort of the WHO was focussed on therapeutic properties of medicinal plants, translating TRM drugs and techniques into biomedical diagnostic and therapeutic frameworks, and training TRM manpower in basic biomedical theory and practice. The main activity of the WHO TRM Programme was a database on the chemistry and pharmacology of natural products, citations and review articles (Akerele, 1984:79; Farnsworth, 1983). This focus also may have been due to the adoption of the Chinese methods of integration, which
strongly emphasised scientific validation of herbal remedies and basic training of manpower. In addition, the magico-religious aspects of TRM were suppressed and shamans, diviners and spiritual healers were explicitly forbidden (Pearce, 1986:240; Pillsbury, 1982:1827; van der Geest, 1985:11). It seemed apparent that concepts underlying TRM systems proved the most difficult to accommodate in formal health care systems, as Unschuld (1976b) claims.

From a technical biomedical perspective (as espoused by the WHO), physical resources were fully exploitable, while the ideologies/philosophies (concepts) underlying their use within TRM systems were dispensable. This trend was also evident in broader literature and research undertaken in TRM. For example, Pederson and Baruffati (1985) analysed references and bibliographies in relation to TRM from Latin America and the Caribbean. Studies related to medicinal plants constituted about a third of all references. This biochemical approach focussed on botanical information and “verifiable” pharmacological properties – data was extracted and handled in a positivist manner. The second major identified trend was the application of “scientificism” where TRM practices were interpreted from the biological and psychological perspective of biomedicine (Pedersen & Baruffati, 1985:8-9).

This research approach was obvious in the activities of the Collaborating Centres, an essential component of the TRM Programme. The first Centre had been designated in Italy in 1979 and by 1981 there were 10 Centres operating, with the first meeting of their Directors held that year in Geneva. The report of that meeting was unpublished. The second meeting of the Directors of the WHO Collaborating Centres for Traditional Medicine was held in Beijing in 1987. By that stage, 21 Collaborating Centres were designated and four more were proposed. One third of the collaborating centres were in China.

Between the first meeting of the Directors of Collaborating Centres in 1981 and the second in 1987, the WHO underwent a major reorientation that affected the Traditional Medicine Programme (WHO, 1988:6, 9). Although it was not specified what this reorientation involved, a main issue appeared to be budgetary restrictions. The report of the second meeting provided insights into the TRM Programme, and hinted at structural and operational difficulties relating to financing and co-ordination. The report gave an overview of the activities of the Collaborating Centres, and it was noted that they lacked cohesion and a common purpose (WHO, 1988:5). It was also acknowledged that the programme had been “held back” due to a lack of adequate financial support, and assistance from external funds would be required (WHO, 1988:7). Completion of the Programmes activities were dependant
upon funding being obtained from other sources, and the limited resources available from the regular budget were to be used only in a “catalytic way” (WHO, 1988:37).

The financial constraints of the Programme were evident in the attendance at the meeting. It had been proposed initially that meetings of the Directors be held every two years. However, the second meeting was held six years later and all Directors could not attend due to cost. The Director-General of WHO had approved this meeting with the proviso that regional offices cover the costs involved. As a consequence, participation was restricted (WHO, 1988:8). This infrequent contact between Directors may have contributed to the lack of cohesion between various activities of the Centres.

The lack of unity of purpose was reflected in the terms of reference for the Centres, and their divergence from the TRM Programme objectives and priorities. Although many of the Collaborating Centres were designated before the Programme had specified a schedule of activities and working agenda (WHO, 1988:9), the main aims of the TRM Programme were clear from inception. Despite that, many of the Collaborating Centres terms of reference lacked essential elements of the Programme rationale (WHO, 1988:12). For example, none of the Centres included tasks on policies and legislation related to TRM or activities regarding supervision, regulation and implementation. Only 8 of the centres included health systems and operational research (WHO, 1988:10). Exchange of information, which was a main intention in the establishment of the Centres, was only mentioned in 7 terms of reference. Clinical and scientific investigations received the most emphasis (WHO, 1988:11).

Reporting of their activities also seemed to present some difficulties. Around a third of the Centres had not provided annual reports for their activities of the year before, and those that had sometimes provided unnecessary or unusable material. The reports were not used as a medium of communication, and were not even distributed between the Centres (WHO, 1988:14). The need for a common frame of reference to guide all activities, directly related to the Programmes objectives, led to the meeting discussing and agreeing on a medium term programme of work. The report was supplemented with an appendix detailing the global medium term programme of traditional medicine (WHO, 1988:29-38).

This programme proposed activities for 1990-1995, and detailed the current status of the TRM Programme. Considering the resource constraints, the proposed activities of the Programme were ambitious. They involved expanding the network of Collaborating Centres, increasing training for both TRM and biomedical practitioners and incorporating useful TRM
practices into health care delivery systems. Evaluating progress on national levels was to be restricted to a set of “indicator countries” rather than asking each country and their “over-worked health administrators to report periodically” (WHO, 1988:37). These countries were basically self-selected, as the nominated group were those that had voluntarily participated in the inter-regional seminar on the role of TRM in PHC in China (WHO, 1986a). This may have been an administrative acknowledgement that interest on national levels was variable, and countries could not be requested to participate and report on what was essentially an optional exercise.

This illustrates that the problem stream on an international level (which identified health systems development in the South as a crucial issue and the development of TRM as a potential means to strengthen this) did not necessarily match the problem stream on national levels. Domestic agendas were faced with myriad and varied economic and social problems jostling for a place on the political agenda; and even where health systems were identified as problems, the solutions pulled out of the policy stream may not be to use TRM. What was agreed on internationally was the product of independent problem, politics and policy streams, which may or may not correspond with the agendas developed on national levels.

While the proponents of TRM could use the WHO endorsement of TRM as leverage on national levels, they were operating in diverse contexts with localised politics, problems and policy streams to contend with. Pushing TRM onto the local agenda therefore required the coupling of those streams nationally; the development of fertile ground and a window of opportunity opening. While this had occurred internationally in the 1970s on the agenda of the WHO, it now needed to reoccur in national governments to receive individual political endorsement under extremely different contexts and constraints.

While the TRM Programme appeared to be beset with difficulties relating to financing and visibility, in the late 1980s a new objective was identified when it was realised that the Programme may have a role to play in HIV/AIDS prevention and control. The two main areas identified were using traditional medical practitioners for health education, counselling and support; and investigating traditional remedies for anti-viral or immunity enhancing properties (WHO, 1988:33). A new health issue had arisen in the problem stream – one that biomedical primary resources were finding difficult to combat. Fragile biomedical infrastructures in developing countries threatened to be engulfed with the consequences of the AIDS epidemic. In addition, many people with AIDS were seeking out and using TRM remedies in a quest to treat the condition.
Therefore the policy of officially incorporating TRM into health care was given an additional problem to enhance and maintain its profile on the agenda – preventing and/or treating HIV/AIDS. This situation bore a resemblance to the mission of the previous decade, that of fertility regulation and family planning. In both cases, seemingly insurmountable problems with grave economic and social consequences (which biomedical resources alone could not adequately tackle), were attached to the TRM agenda. Both health issues required education and counselling efforts, as well as affordable and accessible drugs that may potentially be yielded from the plant kingdom – using ethnomedical knowledge to guide selection and evaluation.\(^48\)

By the end of the decade, HIV/AIDS had become a major agenda item and was absorbing increasing funding in efforts to combat it. Several consultations were held in the latter part of the decade on AIDS and the use of TRM. The TRM Programme aligned itself with the Global Programme on AIDS, a high profile and well funded project. They jointly hosted a conference in Botswana on using TRM practitioners in AIDS education and prevention programmes (WHO, 1990c). In addition two consultations were held on clinical evaluations of TRM remedies for anti-HIV activities (WHO, 1989b, 1990b).

The report of the consultation on using TRM practitioners in AIDS programmes contained country profiles from 8 African countries, which provided a description of current government policy and practice regarding TRM (WHO, 1990c:31-47). These status reports reveal the gap between the internationally endorsed concept of using TRM in health care systems, and the context on national levels. For example, in Cameroon, practising TRM was still illegal although practitioners were forming professional associations to lobby the government (WHO, 1990c:33). In Ethiopia, clinical toxicity testing on TRM remedies had to be abandoned because a TRM practitioner would not allow anything to be done to remedies out of his sight; and an agreement between TRM practitioners and a research committee was automatically rejected by some as they would have to disclose the contents of their remedies (WHO, 1990c:37). Secrecy was a technique employed by TRM practitioners to guard access to their primary resources, and the secondary resource benefits that flowed from that exclusive control.

\(^{48}\) Another example of resorting to TRM to address a major health issue not effectively treated by biomedicine is that of cancer. Between 1956-1981, 32,000 species of flowering plants were randomly collected and tested for anti-tumour activity by the US government. Although millions of dollars were spent, none were pursued further and the low yield was potentially attributed to a lack of regard to TRM information. A European pharmaceutical company later developed a product based on information derived from this project (about the American Indians use of a specific plant for treating skin cancer). This programme was later revived and botanists instructed to use ethnomedical information to guide their selection (Bannerman, 1982:12; WHO, 1989b:5).
The advent of the AIDS epidemic provided an impetus to collaborative biomedical-TRM efforts, and a renewal of support for its use in PHC as it refocused interest on treatment and prevention of communicable diseases at the community level. However, the consultation on using TRM practitioners in HIV/AIDS prevention and treatment (WHO, 1990c) exposed deficiencies on national levels to implementing such programs including legal, conceptual and financial barriers. The review of the situation in various countries also revealed the marked divergences in approaches and progress made between countries – often related to political, cultural and economic factors. The implementation of TRM programs and policy on national levels is detailed in section 4.5.

4.3.1.3b) Essential Drugs Scheme

The concept of essential drugs eventually fared more favourably as a WHO policy objective despite strong initial resistance from biomedical interest groups and variable success in implementation. The scheme expanded in scope throughout the decade. An Action Programme on Essential Drugs was established in 1981 (known as the Drug Action Programme, or DAP) and the focus moved from the selection, to the use of essential drugs and national drug policies more broadly (Reich, 1987:43). This shift in emphasis may have helped it achieve greater acceptance to an initially hostile biomedical coalition, particularly the powerful and vocal pharmaceutical lobby (Chowdary, 1995; Kanji et al., 1992).

In contrast to the TRM Programme, the Drug Action Programme almost doubled in size in terms of staff and budget between 1982 and 1987 and by the middle of the decade over 80 countries had adopted the model (Reich, 1987:44). The very features of the global environment that retarded the expansion and adoption of TRM (such as economic recession and the debt crisis which put extreme pressure on health budgets) were conducive to cost-effective measures such as those promoted by the essential drugs scheme (Reich, 1987:47-48).

Mahler strongly advocated the concept and brought the programme directly into his own office in 1983, giving it a higher profile and symbolic support (Walt & Harnmeijer, 1992:45). In 1985, partly in response to the essential drugs scheme, the United States withheld contributions to the regular budget – the US was the home to 11 of the 18 largest drug companies (Godlee, 1994a). This powerful lobby group strongly resisted the notion of essential drugs primarily because it greatly reduced and restricted the number of drugs that would be sold in the market. The concept reduced exorbitant cost burdens for
pharmaceuticals in developing countries but restricted profit making opportunities (secondary resources):

An innovative minority conceives of the world’s technology, raises most of the world’s food and produces most of the world’s goods. This minority is being challenged by a hostile majority … For this year and next, 70% of WHO’s budget will be paid for by 13 industrialized countries. Certainly this entitles the industrialized world to stand up to WHO. We must have the will to do so (in Lee, 1997:43).

While the essential drugs scheme ran into its own problems and difficulties in implementation (Chowdary, 1995; Kanji et al., 1992), in relation to the TRM programme its direct linkage became weak. Their relationship was perhaps overshadowed by the controversies essential drugs became embroiled in, and the necessity of the WHO to strongly push for its adoption. The policy of essential drugs absorbed greater organisational resources and political energy. TRM and its relationship to essential drugs, in terms of producing cheap alternatives to pharmaceuticals or reducing dependency on biomedical drugs, were not strongly advocated in the WHO despite recognising that it may be a cost effective solution:

The economic crises that many developing countries are facing today may well lead to severe shortages of certain modern drugs and products at the periphery, thereby forcing more people to make use of traditional medicine, whether this is government policy or not (Akerele in WHO, 1986a:75).

The relationship between TRM and essential drugs was not explicitly mentioned in the policy documents prepared by the WHO throughout the decade, even though the use of TRM for essential drugs was an original goal in the selection of essential drugs (WHO, 1977:18). It was only indirectly hinted at, and the main focus of TRM usage was in the PHC sphere. This was regardless of the realities acknowledged that importing all required pharmaceuticals was beyond the capacity of impoverished nations and that most lacked the industry to produce essential drugs domestically. This potential for self reliance in production, and tapping of the resources of TRM for essential drugs was a clear threat to the biomedical coalition as it reduced the reliance on commercially produced drugs. By the end of the decade, the need to produce such drugs locally and use traditional knowledge was reiterated not simply as a cost saving measure but as one of cultural sensitivity:

However, medicinal plants should not be valued solely because of the possibility that they offer for import substitution, but because traditional medicine is an avenue for greater self-reliance, based on appropriate technology in accordance with a country’s cultural heritage and national resources (WHO, 1991e:3).

As the essential drugs programme failed to adequately deliver required pharmaceuticals at low cost on national levels (see Vogel & Stephens, 1989), TRM filled the gap in sometimes
inventive ways. Counterfeit biomedical drugs were being produced in some countries by TRM practitioners keen to take advantage of loopholes in existing legislation and to meet market demand that existing supplies were not satisfying (Chowdary, 1995:85). Therefore, TRM practitioners were seizing the opportunity to access biomedical secondary resources (economic benefits) through substitute primary resources (drugs), that the essential drugs approach had failed to produce on national levels.

4.3.1:3c) Primary Health Care

The fate of the primary health care (PHC) approach inspired much debate and interest, which has been well documented (Gish, 1979, 1982; Heggenhougan, 1984; Macdonald, 1992; Mull, 1990; Newell, 1988; Rifkin & Walt, 1986; van der Geest, Speckmann, & Streefland, 1990). The debate about the concept and implementation of PHC commenced almost as soon as the Alma Ata Declaration endorsing it had been signed. Walsh and Warren (1980) are usually credited with the origination of what Newell (1988) termed a “counter revolution”– selective primary health care rather than comprehensive primary health care. This approach undermined the concept as promoted at Alma Ata, and was accepted widely as a more realistic and practical way to implement PHC.

Briefly, Walsh and Warren argued that comprehensive PHC as advocated was not attainable, and should be replaced instead with targeted interventions. They proposed that fiscal realities required the establishment of a list of priorities – “…a selective attack on the most severe health problems … directed at preventing or treating those few diseases responsible for the greatest mortality …” (1980:145). This rationale was adopted by many agencies responsible for implementing PHC, such as UNICEF. This agency identified several main priorities, codified as GOBI-FF – an acronym for growth monitoring, oral rehydration, breastfeeding, immunization, family planning, food supplements (with female literacy occasionally being listed as a third “F”) (Mull, 1990:33-35). Often, the focus was limited to simply GOBI. These initiatives were considered to be of precedence, and became the focal point of activity.

The selective approach of isolating particular health issues and designing programmes to specifically combat them continued the “vertical intervention” paradigm that had already proven a failure with conditions such as malaria. Advocates of comprehensive PHC considered selective PHC initiatives such as GOBI to be the very antithesis of what PHC was, and a regression to the types of programmes that it was designed to replace (Newell, 1988:904; Walt, 1993:137). For example, while comprehensive PHC advocated a decentralised, horizontal organisational structure; selective PHC replicated a hierarchical
vertical management. The programmes were run as separate projects, with their own staff, facilities, logos and accounting systems (Walt, 2001:682). This approach appealed to bodies responsible for implementation as it confined and strictly defined areas of activity; did not require radical reorganisation of health care systems; absorbed designated amounts of resources and was easier to evaluate and monitor.

The adoption by UNICEF of selective PHC put it at odds with the WHO. Both international health bodies were co-sponsors of the Alma Ata Declaration, and had agreed in principle with the concepts endorsed. However, in implementation, UNICEF diverged markedly in interpretation and application of the PHC approach. Mahler, the Director-General of the WHO, expressed disappointment and frustration that a preventative, multi-sectoral approach had been abandoned in favour of limited and selective interventions (Walt, 1993:137; Walt, 2001:682).

However, some considered that PHC as articulated could never be successfully implemented, as it lacked a clear strategy, there was confusion about its meaning and it could be interpreted differently by various actors in the health sector and political hierarchy (van der Geest, Speckmann, & Streefland, 1990:1025; Wolffers, 1990). Wolffers alluded to PHC as “like an elephant described by blind people. Each person interprets only one of its features” (1990:5). The very flexibility and abstraction of the PHC definition that had allowed it to achieve international consensus was its downfall in application on national levels. Using volunteer community health workers to support PHC was also considered unfeasible without specific enabling conditions (Walt, Perera, & Heggenhougan, 1989).

In the late 1980s, the focus shifted from PHC and how to implement it to the financing of health systems generally (Walt, 2001:684). Thus, the idealistic notions espoused by PHC were buried under more pressing concerns of cost effectiveness and efficiency of services already established. As PHC lost support amidst the realities of implementation, the main vehicle for promoting the use of TRM was also derailed. PHC and Health For All seemed optimistic ideals, which needed to be replaced with simpler and more manageable technical solutions that did not require radical reorganisation or socio-political reorientation. The search for such solutions was the basis for much of the utilisation of social sciences in international health throughout the decade (Coreil, 1990:12; Gish, 1982; Rifkin & Walt, 1986; Walt & Gilson, 1994).

49 The same context was favourable to technical, vertical, disease specific interventions that clearly established their cost effectiveness and efficiency to be promoted (such as tuberculosis programmes) (Ogden, Walt, & Lush, 2003).
The implementation of comprehensive PHC clearly encountered setbacks and obstacles, but using TRM practitioners in PHC remained an Organisational goal. Bannerman, who was the Director of the WHO Traditional Medicine Programme until the early 1980s, argued that as TRM remained the only source of care for many people it was synonymous with PHC (Bannerman, 1982:8; Bannerman, 1983; Maclean & Bannerman, 1982). Bannerman was one of the strongest proponents of this concept (Maclean, 1986:7), and under his leadership the emphasis was placed on integration at the PHC level. For example, at the first meeting of the Directors of TRM Collaborating Centres in 1981, it was recommended that efforts in research be directed to the transfer of results to PHC (WHO, 1988:8); which was re-endorsed at the second meeting in 1987. This primary objective of applying TRM to PHC was also clearly stated in the Programmes statement of activities: “In dealing with traditional medicine, WHO aims at exploiting those aspects of it that provide safe and effective remedies for use in primary health care” (WHO, 1988:30); a sentiment echoed by Bannerman’s successor, who also described PHC as a “natural expression” of TRM (Akerele, 1988:357).

Some observers noted ambivalence and a contradictory stance in WHO documents about the role of TRM published during the decade; and a “sober, more realistic tone” (Velimirovic, 1984b:75). For example, guidelines produced on training PHC workers in 1980 were not supportive of the concept of using TRM, whereas a reader for health practitioners and administrators in 1983 was (Wolffers, 1990). A revised and enlarged edition of the health workers training manual made no reference to TRM at all (WHO, 1987). Documents on strategies to achieve Health For All by the Year 2000 published in 1981 and 1983 barely mentioned TRM and did not refer to integration (Velimirovic, 1984b). However, there had been a policy commitment made to TRM via the resolutions and the TRM programme, even though internal and external pressures may have led to a reduced emphasis compared to the 1970s.

In 1985, the WHO sponsored a seminar in China on their experience of using TRM in PHC (WHO, 1986a). This followed a study commissioned to explore PHC in China more broadly (WHO, 1983). The main objective of the seminar was to assess their use of TRM and to

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50 This ambivalence extended to some programmes. When the Oral Rehydration Programme (ORT) failed in Mozambique, children continued to die from diarrhoea except in the areas where women resorted to TRM. The WHO prevented expansion or encouragement of that, as it promoted the use of home based remedies rather than packaged biomedical ones (Werner & Sanders, 1997:135, 137). The ORT story is another one of stakeholder interests distorting service delivery, and attempting to maintain biomedical authority and control in an aspect of health care that could be devolved.
consider whether this approach could be adopted by participating countries (WHO, 1986a:4). Country reports from participants (WHO, 1986a:54-57) and the round-table discussion (WHO, 1986a:58-66) again revealed divergences between internationally endorsed initiatives and the practical realities on national levels. In Egypt, Sudan, Fiji, Papua New Guinea, and the Solomon Islands TRM remained officially unrecognised, and very few countries had undertaken any formal evaluations of its usage or scope.

The lack of a scientific basis was considered to contribute to its rejection by biomedical doctors. This meant that TRM systems could not speak the language of biomedicine, and gain the status and respect (secondary resources) accorded to “scientific” disciplines. Even in those countries with political support for the concept, there was confusion as to how to implement it and statements of intent rather than reports of progress (WHO, 1986a). Therefore, even where the problem and politics streams had merged on national levels (political recognition that TRM may address health system deficiencies) there was vagueness in policy development in terms of specific solutions and how to implement them.

The costs associated with this process were also a factor, with the Philippines cautious of the direction to take in committing funds and Kuwait conceding that funds were not available to introduce TRM practices into their health care system. In Bangladesh, it was reported that biomedicine holds “pride of place” and although recommendations to integrate TRM into PHC had been made since 1980, nothing had been done by 1985. This lack of activity was attributed to resistance by the biomedical profession (WHO, 1986a:64).

Akerele, chairing this discussion, acknowledged that “Conflicts between the Western-trained doctor and the traditional practitioner are bound to occur, in any society, but [Vietnam] looks to science to resolve this problem. Let us use science wisely to test the values of the past.” (WHO, 1986a:64). This moderating role accorded to science as a neutral arbiter and universal yardstick ignored inherent limitations and prejudices of the biomedical model. Even in China, which had pioneered the modernisation of TRM through the application of scientific methods, the limitations of science as a definitive authority were recognised:

> Our aim is to bring our traditional materia medica into the twentieth century, to evaluate it by modern methods and standards, to select what seems useful and to discard what does not. However, in doing so, we adopt a prudent policy because of the limitations of current science and technology (WHO, 1986a:44, emphasis added).

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51 This belief that not adopting scientific jargon had created misunderstandings and made genuine dialogue difficult was shared by other commentators (Said, 1982:21).
Two further consultations were held on TRM and PHC, specifically regarding the use of herbal remedies and medicinal plants. These meetings were jointly sponsored by the Danish International Development Agency, and held in Asia in 1985 (WHO, 1986b) and Africa in 1989 (WHO, 1991e). Their main purpose was to address issues of safety and efficacy in the use of TRM in PHC. A process for testing for safety and efficacy prior to introduction into PHC programmes was developed and adopted; and a standardised reporting of medicinal plants (herbal formulary) agreed. What was intended to be a low-tech, resource conserving solution to health system problems in the South was being implemented through a high-tech, resource intensive gate-keeping procedure.

It was made clear that testing for safety and efficacy was crucial, and only selected elements of TRM pharmacopoeia were to be incorporated into officially endorsed health programmes. All of the participants at these meetings were involved in clinical and scientific testing of traditional remedies (WHO, 1986b:ii; WHO, 1991e:4). However, a criticism made of the 1989 meeting was that the selection of participants had been biased towards TRM as opposed to “chemists and botanists, who would be the ones actually carrying out the studies being promoted” and that the important role of pharmacology had not been clarified (WHO, 1991e:15). Therefore, in future the “technical and methodological nature” of the course would need to be emphasised to ensure only suitable candidates were chosen to participate (WHO, 1991e:17). This scientific expertise demanded and required to implement the process of clinical evaluation of TRM was greater than what may be available on national levels (WHO, 1991e:16).

The necessity for scientific validation of TRM was linked specifically to its use in PHC programmes, and the fact that TRM remedies should be subject to the same regulation and control as biomedical ones (WHO, 1986b:7). However, it appears that growing commercial interest in TRM was also a factor prompting the “safety and efficacy” agenda, in an effort to moderate enthusiasm and assuage unrestricted profiteering. The WHO made it clear that the primary resource base of TRM had not been legitimised without qualification, only certain aspects that had to meet biomedical standards. In effect, this restricted the officially recognised primary resource base of TRM, and therefore the secondary resources that could flow from it (economic benefits):

… commercial interests have not been slow to recognize and capitalize on the potential financial rewards inherent in this official recognition. This has led to a widespread misunderstanding of the Organization’s clarion call in support of its Traditional Medicine Programme. WHO encourages and supports countries to identify and provide safe and effective remedies and practices for use in the formal and informal health system. This does not however amount to a blind endorsement of all forms of traditional medicine, as some
critics would have us believe. There is a common belief that remedies of natural origin are harmless and carry no risk to the consumer. Nothing could be further from the truth … (WHO, 1991e:1, emphasis in original).\textsuperscript{52}

While pharmaceutical interest in developing and commercialising TRM remedies was high in China, Japan, India and Pakistan, little interest was shown by developed nations in exploring plants as sources of new drugs (Farnsworth et al., 1985:966; WHO, 1991e:2). This was despite the fact that in 1980 in the US alone, consumers spent over $8 billion on prescriptions that contained plant extracts (WHO, 1991e:2) and that medicinal plants remained “virtually unexplored in scientific terms” and may hold the key to “new drugs of inestimable benefit to the global community” (WHO, 1991e:2, 3).

This may have been due to several factors, related to the nature of biomedical concepts, resources and professional motivation. For example, many efficacious treatments are ignored or rejected if they cannot be explained by the biomedical paradigm (Goodwin & Goodwin, 1984). Singer notes the reluctance of major pharmaceutical companies to undertake clinical studies on TRM remedies: “How embarrassing it would be to find out that the herb of choice of the traditional healer is indeed effective” and of course herbs are not patentable (Singer, 1976:17). For most multinational pharmaceutical corporations, the cost involved in research and development was too high, and the potential economic returns (secondary resources) were not clear or guaranteed.

In addition, pharmaceutical interests were notoriously apathetic to drug development specific to health issues or interests of the South. The clinical testing and intensive research and development required in TRM remained framed as an issue relevant to the population needs of the South, despite any apparent fortuitous pharmacological discoveries for the North that may also result. The pharmaceutical industry had little interest in developing drugs from which little profit could be derived – only 13 of 1,233 new drugs between 1975 and 1997 were for tropical diseases (the main killers of the world’s population) (Bello, 2004). Unfortunately countries in the South lacked the scientific infrastructure and expertise necessary to undertake this process independently.\textsuperscript{53}

\textsuperscript{52} A similar statement was made in the preface of the report of the 1985 meeting (WHO, 1986b:ii).

\textsuperscript{53} “… plants will alone give birth to the medicine of the future … A revolution needs to be brought about … so that medicine is no longer dominated by the interests of multinational corporations, which tend to make medical students despise indigenous plants … one needs the facilities of pharmacological laboratories, which do not exist in most of the countries of the Third World, because multinational corporations are not doing any research work there or providing the necessary technology …” (Said, 1982:22).
4.4 World Bank activities

As a significant international organisation, the World Bank is a key actor in the broader policy context. In the 1980s, the World Bank ventured specifically into the health policy domain. It began lending money for health projects, and produced policy papers on health sector issues. This followed a strengthening consensus by economists during the 1980s that “investment in people” and formation of “human capital” was an essential prerequisite to economic growth and social development. The Health, Nutrition and Population sector was initially a “backwater” of the World Bank but increasingly became “a major activity as the bank realised that human development was the key” (Abbasi, 1999a:868).

The World Bank also directly and indirectly affected health systems development through loan conditions. Many critics argued that health achievements in the South were eroded during the 1980s by debt-servicing requirements and structural adjustment loans imposed by the World Bank (Abbasi, 1999a:867; Rich, 1994; Werner & Sanders, 1997). Health services financing reform was incorporated into the conditions of structural adjustment programmes (Walt, 1994:129; Werner & Sanders, 1997:104). Werner and Sanders described the World Bank approach to health policy as undermining the concept of primary health care and focussing on technical interventions (1997:107).

By the end of the 1980s, the Bank had become the leading financer of health sector projects (Buse, 1994; Walt, 1994:128) and had secured a role in setting the agenda for health policy. It also assumed a major role in sponsoring and advising on health sector reform, indicating this direct interest with the publication of *Financing health care: an agenda for reform* in 1987 (Walt, 1994:129). This influential report reflected the current economic trends, and placed financing, efficiency and effectiveness higher on the health policy agenda. It argued for a reduced role of the state and greater reliance on market mechanisms to deliver health services, while later policy documents proposed a greater emphasis on cost effectiveness as a criteria for determining programme priorities (Walt, 1994:129).
Section 3: Activity at national levels

4.5 Debate and activity in the policy stream

TRM and its role in PHC continued to be discussed in the policy stream (where ideas are generated and discussed within communities, such as academics, bureaucrats, and interest groups) throughout the decade, despite the apparent contradictions and difficulties in formulation and implementation. There was little evidence available in the mid-1980s that any country was seriously planning to incorporate TRM practitioners into the delivery of PHC (Maclean, 1986:31). Over ten years after the concept was proposed, its practical application was still being debated. Leslie claimed that “the notion of using indigenous cultural resources in governmental reforms of primary care has not gained the voluntary consent of [biomedical professionals] in any country” (1985b:929).

As the PHC movement itself was stalled by differences and difficulties in definition and interpretation and stymied by a lack of funds (which allowed it to be usurped by the selective PHC concept), the main scheme that TRM was harnessed to seemed to collapse. The primary focus of using TRM was in comprehensive PHC; an initiative that seemed doomed. There was no room for TRM in the selective PHC concept. In addition, the use of TRM was not universally endorsed (or even legal in some countries) and was therefore embroiled in academic and professional debate about validity, efficacy and worth.

However, others went to the opposite extreme and disputed the use of TRM at all and its assumed relationship with PHC. For example, Velimirovic (a prominent critic and biomedical doctor) was one of the more vocal and strident opponents of the use of TRM in PHC. He argued that the ambiguity surrounding the PHC concept led it to be mistakenly conflated with the WHO Traditional Medicine Programme, and its endorsement and promotion was misguided (Velimirovic, 1984a, 1984b, 1990). He noted that “(TRM) has become respectable and many authors have started, wrongly identifying it with PHC, community participation and community workers” (1984b:68). Velimirovic launched a passionate polemic about the validity of TRM in modern health care systems and proposed

54 “Lively discussions about the possibilities of using traditional medicine in PHC continue, but many of the participants are untroubled by knowledge of the subject, while those who know about the problems of implementing PHC as well as what traditional medicine really is, have experience in only one specific country or even district. Their observations on PHC and traditional medicine may differ markedly from those of others. The result is an emotional and often rhetoric (sic) discussion …” (Wolffers, 1990:3).
that its advocacy was a “mistake” and an obstacle to the provision of PHC (1984b:77) as well as social and economic development:

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, [TRM] is marginal at best or a hindrance at the worst (Velimirovic, 1984b:75; Velimirovic, 1982:26).

Velimirovic represented the extreme view that TRM contributed little to the health status of populations, and in fact was dangerous and irrational. He controversially stated that while culture should be preserved and protected, TRM “is that part of culture least worthy of protection as compared to language, art, music, oral tradition, poetry etc” (1984b:66). Velimirovic approved of the WHO’s subtle movement away from calls for integration, and a narrowing of focus in research onto medicinal plants and TBAs – based on cost and utility (1984b:76).

The issue of integration itself and the use of TRM in PHC polarised commentators and observers, especially medical anthropologists. While the WHO considered that the official adoption of traditional medicine in national health care systems “obviously makes good sense” (Akerelle, 1983), others believed that “no responsible or realistic person advocates melding the disparate systems” (Warren et al., 1982) and that in promoting integration “we are playing the academic fool” (Singer, 1988:10). Lock (1990:41) was equally sceptical about calls for integration, particularly if the reasons for this goal were not scrutinised. Wolffers (1990:14-15) and van der Geest (1985:13) felt that efforts to integrate TRM into health care systems were pointless, as integration at the consumer level was already occurring and the interaction between medical systems was beyond regulatory control.

This growing critical awareness about integration partly developed from a more informed understanding of what the process had entailed in China, and the differences between Chinese and other (particularly African) forms of TRM. The Chinese situation was increasingly viewed as an aberration; a peculiar policy that evolved from a peculiar political, social and economic environment (Rosenthal, 1981:612; Sanders & Carver, 1985:183). It was considered a gigantic experiment, “an act of levitation, a magical act that renewed the faith of those … who felt they had been fighting a losing battle in developing countries” (Leslie, 1985b:929).

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55 TCM was more institutionalised, based on a written history and more uniform in theory and practice. The diversity of systems and standards of knowledge in Africa presented more challenges to incorporation (Oppong, 1989:609).
This inspiration provided hope for other countries, but they lacked some of the unique and crucial pre-requisites that provided fertile ground in China (Sanders & Carver, 1985:180-183). For example, an extremely strong political counterforce to the domination and resistance of the biomedical profession (Rosenthal, 1981:612), and a TRM profession that was highly organized and more unified (despite varied traditions), and already partially institutionalised. A range of various economic and social policies were also deemed to contribute to overall improvements in health indices, and not solely the integration of TRM or the barefoot doctor scheme as such (Cox, 1989:44; Sanders & Carver, 1985:180-183).

In addition, there was a dawning realisation that the Chinese model subjugated TRM and did not promote genuine parity between medical systems. The barefoot doctor, once championed as an example of integration, was instead revealed as “an example of … fatal embrace” (van der Geest, 1985:12). Bibeau proposed that African governments looking to export the model used by China to ask them: “What is the actual status of the ‘old’ medical culture inside the new medicine you set up?” (1985:938). The model developed by China was held up to critical scrutiny, and found to differ from what it had been promoted as. The eagerness of China in the 1970s to positively promote its own heritage, while reflecting progress and development, meant that it took some time to more clearly and objectively assess what had actually occurred.

It became clearer that barefoot doctors were not TRM practitioners given basic training in biomedicine, but an entirely new manpower category (Pillsbury, 1982:1832; Velimirovic, 1984b:69). It was considered more difficult and time consuming to forge relations between biomedical and TRM practitioners, than to create an entirely new category of community health workers (Pillsbury, 1982:1830). This directly countered the WHO strategy as articulated in the original technical report on TRM (WHO, 1978b), where it was decided that rather than create a new category of personnel trained in both systems to fill roles in the PHC sphere, the training and development of existing TRM manpower categories in basic biomedicine was preferred (WHO, 1978b:21). However, unlike in China, these workers would expect to be paid. It was idealistic to expect that health services could be extended at no extra cost using volunteers or TRM practitioners trained as community health workers.

56 “The Chinese system does not recognize the indigenous medical system in its own right. It only preserves fragments from the old tradition, entrusting them to the barefoot doctor. Thus the tradition itself seems thoroughly destroyed, swallowed by the imported modern system.” (van der Geest, 1985:12)
What China had achieved was an ideological feat, which had been reinterpreted by WHO in line with its operating assumption of reducing political and social health issues to technical problems:

This profoundly political experience was stripped of its political significance … and presented as a wise and intelligent use of paramedical personnel worthy of imitation in other political environments. It soon became clear that that experiment could not work in other settings. The WHO reports did not seem to have understood that the barefoot doctor was a political event and an outcome of specific political forces. The depoliticization of that event, however, was in itself political (Navarro, 1984:469).

The fact that integration was a political exercise and not a neutral, technical issue explains the lack of consensus about what integration actually was and whether it was positive or negative. How integration is defined and viewed is a political issue. If integration was what had occurred in China, many resisted and rejected it, it as it involved the subordinate absorption of the TRM system. Singer considered Chinese traditional medicine and the WHO TRM Programme as “two cultural gods that have failed” and that anthropologists needed to reassess their foundation, interpretations and work in this field in light of that failure (Singer, 1988:10). By the late 1980s, it was argued that PHC had never been fully implemented in China and that the integration of TRM had never been fully achieved (Chen 1989 in Janes, 1999:1812).

It is interesting to note that the Chinese themselves did not consider their system to be fully integrated, despite years of high level government support and the commitment of resources. Instead, the integration process was considered “long-term” (WHO, 1986a:17) and that fusing the systems together using modern science and technology was a “huge task which will take a long time” (WHO, 1986a:34). “Obviously, there is not complete integration: it is still too early to expect that … In effect, there are now three systems: traditional, Western and integrated.” (WHO, 1986a:35).

In China, a resource imbalance was evident between biomedical and TRM systems, regardless of the stated government policy to put TRM and biomedicine “in a position of equality” and the fact that the promotion of TRM is enshrined in the Constitution (WHO, 1986a:16, 19). For example, while biomedical doctors increased in number between 100-150 000 every five years from the late 1950s, TRM doctors actually decreased between 1957 and 1980. In 1984, there were nearly 2 ½ million biomedical hospital beds compared to less than 90 000 TRM hospital beds (WHO, 1986a:17). It was also acknowledged that biomedical doctors found it difficult to accept TRM concepts, even in those countries with strong
political support over several decades and a strong history of TRM use, such as China and Vietnam (WHO, 1986a:49, 63).

The situation in China revealed the outcomes of different forms of integration. Van der Geest identified two types of integration: one which preserves the identity of TRM (parallel) and one which loses it (integrative) (1985:12). In most cases, it was not clear which concept of integration was being proposed by the WHO but the latter was generally implied – the TRM practitioner loses their unique role and “is reduced to a lowly qualified health worker in the [biomedical] system” (van der Geest, 1985:12). Green avoided the term “incorporation” as there was little evidence of that occurring, and instead preferred the terms collaboration or co-operation (1988:1126). Others asserted that integration must mean more than simple coexistence, given the urgent need to maximise all health resources (Neumann & Lauro, 1982:1819).

Beyond semantic and conceptual confusion, some considered the scope of TRM presented a barrier to simple integration into one level of the health system. Whereas PHC was seen as synonymous with TRM in theory, in practise it was not always the case. For example, many TRM practitioners were specialists, not general health care workers. Like biomedical practitioners, TRM practitioners could be grouped into primary (e.g. midwives, herbalists), or tertiary (e.g. psycho-therapeutic) categories (Coreil in Kleinman, 1984:156; Yoder, 1982:1853). This generalist/specialist distinction was used by some to claim that TRM should not be automatically restricted to the PHC sector alone (Bibeau, 1985:941; Kikhela, Bibeau, & Corin, 1981:99).

While commentators were polarised on the official place of TRM in the health sphere, it amounted to a de-facto alliance that converged on suspicion, caution or opposition to the concept – for widely different reasons. While some felt that it should be protected and thus kept out of “the clutches” of biomedicine and the formal health sphere (van der Geest, 1985:12), some felt (or hoped) it should be eradicated, offered little benefit or would eventually disappear and thus deserved no formal recognition (Velimirovic, 1984a, 1984b; Velimirovic, 1982). Others were more neutral and sought information on costs, benefits and methods of integration before concluding on its merits (Kleinman, 1984).

Therefore, there was a lack of cohesiveness in the international and national policy and politics streams, in terms of how to integrate TRM and whether this was feasible or warranted. Unlike what had occurred in China, where there was consensus and clear integration strategy in the policy stream bound by a common political ideology; elsewhere
the policy and politics streams were fragmented – pulled in different directions by different actors with different interests and pursuing different goals. This divisiveness and debate created a vacuum in which little activity occurred. The development of low-cost health services was still assessed and analysed – with political will, economic and cultural factors and other inputs such as education, sanitation, and water supply determined to be necessary aspects. China, Costa Rica Kerala state (India) and Sri Lanka remained tangible proof that such services could be developed (Halstead, Walsh, & Warren, 1985) although broader transfer remained elusive.

4.5.1 National level implementation

Velimirovic’s ideological stance of promoting and supporting a narrow focus in research onto medicinal plants and TBAs, based on cost and utility (1984b:76) articulated what seemed to be occurring in practise on national levels. Ambivalence about the role of TRM in nations that were focussed on modernisation and economic growth seemed apparent; and a constriction of research and activity to limited dimensions of TRM systems (phytotherapy and TBAs) was evident. The reluctance to fully embrace and incorporate TRM into health care delivery systems (even in countries that had enthusiastically endorsed the concept in WHO resolutions and meetings) was the result of a combination of political, economic and social factors that frustrated implementation. This amalgam of factors varied between countries, but resulted in an almost universal glacial pace of progress on national levels.

Issues related to the state, as well as antagonistic competition within and between TRM and biomedical practitioners all acted to create a stalemate. Maintaining the status quo became the easiest outcome in the face of the conflicting pressures. The high level of activity in the policy stream (discussions, conferences, literature) was not translated into tangible outcomes. Pillsbury considered that only one or two countries had incorporated TRM practitioners into health care systems (1982:1825) and Green found no evidence of “genuine incorporation” anywhere in Africa (Green, 1986; 1988:1126). The conundrum remained that despite national and international statements of support, and the concept appearing to offer a feasible and logical solution to biomedical health system flaws; it was resistant to translation into policies and programmes.
4.5.1.1 State issues in development and adoption of TRM policy

Throughout the 1980s, the lack of progress in implementation became apparent to observers, who began to question the discrepancies between statements of support and lack of activity or resource allocation (Green, 1988; Maclean, 1986; Pillsbury, 1982; Wolffers, 1990). There was a distinct lack of interest in encouraging TRM practitioners in countries where their existence was formerly suppressed (Maclean, 1986:31). The hesitation in promoting popular or traditional forms of healing may have related to national pride – it implicitly reinforced the notion that countries in the South were lagging in medical modernisation efforts (Coreil, 1990:20). A commitment to modernisation and economic development required embracing Western ideals, including biomedicine, as powerful symbols of economic and social advancement. For example, Ivory Coast and Kenya justified their choice to maintain the illegal status of TRM by stating a desire for progress and modernity (Kikhela, Bibeau, & Corin, 1981:97).

The sudden international encouragement to promote TRM conflicted with decades of “development” ideology that previously stressed the eradication of traditional beliefs, ways of life and systems of operating. TRM was considered an “embarrassing anachronism” that represented “the backward, the primitive, the heathen” (Green, 1988:1127). Incidences were documented where TRM practitioners were involved informally in health programmes, but officials were reluctant to acknowledge them: “the very existence of these healers was viewed as a problem and a source of embarrassment, and the prospect of even acknowledging their independent actions appeared to confer undue positive sanction” (Coreil, 1990:20).

The nature and composition of the bureaucracy also presented obstacles to officially endorsing TRM. As the hierarchy in official health systems was dominated by or affiliated with the biomedical profession, the interests of TRM were subordinated and health planning continued to be biomedically driven (Good in Green, 1988:1127; Maclean, 1986:32). Personal priorities of administrators, such as career advancement or the augmentation of salaries, also interfered with the practicalities of policy and programme development (Pillsbury, 1982:1830). Supportive planners, administrators and advisors with authority to push policy proposals through were required, as well as stable and committed staff to maintain and promote programmes. However, political instability created high turnovers and movement of officials between areas or portfolios (Green, 1988:1127; Pillsbury, 1982:1829).
An indifferent or hostile bureaucracy that has difficulty accepting the foundations of TRM will not have the capacity to adequately tackle the complexities of integration. Implementing such a strategy requires an understanding of what TRM actually is, what integration involves and how to go about it. There was very little information available on practical issues such as how to establish programmes or evaluations of pilot projects already undertaken (Neumann & Lauro, 1982:1820, 1823; Pillsbury, 1982:1829; van der Geest, 1985:11). In addition, high level political support that could have compelled administrative action was usually lacking. There was little to gain politically by giving the rural masses something they already had access to (TRM), but rather by promising them resources they did not have and could not produce independent of government support (van der Geest, 1985:11).

Ambiguity in legal codes and health policy therefore resulted from the structural control exerted by the biomedical profession and the lack of political incentives for integration. Political support for TRM risked estrangement of the powerful biomedical coalition, as well as the wider population who may view it as a second rate trade-off for biomedical services. Introducing legislation could actually backfire, as experienced in one country. The WHO noted that there had been little success in African countries with efforts to incorporate TRM into mainstream healthcare systems and gave the example of an unidentified nation that:

… at independence tried to correct the inherited situation by adopting policies and promulgating legislation that were encouraging to traditional health practitioners. But, unfortunately, this alienated the medical profession and the existing gap between the two types of practitioner was further widened. The lack of clear policy and legislation authorizing traditional health care makes progress towards full collaboration between the two systems slow and even impossible (WHO, 1988:31).

The ambivalence on national levels was also partly a consequence of the sheer volume of funding required to implement a strategy that involved a costly verification process and highly qualified personnel to implement. For example, scientifically screening TRM remedies for introduction into a PHC programme was a complicated and resource intensive procedure. In countries crippled with foreign debt and barely able to provide basic social services, such a systematic and expensive programme would be a luxury and beyond the scope of budgetary realities. Therefore, even in countries which had earnestly endorsed the concept or proudly asserted their TRM heritage, the implementation of a strategy as envisaged by the WHO was beyond their grasp (as revealed by country reports WHO, 1986a:58-66).
It was a paradox that although integration of TRM was a cost-saving strategy in the longer term, it could not be implemented due to expense incurred in the short term (van der Geest, 1985:11). Other priorities easily gained precedence over TRM, such as propping up a crumbling biomedical infrastructure that was absorbing far more funding than projected. Maintaining existing services rather than establishing innovative new programmes was the basis of resource allocation (Maclean, 1986:33-34). Inflationary pressures and foreign debt interest repayments curtailed health budgets, and donor bodies stepped in to fund specific health projects. However, these agencies determine the scope and objectives of the funded programmes, and may not be sympathetic to the concept of incorporating TRM (Green, 1986:117; Maclean, 1986:33).

On national levels, the constraints can therefore be summarised as: no funds, no expertise, negative and unstable administrative environments, no practical guidance or understanding of how to proceed, no political commitment and more pressing domestic economic and social issues to resolve. The result was symbolic policy – statements of support, but no resource allocation to match the commitment. Hours called this acceptance of TRM an “alibi” or “smokescreen” constructed due to circumstances:

an institutional alibi, designed to mask the inadequacies of existing policies, in the hope that health problems will be solved by introducing some more or less imaginary dimension … This façade of belief in the virtues of TRM costs little and offers many institutional advantages (Hours, 1986:48, emphasis added).

 Adopting symbolic policies with minimal and restricted programme activity seemed to verify what Dunlop had asserted – informally recognising TRM was the most efficacious policy position and least costly to employ (Dunlop, 1975:585). Lip service to the concept of formally using TRM in health care may therefore have been the most strategic economic and political position to take. It gives the status of official recognition to TRM, without diverting scarce resources from the powerful and dominant biomedical coalition. It meets nationalistic sentiment while still offering the promise of providing adequate biomedical infrastructure. It also avoids the thorny issues surrounding integration and how to achieve it, while the trade-off is that the status quo is maintained and supposed benefits of integration are not realised by any of the stakeholders. However, superficially, all stakeholders are appeased in the short term.

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57 A policy usually has two components – a verbal component (statement of purpose, pledge and intention); and an effectiveness component (regulatory rules, grants and resources). If a policy does not allocate resources it can be termed "symbolic" (Eyestone, 1978:15).
The national level institutional obstacles were compounded by professional tensions between biomedical and TRM practitioners. This friction results from the shifting primary and secondary resource base boundaries that integration entails. Integration enables rivals to re-draw the boundaries of their resource bases, and to re-establish their jurisdictions. The professional attitude of both groups to integration is one of protecting exclusive access to their respective primary resources, while trying to extend access to the others resource base. The goal and motivation for both groups is to increase their primary and secondary resources, which presents an impediment to effective collaboration requiring the sharing of resources.

4.5.1:2 Interest group: Biomedical profession

Ironically, rather than the budgetary profile of TRM being raised in national allocations through international endorsement, the emphasis on scientific validation represented a shift in resources from the TRM to biomedical sector. As gatekeepers of the process to identify, isolate and test active agents for efficacy; the funds required to undertake this process had to be channelled to the biomedical coalition. To compound the irony, the benefits of any compounds “discovered” (biomedically legitimated) also flow to the biomedical fraternity, as they are then absorbed into the biomedical primary resource base. This has been astutely observed as allocating funds against TRM, not in support of it, as the benefits are accrued only by the biomedical profession:

However, the interest shown in traditional medicine, witnessed by the wide proliferation of literature on the subject, has not been supported with funds for action programmes. In many developing countries there has scarcely been any budgetary provision at all for the promotion of traditional medicine as a system of health care in its own right. But huge funds have been allocated to fight against it and exploit its knowledge in order to advance the cause of scientific medicine (Lantum, 1982:16).

Apart from an emphasis on scientific evaluation (that required biomedical personnel for supervision and expertise), and on adopting certain TRM remedies into the biomedical repertoire, TRM concepts were also appropriated to promulgate biomedical health messages. For example, indigenous myths and stories were used to market biomedical techniques such as oral rehydration therapy (ORT) (Coreil, 1990:15). This approach was criticised by Crandon, even though it may save lives. Using indigenous concepts to ensure conformity with imported medical conventions causes the eventual eradication of the local tradition,
through its transformation and absorption into the hegemonic biomedical system (in Donahue, 1990:84).

This selective use of dimensions of TRM systems (particular plants, groups of manpower, concepts) can therefore be perceived as a manipulation of policy by the structurally dominant biomedical profession, to enlarge their own primary resource base, secure and increase access to secondary resources, maintain structural strength and increase their functional strength. Rather than an integration strategy that enabled resources to be directed to and shared with TRM systems, it was instead carefully controlled and effectively subverted by the biomedical group.

Specific dimensions of TRM were in fact harnessed to extend biomedical services. Those aspects of TRM that did not challenge the biomedical model or power structure were accepted readily. “However, when the suggested element conflicts with established knowledge and political structures, opposition is the most frequent reaction” and the scientific soundness of such recommendations was used to justify the rejection (Coreil, 1990:18). This attitude was reflected by the British Medical Association’s report on CAM in 1986, which discredited it as “unscientific” (Fairfoot, 1987; Saks, 1998:207; Sharma, 2000:214). The biomedical profession assumed a right to arbitrate the claims of CAM, on the grounds of their scientific expertise (Sharma, 2000:214).

These strategies created an effective barrier on national levels to shifting resources – both in allocating funds to TRM (secondary resources) and in formally acknowledging their primary resource base. Anything that conflicted with the dominance of biomedical primary resources (knowledge, techniques) was rejected, while anything that could be appropriated was absorbed – primarily in the restricted sphere of PHC. Therefore, the boundaries of the biomedical primary and secondary resource bases were being reinforced, using the tool of scientific discourse. This was generally presented as in the interests of patient welfare. On safety and efficacy (scientific legitimacy) or professional authority grounds, biomedical practitioners refused to share access to their primary resources and also attempted to constrict the primary resource base of TRM practitioners.

Using analogies and metaphors based on indigenous health concepts and language to promote biomedical health education strategies is described by Nichter and Nichter (1986). This approach was described as not logical in a “scientific sense” but rational in that it enhanced rapport and communication with communities. Therefore, science was abandoned to more effectively sell biomedical concepts at local levels (gain functional strength).

Gieryn explores the construction of boundaries between science and non-science, which is “useful for … [the] pursuit of professional goals: acquisition of intellectual authority and career opportunities; denial of these resources to “pseudoscientists” … (1983:781).
This can be illustrated by biomedical practitioner responses to programmes that advocated the use of TRM practitioners to distribute or use biomedical drugs, knowledge, or techniques (primary resources). Medical techniques and the use of drugs (primary resources) are unlikely to be relinquished by physicians “if they perceive themselves as being in competition for patients and general social status” (secondary resources) (MacCormack, 1986:153). For example, in Swaziland, a scheme for TRM practitioners to promote and distribute packages of oral rehydration salts was thwarted by biomedical physicians and health officials who argued that they could not be “trusted” with modern medicine (Green, 1988:1129).

In Botswana, a programme to distribute condoms by TRM practitioners failed in some cases due to lack of support from biomedical practitioners (WHO, 1990c:32). In Ghana, instruction for TRM practitioners in the use of some basic biomedicines was abandoned due to limited supply. The biomedical primary resource base (drugs) was considered insufficient to share (Warren et al., 1982:1877). In India, biomedical doctors argued against other health personnel having the authority to give injections at PHC level, as they were “unqualified” and “their own status [would] be undermined and a source of fee collection [secondary resources] lost to others” (Nichter, 1996:248).

At the same time, the primary resource base of TRM was attacked as being detrimental to public health, or at least as potentially dangerous.60 This approach was strengthened by combining it with the new emphasis on economic appraisals, and contrasting TRM effectiveness and efficiency with biomedicine – most clearly expressed by Warren, an architect of the selective PHC approach:

Another key question is the relative effectiveness of modern versus traditional technologies. Evans noted that the use of chemotherapy for tuberculosis for blacks in New York City and Maoris in New Zealand has shown that advances in medical technology can be very effective in reducing mortality promptly without any preceding improvements in living standards … In contrast, Nyazema in his paper entitled ‘Herbal toxicity in Zimbabwe’ reported high mortality rates from poisoning due to traditional remedies in hospitals in Africa … none of the traditional healers interviewed believed in documenting their practice, but 90% were aware that some of their remedies were toxic (Warren, 1988:896).

Undoubtedly, some of the techniques criticised were dangerous, such as giving herbal enemas to treat diarrhoea (Green, 1988:1127), uvulectomy to treat coughs and colds (Bai, 60“There is a common belief that remedies of natural origin are harmless and carry no risk to the consumer. Nothing could be further from the truth … ” (WHO, 1991e:1).
1985), nutritional taboos during pregnancy (Sood & Kapil, 1984) or using cow dung on umbilical stumps (Velimirovic, 1990:56). However, the over-emphasis on detrimental impacts of TRM medicines or techniques neglected the fact that it was unclear whether the harm caused from such treatments was equivalent to or greater than the estimated 20% of all illnesses due to the iatrogenic impact of biomedicine (Heggenhougan, 1981:97).

To place this in perspective, Bodeker noted that in the United States in 1989, plant poisonings were almost all due to the consumption of toxic ornamental plants and resulted in 1 fatality, whereas in the same year non-suicide deaths from a small group of pharmaceuticals was 414 (Bodeker, 1994b:14). The biomedical focus on TRM as dangerous superstition, myth and irrational belief reflects the “rule” that “other people’s quackery appears worse than one’s own” (Leslie, 1980:193; Wolffers, 1990:3). The biomedical primary resource base was reasserted as offering the most value to public health, and as being superior in all respects to TRM. For example, Boris Velimirovic noted that TRM had not helped in combating a host of diseases such as cholera, yellow fever, leprosy, trachoma, malaria, or tuberculosis, and had not prevented high death rates and infant mortality (1990:52). Helga Velimirovic similarly argued that it was out of the question to substitute herbal remedies for the effective biomedicines available, even if it was recognised that they may have some advantages over biomedicines (1982:26).

Shifting primary resources from one group to another is easier, once it is recognised “that these resources will be of use in gaining access to more secondary resources [status, economic benefits]” (Unschuld, 1976b:8). This had not yet occurred with the biomedical profession and subsequently there was very little incentive to adopt or accept TRM primary resources beyond the limited aspects already mentioned (such as absorbing research funds for clinical investigation). The lack of incentives (secondary resources) therefore hindered the adoption or recognition of TRM primary resources by biomedical practitioners. At the same time, preserving their existing secondary resources led to an unwillingness to share biomedical primary resources or co-operate with TRM practitioners.

Other scientists or biomedical practitioners disputed the validity of ethnomedical knowledge, and argued that TRM had “discovered” only a fraction of the known therapeutic uses of

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61 Note the similarity to techniques employed by the biomedical profession in the North to alternative health systems throughout the 19th and 20th centuries — “… its initial strategy in coping with them has tended to involve a campaign by which its rivals would be discredited and ultimately eliminated, or at least greatly restricted in practice. Although [biomedicine] often justifies such a strategy as being an attempt to protect the public from ‘quacks’ and inferior if not dangerous medical care, it is clear that the elimination of economic competition plays a major role in this area” (Baer, 1981:703, emphasis added).
plants, and that science alone held the key to understanding and developing phytotherapy (Gottlieb, 1982:15). In the professional competition between sectors, biomedical practitioners referred to the lack of scientific knowledge of TRM practitioners (Pearce, 1986:237). The limits of ethnomedical knowledge or medicinal plants (primary resources) was stressed, and the advantages of biomedical primary resources promoted: “… we must bear in mind that we live in the modern world and should not deny the progress of immunology and chemotherapy to populations…” (Marini Bettolo, 1982:18-19).

The pinnacle of health service evolution was held to be biomedicine, because it was more “scientific” and therefore automatically more efficacious than any type of TRM system encountered (Fairfoot, 1987; Riley, 1977:549). Polunin reminded the biomedical profession that some of its values and practices were derived from cultural or social (not scientific) sources, and may be merely “foreign tribal customs”. It was therefore important to establish they were truly scientific before imposing them on local cultures (Polunin, 1982:21). However, the aura of authority and prestige attached to biomedicine meant that its universal superiority was generally assumed. There was an automatic link made between biomedicine-modern-scientific and therefore positive, effective medicine; and other systems as pre-modern, irrational and negative (West, 1984:343).

This dismissal of anything other than those treatments that had been biomedically or scientifically-verified as legitimate protects biomedical primary and secondary resources. However, this rigid demarcation and application of scientific principles risked the rejection of alternative therapies that may have been in the interests of patients to provide (Goodwin & Goodwin, 1984:2389). This can be seen as another example of what McKeown considers a failure to distinguish between the interests of the doctor and the interests of the patient (1984:107). As Riley noted, the ideological commitment of biomedicine to science may compete with a practical commitment to health, and the costs of pursuing a scientific agenda may ultimately be negative in terms of health care (Riley, 1977:557).

The very rigours of the scientific method that are responsible for the technical pre-eminence of [biomedicine] are obstacles to full therapeutic effectiveness. The scientific doctor feels comfortable only with therapies for which he can find a rational basis … However, it seems that the doctor may be protecting his scientific integrity at some cost to the patients well-being (Polunin, 1982:20).

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[^62]: Clearly, ethnomedical knowledge presented valuable clues to biomedical applications, and such assertions could be viewed as an interest group tactic to negate and discredit the knowledge base of their rivals. For example, of 121 drugs obtained from higher plants, 74% were discovered by scientists investigating the plants on the basis of ethnomedical claims (WHO, 1989b:4). Selection of plants for biochemical screening is far more efficient if guided by TRM practitioners (Barsh, 1997:28).
4.5.1:3 Interest group: TRM practitioners

If the impression is given that biomedical interests were unique in being driven by acquisition of secondary resources, Elling reminds us that “[w]ith no monopoly on crass economic motivations, these medicine men [TRM practitioners] share a good deal with some of their modern medical brothers …” (1981b:91). To entrenched vested interests, the benefits of an integration process would seem to flow personally to TRM practitioners: “more prestige, more security and probably more income” (Wolffers, 1990:14). Integration offered increased access to limited secondary resources (status, income) and official acknowledgment of their primary resource base. The reward for official government recognition is “ultimately a share in the salaries, supplies and buildings provided by the government” (Last, 1986:11).

The move to work formally within the biomedical health sector brought the opportunity for TRM practitioners to enlarge their primary resource base through training and access to biomedical knowledge, techniques and drugs. Therefore, most commentators noted readiness on their behalf to learn about and collaborate with the biomedical sector. Green considers that “prestige and recognition” (secondary resources) were primary motivating factors (Green, 1986:121; 1988:1128). This incentive develops from government and biomedical association providing legitimacy and status. “This prestige, along with any skills acquired in Western medicine [primary resources] … enables a healer to attract more clients and expand his or her practice [secondary resources]” (Green, 1988:1128).

For example, in Swaziland TRM practitioners admired the technical skills and drugs (primary resources) of biomedical practitioners. They expressed interest in learning about x-ray technology, blood transfusions and injections of antibiotics (Green, 1988:1129; Green & Makhubu, 1984:1073). However, as MacCormack noted, these aspects of the primary resource base (techniques, drugs) were the least likely that biomedical practitioners would surrender to their rivals in the competition to secure patients (providers of secondary resources) (MacCormack, 1986:153). While TRM practitioners coveted access to biomedical primary resources, biomedical practitioners were more likely to guard it than share it with them, and suffer the loss of secondary resources this would also entail.

Despite this potential (yet limited) opportunity to expand access to resources, many TRM practitioners also felt there were disadvantages in interacting officially with the formal health care sector, as it involved rationalising their primary resource base along biomedical
principles. Their remedies, therapies, treatment modalities would have to be open to scrutiny and standardisation. They would have to accept “a change in, and possibly even a disappearance of the tradition” (Wolffers, 1990:14). It also threatened the secondary resources already enjoyed – the status of charismatic healer, the untaxed and unregulated incomes directly received from their patients, as well as the freedom from rules of conduct or of training and qualification.

The move to integration thus encompassed a contradiction for TRM practitioners – it involved the opportunity to access greater secondary resources (status, salaries and resources from the state; enhanced economic benefits and prestige flowing from adopted biomedical skills). However, it also involved accepting a potential constriction of their primary resource base and the granting of biomedical access to it. This serves to simultaneously reduce access to secondary resources already obtained from an unrestricted ability to practice in the private sphere. “Healers are ready to collaborate but not at any price: they do not want to be absorbed by modern medicine which will regulate them to the role of mini-nurse, nor do they want to leave their products and techniques [primary resources] to modern health practitioners” (Bibeau, 1982:1849).

Therefore, TRM practitioners were placed in a bind where the ultimate outcomes and benefits from integration were unclear. While this process may offer potentially greater secondary resources (status, income), it may not be larger than that already enjoyed and it could in fact be jeopardised. Therefore, the amount of secondary resources already enjoyed by the practitioner seemed to be pivotal to their attitude to integration. Sacrificing their autonomy may not be worth it if the secondary resources could not be guaranteed and their authority over their primary resource base had to be relinquished. As mentioned in the previous chapter, the attitude of TRM practitioners to integration therefore seems to be related to their degree of professionalisation, as this correlates to the control they exert over their primary resource base (which allows them to then secure secondary resources). Some observers, aware of this bind:

… question why any respected local practitioners would want to join a national health service in its lowest ranks. They will be at the bottom of the bureaucratic heap, poorly paid or asked to do work for free, given least prestige [secondary resources], the last to be supplied with drugs and in-service training [primary resources]. If they remain independent, they can continue to work on a fee-for-service basis, and retain local respect by being readily available and able to use traditional herbal and other techniques when the supply of drugs to Government health workers dries up (MacCormack, 1986:154).

A lack of professional cohesiveness and fragmentation within TRM hindered the development of professional associations; however professionalisation increased in this
decade especially in Africa. In 1985, healers associations were operating at national or district levels in 23 African countries (see Green, 1986:141; Last & Chavunduka, 1986). The lack of professional associations and representation elsewhere prevented adequate political recognition and created uncertainty to the process of official incorporation, and practitioners were urged by the WHO to formalise their associations:

Traditional health practitioners should group themselves into associations through which they could interface with the modern health system, whether or not they are formally part of it. An association of this nature could be a regulatory body with responsibility for ethical and professional matters. Without this formal structure, the confusion that exists now is likely to continue (WHO, 1991:6).

This quandary over resource control for TRM practitioners and lack of strong professional advocacy, combined with resistance from biomedical practitioners and the practical logistical difficulties of implementation, led to negligible activity on national levels. The operation of these compounding factors is illustrated below in the examples of 6 countries (Thailand, Botswana, Ethiopia, Nigeria, Ghana, and Swaziland). These examples of country level implementation demonstrate the problems described above and how they manifested in different contexts.

4.5.1:4 National examples of implementation

In Thailand, a pilot project was implemented from 1974-1981, which involved training 300 TBAs to deliver health services. Although this project was regarded as successful, when it was expanded across other provinces as part of a PHC programme, no TRM practitioners were included. This was despite early planning documents indicating that this was to be an aspect of the programme (Pillsbury, 1982:1828). Later, there was successful co-operation between practitioners only because there was a clear demarcation of roles and responsibilities, and these were defined by biomedical practitioners. For example, TRM practitioners could only treat people with simple and self-limiting complaints (Wolffers, 1990:13). Formal recognition of TRM as a “non-scientific system” was in a subordinate position to biomedicine, and the attitudes of biomedical doctors to TRM practitioners was one of “almost complete rejection” and mutual hostility (Cohen, 1989:165).

Biomedical resistance to collaboration with TRM practitioners was considered a barrier to integration in Botswana (Barbee, 1986). Barbee concluded that the attitudes of biomedical practitioners were crucial to the success of integration programs, and in Botswana nurses occupied a brokering role. The nurses she canvassed opposed the idea of formal co-operation
with TRM practitioners as they were associated with sorcery and were not considered legitimate providers of health care (1986:79-80). “In their view co-operation means that traditional specialists should refer patients to biomedicine not the reverse” (1986:79).

In Botswana, attempts to integrate the two systems had not been pursued as “it is felt one or other of them might suffer in the process; instead, parallel development is encouraged” (WHO, 1990c:31). Legislation regarding the regulation of TRM practitioners had still not been passed, and these practitioners felt that referral of patients had been unidirectional with biomedical practitioners rarely referring in return. Conflict was even evident between various groups within the ethnomedical system. For example, TRM practitioners and spiritual healers were reported as not co-operating with each other and their basic relationship was described as “competitive antagonism” (Barbee, 1986:78).

Slikkerveer (1982) assessed the operation of pluralistic medical systems in Ethiopia, and concluded that although a unified system and progressive integration was desirable, it was impeded by various constraints and obstacles. These included differences in beliefs, values and practices; commercial motivations; reluctance to share and exchange details of medicinal plants and customs; prejudices against TRM diagnosis and treatments; and fear by TRM practitioners of prosecution, taxation and humiliation from official contact (1982:1867). This reality contrasted with a tolerant legal position, and TRM was administratively ignored “partly due to scepticism and a lack of confidence in [TRM] and partly to the prestige connected with an ‘intelligent’ and ‘modern’ use of Western sophisticated medicines” (1982:1868). Historically entrenched ethnic, religious and political rivalries also militated against collaborative efforts and there were hardly any attempts to officially utilise TRM in the formal health care system.

The lag in policy implementation and program development in Ethiopia was recognised, despite Government statements of support. It created suspicion amongst TRM practitioners about the sincerity and intentions of the Ministry of Health. The organisation and registration of healers had met with problems, and professional associations lacked funds, guidance and personnel to effectively promote the interests of practitioners (WHO, 1990c:36). Health education efforts were also directed to TRM practitioners in a “derogatory manner” (WHO, 1990c:38).

An important point of contention in Ethiopia was that “exclusive emphasis” was placed on research into herbal medicine (phytotherapy). Limited resources were directed to seeking detailed information on TRM medicines. TRM practitioners resented this, as there were no
assurances of involving them in testing their drugs or the sharing of any economic benefits if this led to commercialisation (secondary resources) (WHO, 1990c:37). There was resistance on both sides to mutually exchanging information: TRM practitioners were reluctant to disclose details of their primary resource base without clear legal rights to the outcomes, and biomedical practitioners were dismissive of potential validity (WHO, 1990c:37-38). This tension reflects asserting control over primary resources and access to any secondary resources that may flow from that control.

In Nigeria, the majority of the population used TRM, and surveys conducted revealed support between TRM and biomedical practitioners for integration (Chiwuzie et al., 1987). However, it was also acknowledged that the greatest opposition to TRM came from biomedical professionals (1987:240) and that little practical research had been undertaken into how to implement integration (1987:241). The concept of integration as endorsed by the biomedical profession was also conditional and restricted: in separate institutions, only in some fields, only at the PHC level, after standardisation, if adequately monitored, and for purposes of research on medicinal plants. Very few recognised any positive aspects of TRM, and most considered that the reason TRM was popular was due to a lack of access to biomedicine (1987:242). The idea for integration was supported by more TRM than biomedical practitioners.  

While Chiwuzie et al., (1987) found conditional support amongst practitioners for integration in Nigeria, Pearce (1986) found that biomedical practitioners were reluctant for TRM practitioners to be included as personnel in the formal health care system. The majority of biomedical practitioners were not interested in co-operating with their TRM counterparts either as colleagues or junior workers (Pearce, 1986:239). In addition, biomedical practitioner acknowledgement of TRM knowledge depended upon whether it could be submitted to scientific analysis, which was a “convenient rallying-point for preserving the present status/legal differences” (Pearce, 1986:240). The attitude of TRM practitioners to integration was mixed – while they wanted official recognition, they were also apprehensive and feared being “wiped out as practitioners”, their knowledge being absorbed, and becoming subject to interference or control by biomedical practitioners (Pearce, 1986:240-241).

While 20% of biomedical doctors favoured integration, 50% favoured it conditionally and 30% did not favour it (Chiwuzie et al., 1987:241). In contrast, out of 175 TRM practitioners, 81 favoured integration in the same institutions; 80 favoured integration in separate or special institutions or in some fields; and 14 did not favour integration (Chiwuzie et al., 1987:243).
A programme implemented in Ghana (Warren, 1986; Warren et al., 1982) was both “inspiring and depressing” (Maclean, 1986:29). It showed that while some progress could be made, it required vast amounts of time, effort and financial support that would be beyond the scope of the majority of communities in Africa. Maclean also criticises it as it was based on a one-way transfer of knowledge from biomedicine to TRM. The initiator of the programme notes that it was based on the “simplest form of collaboration … where traditional healers are shown selected Western methods of dealing with common problems” (Warren et al., 1982:1879).

In Ghana, besides the programme mentioned and TBAs, little attention had been paid to TRM practitioners by health policy makers. Despite sharing a common goal to protect health “the predominant attitude between [TRM and biomedical practitioners] has been mutual disregard” (Warren et al., 1982:1873). The role of TRM in health policy was described as “purposefully ambiguous” although cautious acceptance was indicated by programmes using TBAs, the establishment of a research centre of plant medicines and recognition of a TRM professional association (Warren et al., 1982:1875).

Green and Makhubu (1984) pointed out, in their study of Swaziland, that most TRM practitioners’ received sufficient incomes from their private practices, and would not be attracted to the meagre salaries provided by government employment. However, if they were officially used to extend health services, they would expect financial reimbursement (1984:1074-1075). There was a noticeable degree of suspicion and competition between different types of TRM practitioners, as also noted in Botswana. For example, diviners criticised herbalists as unguided by spirits, while herbalists condemned diviners for going beyond their diagnostic function and using plant therapies they did not understand (1984:1072). As also experienced in Ethiopia, obstacles existed to integration in the form of incompatible theory and practices; a bias against TRM and suspicions about the motivations of the government by TRM practitioners (Green & Makhubu, 1984:1077).

Programmes implemented in Swaziland which were based on TRM practitioners participation created animosity from biomedical practitioners, and were met with vague responses from the TRM practitioners themselves (Gort, 1989:1100). The growing interest in their activities caused confusion as TRM practitioners were “unaccustomed to having

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64 The training course covered environmental health, preventative and promotive health measures, the Billings method of contraception and simple biomedicine. As mentioned, instruction in the use of basic biomedicines was abandoned due to limited supply and uncertainty over future provision (Warren et al., 1982:1877). This official reason for limiting training may have reflected biomedical concern over access to their primary resources, and indicated that their primary resource base (drugs) was considered insufficient to share.
normally culturally biased Westerners extol their virtues” (1989:1100). While some TRM practitioners were willing to co-operate with biomedicine, others were indifferent or even hostile. Those practitioners who were the most successful (greatest secondary resources) were the most resistant to collaboration:

They suspect that ‘standardizing practices’, adhering to a regulated fee schedule, and becoming part of a poorly paid and highly regulated government bureaucracy would be neither beneficial or lucrative … they fear that cooperation could actually undermine their relationships with patients by having the healer appear to be answerable to secular rather than sacred forces (Gort, 1989:1100, emphasis added).

The realities of implementation experienced on national levels were congruent with what had been predicted in the technical report on TRM (WHO, 1978b). The deliberating committee had recognised then that even in situations where the policy on integration was “favourable”, other potential limitations may impede practical implementation. Included in the list was “payment of lip-service” (symbolic policies); apprehension about possible harmful effects of TRM; opposition by intractable advocates of different medical systems, and legal apparatus that protects the entrenched biomedical system, encourages monopoly, and even excludes or forbids the practice of other systems (WHO, 1978b:18-19). These obstacles were discernible throughout the 1980s, and hindered the practical re-organisation of formal health services to accommodate TRM.

4.6 Conclusion

Throughout the 1980s, the idealistic health policy concepts that had gained international support in the 1970s (such as HFA, PHC and the integration of TRM in formal health care systems to provide increased access to affordable health care) were confronted with harsh economic and political realities that retarded their execution and operation at national levels. The enthusiasm displayed in policy formulation in the 1970s for these notions did not transform into substantial, sustained or systematic activity in the following decade either within the WHO as an organisation or within countries that had endorsed the initiatives. There was a wide gap between the policy pronouncements and actual programme development.

The politics stream in the 1980s was not favourable to the implementation of schemes that required large investments of public funds, major restructuring of infrastructure, strong political commitment to social welfare goals and the expansion of services. The political environment was dominated by neo-liberal economic schools of thought, which shaped the
way in which problems were recognised and framed, and the policy solutions that were deemed effective to meet them. The global recession in the 1980s provided the conditions for neo-liberal and economic rationalist thought to become firmly entrenched on the policy agenda. Many countries faced high inflation, spiralling debt, and wide unemployment and therefore efficiency in resource allocation and reducing costs became paramount.

In this decade, issues such as community based health interventions and the development of longer term programmes to provide increased health care coverage were overshadowed on the agenda by higher profile issues that were competing for recognition and resolution. Economic and not health or social welfare issues were at the forefront of domestic and international agendas. Political volatility, instability and conflict also absorbed much of the focus – for example, nations in Eastern Europe, China, Latin America and Africa were reorienting political and economic systems and coping with domestic crisis. The WHO was also buffeted by political conflicts surrounding its support of high profile, contentious health policies (essential drugs, primary health care, infant formula debate) and financial pressures. In this milieu, TRM struggled to maintain visibility on the agenda but fortuitously gained some leverage from newly emerging problems such as environmental conservation and HIV/AIDS.

Reich (1987) described some of the difficulties surrounding the essential drugs concept, and these features are also common to the PHC and TRM programmes. These concepts were all inspired, adopted globally and modelled after the successful implementation of similar initiatives in particular locations – for example, Essential Drugs (Cuba, Sri Lanka, Egypt, Costa Rica), PHC (Kenya, Indonesia, Philippines, Tanzania) and integration of TRM (China). After achieving international support, these policies then required national level transfer and replication in very different and sometimes unfavourable contexts. Difficulties were encountered in the transfer phase due to both the ambiguity of the concepts (which was required to reach consensus at the global level) and also because they raised complex and contentious economic, political and ethical issues. While ambiguity may be functional at the international level, it is not helpful in making difficult decisions at national levels (Reich, 1987:49).

Opponents to change or to specific policies know that the window for opportunity closes quickly, and therefore can prevent policy adoption or implementation by stalling and delaying required or agreed changes (Kingdon, 1984:170). The window of opportunity for integration quickly closed in the 1980s when global recession and neo-liberal policies took hold. Economic and political circumstances in the politics stream conspired against the
concept of integration, and it appeared to flounder in a mire of conceptual and practical difficulties of interpretation and implementation. There was also a lack of consistent and clear guidance from the WHO to resolve such complications. In this global environment, TRM suffered from a lack of political advocacy and economic support on both international and national levels.

TRM was hindered in the political sphere due to its heterogenous nature and the fact that it did not have the strength of organised and well funded professional bodies to more forcefully push claims. The integration process could therefore more easily be dominated and manipulated by the biomedical profession. This enabled biomedicine to assume the role of gatekeepers, dominate the policy process and limit the parameters of integration (for example, by demanding scientific evidence of safety and efficacy of the TRM primary resource base).

In addition, the professional motivations of TRM and biomedical practitioners created a deadlock in policy and programme development, as co-operation was largely absent due to the lack of secondary resources (economic benefits, status, prestige) that was required for the necessary collaboration. Biomedical practitioners did not want to lose their existing secondary resources to competitors, and thus promoted and protected their primary resources and discredited TRM. Similarly, TRM practitioners were ambivalent about integration and collaboration as any secondary resources to be gained from this process were unclear. Integration potentially reduced the existing primary and secondary resources they already enjoyed and there were few incentives offered for co-operation which was vital for integration to proceed.

The predicaments over formal legal recognition of TRM were shared by CAM in the North. TRM/CAM increasingly sought political recognition but faced a dilemma over the process required to achieve it. A realisation of the need to formalise their roles through associations (professionalise) was tempered by an acknowledgement that this could threaten their primary resource base. “If defining the scope and conditions of practice for new alternative practitioners is left to [bio]medical doctors, holistic health care will tend to conform to the constructs of scientific medicine” and they would need to accept biomedical dominance (Berliner & Salmon, 1980a:540). Thus the situation remained:

There is a growing sense of urgency to secure some formal recognition by Act of Parliament. But just how, and for whom, is difficult to sort out. For many reasons, it might be best to leave things as they are … But there is a threat from [biomedicine] … the worry is that the
alternatives that appeal to the doctors will be medicalised … the monopoly will thus reassert itself … (West, 1984:344).

In the 1990s, the problem stream changed rapidly and thus propelled TRM (along with CAM) onto the political agenda. While the 1980s appeared to present only lost opportunities to implement a radical new direction in health systems structure and policy, new economic and political conditions in the 1990s revived the concept of integration. Continuing lagging or ad hoc national level policy development became an untenable position, and the policy agenda again became receptive to the concept of integration. However, the questions of how best to do this and how to practically implement integration still remained politically contentious and difficult to resolve. The following chapter considers the policy context in the 1990s, and the impact of political, economic and social developments in terms of the content and fate of CAM/TRM in health policy.
5. 1990s: Re-emergence of TRM on the health agenda

...the current globalization of the herbal industry is a phenomenon of international
capitalism and a contributing cause of multiple inequalities ... the taken for granted
dominance of 'science' and 'technology' ... used as social and cultural policy, continue to
attack different cultural frameworks as primitive/pre-science/irrational.

(Jagtenberg & Evans, 2003:323)

In the 1990s, the policy terrain for TRM changed dramatically as TRM/CAM became an
established massive multi-billion dollar industry. This was a fundamental factor behind the
sudden re-emergence of TRM as an international health policy priority in 2002, when the
WHO released a global Traditional Medicine Strategy (WHO, 2002e) (outlined further in the
next chapter). While the policy of integration had failed to take root and was deteriorating in
an arid political and economic environment throughout the 1980s, in the 1990s conditions
developed that fostered regeneration. The revolution in healthcare delivery advocated in the
1970s had failed to eventuate, but in the 1990s a consumer led revolution pushed TRM back
onto the policy agenda.

The unanticipated and rapid development of a global market for TRM was both an
opportunity and a threat to TRM systems of health care. While such patronage raised their
profile and profitability (secondary resources) it also left them vulnerable to exploitation as
their primary resource base was threatened by the intense clinical and commercial interest
from the North. This situation was compounded by environmental degradation. In 1993,
UNESCO/WWF reported that in Africa the supply of medicinal plants was failing to meet
demand (Bodeker & Bichan, 1996:390), and by the end of the decade 9 000 species of
medicinal plants were threatened with extinction (Burford et al., 2000:11). Akerele further
estimated that 60 000 species or nearly a quarter of the world’s total would be extinct by the
middle of the 21st century if present trends continued (1993:390).

The lag in development and implementation of national policy and regulation now presented
a serious impediment to protecting TRM primary resources used by communities in the
South for basic health care, and in preserving the economic benefits (secondary resources)
that flowed from the use of such resources. The wealth of potential for commercial
development of pharmaceuticals, nutritional supplements, cosmetics and other products
based on TRM/CAM primary resources meant that the previously neglected field was being
“mined” by biomedical interests.
According to some, in a trend that mimicked the commodities mentality of the colonial era (when the South was viewed as an exploitable source of minerals, gems, timber, fibres or food) – indigenous knowledge, TRM and ecosystems were now sources of a new form of gold, “mines of green gold” (EU, 2002) transformed into drugs, supplements and health products. Prospecting for this new bounty became a lucrative business that was fuelled by the biotechnology industry, viewed as a form of neo-colonialism (Bodeker, 1994b:14; Idris, 2003; Shiva, 1997, 2001). New economic incentives were threatening the survival of plant species (especially through over-harvesting) and therefore ultimately the health of populations in the South (Eskinazi & Mindes, 2001:22).

In the 1990s, trade, environment, biodiversity, agriculture, sustainable development, indigenous resources, traditional knowledge systems, and globalisation all became topical and controversial issues. TRM is a field that intersects all these areas, and therefore became increasingly complex and contentious. New words entered the vocabulary of this policy domain, such as “bio-prospecting” and “biopiracy”. Biopiracy was a term coined as a defence in the South, which had been accused by the North of “intellectual piracy”. Biopiracy refers to the unauthorised extraction (theft) and/or patenting of biological resources or traditional knowledge (primary resources) (Dutfield, 2000:8; Wayland, 2003). While the North accused the South of intellectual piracy, the South protested the systematic looting of their biological heritage.

In this way, TRM became bound up with trade and development issues, convoluted patent disputes, and legal interpretations on ownership and rights. TRM represented an interface of North-South conflict. It moved beyond the health arena to unfamiliar territory – the World Trade Organisation (WTO), World Bank, World Intellectual Property Organisation (WIPO) and United Nations Conference on Trade and Development (UNCTAD). The growth in popularity of TRM/CAM had generated a bonanza of secondary resources that stakeholders were now keen to lay claim to. Other international bodies also took an active role in TRM in their roles as conservation advocates or watchdogs (such as the World Wide Fund for Nature and The World Conservation Union). The policy domain became a confusing tangle of acronyms, protocols, conventions and guidelines as it was split across many agencies, each with different priorities and mandates.

The urgency of resolving economic, environmental, legal and public health matters meant that TRM as a policy issue could no longer be ignored or avoided. In 2002, a window opened in the problem, politics and policy streams again and the policy of integration of TRM was
re-born in the form of the WHO *Strategy on TRM* (WHO, 2002c), the first global policy in this field. The broader policy context (below) establishes the circumstances surrounding the emergence of the Strategy, as according to Kingdon (1984) the policy environment is crucial to understanding why and when particular issues arise on the agenda. The broader context forms the backdrop to activity in the TRM policy field, and can only be understood in relation to it.

**Section 1: Policy context**

**5.1 The broader policy context**

The 1990s did not usher in a period of prosperity and peace that the end of the Cold War and apartheid seemed to promise. With the dissolution of superpower blocs, an emphasis on the arms race and weapons stockpiling was no longer required and it was anticipated that such expenditure could be channelled to development efforts. This became urgent as economic growth and development had still not managed to address basic needs in the South. However, ethnic and political instability in Europe, Africa Asia and the Middle East led to an ongoing succession of international and civil conflicts and humanitarian crises.

The transition from central planning to free market economies had been particularly challenging in many countries. In Africa, drought and falls in commodity prices hindered economic growth. Asia experienced a currency collapse and debt crisis, despite economic liberalisation. Although economic and trade issues related to TRM was a new development, there was a resemblance in the broader policy environment to many of the prominent issues of the 1970s, such as a concern with population growth, development, and longer term resource management. Later in the decade, social justice issues (for example, alleviation of poverty, child and maternal health, improving access to education) and basic needs also became increasingly significant in international bodies such as the United Nations. As in the 1970s, social justice and natural resource management issues came to the fore, but tempered this time around with a pragmatic economic rationalism.

**5.1.1 Sustainability and Development**

In 1998, the WWF estimated that one third of the world’s natural wealth was lost between 1970 and 1995 as a result of human activity (Klare, 2001:18), and the finiteness of natural resources loomed large throughout the decade. Prompted by the Brundtland Commission
(1987), which had articulated the concept of sustainable development, the United Nations held a conference on Environment and Development (1992) known as the Earth Summit - the first of seven UN conferences exploring the themes of environmentally sound development. Development efforts were increasingly moderated with an awareness of meeting the needs of the present without compromising the ability of future generations to also meet their needs. Other significant forums along this theme were the International Conference on Population and Development (1994), World Summit for Social Development (1995) and Human Settlements – Habitat II (1996). At the 1995 Summit, the 20/20 initiative was endorsed which called for 20% of public expenditure in low income countries and 20% of official assistance to be spent on basic social needs (Lee et al., 1996).

Sustainable development was linked with international development more broadly, in terms of encouraging self-reliance and self-sufficiency while conserving and protecting natural resources. The Earth Summit had in fact been overshadowed by demands from the South for better terms of trade, debt relief, and increased aid – harking back to the New International Economic Order (NIEO) manifesto of the 1970s (Sachs, 1993:6). In 2000, the largest ever gathering of heads of state agreed to a series of goals called the UN Millennium Declaration (UN, 2000). Many of these targets were first set out by international conferences and summits held throughout the 1990s. They included eradicating poverty and hunger; achieving universal primary education; promoting gender equality; reducing child mortality; improving maternal health; combating HIV/AIDS, malaria, and other diseases; ensuring environmental sustainability; and developing a global partnership for development. Abbasi (2004) points out, that aside from HIV/AIDS, these goals were essentially unchanged from objectives held since 1900.

The goals to be achieved by 2015 were a pact between the North and the South. In that sense, this Declaration differed from previous agreements where targets had been set for developing countries to aspire to (Abbasi, 2004; Haines & Cassels, 2004). In contrast, the UN Millennium Declaration acknowledged that the North also had a role in terms of fair trade, development assistance, debt relief, access to essential medicines, and technology transfer. This concept was reaffirmed in 2002 at the international conference in Mexico on financing development (Haines & Cassels, 2004).
5.1.2 Trade and Intellectual Property Rights

The entrenched poverty, under-development and lack of access to basic services in the South were argued by some to be related to unfair trade arrangements that favoured the North, and further polarised wealth and power (Adams, 1993; Amin, 1997; Danaher, 2001; Dasgupta, 1998; Gelinas, 2003). As the NIEO initiative of the 1970s had failed to eventuate, the South was left in a weakened economic and political position in many of the negotiations. International frameworks favoured the North and allowed their capitalisation of indigenous resources from the South (Elliot, 1998; Gedicks, 1994; Hawthorne, 2002). In addition, many countries in the South endured great hardships in implementing the requirements of the international agreements, while struggling with external debt and facing dwindling development aid (Abbasi 1999:867). This directly affected the quality of health and social service sectors (Mogedal & Steen, 1995:351). The UN Millennium Goals were an effort in part to address these concerns and a concession to North-South power imbalance in trade and economic negotiations.

The World Trade Organisation (WTO) came under increasingly hostile attack during the decade, particularly from the anti-globalisation movement which represented diverse groups bound by commitment to human rights, social-democratic principles and a rejection of rapid economic liberalisation and international capitalist expansion. For example, the celebration to mark the 50th anniversary of the founding of the General Agreement on Trade and Tariffs (GATT, the predecessor of the WTO) in Geneva, 1998 turned into a riot with thousands of demonstrators protesting the free-trade system which the WTO represented and promoted. The irony of “free-trade” was that while it espoused economic liberalisation, it simultaneously allowed the North to establish protective barriers like tariffs and subsidies, imposing more costs than benefits on the South (Amin, 1997; Dunkley, 1997; Ellwood, 2001; Khor, 2000, 2001; Lang & Hines, 1993).

Further massive protests continued to dog the WTO and other international bodies such as the World Bank, International Monetary Fund (IMF) and Organisation for Economic Co-operation and Development (OECD). The neo-liberal philosophy promoted by these supranational bodies was called into question by development, social and environmental groups. These agencies were seen to undermine national sovereignty and self-determination, through imposing economic and social policy conditions for the receipt of loans (structural adjustments) and locking the South into debt-servicing. The interests of multi-national corporations and more powerful nations seemed to dominate the interests or needs of
communities (Bello, 1994). Echoing another theme from the 1970s – whether economic growth itself was intrinsically beneficial (Schumacher, 1973), the merits and meaning of development again became increasingly questioned (Dharmasiri, 1997; Hamilton, 2003; Sachs, 1992).

A significant emerging issue during the decade was the Trade Related aspects of Intellectual Property Rights Agreement (TRIPS) under the auspices of General Agreement on Trade and Tariffs (GATT) in 1994. TRIPS aimed to globalise the standards of intellectual property rights (IPR) protection. All members of WTO were expected to abide with the standards by 2005. TRIPS covered various types of IPR, among them patents, geographical indications, undisclosed information (“trade secrets”) and trademarks. TRIPS had controversial impacts on the provision and pricing of biomedical pharmaceuticals, but also had complex influences on TRM and a complicated interplay with trade, conservation, biodiversity and indigenous knowledge protection frameworks (Kumar, 2000b; Mbeva, 2000; Timmermans, 2003; WHO, 2000c).

5.1.3 Environment – biodiversity, climate change

The concept of “sustainable development” was linked to environmental issues more generally. At the Earth Summit in 1992, a Convention on Biological Diversity (CBD) was agreed. Due to the relationship of Intellectual Property Rights (IPR) with conservation, sustainability and benefit sharing, they were included as part of the negotiations. The Convention gave nations sovereign rights over their biological resources, which had previously been considered the “common heritage of mankind”. This agreement theoretically enabled countries in the South greater control and a more equitable share of benefits obtained from the economic exploitation of their natural resources and traditional knowledge. Considering that wealth and technology were concentrated in the North, and biodiversity and poverty in the South, questions of equity in using genetic resources for sustainable development were particularly hard to address to the satisfaction of all stakeholders (Shiva, 1993; WRI, 1993).

Climate change firmly entered the international agenda in 1988, and atmospheric pollution (acid rain, ozone depletion, and global warming) were all considered crucial to future environmental health, including biodiversity. Various conferences and negotiations were held throughout the 1990s, leading to the Kyoto Protocol on Climate Change in 1997. Some countries in the North did not support either the CBD or the Kyoto Protocol. The US withdrew support for the Protocol in 2001, arguing that the scientific justification for it was
not sound and it would interfere with economic growth. The balance between environmental conservation and trade, development and economic progress was proving difficult to mediate (Khan, 2002; Meyer-Abich, 1993).

Natural resources and their management became an arena of political discord (Gedicks, 1994; Sachs, 1993). Klare (2001) argued that resource scarcity and security (oil, water, minerals, timber) was an emerging area of global conflict, aggravated by the sharply diminishing vital natural resource base. Plants (agricultural and medicinal) could be added to this list of contested resources. An indigenous dimension was laced throughout this conflict, in relation to a wide range of natural resources (e.g. land, water, forests) that held spiritual, cultural and traditional meanings to indigenous communities and not simply as ends to economic growth (Gedicks, 1994; Shiva, 1991, 1997).

5.1.4 Indigenous Knowledge and Biopiracy

During the 1990s, indigenous knowledge systems and traditional biological resources were recognised as valuable assets. Indigenous knowledge was an essential aspect of environmental **conservation** and **biodiversity**, indispensable to survival (**health**) for communities in the South and mankind, a component of **sustainable development**, and potentially generated significant **economic benefits** as a source of revenue (Biber-Klemm, 2000; Dutfield, 2000, 2002; Mhame, 2000). TRM was no longer just a matter of cost-effective health care or an adjunct to delivering basic biomedical services; it was intricately bound up with other policy concerns on the international agenda.

The new found respect for indigenous peoples and knowledge was reflected in the United Nations announcing 1993 as the “Year of the World’s Indigenous People” and an International Decade of the World’s Indigenous People (1995-2004) in December of that year. The main objective of these initiatives was to resolve problems faced by indigenous people in such areas as human rights, the environment, development, education and health. In 2000, the Commission on Human Rights established a Permanent Forum on Indigenous Issues. This new appreciation of indigenous knowledge systems followed the Brundtland Commission (1987) which had suggested traditional or indigenous types of land use may be more compatible with sustainable development than modern practices (Kennedy & Olsson, 1996:42). The World Bank and other development bodies also developed an emphasis on the utilisation and promotion of indigenous knowledge (IK), or traditional knowledge (TK) for furthering development.
The Convention on Biological Diversity (CBD) aimed to protect indigenous knowledge and assert ownership rights by communities, however TRIPS was far more powerful and had a greater influence on trade. TRIPS made no reference to the protection of traditional knowledge (Bodeker, 2000; Bodeker & Kronenberg, 2002). This aspect was contentious and review was sought by many countries in the South (Raghavan, 2000). These countries were especially concerned that the TRIPS agreement did not encourage those seeking biotechnology patents to respect the principles of the CBD, including obtaining permission from the community or country of origin and sharing benefits. An obligation to disclose the geographical origin of any biological material used in biotech inventions was proposed in 2002 in order to harmonise the application of TRIPS and CBD.

The crux of this contentious issue was the transformation of traditional knowledge into commodities and the subsequent benefit sharing. TRM featured prominently in these debates and generated some of the more highly publicised biopiracy disputes. When the value of indigenous knowledge was recognised and exploited, commercial interests and indigenous philosophies collided. This issue is too complex to discuss here beyond briefly mentioning it as one important aspect of the policy context (Bodeker, 2000; Dutfield, 2000, 2002; Mbeva, 2000; Shiva, 1997, 2001; Timmermans, 2003). A central problem was that indigenous taxonomies for classifying natural resources diverged from Western classificatory frameworks and assumptions, but patent and regulatory frameworks were built on Western scientific and ownership concepts (Shiva, 2001). For example, patent and copyright laws face difficulties accommodating TRM primary resources (Airhihenbuwa, 1995:57; Kumar, 2000b; WHO, 2000c:5-7). These discrepancies and a lack of national legal frameworks for IPR, funds and expertise in the South allowed the North to patent food, plants, genes and biological resources.

Third World resources and knowledge are thus being converted into the “intellectual property” of northern corporations, which will collect royalties from Third World countries similar to the time when colonizers took resources from them in the first instance (Shiva, 2001:29).

5.2 Trends in the health field

The main trends present internationally in the health field during the 1990s again reflect the themes of the broader policy context. These themes include an escalating contraction of resources for social services that encouraged an emphasis on the effectiveness and efficiency of existing health services and treatments (flowing through into the development of evidence based medicine), and their sustainable longer term development. A surging interest in
natural, holistic forms of health care and the social and physical environmental aspects of human health also became more prominent, reflecting an environmental consciousness (see Macdonald, 2005; Wilkinson & Marmot, 1999; 2003). Economic and environmental themes are therefore woven through many of the health policy trends and agenda priorities of the decade, and filtered through to institutional activities.

5.2.1 Financing (Effectiveness & Efficiency)

The issues related to financing reform of health care systems are very complex and contentious, and cannot be discussed adequately in the space available. Broad trends are instead noted, as they influenced the context of the policy domain and shaped debate in the field. Neo-liberal economic policies of market deregulation, trade liberalisation and privatisation all had an impact on the provision of health services, which became even more strictly governed by an emphasis on efficiency and effectiveness. Privatisation of health services, user fees and encouraging private health insurance were all outcomes of the new economic perspective. The influential neo-liberal economic paradigm redefined health as a commodity or investment, rather than a human right (Buse & Walt, 2000:177; Laurell & Lopez-Arellano, 1996:1).

The World Bank World Development Report *Investing in Health* (1993) is considered the cornerstone of this paradigm, and is considered to have strongly influenced health policy development (Buse, 1994; Werner & Sanders, 1997; Zwi & Mills, 1995:313-314). Health was considered a private responsibility and health care a private (not public) good that could be adequately and equitably provided by market mechanisms (Laurell & Lopez-Arellano, 1996). *Investing in Health* introduced the metric of “disability adjusted life years” (DALY’s). This indicator was used as a method to guide resource allocation, as health interventions and services that would reduce the DALY were considered the most efficient use of health care resources (Abbasi, 1999f:1005-1006). However, the methodology used to develop the DALY calculation and assumptions underlying it were heavily criticised – for example, it linked health with economic productivity (Werner, 2001; Werner & Sanders, 1997) and was considered inequitable (Abbasi, 1999f:1006).

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65 Health is often recognised as a fundamental, or human right, in international declarations including the Universal Declaration of Human Rights (Hancock, 1999:6). “... Health cannot be an enforceable ‘right’ but health services, as a means of achieving health, and the manner in which they are distributed, may be” (Hancock, 1999:6 quoting Lenaghan 1996:i).
The primacy of economics became embedded within health systems development and seemed to over-ride ethical, equity and social justice priorities (Hanson & Callahan, 1999). The newly emerging “evidence based medicine” paradigm (Guyatt, Cairns, & Churchill, 1992) became quickly entrenched in health services policy and practice and tied neatly with the neo-liberal approach to provision of services. Pioneered by Cochrane (1972), “evidence based medicine” applied standards of evidence based on scientific method and offered an “objective” method to determine effective and efficient allocation (or rationing) of health care (Hancock, 1999:94). It thus corresponded with the contemporary economic climate. Biomedicine, and all other treatment modalities including TRM/CAM, had to clearly demonstrate efficacy and evidence of cost-effectiveness to be part of efficient health care provision.

5.2.2 Health systems development

The future financing of health systems and their organisation to meet needs in the 21st century became a compelling issue by the turn of the century (Frenk et al., 1997; Mogedal & Steen, 1995). It appeared that the goals and development objectives set could only be reached with strengthening health systems, but the climate of economic stringency overshadowed the nature of reforms canvassed. Escalating health costs combined with shrinking resources resulted in an emphasis on ways to control and restrict costs. Health systems development was heavily influenced by such concepts, under the stewardship of the World Bank which had begun to overshadow the WHO.

Concerns with economics, efficiency, organisation, and technical aspects resulted in equity, needs, and ethics problems being frequently neglected (Bodeker, 2001c; Hanson & Callahan, 1999:53). However, the peculiarities of the health care market meant that economics alone could not address all resource allocation questions (Easthope, 1993; Walt & Gilson, 1994:290-291) and reducing inequities remained problematic (Gwatkin, 2002). Almost all policy tools used aimed at cost containment, but the effectiveness of these tools on allocative efficiency was not well understood (Xingzhu, 2003:6). Although there was evidence that the allocation of more resources to primary and preventive care (such as that offered by TRM/CAM) is highly cost effective and even cost saving, and would improve efficiency of health services, there appeared to be no clear mechanism for achieving the desirable resource shifts (Xingzhu, 2003:5).

At the same time, the regressive impacts of globalisation were becoming more apparent. For example, in China health care indices deteriorated after the adoption of a free market.
philosophy. Statistics demonstrated that the remarkable health improvements achieved during the Communist government (partly attained due to the pragmatic use of all medical/health resources, as well as equitable access to other services) were rapidly reversing. This was correlated with an increasing polarisation of wealth and other social policy failures (see Liu et al., 2001). In China, increasing expenditure per capita for health care through neo-liberal concepts of free market, user fees and health insurance did not produce corresponding improvements in health status (Hsiao, 1995:1047) and Chinese biomedical practitioners increased drug prescription, used expensive drugs and adopted high-technology tests in order to increase profits (secondary resources) (Hsiao, 1995:1054).

5.2.3 Complementary and Alternative Medicine

Much has been written on the rise of CAM in the North in the 1990s, and the reasons for it, of which only a brief reference can be made here (see Astin, 1998; Astin et al., 1998; Barrett, 2003; Barrett et al., 2003; Cant & Sharma, 2000; Easthope, 1993; Jonas & Levin, 1999; Saks, 1998; Sharma, 1992). The increasing resort to these healing modalities can be seen as an interesting parallel to the paradox of continued and even strengthening use of TRM in the South. Treating the “maladies of modernisation” (such as chronic diet and lifestyle related conditions including obesity, diabetes, heart disease, anxiety, stress and depression) required an emphasis on psycho-social and preventive dimensions of healing.

Biomedicine was not meeting the full needs of populations (as had been recognised in the South in the 1970s), and the rising global use of TRM/CAM created a progressively pluralistic health care sphere. For example, demographic and health transitions such as an ageing population and a growth in some chronic conditions, encouraged recourse to TRM/CAM in the North. Health conditions associated with obesity and depression rapidly became problematic issues not readily resolved by biomedicine, and threatened to become major costs to the state by 2020 (Janes, 1999:1807). People using CAM were not poor, neurotic or uneducated and it was both a pragmatic and rational use of resources (Jonas & Levin, 1999:4).

There have been various commentaries conjecturing on the rising use of CAM, as mentioned in the previous chapter. While the reasons for this growth and the scope of these healing modalities are interesting, for the purposes of this research only several factors are salient. Firstly, the rapid growth in CAM served to fragment and erode biomedical power and monopoly in the health services sphere, and biomedical authority was being undermined from below (community) not above (state). Secondly, this extraordinary growth in demand
for CAM created a massive global market for plant/herbal remedies, and TRM treatment modalities.

New consumers in the North gave economic and political weight to medical pluralism as they adopted TRM/CAM primary resources and therefore generated unprecedented secondary resources (status, prestige, economic benefits) for the sector. The number of practitioners of CAM increased rapidly – in the 1990s in Great Britain the number of CAM practitioners doubled to 60,000 and exceeded the number of biomedical general practitioners (Saks, 2003a:144). This represented a seismic shift in healthcare that threatened to reduce biomedical monopoly, professional dominance and status (secondary resources) (Cant & Sharma, 2000; Easthope, 1993; Saks, 1994; Sharma, 1992) but also offered an opportunity to potentially expand their primary resource base through co-option. Conversely, it represented an augmentation and increase of previously disparate TRM/CAM secondary resources (material rewards, status, and prestige) and an opportunity to increase structural strength on national levels.

Therefore, a tension and complex power balance resulted, with stakeholders needing to assess their situation and either re-align or mobilise strategies in defence to protect existing interests. Conflict can be seen to centre on primary resources – specifically the control, regulation, and authority to distribute the “new” resources in the North (CAM), and also access to the secondary resources that had now accrued globally. This again was played out and resolved with recourse to scientific discourse and professionalisation (discussed further in section 5.5). The WHO (to which we now turn) initially neglected or ignored and then tried to neutralise many of these conflicts. However, it was not operating as an impartial agent but as a stakeholder with its own imperatives and rationales.

Section 2: International bodies

5.3 WHO activities

During the 1990s, the WHO faced a range of crises across the full gamut of management, leadership, administration, structure, finances, objectives and direction (Godlee, 1994a, 1994b, 1994c, 1995b, 1997; Lee et al., 1996; Saracci, 1997; Walt, 1993). By the mid-1990s, the WHO was in a precarious financial position. In 1995, the rate of member contribution collection had fallen dramatically, to the lowest rate in the history of the organisation and even lower than 1948, the year of its establishment. The shortfall was unprecedented, and
related to the unstable economic position of some member states, but also expressed donor and member state dissatisfaction over policy and programme development within the WHO and the lack of confidence in Nakajima (Godlee, 1994c).

Nakajima, who had taken over as Director-General from Mahler in the late 1980s, was criticised as an unpopular and ineffectual leader, who left many staff and donors unimpressed (Godlee, 1994c, 1995a). His management style and personal commitment to health issues differed greatly from that of Mahler. For example, Mahler had shown extraordinary ability to take political risks, entering into the advocacy arena and diplomatically balancing competing stakeholder interests while promoting equity in health systems development. His response to pharmaceutical lobbying and pressure over the essential drugs scheme was to bring it into his own office and personally oversee it, giving it strategic support, protection and higher visibility (Walt & Harnmeijer, 1992:45). In contrast, one of the first actions of Nakajima was to move it into the Drugs Policy and Management Division (Walt & Harnmeijer, 1992:42).

Nakajima characterised the new direction of the organisation, which distanced itself from controversial or political issues and remained aloof from national level health systems concerns rather than taking the lead in policy direction. Matters like TRM did not find a receptive environment in senior management, despite Nakajima presiding over the second meeting of Directors of TRM Collaborating Centres in 1987 (as the then Director of the Western Pacific Regional Office) and espousing the merits of TRM in achieving HFA. Instead, the focus was strictly on the technical, biomedical realm and only providing guidance as requested. However, Nakajima himself did not remain untainted by controversy and scandal – in 1993 donors (concerned with the weakening of WHO influence under his guidance) took the unprecedented step of requesting Japan to withdraw his candidature for re-election. Allegations of corruption and undue political interference in the nomination process were also made (Godlee, 1994c). An external audit did not substantiate the corruption charges, but was critical of shortcomings in management (Godlee, 1994c).

This turmoil, combined with obvious failures in major policy initiatives such as HFA and PHC created much soul searching within the organisation and a fundamental reorientation. Godlee (1994c) noted that in the absence of coherent policy and clear strategy, the WHO

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Nakajima had in fact been the first head of the Drugs Policy and Management Division, where essential drugs was initially located (Walt & Harnmeijer, 1992:27) and had previously worked for the multinational pharmaceutical company Hoffman La Roche (Chowdary, 1995:141). His background and experience was thus clearly in the biomedical pharmaceutical sphere.
floundered internationally and was beset with internal conflict, low staff morale, and a
deepening budgetary crisis. In this void, the World Bank (and other agencies including
UNICEF and donor bodies) easily picked up the mantle of health policy direction (Zwi &
Mills, 1995:313). Some critics lamented the powerlessness of the WHO, and its perceived
inability to address social, environmental, economic or political factors influencing health
outcomes. Prior promotion of equity and universal health care were “drowned out” by the
conflicting objectives of the World Bank encouraging efficiency and economic growth
(Godlee, 1997). Chowdary questioned whether WHO passiveness was due to fear from
donors retaliating by withdrawing funds, or from staff being composed primarily of
biomedical doctors, which caused an adherence to:

an apolitical neutral stand [in which it] refrains from mentioning colonialism, neo-
colonialism and imperialism, all of which have played a significant role in the causation and
spread of diseases among the exploited and oppressed people of the world (Chowdary,

In 1998, Brundtland (a biomedical doctor with a Masters degree in Public Health from
Harvard, Chair of the Commission which had developed the notion of sustainable
development in 1987, and previous Prime Minister of Norway) was appointed the new
Director General. Brundtland personified how environment, sustainable development and
economics had become intertwined on the international health agenda. She immediately
undertook a senior management reshuffle, restructured the organisation and began to apply
private sector approaches to public sector health priorities (Mach, 1998), using the World
Brundtland emphasised the partnership with the World Bank, and established a Commission
on Macroeconomics and Health. A new unit was established – “Evidence and Information
for Policy” which was staffed by the authors of the *Investing in Health* Report, leading some
to object that the WHO had become a branch of the World Bank (Yamey, 2002).

This unit produced the World Health Report 2000, which introduced the concept of “new
universalism” and assessed national health systems’ performance in an index. “New
universalism” replaced the concepts of PHC and HFA. It advocated delivery only of
essential care defined by criteria of effectiveness, cost and acceptability, rather than “all
possible care for everyone” or simple, basic care for the poor. The ranking and index of
health systems performance sparked a furore as the WHO assessed health systems
performance, and some claimed it had breached its mandate and was infringing sovereign
rights of nations (Lucas, 2003). Whether the WHO will take a higher profile in guiding
health systems development remains to be seen. Brundtland’s reforms and initiatives had a
mixed reception and she stunned observers in 2002 by announcing she would not stand for re-election.

5.3.1 Progress on TRM policy and programme implementation

The crisis in administration within the WHO throughout the 1990s probably absorbed more attention and were higher priorities than small Programmes such as TRM.\(^\text{67}\) While the WHO navigated its way through internal strife, financial upheaval and critical analysis of its performance in international public health governance, it also faced critics on both sides of the TRM policy divide. While implementation of integration remained an “elusive goal” (Kennedy & Olsson, 1996:45), some castigated its lack of activity and leadership (Bodeker, 1996:325) while others rebuked the organisation for entering the policy domain and believed it should promptly withdraw from the field even if it was not willing to admit any error:

The WHO [TRM] drive was an erroneous approach, the helplessness of which has become apparent in the past years, and whose lack of relevance to the pressing health problems of the world is becoming more and more obvious. It is a blind avenue, not helping in the solution of AIDS or other multiple problems facing the Third World. However, it is realized that WHO will hesitate to admit this mistake because of political reasons (Velimirovic, 1992:77-78).

Proclaiming the failure and futility of TRM policy in the early 1990s, as Velimirovic stated above, may have seemed plausible in light of activity in the 1980s. However it was premature, as towards the end of the decade and turn of the century policy activity intensified in relation to TRM. Headquarters produced two worldwide reviews on the regulatory status of herbal medicines (WHO, 1998f) and legal status of TRM/CAM (WHO, 2001b). These reviews were a co-ordinated effort to clarify and develop a global overview of national activities. The review of legal status took nearly a decade to complete, mostly due to a lack of financial resources but also due to the difficulty in obtaining accurate and current information on even basic aspects of TRM/CAM, reflecting the low policy status it was accorded. Only 123 of the 191 member states contributed (WHO, 2001b:ix).

This intensification of policy activity was directly related to the growing market for natural and herbal therapies in the North, which rapidly increased throughout the 1990s and showed no signs of abating. For example, in Japan, the herbal medicines market doubled in only

\(^{67}\) “…the primary concern of every bureaucracy and its personnel is the corporate survival and, if possible, the growth of the organisation, and the simultaneous protection of the position of staff members. Only when these concerns are taken care of can a bureaucracy turn full attention to its client group; and on those occasions when corporate or individual survival are threatened, this group may receive short shrift” (Foster, 1977:531).
three years (it was worth US$1 billion in 1991 and US$2 billion in 1994). In the USA it
tripled in five years (estimated at US$1.6 billion in 1994, US$3 billion in 1997, and US$5.4
billion in 2000). In Arab countries, the import of herbal medicine increased nearly four-fold
in 2001 compared with 2000 (WHO, 2002f). In the latter half of the decade, spending by
consumers began to outstrip that of biomedicine in some countries. For example, in Malaysia
it was estimated that annually US$300 million was spent on biomedicine compared to
US$500 million on TRM/CAM (WHO, 2002e:2). The World Bank projected that the market
for herbal products would be US$3 trillion by the middle of the 21st century (Bodeker, 2000).

By 2000, the economic value and trade importance of TRM forced a range of regulatory and
legal issues onto the agenda, discussed at an inter-regional workshop on IPR in the context
of TRM (WHO, 2000c). Clarifying and establishing IPR became crucial in order to stake
claims on secondary resources (economic benefits) generated from this surge in sales of
TRM/CAM primary resources (plants, herbs). The introduction to the report of the workshop
noted that there was an “increasing awareness of the value of traditional knowledge and
biodiversity resources as economic and tradable commodities. This, coupled with the impact
of the … (TRIPS Agreement) on pharmaceuticals, including [TRM] necessitates this
meeting” (WHO, 2000c:1.1). TRM was considered the foremost area driving the IPR agenda
in the field of traditional knowledge (WHO, 2000c:1.1). TRIPS and trade issues had a
significant impact on both TRM and the essential drugs scheme, and became inherently
linked with the fate of these programmes throughout the decade.

The Western Pacific Regional Office publications also became more directly focussed on
policy and regulatory aspects. Development of National Policy on Traditional Medicine
(WHO, 2000a) and Traditional and Modern Medicine: Harmonizing the Two Approaches
(WHO, 2000d) were published as reports of consultations held in China in October and
November 1999. These activities were supplemented with international symposiums held in
Japan, sponsored by a new WHO Centre. The WHO Kobe Centre for Health Development
was established in 1998 to conduct research into the health consequences of social,
economic, environmental and technological changes and their implications for health
policies. In this capacity, it took an active interest in TRM and published the proceedings of
meetings exploring policy, services and utilisation (WHO, 2000e, 2001a, 2001c).

This flurry of activity between 1999 and 2001 culminated in the WHO Traditional Medicine
Strategy 2002-2005 (WHO, 2002e), which is explored in the subsequent chapter and referred
to as the TRM Strategy. The documents produced throughout the 1990s are discussed in
more detail below, along with WHO activities in relation to TRM. In the analysis of

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developments, it will be demonstrated that the WHO activity was clearly linked to the rising economic weight of TRM in the global trade arena and unregulated health care sector, and efforts to moderate, control or oversee this growth.

The issue of newly discovered or imported primary resources intensifies conflict, as it ignites a battle for control (Unschuld, 1975:311), and administratively the WHO (while placing itself as a neutral arbiter) is operating from a biomedical perspective thus forming a de-facto alliance with the biomedical coalition. The remainder of this chapter is structured in the same way as the previous chapters, assessing the WHO activities in relation to traditional medicine in discrete policy areas – 1) traditional birth attendants, 2) resolutions, and 3) programme development including: a. TRM Programme, b. essential drugs and c. PHC.

5.3.1:1) Traditional birth attendants

A joint statement on TBAs was released by the WHO, UNFPA and UNICEF in 1992. This appeared to acknowledge the limitations on training of TBAs, and also pass the mantle onto other organisations for future work.68 Guidelines for training TBAs were published in the same year (WHO, 1992b, 1992c, 1992d). Apart from this activity early in the decade, TBAs appeared to totally disappear off the agenda and no meetings were held or publications produced solely by the WHO in relation to this type of TRM practitioner throughout the rest of the 1990s. What had been one of the initial focal points for the WHO in the TRM field in the 1970s had no profile at all two decades later. This shifting focus was referred to at the third meeting of Directors of the TRM Collaborating Centres:

[1]In the light of …the recognized successes of the Traditional Birth Attendants and Traditional Bone Setters, it is now time to redirect our efforts to promote the use of traditional herbal medicines and acupuncture … (WHO, 1996e:54).

The reasons for the diminished role of TBAs in the TRM Programme can only be speculated upon. In the face of budgetary restrictions, those programmes difficult to quantify or evaluate may have been the first to be scaled back. Other agencies with a direct or specific interest in maternal and child health (such as UNICEF and UNFPA) may have taken this objective on board. It appears unlikely that the reason as stated (“mission accomplished”) is the rationale,

68 “Training of TBAs cannot be used as a single approach to improving maternal and child health care. Without implementation of appropriate technologies and strengthening of referral and support systems, TBA training alone cannot contribute to a substantial improvement in health care. Furthermore, trained TBAs cannot be expected to reduce overall mortality and morbidity rates when poverty, illiteracy and discrimination – the underlying causes of these problems – are not addressed.” (WHO, 1992a:15)
as there is no evidence presented of any recognised and sustained successes. One study found little outcome evaluation studies, concluding that beneficial impacts of training TBAs was not “compelling” and suggesting alternative investments and more realism about the impact of programmes (Smith et al., 2000). A combination of budgetary restrictions, shifting priorities and difficulty implementing and evaluating such programmes may be a more realistic explanation of lack of focus on TBAs by the WHO in the 1990s.

5.3.2:2) Resolutions

In 1991, the Executive Board recommended that the World Health Assembly adopt a resolution on TRM and modern health care (EB87.R24). This resolution was adopted (WHA44.34), although with slight modifications from the resolution of the Executive Board. It also noted that increased funding was required to enable TRM “to take its rightful place in health care” and requested member states to introduce measures for the regulation and control of acupuncture. The wording of resolutions and debate surrounding them reflects that the World Health Assembly, Executive Board, member states, and the WHO management and administration operate according to divergent political and economic influences and priorities. These interests can be moderated via various mechanisms such as through debate on resolutions and their wording, internal resource allocation, policy and programme development and implementation both within the organisation and on national levels.

5.3.2:2a) Resolution WHA44.34 (1991)

This resolution recalled the previous resolutions in relation to TRM, acknowledged the importance of TRM to health care, the potential medical and economic value of plant substances, and the fact that many medicinal plants were threatened by ecological and environmental changes. Both economic and environmental concerns were dual factors pushing TRM consideration, and the emphasis shifted from an almost exclusive focus on manpower to one of medicinal plants (and acupuncture).

Member states were urged to increase funding and accelerate activities to strengthen cooperation between TRM and biomedical health care providers, particularly in relation to the use of “scientifically proven, safe and effective traditional remedies to reduce national drug costs” and the regulation and control of acupuncture. The Director-General was requested to continue to recognise the importance of the TRM Programme and to “ensure that the contribution of scientifically proven traditional medicine is fully exploited within all of the WHO programmes where plant derived and other natural products may lead to the discovery
of new therapeutic substances”. TRM practitioners considered as manpower to extend basic health care services were diminished in importance in comparison to the 1970s, and became almost invisible. The economic value of TRM remedies was paramount – they could potentially reduce the cost of health care in the South while providing exploitable biomedical pharmaceuticals for the North. This trend continued the focus from previous years, but inflated phytotherapy (ethnobotany) above manpower considerations.

5.3.2:3) Programme development and promotion

Throughout the 1990s, the TRM programme, essential drugs scheme and PHC all had various successes and failures. By the turn of the century, PHC and TRM as discrete organisational objectives ceased to exist. In contrast, essential drugs took a more prominent role. The WHO appeared to conceive of TRM purely as an adjunct to essential drugs (as it had to PHC earlier in the decade). This view considered TRM only from the perspective as to how it could be utilised primarily as a source of pharmacologically active raw materials, and “overlooks the potential for wider involvement … and appears not to value ancient and well-documented traditions and knowledge of [TRM] which may be able to manage some chronic and debilitating disorders better than [biomedicine]” (Bodeker & Bichan, 1996:395).

5.3.2:3a) Traditional Medicine Programme

The TRM Programme had been moved into the newly established Drugs Policy and Management Division in the late 1980s (Akerele, 1988:359), alongside essential drugs. Later, TRM was located within the Department of Essential Drugs and Medicine Policy. The downgrading of the TRM Programme may have been undertaken as part of the general administrative and organisational re-structuring of the WHO, prompted by their financial and management crisis. According to the WHO, this administrative change signalled “the importance of plants as sources of products of medicinal value” (Zhang, 1994:141). It also reflected the subordinate status of TRM to biomedical authority, and a technical, biomedical, reductionist view on TRM systems.

The TRM Programme was subject to a progress report in 1991, a review of activities in the African Region in 1993, and was due for its first formal evaluation at the WHO Executive June 1994.

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69 Only 1,100 of the earth’s 265,000 species of plants had been studied by scientists, and as many as 40,000 of them may have medicinal or nutritional value (according to the Director of the New York Botanical Garden’s Institute of Economic Botany) (Dharmasiri, 1997:175). Plants form the basis of many prescription medicines, between 1959 and 1980 approximately 25% of all prescriptions in the US contained material from plants (Farnsworth & Soejarto, 1985).
Board meeting in January 1996. The 1991 progress report by the Director General appeared to sanction a more restrained stance on TRM, and was a marked difference in attitude to Mahler whom he had recently replaced:

… there are limits to the scope of the WHO TRM Programme. It receives innumerable requests which, if acted upon, would involve it in activities for which it is not prepared or which are contrary to its objectives. WHO is often asked to sanction all kinds of traditional and alternative medicine practices, many of which are of highly dubious value and some of which are outright dangerous … (Nakajima, Director General of WHO in 1991 progress report on the TRM Programme, in Velimirovic, 1992:77).

The first formal evaluation was foremost in the minds of those attending the meeting of Directors of TRM Collaborating Centres in late 1995, and they were reminded that the outcomes of that meeting would be of great importance in determining the fate of the TRM Programme (WHO, 1996e:6). However, no record of the evaluation at that Executive Board meeting, or any subsequent meetings, could be located. The TRM Programme was only mentioned by a representative of the World Federation of Proprietary Medicine Manufacturers, which had an obvious commercial interest in promoting the use and distribution of non-prescription medicines. He was impressed with the efforts and achievements of the Programme, particularly the development of guidelines for herbal medicines. In light of increasing international trade that demanded standardisation, he hoped that this importance would be reflected in future financing of the Programme (WHO, 1996a).

Despite such appeals and the resolution of 1991 calling for increased activity and co-ordination, throughout this decade the TRM Programme was progressively scaled back in staff and financial input, with a total budget of only US$180 000 in 1996 (Bodeker & Bichan, 1996:395). In the budget for 1996-1997 it was proposed to reduce the activities at headquarters in relation to TRM. The lowering priority of TRM within the WHO in the mid-1990s seemed to paradoxically correspond with the increasing global functional strength of TRM/CAM.

The TRM Programme had already been weakened by the lack of a dedicated and permanent Programme Director, following the retirement of Akerele in the early 1990s. Akerele was replaced with Dr. Zhang, in an acting (temporary) co-ordinating role and the position of Director was downgraded to programme officer. Emasculated by minimal funding, the TRM

70 None of these progress reports or evaluations (1991, 1993, 1996) could be located.
71 In 1989 this group (WFPMM) had collaborated with the TRM Programme in a working party on herbal medicines, which led to the development of guidelines for their assessment.
Programme now also lacked a senior advocate (*policy entrepreneur*) within the Organisation. The discrete re-shuffling of programmes resulted in “almost silently” placing TRM in Drug Policies and Management where it was “dying a slow death” (Ventevogel 1996 in van der Geest, 1997:904). The low priority given to TRM at WHO Headquarters was considered indicative of a lack of international leadership in this policy field despite the massive growth in popularity of TRM/CAM, and the WHO instead left a “vacuum in the face of a vast plebiscite [in favour of it]” (Bodeker, 1996:325).

The **scope** of the programme became more tightly defined in the 1990s, which is evident in the report of the third meeting of the Collaborating Centres for TRM (WHO, 1996e). A focus on activities related to the dual priorities of *medicinal plants* and *acupuncture* was mentioned at least half a dozen times throughout the body of this report. They were considered significant areas that efforts should be directed towards, as they were the “most important” to national health services (WHO, 1996e:5, 11, 26, 28, 53, 54). While manpower and training received attention in the 1970s, in the 1980s an emphasis on herbal medicines was obvious, and this now also explicitly included acupuncture.

This was not completely unforeseen, considering the references to acupuncture from the initial technical report on traditional medicine (WHO, 1978b), the recommendations of the second meeting of Directors of Collaborating Centres (WHO, 1988:17) which encouraged acupuncture alongside herbal medicines, and the resolution in 1991 (WHA44.34). The WHO Regional Office for the Western Pacific had convened meetings on acupuncture since 1981, and produced a series of documents on standardising acupuncture nomenclature as well as testing, training and safety (Bergstrom & Mocumbi, 1996; WHO, 1984, 1991b, 1991c, 1993b, 1999, 2002a). These meetings and publications had the goal of standardising acupuncture for global application, as well as encouraging clinical studies to validate it and improve “its acceptability to modern medicine … thus extending its use as a simple, inexpensive and effective therapeutic option” (Bergstrom & Mocumbi, 1996). The guidelines were designed to assist in training programmes for biomedical practitioners who wished to adopt acupuncture as a clinical practice (WHO, 1999), a process which could be seen to support and promote the trend for biomedicine to absorb it into their therapeutic range.

The elevation of acupuncture alongside herbal remedies as a WHO Programme priority can be considered a coup for the Chinese government, which had energetically promoted the clinical effectiveness of acupuncture since the 1970s. Now the WHO was encouraging and assisting the global dissemination of this particular treatment modality, specific to traditional
Chinese medicine (TCM). There can be a number of reasons conjectured for this development. Clearly, the influence of the Chinese government on programme and policy development on TRM within the WHO may be considered a factor. Beyond inspiring the initial promotion of TRM on an international level, it continued to host and sponsor meetings, exchanges of health professionals and to actively promote the merits of TCM.\textsuperscript{72}

In addition, acupuncture had received great clinical interest and scientific validation for treatment of certain conditions, which provided legitimacy to biomedical practitioners. According to the WHO, the efficacy of acupuncture to treat conditions such as pain and nausea had been “conclusively demonstrated and … acknowledged worldwide” (WHO, 2002e:23). Acupuncture also shared techniques common to biomedical primary resources (needles), despite the underlying philosophy of energy meridians being completely outside the boundaries of the Western scientific paradigm. Finally, by the 1990s, acupuncture had become increasingly popular in the North and therefore generated secondary resources that biomedical practitioners were keen to access and therefore incorporate into their practice (Easthope et al., 1998; Easthope, Tranter, & Gill, 2001; Saks, 1992b, 1995b).\textsuperscript{73}

This specific interest in acupuncture was reflected in the WHO TRM Strategy (WHO, 2002e), which made over a dozen references to acupuncture as opposed to two passing references to spiritual therapies and four similarly negligible references to manual therapies. Amongst all therapeutic techniques used in TRM, acupuncture was successfully promoted as a pre-eminent treatment modality and the only one endorsed by the WHO for global transfer. This illustrates the trend Lee (1982) observes – that a TRM therapy (e.g. acupuncture) may try to increase structural strength through the adoption of scientific discourse and professionalisation, but that this ultimately facilitates absorption within biomedical systems (which in turn serves to further increase the structural strength of biomedicine).

How this endorsement was regarded in other regions, such as Africa or the Eastern Mediterranean, is not clear. It appears to move beyond the boundaries of the TRM Programme as initially proposed and espoused at the PHC meeting in Alma Ata, which was to encourage the use of local resources to supplement health care. While the attention given to acupuncture can be traced to the 1978 technical report on TRM, it had not been singled

\textsuperscript{72} The success of the Chinese promotion of TCM was recognised by competitors: “China has achieved official recognition of acupuncture treatment and has successfully captured a large chunk of the herbal medicine market in the US. It is high time the government of India, Ayurvedic medical community and the Ayurvedic industry aggressively seize the opportunity and make a mark in the frontiers of medicine” (Shah, 2003).

\textsuperscript{73} In Switzerland, nearly 50% of biomedical doctors had used some form of CAM – mainly acupuncture and homeopathy, in Belgium 74% of acupuncture treatment was administered by biomedical practitioners, and in the UK 46% of biomedical doctors either used acupuncture or recommended it to patients (WHO, 2002e:11-12).
out but mentioned as only one among various TRM treatments considered to have therapeutic merit. Other therapies and TRM systems mentioned in that report included moxibustion, Ayurveda, Siddha, Unani and yoga. It appeared that the very trend that the technical report had warned against – that of reducing the therapeutic value of TRM to medicinal plants (WHO, 1978b:10) had materialised, with the addition only of acupuncture as a treatment modality.

China actively capitalised on the endorsement of and interest in acupuncture. For example, The WHO Collaborating Centre in Beijing sent instructors to Chile, India, Japan, Mauritius, Papua New Guinea, Spain and Turkey to train biomedical doctors, and held various courses which trained over 2500 people from 70 different countries (WHO, 1996e:40). Four Collaborating Centres were significantly or solely devoted to clinical research in acupuncture, demonstrating its scientific basis and effectiveness in biomedical terms (particularly as an analgesic). For example, areas of research included identifying the scientific basis of yang and yin deficiency (WHO, 1996e:45) and controlled biomedical studies on the validity and strength of various acupuncture points (WHO, 1996e:47).

The third meeting of the Directors of the Collaborating Centres on TRM was held in China in 1995 (WHO, 1996e). Only 17 of the 25 Directors could attend, due to financial stringency. The Report did not publish the full details of their activities, but instead chose only to include selected excerpts due to constraints of space (WHO, 1996e:31-52). Regional activities were also reported on, but only from the African, Eastern Mediterranean and Western Pacific Regions (WHO, 1996e:17-30); reflecting the geographic distribution of TRM systems still heavily patronised by populations.

The reports of the collaborating centres and regional offices are notable for their heavy use of biomedical and scientific discourse to describe their activities and outcomes. The biomedical effectiveness of TRM was considered necessary to ensure its role in health care systems (WHO, 1996e:25), enhancing its acceptance and improving its application (WHO, 1996e:28). None of the Centres made reference to policy or health system issues, or regulatory issues related to TRM in their reports of activities. Activities were almost exclusively centred on screening, identifying, extracting and testing plant compounds. This tone was set in the progress report from China, the only single country to present a report which was provided as part of the preparatory statements. This also reflected the paramount position achieved by China in guiding and setting parameters of discussion. In 1987, TCM had been proclaimed the “most highly developed” of TRM systems in the Western Pacific
Region (WHO, 1988:39), a status practitioners of other systems (such as Ayurveda) may have found contentious.

In the presentation from China, achievements were couched in terms of what TRM had contributed to biomedicine. The biomedical terminology is so profuse that large sections of the report would be incomprehensible to a lay-person or most TRM practitioners and Chinese remedies were translated into and ranked against a biomedical framework. The adoption of scientific techniques (such as extraction and artificial synthesis of compounds, artificial cultivation, classification and examination for quality control) were viewed as promoting TRM. Future development and accomplishments were considered possible with collaboration from scientists (WHO, 1996e:10). Efforts to increase yield, standardise and simplify cultivation, genetically modify and selectively breed plants to reduce variability and produce more uniform raw materials, and standardise and regulate active ingredients were both necessitated by and facilitated further industrial production and commercialisation of TRM.

The growing nexus between science, technology, TRM and market imperatives can be illustrated with the Chinese progress report (WHO, 1996e:7-10) which described their policy to promote scientific research of TRM, and the transfer of this research into pragmatic outcomes including economic benefits. This policy was an extremely inventive approach that tied salary and professional status and prestige (secondary resources) to contributions made to scientific research projects. Operating on a five year cycle, the state determined and assigned key projects to various groups, supported by a science fund. The research outcomes were then ranked according to academic value and profits obtained, and were accordingly awarded honours of different grades. Salaries were linked to the contributions of individuals to the awarded projects, and it was noted that this initiative had spurred the expansion of scientific research institutes and personnel.

Most of the recognised achievements used Western scientific methods (including biomedicine) and were based on clinically analysing and systematising TRM (WHO, 1996e:8).

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74 For example: “Anisodamine, an alkaloid extract from Anisodus tanguticus (maxium) pascher can be semi-synthesised into 654-2. The latter is comparable in effectiveness to the natural 654 in the treatment of fulminating epidemic encephalo-spinal meningitis ... An anti-cholinergic drug, anisodine hydrobromate, for oral or parenteral administration, has been prepared. It is effective in vasospastic conditions (e.g., central retinopathies, obstructive cerebro-vascular disorders ...) Huperzine A, a new and true cholinesterase suppressor, isolated from Huperzina serrata (Thunb) Trev. and Pinus massoniana Lamb., which were screened from more than 3000 different Chinese medicinal herbs, is superior to neostigmin for myasthenia gravis. Biphenyl-dimethyl-dicarboxylate and Schizandrol, designed and prepared according to the pharmacological actions of Fructus Schizandreae are indicated for chronic hepatitis ...” (WHO, 1996e:8).

75 At the end of 1994, there were over 10 000 professional technicians, and 170 TCM institutions which included 77 independent scientific research institutions. Over 1300 prizes had been awarded (WHO, 1996e:7).
Both TCM and biomedicine were therefore sharing secondary resources (status, economic benefits), although the status of TCM was defined only in relation to biomedical parameters. Therefore their primary resource base was indirectly controlled by biomedical practitioners, and secondary resources contingent upon conformity to biomedical standards and frameworks.

This use of Western science to validate and “modernise” TCM appeared to have ultimately aided in its successful global export (especially as this facilitated industrial production and regulatory compliance). For example, the use of scientific approaches had enabled quality control, so that TCM products could enter the international market and compete with other botanical products (particularly in Europe) (Eskinazi & Mindes, 2001:21). Whatever the origins or motivations of this technique, demonstrating scientific validity was most successfully embodied by the Chinese government. It made an extraordinary political and financial commitment to this mission, which was now paying financial dividends as TCM became the most widely exported TRM system. While this strategy may have resulted in domestic economic savings in the form of low cost health services from the 1950s to the 1970s, between the 1980s and 1990s it also generated considerable revenue. In 1995, there were 1500 factories processing raw plant materials and nearly 700 factories producing patent TCM remedies, exported to more than 100 countries (WHO, 1996e:30) and generating US$1.8 billion in annual sales within China alone (see Chaudhury, 1992; WHO, 1996e:27).

Other regions and collaborating centres were less active and profitable, and were severely constrained by a lack of funds. Headquarters was not providing financial support (WHO, 1996e:12), and the Collaborating Centres were urged to become self-sufficient or seek funds from their respective national governments (WHO, 1996e:53) or even external donors. The WHO identified one role in relation to TRM as guiding the Centres to locate financial assistance from other agencies (WHO, 1996e:54). The African region noted that their funds were inadequate to meet the challenges posed in terms of requests for policy assistance from member states (WHO, 1996e:17). In Nigeria, medicinal plants had not been pharmacologically screened due to the lack of funds for extraction (WHO, 1996e:33). The Western Pacific region also mentioned the need for financial assistance (WHO, 1996e:30).

National level activity is discussed in more detail later in the chapter (section 5.5), with a general observation here that the Collaborating Centre reports and regional activities demonstrated the extremely wide variability on national levels in both political commitment and financial support. While 25 centres were operating in 1996, this had contracted to 19 Centres by 2002. Nigeria, Sudan, India and two European Centres had all either ceased
operating or were no longer affiliated with the WHO, leaving the Eastern Mediterranean Region unrepresented, and South East Asia with one Centre. Meanwhile, over 60% of the Centres were located in the Western Pacific Region with 7 alone in China.  

There were no further meetings of the Directors of Collaborating Centres following the downgrade in TRM Programme status, with a total of only three meetings in 25 years of operation. At least a dozen meetings would have been held in the same period if the meeting schedule initially proposed had been adhered to. This can be interpreted as reflecting the low priority of TRM within the Organisation, although some may further contend that it (whether inadvertently or deliberately) served to weaken and fragment TRM collaboration and centralise policy power in China, which had benefited from a dominant position in TRM policy development from inception.

In the meantime, while AIDS remained an urgent health problem and absorbed increasing amounts of funding and attention, the direct association between HIV/AIDS and the TRM Programme (as mentioned in the previous chapter) became tenuous. The initial efforts at using TRM remedies or practitioners (WHO, 1989b, 1990b, 1990c) did not translate into a solid programme objective during the 1990s. AIDS became a huge priority within the WHO, and grew to the single largest programme by the mid-1990s accounting for a third of the organisation’s entire budget (Peabody, 1995:731). However, in 1993 the United Nations removed the Global AIDS Programme out of the sole control of the WHO, and it became a multi-agency programme jointly managed by the WHO and two other United Nations bodies (the UN Development Programme and the UN Population Fund). This was interpreted by some as a vote of no-confidence in the WHO, and in its ability to tackle complex health issues while operating from such a narrow technical base (Godlee, 1994a:1493) – a factor which may also be relevant in explaining difficulties the organisation faced in addressing the role of TRM in health care systems.

The fact that the Global AIDS Programme was no longer under the sole purview of the WHO may be a factor for the lack of co-ordination between it and other WHO Programmes, such as the TRM Programme. The budgetary restrictions of the TRM Programme and its downgraded status within the WHO could also explain a reduced role. The co-operation required between TRM and biomedical practitioners to clinically explore TRM remedies may also have been difficult to encourage and sustain. For whatever reason, AIDS and TRM

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76 The regional breakdown of Collaborating Centres was Africa (3), Americas (2), Europe (1), South East Asia (1) and Western Pacific (12) (WHO, 2002e:49).
did not continue to be directly linked within the WHO as earlier demonstrated, in terms of clinical screening for potential treatments or programme development using TRM practitioners in prevention or support efforts.\textsuperscript{77} However, AIDS did continue to impact on TRM systems of health on national levels. For example, many people afflicted with AIDS sought treatment from TRM practitioners, and a lack of affordable and accessible biomedical treatments encouraged people to desperately seek alternative remedies. Surveys revealed that over three-quarters of AIDS patients in Africa, North America and Europe used traditional or complementary medicine for various symptoms (WHO, 2002f).

This new demand for TRM had broader and unanticipated impacts – for example, stocks of wild African potato (\textit{Hypoxis hemerocallidea}) were threatened with extinction after it received publicity as an AIDS treatment (WHO, 2002e:25), and TRM/CAM remedies interacted in sometimes negative and dangerous ways with biomedical treatments for AIDS (WHO, 2002e:27).\textsuperscript{78} It was argued that despite a lack of official recognition, TRM was carrying the burden of the AIDS epidemic in the South and this role was being overlooked by national governments and international agencies (editorial, 2002a; WHO, 2002e:13). Some countries and agencies did see the potential for greater co-ordination between TRM and biomedical practitioners, albeit belatedly and without direct guidance or assistance from the WHO (see Burford et al., 2000). For example, in South Africa TRM practitioners were trained in AIDS diagnosis and biomedical referral, while they provided psychological and spiritual support (du Venage, 2003).

The AIDS Foundation in South Africa (a non-governmental organisation) trained over 6000 local practitioners in this role, which was only a small part of the “informal hospice” TRM practitioners often offered to AIDS patients – including food, shelter, compassion, and even caring for children left orphaned. Dispensing anti-retroviral drugs was considered the ultimate goal, but one that seemed distant (du Venage, 2003). This was probably not only due to the demonstrated general reluctance of biomedicine to share its primary resource base with TRM practitioners, but also because of the expense and limited supply of these drugs in the South due to patent and intellectual property rights disputes (disputed access to secondary resources). The pharmaceutical monopoly on production and pricing limited the

\textsuperscript{77} The joint programme on AIDS did explore the use of TRM practitioners later in the decade (UNAIDS, 1999) - after AIDS became a joint UN programme and not the sole responsibility of WHO.

\textsuperscript{78} For example, if an AIDS patient was taking the herb St John’s Wort and also taking indinavir (an HIV protease inhibitor), the levels of indinavir in the blood would be reduced to below the level required to block HIV multiplication (WHO, 2002e:27). The trend to “pick and mix” treatments from biomedicine and TRM/CAM could therefore result in unanticipated health consequences. The primary resource bases of TRM/CAM and biomedicine were not always compatible.
potential for generic drugs to be cheaply produced and supplied, and the need for an affordable alternative became even more pressing.

Aside from environmental threats posed by uncontrolled harvesting of plants to meet the escalating need for alternatives, there were also economic threats and challenges. There was a serious concern about the commercial potential to patent plant remedies that would ultimately price them beyond the financial reach of communities (Bodeker, 2000; WHO, 2002c:17). For example, African communities feared that another indigenous plant that offered a cheap, natural AIDS treatment (*Sutherlandia frutescens microphylla*) could be patented by drugs companies (Independent, 2001). A month’s supply of this drug cost only US$2.50, but if patented it would be subject to the monopoly pricing of other pharmaceuticals and thus out of reach of the communities it could effectively treat. In seeking to maximise secondary resources (economic benefits), pharmaceutical companies were therefore restricting access to primary resources (drugs) - ironically to the very communities who may have been the original custodians of those resources and in most need of them.

Biomedical capitalisation of TRM knowledge and primary resources was a threat that TRM practitioners were aware of in the initial consultations held on AIDS, which was why some practitioners were possessive of their remedies and decided to keep them secret (WHO, 1990c:37). So in protecting their own primary and secondary resources, they were also preventing the broader distribution of such remedies through biomedical channels. The secondary resources attached to treating HIV/AIDS were significant. For example, Ethiopian women who had used plants to treat AIDS-related opportunistic infections received both financial and political benefits, with some achieving the position of community leader (Burford et al., 2000:10).

AIDS was mentioned in the TRM Strategy (WHO, 2002e), so indirectly it was a factor that forced TRM back on the agenda even though this relationship appeared neglected by the WHO throughout the decade. While the WHO TRM Programme did not take an active role in AIDS prevention and cure, malaria assumed a greater importance. Although research on anti-malarials was undertaken in the 1980s (WHO, 1988:41), the prominence given to it increased in the 1990s, evidenced in the Report of the third meeting of Directors of Collaborating Centres. It is mentioned frequently (WHO, 1996e:5, 8, 32, 37, 41), and listed
as a distinct area of activity in three centres. It had re-emerged as an important public health issue due to the development of strains of malaria that were resistant to standard biomedical treatments (primary resources), while the natural source of these synthetic biomedical compounds was still effective (Bodeker, 1994b:12). By 2004, biomedical treatments were 90% ineffective, deaths from malaria were estimated by some to be over 2 million per year and it was consuming up to 40% of African health budgets (Henderson, 2004).

TRM was still being widely used to combat malaria. In Ghana, Mali, Nigeria and Zambia, herbal medicine was the first line of treatment for more than 60% of children with malarial fever, and clinical studies on anti-malarial herbal medicines showed they could remove the parasites within one week (WHO, 2002f). In Ghana and Kenya, biomedical antimalarials cost several dollars (when total per capita out of pocket health expenditure annually was US$6) while the cost of self-treatment with herbs was estimated at 10c. Payment in kind was also possible in TRM health systems (WHO, 2002c:13). What had been emphasised in the 1970s was still relevant in the 1990s - TRM was more affordable, accessible and appropriate for many communities in the South, and may offer a viable alternative to treat some intractable problems.

Ironically, malaria eradication programmes had failed in the 1970s due to increasing DDT resistance (now banned for environmental reasons) and lack of biomedical infrastructure, and this was one of the failures that had originally pushed PHC onto the agenda (Mull, 1990:28; Newell, 1988:903; Walt, 1994). Two decades later, malaria again defeated biomedical vertical interventions (such as the roll-back malaria campaign), and inspired the push to look for alternative, cheaper and more effective solutions that cast TRM back under the biomedical gaze. However, in this case, it was to be used for the development of more potent pharmaceuticals rather than in delivering comprehensive, preventative community based health care (drugs, not manpower or public health campaigns).

In comparison to the new emphasis on malaria, a passing reference to AIDS was made by only one Collaborating Centre, which acted as a clearing house for secondary information, and was not involved in clinical testing. Both AIDS and malaria were mentioned with an almost equal number of references in the TRM Strategy (WHO, 2002e), and were the only

79 A new anti-malarial drug had been developed from a TCM remedy (Artemisia annua) and this was now being commercially produced in Europe following a licensing agreement with the Chinese government, a feat they were proud of on both economic and medical grounds. In 2004, another (cheaper, synthetic) anti-malarial drug was developed from the same TCM remedy (Henderson, 2004).
medical conditions to receive a separate listing in the index and the strategy objectives. AIDS and malaria represented a large burden of disease in the South, were the two leading causes of mortality and were crippling national health systems and economies – making them priority areas for TRM (Bodeker, 2001c:46). In sub-Saharan Africa in 1999, there were 6,027 deaths a day due to the HIV/AIDS epidemic, and 2,345 deaths a day due to malaria (with 8,181 deaths a day from diarrhoea) (Burford et al., 2000:13). They were still inadequately addressed by biomedical primary resources – as were many other diseases, which required access to either essential drugs or cheaper locally produced alternatives. What the history of HIV/AIDS and malaria demonstrated was that for some conditions, neither biomedicine nor TRM were independently fully effective. Both systems required an interaction and co-operation with the other to tackle problematic public health issues.

5.3.2:3b) Essential Drugs Scheme

The focus of the WHO in the TRM field was most clearly illustrated by the TRM Programme’s absorption within the Department of Essential Drugs and Medicine Policy. At first glance, the link between these areas may not be obvious and TRM and essential drugs may even appear inherently contradictory. However, the genesis of both programmes was common and they were originally linked in intent. In the 1970s, these programmes derived from the objective of encouraging the development of low cost health services in the South, equity of access, and rationality in resource allocation. They were all members of the PHC family, and interlinked spokes of the WHO policy platform that evolved in the 1970s to achieve HFA by the year 2000.

The programmes were closely related – the initial essential drugs report recommended that “the benefits and safety of traditional medicines, including medicinal plants” be evaluated (1977:18), and therefore TRM was always meant to be one aspect of the essential drugs approach. The common ground between them was the development of cheaper, culturally appropriate plant based alternatives to treat preventable health conditions in the South. They were both directed to achieving affordable, accessible and appropriate health care, the principles of PHC in operation. However, the international regulatory environment was not conducive to the development and use of natural products (TRM) as essential drugs

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80 It could be argued that family planning and maternal/child health initiatives of the 1970s, which were an original impetus propelling TRM onto the health care agenda, demonstrated the same thing. In the North, chronic diet and lifestyle related conditions (such as obesity, diabetes, heart disease, anxiety, stress and depression), and conditions associated with aging, also demonstrate this. All require a focus on health education, prevention and/or psycho-social support mechanisms. While clinical interventions may also be necessary; prevention, education and support (of which TRM/CAM systems focus) are equally or more important aspects. A focus on upstream, not downstream approaches may prove more effective in the long-term.
(Bodeker, 1996:325). For example, over two decades of medicinal plant research in Africa had not led to the development of a single medicine produced for national distribution (Burford et al., 2000:7) and the WHO did not show any interest in encouraging the necessary research in this area (Chaudhury, 1992:79).

The apparent co-ordination between the two programmes within the WHO in the intervening years had also not been strong. There is little reference in TRM programme documentation to essential drugs, and vice versa. This is also reflected on commentary on the essential drugs programme. For example *Drugs Policy in Developing Countries* (Kanji et al., 1992) analysed the implementation of this policy on national levels, but only referred to TRM in the context of TRM practitioners misusing biomedical drugs such as antibiotics (Kanji & Hardon, 1992:102). Essential drugs policy certainly had a higher profile, and was generally restricted in interpretation to pharmaceuticals. While essential drugs expanded its ambit and grew more robust over time, eventually celebrating 25 years in operation, the adoption of the concept in over 150 countries and even its own newsletter (WHO, 2003a), the TRM Programme progressively atrophied and was eventually subsumed by its thriving sibling.

This may have been partly related to the nature of the WHO as an organisation, which was more comfortable and familiar with essential drugs as a concept. It was easily quantified, evaluated and implemented and a more compatible match with the technical, vertical, biomedical foundation of the WHO. In addition, as mentioned in the previous chapter, a bleak economic environment dominated by neo-liberal philosophies released contradictory forces which affected the evolution of these programmes differently. While such an environment was a positive force for the essential drugs concept, it was negative for TRM and community based health care approaches more broadly.

These same restrictive economic conditions meant that at community levels, people who were unable to afford or access biomedicine (under privatised health systems) resorted to TRM. For example, a survey in Abidjan, Cote d’Ivoire found that 13.5% of households had replaced biomedicine with TRM for health care after the Ivorian franc was devalued, and in some regions of Africa people used TRM more often after the introduction of user fees for previously free government biomedical services (Bodeker, 1996:324; Bodeker, 2001c:54; Tsey, 1997:1065). The introduction of private insurance schemes for biomedical services can also lead to the uninsured seeking more TRM services (Bodeker, 2001c:57) – reimbursement or subsidies under private and public insurance schemes affects access to and utilisation of TRM/CAM in complex ways (Bodeker, 2001c:57-58).
This example illustrates the multidimensional nature of the factors linking these policy fields, and operating in a sometimes conflicting fashion. While TRM received less political and economic support at international and national levels, on community levels it was being sustained as a pragmatic response to the operational failures of the higher profile programmes – essential drugs, and the struggling PHC concept. Neo-liberal health policies which flourished internationally during the 1980s and 1990s caused a contraction of biomedical services and encouraged TRM use for practical economic grounds at the local level.

The increasing cost of modern drugs coupled with the decline in the purchasing power of the African people caused by the weakening of the African currencies and the limited national resources make it mandatory that efforts should be intensified to produce drugs from plants in Africa (Sofowora, 1996:371).

While the essential drugs programme was an organisational success, fully achieving its objectives remained elusive. In 2002, about a third of the world’s population, and 50% in Asia and Africa, lacked regular access to essential drugs (WHO, 2002d:3). Paradoxically, this very failure assisted in forcing TRM back onto the agenda, and for exactly the same reasons present in the 1970s. People in the South were dying from preventable diseases, the distribution and supply of biomedical facilities (primary resources) had proven inadequate to meet their needs, costs were escalating and communities were using TRM regardless of whether this was officially mandated or regulated.

Why the essential drugs programme failed to really redress the inequities in supply and delivery is a separate (although related) issue that cannot be fully addressed here. Again it is associated with entrenched vested interests, powerful interest groups, as well as economic, political and social issues and their complex interactions on different policy levels that all affect access to and provision of resources (see Chowdary, 1995; Kanji et al., 1992 for more detail). A large factor was pharmaceutical industry (biomedical) protection of patent and IPR rights (secondary resources) which was played out in forums such as the WTO, and the economics of drug development and supply.81 The WHO commented in relation to the stark statistics on access to essential drugs: “[t]he reasons [for this] are well known and include

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81 The industry did not have incentives to develop drugs for which there was “great need but from which one can derive little profit” (Bello, 2004). In 2001, after pressure from the South, the WTO declared that public health concerns overrode IPR - but this battle is far from won. A lot is at stake, not only in terms of lives, but in terms of profits (secondary resources) – the pharmaceutical industry is the most profitable one in the US and growing (Angell, 2005); Biomedical industries have become one of the most important areas of competition in advanced capitalism. “Technological innovation, once offered as a weapon against disease, is now an economic weapon in the struggles between capitalist states” (Moran & Alexander, 1997:594). For a detailed discussion of TRIPS and essential drugs see Mecurio (2004).
inadequate financing and poor health care delivery” (WHO, 2002e:25). Improving access to essential drugs was included as one aspect of the Millennium Development Goals in 2000, which can be seen as an acknowledgement of market failure in the equitable provision and distribution of pharmaceuticals.

Once the TRM Programme was absorbed within the Department of Essential Drugs, there was a subtle change of tone and direction of publications, perhaps most clearly reflected in the medicinal plant monograph series. Those on China (WHO, 1989a) and Vietnam (WHO, 1990a) were to impart ancient and valid information about herbal medicines and medicinal plants as alternatives to biomedicine.82 In contrast, the monographs on the Republic of Korea (WHO, 1998c) and South Pacific (WHO, 1998d) were produced after the Programme was incorporated within Drugs Policy and Management, and were directed to the specialist scientific community (ethnobotanists, phytochemists and pharmacologists) to disseminate data on clinical uses of plants.83 In the latter case, the plants were potential sources of biomedical compounds and not alternatives to them.

The clinical, pharmacological expertise of the Drugs Policy and Management Division was perfectly suited to the growing need to oversee the international standardisation and regulation of herbal remedies for mass production. This need to assess and monitor the production and use of herbal remedies resulted in publications including Guidelines for the assessment of herbal medicines (WHO, 1991a, 1996d), Research guidelines for evaluating the safety and efficacy of herbal medicines (WHO, 1993a), Good Manufacturing Practices: Supplementary guidelines for the Manufacture of Herbal Medicinal Products (WHO, 1996c); Quality Control Methods for Medicinal Plant Materials (WHO, 1998e); Basic tests for drugs: pharmaceutical substances, medicinal plant materials and dosage forms (WHO, 1998d); Guidelines for the Appropriate Use of Herbal Medicines (WHO, 1998b) and General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine (WHO, 2000b). These documents all attempted to standardise and promote common procedures, terms and methodologies for research and evaluation in order to facilitate production and regulation, which was a pre-requisite for global trade. In these publications and activities, the development and promotion of low-cost alternative drugs for use in PHC seemed marginal.

82 "[T]o communicate knowledge about herbal medicine that has accumulated over thousands of years, has been confirmed through both empirical experience and scientific evaluation, and yet has rarely been published ... The book also responds to increasing respect for the value of medicinal plants as a source of efficacious and inexpensive new drugs that offer an important alternative to chemically synthesized medicines."

83 “Addressed to ethnobotanists, phytochemists, and pharmacologists ... to document traditional clinical uses and bring these to the attention of the international scientific community, while also preserving knowledge about ... distinctive indigenous practices.”
5.3.2:3c) Primary Health Care

In the 1990s, the PHC concept had not been implemented as envisaged in 1978 at Alma Ata, and contributing factors for this policy demise were being analysed (see Macdonald, 1992). In the 1970s, many expectations had been attached to this promising reorganisation of health care. It was to be a new way to develop basic services, and alleviate the suffering of underserved populations in the South. Now, those who had been optimistically committed to the concept stood back and bitterly reviewed the lack of progress and the worsening conditions in the South at the dawn of a new century. Instead of “Health for All by the Year 2000”, the gaps had only widened. One consequence of globalisation was a worsening of socio-economic, political and environmental problems (Dodgson, Lee, & Drager, 2002:8), and the increasing disparities in wealth distribution within and between countries had a regressive impact on global public health (Werner & Sanders, 1997:108). The HFA goal seemed even less probable by the mid-1990s than it had in 1978 (Bergstrom & Mocumbi, 1996).

Around that time, the WHO seemed to abandon both PHC and HFA as achievable objectives. HFA by the Year 2000 subtly transformed into a vague “Health for All in the 21st Century”, considered an abstract, longer term ideal, and the original notional deadline for this goal passed without comment. In 2000, “New Universalism” became the new mantra, and PHC was condemned:

> Despite its many virtues … it gave too little attention to people’s demand for health care, and instead concentrated almost exclusively on their perceived needs. Systems have foundered when these two concepts did not match, because then the supply of services offered could not possibly align with both (WHO, 2000f:overview).

While the WHO appeared to overlook any critical assessment or objective evaluation of the PHC failure (apart from determining it was a mismatch between supply and demand), others were more vocal in their criticism and in identifying culpability. Werner (1995) considered three main reasons were responsible for “sabotaging” the PHC policy concept – selective primary health care, structural adjustment programmes as imposed by the World Bank, and the paradigm of health introduced by the World Bank in 1993 when it released *Investing in Health* to guide policy formulation. These inter-related factors were all corrosive to the very foundations of PHC and acted as counter-forces to both improving living conditions in the South, and providing the necessary fertile political and economic ground for establishing

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84 The failure of the NIEO could be considered a major factor, as the PHC movement itself was premised on this (economic redistribution between North-South) and it had also failed.
comprehensive, basic health care. While the concept was viable (as practically demonstrated in some countries), the neo-liberal international context was not favourable:

Community-based interventions that demonstrate the need for an integrated approach to health appear to offer great promise. Such programs … require close collaboration across health, economic and social sectors and broad population … participation and education. Such ‘development-focussed’ and fine-tuned interventions are less predictable, more laborious, and do not lend themselves to the development of commercial products [secondary resources]. As a result, they are less likely to be promoted in this global environment (Zielinski Gutierrez & Kendall, 2000:86).

With PHC taking a lower profile, the specific focus of using TRM as initially proposed was reduced. Instead, TRM became almost exclusively viewed as a raw material for the creation of biomedical drugs, and not as an intrinsically valid health care system in its own right (Bodeker, 1994b:11). The trend to view TRM as a source for biomedical pharmaceuticals overlooked the development and promotion of TRM as low-cost health care alternative for communities in the South (its original constituency and the initial objective), but instead used TRM knowledge to meet the growing demand for new drugs in the North for conditions such as heart disease and cancer (Bodeker, 1994b:11). Obesity, depression, arthritis, dementia and a host of other conditions related to changing lifestyle, demographics and morbidity and mortality patterns in the North could be added to this list. “There has been no attempt …in addressing the [PHC] needs of the populations in the areas from which the plants come” (Bodeker, 1994b:11).

Millions of dollars were instead being spent on identifying, isolating, clinically testing and then marketing new drugs in the North, rather than addressing the conditions that were still decimating populations in the South. Economic incentives (secondary resources) for the pharmaceutical industry were skewing research and development from the use of TRM in PHC, towards production of profitable drugs for markets in industrialised countries. A few examples can illustrate this trend. A medicinal plant from Madagascar (rosy periwinkle plant) was used to develop two drugs to treat cancer (vincristine and vinblastine), sales of which quickly exceeded US$100 million (Barsh, 1997:28). In Nigeria, TRM ethnobotanical knowledge was used in the development of a drug for sickle-cell anaemia (Raufu, 2003). Similarly, millions of dollars were invested developing a synthetic anti-obesity drug from a compound found in a cactus (hoodia gordonii). This South African plant was used by indigenous San peoples as a natural and powerful appetite suppressant and thirst quencher. While they now live in poverty, the Pfizer pharmaceutical company can expect very handsome returns when the product reaches the market in the North in 2007. The traditional custodians were described as “a sad, impoverished and displaced tribe, still unaware they are
sitting on top of a goldmine” who “smoke large quantities of marijuana, suffer from alcoholism, and have neither possessions nor any sense of the value of money”. Meanwhile the lawyer trying to negotiate royalties on their behalf envisaged “Hoodia cafes” in London and New York, serving hoodia sliced like cucumber salad to overweight and wealthy patrons keen to sample the exotic (Mangold, 2003).

This is not an isolated or unusual case. An Indian community (the Kani from Kerala) used the *Arogyapacha* plant (*Trychopus zeylanicus*) for its rejuvenating properties. Scientists who “stumbled upon” this developed a drug claimed to have immune enhancing and anti-fatigue properties. In 1995, this formula was sold to a company which was then inundated with orders from around the world. International drug companies also showed commercial interest, the business potential of which was compared to Korea’s ginseng. Despite the Kani’s “good fortune”, government bureaucracy prevented any money being transferred to the community for over two years. More drugs including a herbal sports medicine (Kumar, 1999), tea for osteoporosis, and cough syrup with anti-oxidant properties (Nandakumar, 2004) are now being developed from their knowledge. The Indian domestic pharmaceutical industry keenly monitored international markets and soon began exporting other products based on TRM knowledge including a brain tonic and a herbal remedy for erectile dysfunction (Kumar, 2000a; see also Sofowora, 1996:369-370 for African examples).

Foreigners come down here, they do research. We tell them this plant [primary resource] is for this, this plant is for that. Then they go and make an anti-cancer drug, an HIV drug and what will we get? Nothing. No money, no credit, no thanks [secondary resources]. Nothing. (Wayland, 2003)

The biomedical pharmaceutical coalition had recognised that TRM primary resources would enable them to gain access to more secondary resources (status, economic benefits), which is required to motivate the adoption of primary resources from a competing medical system (Unschuld, 1976b:8). While markets in the South were huge and demand for drugs at PHC level high, returns for developing and distributing medications for communicable diseases were low. As the economics of pharmaceutical supply and demand (secondary resources) continued to drive private sector production efforts, some national Governments persisted

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85 That they had been able to enter into negotiations for royalties at all was very fortunate. The pharmaceutical company had strongly denied their existence and insisted the nomadic peoples had “died out”. About 100,000 San still populate regions of Angola, South Africa, Botswana, and Namibia and after proving their existence, secured legal representation. “The San thought nobody was interested in them. Now *Hoodia* cactus has come along. They are excited and have even become a bit secretive about their use of plants … that could change now that there is this mass market of the developed world wanting to use their discovery for body [enhancement]. What struck them was that anybody would want to use such medicines to lose weight …” These media reports from the National Geographic, Guardian, BBC and Times are used as a sales pitch on a United Kingdom website selling the diet pills, which promised that coming soon would be hoodia tea, hoodia fruit juices and hoodia snack bars: http://www.hoodiadietpills.org/
with the ideal of using TRM in a form of PHC. For example, the Laotian Government produced *Medicines in Your Garden* and in Thailand the Ministry of Health published a *Manual of Medical Plants for Primary Health Care*. The Philippines, Vietnam and Guatemala also undertook government sponsored promotion of medicinal plants. In India 10 TRM remedies were approved in 2000 for use in a family welfare programme partly funded by the World Bank. These remedies were to treat conditions associated with pregnancy and post-partum care such as anaemia, oedema, pain, nutritional deficiencies and childhood diarrhoea (Bodeker, 2001b).

Although the PHC concept was presenting challenges in implementation, the WHO had not totally abandoned the idea of using TRM in PHC in the early 1990s. It continued to promote the concept by publishing two guides on using practitioners as PHC workers in the mid-1990s: *Guidelines for Training Traditional Health Practitioners in Primary Health Care* (WHO, 1995a) and *Traditional Practitioners as Primary Health Care Workers* (WHO, 1995b). These reports were part of a contracted research project, with the latter consisting of case studies (Ghana, Mexico, Bangladesh) which had informed the development of the guidelines. The guidelines also drew on an unpublished document reviewing traditional healers and community health (WHO, 1991d). It consisted of clear step-by-step procedures for planning, training and evaluating TRM practitioners in PHC programmes. However, as little implementation of PHC seemed to be occurring on national levels, the practical use of such guides was debatable and they appeared long overdue.

According to Unschuld’s theory of contested resources (1975; 1976b), without any secondary resources, it would be very difficult to recruit and maintain TRM practitioners as PHC workers. In Unschuld’s perspective, social and economic benefits (secondary resources) are necessary to encourage the adoption of a different primary resource base (such as activities related to PHC). The guidelines recognised this with the suggestion to offer some form of remuneration or reward (WHO, 1995a:11). It was acknowledged that there was often a lack of payment for undertaking extra PHC duties, and therefore minimal incentives for participation. It was suggested that communities could make a payment-in-kind (such as food, labour, or building a clinic) and agencies could assist the TRM practitioner trained as a PHC worker with establishing income generating activities (e.g. bee-keeping) (WHO, 1995a:11).

The case-study report was prefaced with the reasons for the review, mentioning the by now monotonously familiar argument that the WHO had promoted the use of TRM from the 1970s and without mobilising all resources for health care, HFA could not be achieved. It
also noted that over the past decade “the gulf of misunderstanding between modern and traditional practitioners has begun to narrow. A growing realization has developed that it is possible for traditional and modern medicine to work hand in hand” (WHO, 1995b:3). The introduction perhaps inadvertently revealed the extent of mistrust, antipathy and long delay in formalising the role of TRM, considering it had been nearly two decades since the original WHO recognition of TRM:

There has been a broad gap between the need of the family for prevention and intervention, and the view of many Western health practitioners who believe healers are charlatans and profiteers preying on the superstitions of local families. Now because of ... worldwide health problems combined with shrinking resources, the importance of the traditional healer is undergoing a gradual re-evaluation (WHO, 1995b:4).

The review of activities asked some very pertinent questions including whether the differences between TRM and biomedicine were surmountable, and if the two groups of practitioners were able to collaborate effectively to provide a sustainable health care system (WHO, 1995b:4). However, the comprehensive global overview of programmes and the case studies did not directly address such issues. Despite the hundreds of documents reviewed, very few evaluations of programmes involving TRM practitioners were actually located (WHO, 1995b:39).

Overall, it was concluded that involving TRM practitioners in PHC programmes produced positive outcomes and was cost-effective (WHO, 1995b:40-43). Constraints to national level implementation included those mentioned in the previous chapter – a lack of policy guidance and government commitment, lack of dialogue and co-operation between the two groups of practitioners, conflict between practices and paradigms of health, poorly defined roles, lack of organised representative groups for TRM practitioners, and little practical evaluation of existing programmes (WHO, 1995b:43-45).

As the emphasis on PHC diminished within the organisation throughout the remainder of the decade, so did further specific activity on PHC and TRM at headquarters. The TRM Strategy 2002-2005 (WHO, 2002e) only mentioned PHC in terms of priorities and activities in some regional areas, and no reference was made to PHC in the objectives and components of the TRM strategy (WHO, 2002e:45). This is logical considering that strengthening PHC had ceased to exist as a distinct organisational objective in 2000 and “new universalism” was now the new directive for health systems development. The main emphasis on using TRM in the 1970s to improve health service delivery (specifically PHC, HFA and also TBAs) had disappeared by the turn of the century.
Other factors and problems were behind the propulsion of TRM back onto the policy agenda in 2002. While the tone and content of the TRM Strategy (WHO, 2002e) was very different from the technical report on TRM in 1978 (WHO, 1978b), they ultimately shared core underlying principles, as the analysis in the next chapter (chapter 6) demonstrates. Concurrent with the escalating WHO activities prompted by commercialisation of the TRM/CAM field, the World Bank was addressing economic and corporate interests in the TRM arena.

5.4 World Bank activities

As mentioned, the influential World Bank World Development Report Investing in Health (1993) signalled a significant shift in global health policy development, and had a major impact on policy formulation and programme implementation. The policy context became dominated by neo-liberal economic tenets, which filtered through to the health field. Combined with increasing loans for health projects, the 1990s marked a turning point where the World Bank began to overshadow the WHO in guiding and influencing debate and activity in the health policy arena (Abbasi, 1999a; Buse, 1994; Buse & Walt, 2000; Walt, 1994).

A series of articles by Abassi (1999a; 1999b; 1999c; 1999d; 1999e; 1999f) examines in detail the changing international role of the World Bank in relation to health. Between 1995-1996 health lending doubled from $1160 million to $2350 million (11% of total bank lending) and the World Bank eclipsed the WHO in terms of resource allocation (Abbasi, 1999a:868). While the World Bank, as previously mentioned, had set the tone for health policy with the 1993 Development Report “Investing in Health” it now also became the major funding body and determined the parameters and principles of health system development (often directly through conditions attached to loans).

However, some were critical of World Bank activities in the health sphere (Ramprasad, 1994:134-135) and argued that debt servicing requirements and structural adjustment programs were countering efforts to improving the health status of populations in the South (Bello, 1994; Rich, 1994; Werner, 1995, 1998). The values and objectives of Investing in Health were also criticised, with some contending that the World Bank was exceeding its mandate as a development and lending institution and promoting “a market-friendly version of Selective Primary Health Care, supplemented by privatization of medical services and user financed cost recovery” (Werner & Sanders, 1997:107).
The World Bank explicitly entered the TRM policy domain in the 1990s, linked to their recognition that indigenous knowledge systems can be utilised in development efforts (see for example World Bank, 1998). This attitude marked a new direction in development theory, one that considered education, knowledge and health (investment in “human capital”) the keys to future sustainable social and economic development. These sentiments were expressed in the 1998/99 Development Report Knowledge for Development, and the launching of the Indigenous Knowledge for Development Program in the same year. Wolfensohn, the then President of the Bank clarified this position in his statement: “We need to learn from local communities to enrich the development process” (in Gorjestani, 2000:1).

The first World Bank publication specifically related to TRM was *Traditional Medicine in Sub-Saharan Africa: Its importance and Potential Policy Options* (DeJong, 1991). This document has a more overt political and economic overtone than the WHO publications, of which it made little reference. Out of over 60 references, only a few of these were WHO documents, which may have indicated a lack of familiarity with the WHO policy history in the field and poor co-ordination or dialogue between the two agencies. TRM was a “valuable resource” which “should be incorporated into a country’s health care system” and there were various policy options to do so. Paralleling options reminiscent of those raised by Dunlop (1975), the first was to simply leave TRM in the informal sector although that would “not take full advantage of the positive contributions [TRM] can make” and would not allow regulation and control of their activities “in the interests of their patients”. More “active” options included encouraging professionalisation through licensing, professional associations and providing them with access to drugs and “better techniques” (implicitly, biomedical primary resources) (DeJong, 1991:i).

The most compatible areas identified for co-operation were with TBAs, to treat psychosomatic and psychological conditions, counselling those with terminal illnesses, or as community health workers (providing primary health care). It is ironic that *Traditional Medicine in Sub-Saharan Africa: Its importance and Potential Policy Options* (1991) could have easily been dated as a product of the 1970’s – which is indicative of the lack of policy development and programme implementation that had taken place in the meantime. However, it provides a comprehensive overview of the policy issue, which realistically assesses the obstacles and complexities of the matter. It concludes that professional competition between the groups is likely to intensify (especially if traditional medical practitioners adopt the primary resources of biomedicine) and that policies to address this conflict would need to be developed (DeJong, 1991:15).
In the mid 1990s, the reports on TRM became more overtly economically and environmentally orientated. This focus correlated with international trends. *Medicinal Plants: An Expanding Role in Development* (Srivastava, Lambert, & Vietmeyer, 1996) and *Medicinal Plants: Rescuing a Global Heritage* (Lambert, Srivastava, & Vietmeyer, 1997) reflected this new development and conservation focus. The former report acknowledged that to date, medicinal plants were “hardly a priority in the World Bank” and found only six references in the World Bank Lending Operations Database and Report Bibliography Service to medicinal plants or traditional medicine between the period 1979 and 1996 (Srivastava, Lambert, & Vietmeyer, 1996:9). However, it recommended that a strategy on medicinal plants should be developed because they were likely to continue to increase in importance in both industrialised and developing countries as “rising population growth and falling economic levels will probably make [them] more important than today” (Srivastava, Lambert, & Vietmeyer, 1996:11).

The latter report had a more explicit commercial tone. For example, in noting that many medicinal plants were in danger of extinction from over harvesting it concluded that “Nonetheless, what looks like a problem actually provides numerous opportunities for developing nations to advance rural well-being. After all, medicinal plants are one of the few (legal) developing-country natural products that sell at premium prices” (Lambert, Srivastava, & Vietmeyer, 1997:v). This document provides one of the most thorough and concise overviews of the medicinal plant field, from both a regulatory and commercial perspective. In contrast to WHO documents, the World Bank assessments contained solid market data, politically astute observations, historical and social contexts, and information on the current relevant activity of a range of bodies and various national governments.

By the mid-late 1990s, it was clear that medicinal plants and consequently TRM had secured a firm place in the international policy agenda. Its position at the confluence of environmental, conservation, development, health and indigenous knowledge issues resulted in TRM being afforded a prominent place in many debates and activities across a broad spectrum of organisations. It was no longer relegated to being a quaint anachronism in the health field, but suddenly became a commercial force that took the centre stage of several prominent contemporary policy imperatives.

The World Bank activity was an effective gauge of this new found respect for TRM. While only a handful of references to TRM had been made prior to 1996, in the latter half of that decade the World Bank produced several reports on the issue, established indigenous
knowledge research centres and supervised projects (as an implementing body of the Global Environment Facility) for the conservation and commercial cultivation of medicinal plants.\textsuperscript{86} TRM now had economic clout, and this new found status significantly increased its political leverage in the policy domain.

\textbf{Section 3: Activity at national levels}

\textbf{5.5 Debate and activity in the policy stream}

Activity by policy communities (such as academics and stakeholders) accelerated in the mid-late 1990s, with much commentary on the role of TRM/CAM and techniques to evaluate and formalise it in health care systems. Many of the same questions asked in the 1970s were being asked again in the 1990s – What does integration and PHC mean? (Bishaw, 1991). How is this achieved? (Bruce, 2002; Hesketh & Zhu, 1997). Does it represent a feasible solution to biomedical delivery and supply failures? (Freeman & Motsei, 1992). How are various medical systems classified and evaluated? (Cassidy, 2002; Tataryn, 2002). How does medical pluralism operate in practise? (Gilbert, 2004; Haram, 1991; Hsu, 2002; Le Grand, Sri-Ngernyuang, & Streefland, 1993; Muela, Mushir, & Ribera, 2000; Ooi, 1993; Upvall, 1992). What is the best policy model to adopt? (Bodeker, 2001b; Brekke, 1998; Chi, 1994; Kale, 1995; Kennedy & Olsson, 1996; Leckridge, 2004). How are conceptual gulfs bridged and a common language developed to enable co-operation? (Anderson, 1999; Bauer, 1998; Christie, 1991; Vora & Tokar, 1999).

Lock (1990:42) felt such discussion was simply a “red herring” – as it side-stepped the more important issues of social and economic origins of illnesses, a fact Elling had already noted when he concluded that the actual mixing of biomedicine and TRM or technical nature of their policy relationship was less important to the health status of communities than the distribution of resources across that society (Elling, 1981a). Poverty and inequality in access to social services such as education, housing, water and basic health care would always create poor health status regardless of the nature of health care service structure (issues addressed by WHO in the context of "social determinants of health", see for example Wilkinson & Marmot, 1999; 2003).

\textsuperscript{86} The Global Environment Facility (GEF) funded at least 8 projects on the conservation and sustainable development of medicinal plants Sri Lanka, India, Ethiopia, Egypt, Zimbabwe, Ghana, Jordan and the Caribbean.
Van der Geest (1997) notes that by the 1990s, there was “a library of publications advocating or rejecting the idea of integrating traditional and biomedical services” but that “amazingly, the question of whether local communities favour [this] has hardly been raised, let alone investigated” (1997:904). He suggested that a community perspective was required in the debate – the only question that needed to be asked was what the community would gain from any integration process. Van der Geest argued that such a process provided few tangible benefits to the community (they would be indifferent to integration) as basic health care would not improve anyway. Improving basic health care was thus the crux of the problem, and not integration as such.

The actual implementation of integration to date was considered to be based on a “donor-deficit model” (Airhihenbuwa, 1995:57), where the guiding belief is one that TRM practitioners are “deficit” in knowledge and can be modernised by having biomedical practitioners train them. In the process however, biomedical practitioners find out what TRM practitioners know (their primary resources) and apply (or absorb) it into biomedical practice. The fundamental assumption is that TRM practitioners need training and can make no reciprocal contribution to biomedical skills.

… seldom has the traditional healer been viewed as a health provider with adequate or superior knowledge in certain aspects of health care that will be of benefit to the [biomedical doctor] … The sources of the traditional healers’ concoctions and pharmacopoeia, however, are eagerly, even exploitatively sought … Instead of receiving proper and due recognition for the areas in which they are known to be efficient and effective, healers are encouraged to surrender their herbal lore for the advancement of science (Airhihenbuwa, 1995:57).

Chaudhury (1992:80) argued that national governments should focus on developing an infrastructure for research on medicinal plants, and that in the field of primary health care governments allow TRM practitioners to work outside the formal framework of national health services controlled by biomedical practitioners. Instead, state assistance should involve access to training by their own teachers and specialists, ensuring they have a regular and good quality supply of herbal medicines, and giving them recognition for their service. It is interesting that this report was a WHO publication, as it was not consistent with the general WHO policy position towards integration and reflected continued ambivalence about the formalisation of TRM in health care services:

This will be much more rewarding than insisting that all medicines used by them should undergo clinical evaluation for efficacy, that the two systems [biomedicine and TRM] should be integrated and that the traditional medical practitioners be brought within the existing framework of national health services (Chaudhury, 1992:81).
5.5.1 National level implementation

While countries in the South continued to struggle with interpretation of WHO directives, very few managed to achieve actual implementation of integrating TRM into formal health care structures (Pigg, 1995:52) (see appendix 7; page 361 for an excerpt of WHO country reports, or Islam and Wiltshire (1994) for a discussion of practical and conceptual difficulties encountered). However, informal integration in the private sphere had taken place in the North, as consumers embraced TRM/CAM in the health market. Governments in the North quickly began to allocate funding to assess CAM. For example, the funding allocated in the US to research CAM increased from $2 million in 1992 to $68.3 million in 2000 (WHO, 2002a:18).

The recognition of TRM/CAM was often explicitly linked to economic factors: “In 1996, the Australian Minister of Health pointed out that it was very difficult to argue that an industry that generated A$1 billion in turnover and had directly affected 50% of the population in the past year should not be considered an integral part of Australian health care” (WHO, 2002c). Informally, the sector was a significant aspect of health care systems and the economic value of it was frequently used to give weight to the proposition to formalise its role. In addition, CAM offered potential cost savings to the state through reducing pharmaceutical bills and reliance on biomedical technology, and promoting preventive measures (Easthope, 1993:299; Jonas & Levin, 1999:11; Sharma, 2000:217). If improvements in people’s health and capacities are factored in, the country reaps a financial dividend about six times the market value of the plant products themselves (Srivastava, Lambert, & Vietmeyer, 1996:4).

Reports from various countries in WHO documents reveal that the problems already prevalent in the 1970s and 1980s remained equally pervasive in the 1990s, with intellectual property rights now also joining the fray and driving the policy process. There still existed a lack of mutual understanding between traditional healers and biomedical practitioners; insufficient communication between governments and healers; a scarcity of “evidence” based on scientific research (which was considered a pre-requisite to formalisation); and minimal funds and human resources as well as a lack of measures to protect intellectual properties and patents (WHO, 2000a:11).

The lack of relevant legislation, political commitment and professional organisation of TRM was a major detriment to formalising the role of TRM in health care. The weak position of TRM in policy was reflected by the fact that in Africa, if TRM was recognised officially at all, it was often in the Ministry of Culture and not Health (Burford et al., 2000:8). The policy
on integration of TRM appeared to have no traction on national levels in the South – it remained bogged down in what appeared to be irreconcilable differences stemming from conceptual gulfs and practical difficulties, and hindered by a lack of budgetary appropriations despite statements of support. Often, only around 2-3% of health budgets were allocated to TRM even in countries committed in principle to TRM (e.g. Nepal and Sri Lanka) (Singh & Foran, 2002). When funds were allocated to the traditional medicine sector in resource-poor countries, resentment was generated in under-funded sections of the conventional medical sector (Bodeker, 2001c:55; Bodeker & Kronenberg, 2002). Competition for diminishing state resources worked to divide rather than unite the differing medical systems.

Meanwhile, the rapid rising use of CAM in the North resulted in state concern regarding how to regulate and incorporate such modalities in the existing health services infrastructure and markets. The practice of TRM had expanded beyond its original ethnic boundary (WHO, 2000a:12) which left governments in the North with some particularly difficult policy conundrums. The main issues revolved around how to accommodate TRM/CAM in rational-legal frameworks, whilst also mediating various economic and political interests (see Easthope, 1993:296-299). Efficiency and cost benefits needed to be clearly established for formal inclusion in health services (Bodeker, 2001c:53-60), as well as safety and efficacy – reinforcing both scientific ideology/methodology and economic rationalism as guiding principles in evaluating and funding research in TRM/CAM.

Physicians, insurance plans, medical centres and hospitals, managed care organisations and government policy makers should base decisions regarding incorporation of and payment for alternative medicine therapies on evidence based research and objective cost-effective analysis rather than consumer interest, market demand or competition or political pressures (Fontanarosa & Lundberg, 1998:1618).

Around the turn of the century, TRM/CAM had moved firmly into the mainstream – these systems of health care were strictly no longer either “alternative” or “complementary” but more obviously direct competitors to biomedicine for secondary resources, reflected in media coverage and health insurance schemes. For example, the Journal of the American Medical Association (1998), the Archives of Internal Medicine (1998), American Journal of Public Health (2002), and the British Medical Journal (December 2002) devoted entire issues to it. CAM/TRM were cover stories of Newsweek, Time (January 2003) and Readers Digest (August 2003). By 2004, health insurance companies in the North offered coverage for a wide range of modalities beyond standard biomedical treatments, including naturopathy, acupuncture, massage, herbalism, aromatherapy, reflexology, yoga and
hypnotherapy. Secondary resources were flowing to TRM/CAM regardless of the lack of formalisation in national health care systems.

5.5.1:1 State issues in development and adoption of TRM policy

State pressures to formalise the roles of TRM/CAM were now widespread in both the North and South, but were different in nature. While many of the relevant issues in the South were mentioned in the last chapter, a new one emerged related to sustainable development of TRM as an export commodity. The rush to now regulate TRM was fuelled by dual economic and environmental priorities. The rapid commercial growth of the TRM/CAM sphere had serious environmental consequences for the management of biological resources in the South.

On national levels in the South, global economic forces had a variety of impacts (as mentioned). People could not afford essential medicines and therefore used TRM; and economic stringency in health care systems meant that it also became more important to find cheap, local alternatives. In addition, the new interest in TRM from the North generated revenue and therefore it became a valuable export and source of foreign exchange (Kumar, 2000b; Mhame, 2000; Sofowora, 1996:371). In the South (e.g. India, Nepal), new foreign interest was used to argue for increased funding for TRM, but often to service international demand and not for basic PHC (Janes, 1995; Singh & Foran, 2002). Safety, efficacy and quality standards were some hurdles to be overcome in this new opportunity of massive export markets for TRM/CAM. A focus on safety, efficacy and quality to develop marketable products (while leading to potentially large secondary resources) diverts resources away from constructing TRM in PHC programmes on community levels in the South (Bodeker, 1994b).

TRM was now a marketable commodity, a tool which could be used to build export industries and enhance local capacity building (if IPR could be secured). This potential had been recognised in the late 1980s when herbal medicines and plants were considered an economically exploitable resource for the South, but one that needed scientific regulation in order to standardise and enhance genetic qualities:

The application of modern scientific methods in the cultivation, selection, manufacture and clinical trials of herbal medicines is the most appropriate way to transform traditional trade into modern industrial practice. In this connection, the Japanese and Chinese models … could be considered by other countries when developing their own systems. Industrial production would require the adoption of appropriate agro-industrial technology in order to obtain adequate quantities of medicinal plants of standard physical and chemical quality. Thus there
is a need for the large-scale cultivation of such plants and to devote attention to their genetic improvement (Akerele, 1988:359).

The need to regulate TRM/CAM due to economic, environmental and public health grounds, whilst maintaining the integrity of primary resources and balancing competing interests, was a fraught exercise. Around 1990 new regulations on herbal medicine manufacture were introduced in Germany. This squeezed 85% of small-scale producers out of the market, with the remaining 15% of producers being partly or wholly owned by multinational pharmaceutical companies. Many observers believed such legislation (imposing high standards on manufacture and production) was a monopolistic technique by the biomedical fraternity to control the market (Anonymous, 2001). The German model was later promoted as a global standard. In a meeting held in India in 1999, health ministers from the South called on the WHO not to impose the German standard on them (Anonymous, 2001). Economic imperatives that pushed for the global industrialised, commercial development of TRM also fostered the transformation of TRM in new cultural settings:

Whereas the active co-operation of various systems of medicine is an important goal, a hasty integration will limit us to a “Disneyworld” version of these vast and varied medical approaches. That is, we may find ourselves using only some of the form and some of the substance of complex traditional systems of natural medicine squeezed into easily marketable and saleable forms (Vora & Tokar, 1999).

This transformation and reconstruction of imported TRM systems had already began to occur in the North in the 1970s when TCM was first exported (Taylor, 2004) and also occurred in the South (Hsu, 2002). New and often simplified forms of TRM theories and concepts, or mixtures of different TRM traditions in eclectic versions of “new” forms of health care were offered to eager consumers. For example, mixing Ayurveda with acupuncture (Ros, 1997), and books based on a synthesis of western herbalism and Ayurveda and/or TCM (Jagtenberg & Evans, 2003:325). Other examples of copyrighted synthesised therapies are “yogalates” (a hybrid of yoga and pilates), Maharishi Ayurved (a specific form of meditation blended with Ayurveda), Bikram Yoga (yoga in a room heated to a certain temperature), Yoga Nidra (yoga with a type of relaxation technique).

These inventive adaptations and modifications enabled copyright to be obtained, as the new discipline was then not purely “traditional” but based on “new discoveries” or new applications of the TRM knowledge. This caused dismay and consternation in some TRM/CAM sectors, who argued these disciplines were in the public domain and thousands
of years old. Despite ethical concerns, it was a legal application of trademark laws and appealed to consumers in the North who constantly sought new health care techniques and products in a saturated and increasingly competitive health care market. The integrity of the conceptual foundations of TRM/CAM was therefore threatened by cross-cultural export that simplified and extracted only profitable aspects of the health care modalities for commodification:

… the economic potential of growing [CAM] markets has meant that much business and research interest … to date has been focused on specific techniques and products that can be marketed. On the other hand, the ‘healthcare industry’ or even academia, have rarely paid attention to conceptual and philosophical principles on which the use of those products and techniques are based. This trend is even reflected in government sponsored research (Eskinazi & Mindes, 2001:22).

International research efforts are increasingly driven by industry and other groups seeking to produce products for the growing world market … We must keep in mind that our research should be true to the great healing traditions … and be careful not to tease the pieces apart for sale on the global market in a way that is appealing to various audiences, but compromises the provision of medicine in the complex manner and the holistic framework in which it is practiced (Kronenberg, 2001:25).

Acupuncture clearly illustrates this trend to modify, simplify, mix and/or ignore fundamental concepts based on economic or political expediency. In contrast to the Western use of acupuncture, in China it is rarely performed alone but is only one of various simultaneous treatments. Needles used are traditionally made of various metals, usually gold and silver depending on the effect required (Scarpa, 1981:319). This is usually overlooked in the North, where needles are often only stainless steel, it is used as and has become a distinct profession (or an adjunct to biomedicine); and biomedical anatomy and physiology is often used along with Western terms, rather than original TCM nomenclature and concepts. In the transfer, acupuncture became underpinned by neuro-physiological and biomedical causal explanations, such as the release of endorphins for pain control (Saks, 1995a:112; Saks, 1995b). The Western understanding of acupuncture is not based on qi (or chi), the traditional understanding of invisible energy (Jonas, 1999:319). Globalisation led to a rationalisation and standardisation of terms and practices as well as primary resources, to conform to new and foreign contexts.

In the North, Governments made rapid moves to try to ascertain the extent of CAM use and how to manage it within existing health systems, raising both practical and ethical issues (Thorne et al., 2002). In the United States, a new research centre for alternative medicines (OAM) was established within the National Institutes for Health (NIH) in 1992. Its budget

87 See for example http://www.yogaunity.org/ which is a non-profit organisation to fight Bikram Yoga copyright.
was doubled by 1995 to US$6 million which still represented only a fraction (0.05%) of NIH appropriation – but even this did not go uncontested (Marshall, 1994). This organisation was succeeded in 1999 by the National Center for Complementary and Alternative Medicine (NCCAM). According to Cant and Sharma (2000:436), only certain therapies received government support – those that had altered their organisational structure and limited their medical claims “thus reducing their competition with approved medical approaches to health care” (in Freund, McGuire, & Podhurst, 2003:187).

Significantly, both of these bodies were dominated by biomedical professionals (Baer, 2002). Despite that, some of the initial research was scorned by the biomedical community for both research methods and scope: hypnosis to speed bone healing, music therapy for brain injury, dance for treating cystic fibrosis, yoga for heroin addiction, prayer for drug abuse (Marshall, 1994:2001). The congress and general public have “consistently put pressure” on the OAM (and later the NCCAM) to fulfil its mandate while the National Institutes for Health “has been reluctant to progress too fast in a field it does not consider ‘scientific’” (Eskinazi & Mindes, 2001:21). A White House Commission on CAM policy was also established in 2000. Important aspects of these (and other government sponsored research and inquiries) was the education and training, professional regulation and efficacy of primary resources of TRM/CAM (White House Commission on Complementary and Alternative Medicine Policy, 2001).

In 2000 the United Kingdom government assessed CAM, and the House of Lords (Select Committee on Science and Technology) produced a controversial report (Bodeker, 2001a; McIntyre, 2001). The main point of contention was on the use of scientific validity (efficacy) to rank and categorise TRM/CAM, which went beyond the terms of reference. The Committee devised three groups to define TRM/CAM, based on factors such as their level of professionalisation, and adherence to or compatibility with biomedical tenets. The criteria used for categorising TRM/CAM revealed an underlying assumption about the superiority of biomedicine. The Committee was explicitly ranking TRM/CAM according to how closely it had assimilated to or was compatible with biomedical ideals.

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88 Group 1 was considered professionally organised (acupuncture, chiropractic, herbalism, homoeopathy, osteopathy); Group 2 was considered supplementary to biomedicine (Alexander technique, counselling, hypnotherapy, shiatsu, reflexology, yoga); while Group 3 was considered “indifferent to the scientific principles of biomedicine” and divided into (a) ancient traditional systems (e.g. Ayurveda, TCM) and (b) those lacking any credible evidence base (crystal therapy, dowsing, iridology, radionics). (Note that acupuncture has been separated from TCM and is presented as an independent therapy in group 1) (House of Lords Select Committee on Science and Technology, 2000).
The Indian government immediately sent a delegation to the United Kingdom to present scientific evidence of the efficacy of Ayurveda, to no avail. This case was viewed by Bodeker as an extension of hostile colonial attitudes and power plays between biomedicine and TRM that had existed for over 165 years based on “linguistic, cultural, and epistemologic [sic] differences between the traditions, leading each side to view that the other has no sound basis in theory or practice” (Bodeker, 2001a:390). Contested aspects of TRM/CAM now came to a head, as the regulation process established the boundaries of primary resources and therefore, crucially established the access to secondary resources (economic benefits, prestige).

Regulation required the classification of primary resources and defining the boundaries of primary resource bases. In regulating TRM primary resources, the question of whether it is it a food, herb, vitamin, drug or weed needs to be objectively asked and answered. This is not a clear-cut process, and the categories may not be mutually exclusive. In Korea, India, Japan and China (amongst other cultures and countries) food has been used for thousands of years for medicinal purposes (Grivetti, 1991a, 1991b, 1991c, 1991d; Joo-Lee, 2003; Junsheng, 2003; Keen, 2001; Krishnaswamy, 2003). This concept became popular in the North in the 1990s as “functional foods” and “nutraceuticals” – scientifically appraised common food items from which active compounds are identified and then transformed into supplements or commodities (Dow, 2003), the global market for which was US$80 billion in 2004 (Nandakumar, 2004).

The issue of regulation and classification of primary resources is political as it allocates benefits to particular groups, rather than technical (neutral, with no sectional interests served). This question needed to be addressed in the North (Mills, 2002; Mitka, 1998) as well as the South (Burford et al., 2000:8). It remained problematic in the South, as there was often no distinction between food and medicine – food therapy was a core component of TRM systems. Different assessments and value judgements resulted in different classifications. For example: Gingko Biloba, St. John’s Wort, chamomile, guarana, and kava were given different labels such as medicine, supplement or health product depending on location (Pollock, 2000:5).

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89 For example, scientists recently discovered that blueberries lower cholesterol more effectively than biomedical drugs prescribed for that purpose. They believe blueberries may hold the key to fighting obesity and heart disease – and are currently developing a new product (nutraceutical) from the compound isolated (pterostilbene) (Anonymous, 2004).
Bodeker (1996:325) provides the example of *Chromolaena odorata*, listed as one of the most serious weeds affecting coconut, rubber and oil palm cultivation in Sri Lanka, Indonesia, Malaysia and Nigeria. However, these crops are amongst the lowest earning commodities while the “weed” is a medicinal plant used as an antimicrobial to treat burns and wounds. A tube of the herbal medicine costs around US$0.25c, while the imported biomedical equivalent costs between $US5-6.

Which is the real cash crop here: coconuts or Chromolaena? Could it be that some of the world’s worst weeds, if only we looked, might turn out to be some of the world’s best medicines? (Bodeker, 1996:325)

The necessity to define and categorise foods, herbs, plants and drugs was driven mainly by commercial incentives. It was required to enable standardisation, regulation, commodification, quality control and mass production and distribution. Globally, it became more urgent to undertake this classification as consumers were buying products in the unregulated private sphere, or in a public sphere which was lagging in supervision capacities. In the 1990s there was a sudden imperative to regulate the trade of foods, plants and herbs associated with burgeoning domestic and international consumer demand. This defining and categorising was also a process of exclusion and restriction of TRM/CAM primary resources (Jagtenberg & Evans, 2003).

In China, regulations for “functional foods” (foods with medicinal value) were introduced in 1996/1997 after which the market expanded rapidly, as production moved from small family/local industries to large scale manufacturing enterprises. There are now more than 2000 such enterprises, with a market capacity of US$6.3 billion and over 4000 functional foods registered with the Ministry of Health. The registration process involves scientific proof of the active ingredients to demonstrate efficacy or health functions, and quality control specifications. No therapeutic claims can be made (Junsheng, 2003). Functional foods are therefore nutritional supplements, not medicines (in contrast to no such distinction being made in TRM conceptual frameworks).

TRM/CAM therefore needed to conform to economic and regulatory frameworks that could not fully comprehend or accommodate its primary resources and underlying principles (e.g. spiritual aspects, the conflation of food/medicine). This also was evident in legal jurisdictions (Okoth-Owiro, 1994), which were being presented with difficulties in interpretation and application of principles in TRM/CAM cases. For example, in New Zealand a man was charged with driving under the influence of kava, but was acquitted as kava had not been registered or recognised as a drug (Pollock, 2000:2). In British Columbia,
a person sued TRM practitioners who had forced him into a TRM therapy ("spirit dance"), without his consent but according to traditional practices. The judge agreed that it constituted assault, battery and false imprisonment and awarded damages to the plaintiff (Waldram, 2000:618).

These examples illustrate that there is a fine line between determining or demarcating food/drugs/weeds and healing/hoax (placebo)/assault, that the categorisation is subjective, and allows allocation of different secondary resources to different recipients. This direct clash of TRM/CAM and biomedicine in legal or regulatory arenas usually resulted in favour of biomedicine. As Saks presents it, TRM/CAM and biomedicine are two sides of the same coin – but when tossed it always lands heads up (biomedicine) (Saks, 2003a:143). It is very difficult to apply the same regulations to TRM/CAM as applied to biomedical devices and products, especially those used in traditional practices from other cultures (Eskinazi & Mindes, 2001:21), and it was not always easy to understand the logic and wide variation in approaches (Chaudhury, 1992:73).

The structurally weaker TRM/CAM was still perceived as inadequate or unsafe in comparison to biomedicine. There appeared to be a distortion in public and media perception about safety and efficacy of TRM/CAM in comparison to biomedicine. For example, in Australia panic ensued when an herbal medication caused the hospitalisation of 19 people. It absorbed much media attention, caused the largest product re-call in Australian history and crippled the CAM industry, when 219 CAM medicines were pulled from shelves (costing millions of dollars) (Harris & Gottliebsen, 2003; Tobler, 2003).

A few months later, a study was released (cited by Steketee, 2003) which found that in Australia, 16.6% of hospital admissions (representing 470 000 patients) resulted in an “adverse event” and caused 18 000 deaths and 50 000 cases of permanent disability annually. It was conservatively estimated that at least 25% (4 500) of the deaths could have been prevented. These statistics compare to 122 deaths from AIDS and 1721 fatal car accidents per year. A health economist was quoted, declaring that biomedical error was the major epidemic of our time, preventable errors cost $4.5bn a year and public knowledge of this would cause a major scandal (Steketee, 2003). However, this report went largely unnoticed.
and inspired limited press coverage. Similarly, in the United Kingdom more than a quarter of a million patients were admitted to hospitals annually due to adverse drug reactions (Hitchen, 2006). The seriousness of biomedical iatrogenesis was overlooked, and iatrogenesis of TRM/CAM exaggerated.

Many of the complexities arising from the state regulation, tensions between local-global spheres of use, and market imperatives of TRM can be highlighted with a detailed example. Appendix 8 (page 362) offers an overview of some of the issues discussed in this chapter in relation to a particular location, with reference to kava. The positions of interest groups and stakeholders (biomedical and TRM/CAM practitioners) are detailed below, in a generalised way. For example, these groups were not always in direct “conflict” or “opposition” to each other – throughout the 1990s examples of biomedical and TRM practitioners working together and co-operating did occur, usually in mutually beneficial (albeit often unequal) arrangements where both obtained secondary resources (see Sofowora, 1996). Biomedical practitioners sometimes did make patient referrals to CAM, particularly for chronic illnesses and conditions biomedicine had proven ineffective in treating (Astin et al., 1998; Cant & Sharma, 2000:430). However, in general the interest groups are distinct and are presented as such for clarity.

5.5.1:2 Interest group: Biomedical profession

The rising use of TRM/CAM in the 1990s represented a serious threat to the biomedical profession, on two fronts. Firstly, their primary resource base was being challenged with alternatives that were readily embraced by consumers. In addition, their secondary resources were being depleted as TRM/CAM practitioners gained more status and prestige as well as economic and social benefits from their practice. This decade represented a “watershed” where “it was more in the interests of the [bio]medical profession to incorporate [TRM]/CAM on its own terms rather than reject it” (Saks, 2003a:144).

Therefore, the biomedical profession strengthened control of the integration process, and responded to this challenge in multiple ways to maintain their structural professional dominance and authority. These responses were “based on incorporation or subordination” (Saks, 1998:211), or “exclusion, reformulation, incorporation” (Easthope, 1993:294). The biomedical profession responded with scepticism about the scientific validity of anything biomedicine, and properly delivered biomedical treatments are the sixth leading cause of death in the West (Jonas & Levin, 1999:5).
outside their own boundaries, and attempted incorporation of some of the techniques (Gabe, Kelleher, & Williams, 1994:xv). Such strategies had been commonly employed by the biomedical profession in the past (Baer, 1981; Fairfoot, 1987; Janes, 2002; Jonas & Levin, 1999; Leslie, 1980; Lock, 1990).

Whereas in the 1980s, the dangers and risks associated with CAM/TRM had been emphasised by the biomedical profession, in the 1990s the attitude generally became more positive (Saks, 2003a:144) to enable selective incorporation of CAM/TRM primary resources. “So after dismissing CAM therapies as quackery for the better part of a century, the medical establishment now finds itself racing to evaluate them ...” (Cowley, Underwood, & Braiker, 2002). This was done under the rubric of “evidence based medicine” (Guyatt, Cairns, & Churchill, 1992), where a medicine or therapy had to demonstrate improved patient outcomes with randomised controlled clinical trials. Only those treatments that had clearly demonstrated this were to be absorbed within the repertoire of biomedical primary resources (Dalen, 1998:2180; Harlan, 2000:13, 14). The application of scientific discourse thus continued to be used as a filter to exclude or incorporate TRM/CAM primary resources, and allowed biomedicine to exert control and authority over the legitimation of competing health care discourses.

Lewis (2003) analysed how this shifting attitude is reflected in biomedical literature, and found that a rhetoric of danger was constructed about herbal medicines which served as a tool to legitimate biomedical hegemony. Safety and danger are key concepts in disputes between medical systems (O'Neill, 1994) as this enables restriction over the use of primary resources by potential competitors. Lewis (2003) assessed the Medical Journal of Australia between 1968 and 2002 and found that any acknowledgement of the benefits of herbal medicines did not appear until 1997 and had been totally absent in the 1980s. However, by the turn of the century, “efficacy” rather than “danger” became the more prominent discourse (Lewis, 2003).

As already mentioned (and discussed in more detail in the following chapter on the WHO TRM Strategy), the safety, efficacy and evidence based medicine agenda allows more stringent control over economic resources directed to CAM/TRM research, as the biomedical coalition can control funding and the focus of research through the expertise and qualifications required to undertake tests. The efficacy agenda absorbs massive amounts of funding while neglecting public health concerns (Bodeker & Kronenberg, 2002), and limits the secondary resources channelled to their competitors. Kennedy and Olsson argued that
“for effective integration to occur both traditional and biomedical approaches to medicine would need to compromise on the use of safe and effective cures” (1996:45).

While there is much literature on the topic of efficacy that is beyond the scope of this research to discuss, a limited number of observations are relevant and worth making. The dismissal of anything functioning as a placebo can be seen to serve a political purpose by the biomedical coalition: “[it] is an intentional act and part of biomedicine’s quest to identify those aspects of human experience over which it can claim authority and therefore assert control” (Waldram, 2000:617). It also serves to greatly limit what is recognised as the legitimate primary resource base of TRM/CAM. An emphasis on efficacy is therefore an effective strategy to limit and reject the scope of alternative healing modalities (primary resources), which directly impinges upon the secondary resources (economic and social benefits) that can accrue to TRM/CAM. It also overlooks the demonstrated limited and questionable effectiveness of many biomedical treatments (Dalen, 1998; Peabody et al., 1999:127; Smith, 1991), as well as the sheer scope of the task (Chaudhury, 1992:77; Last, 1986:4).

Similarly the differential and disproportionate emphasis on “safety” places biomedicine above the very standards of safety and efficacy that the profession imposes on other groups within the health care sphere, and gives them the authority and power as gatekeepers to exclude their own competitors from the market. Domination by biomedical interests was one reason integration was resisted by TRM practitioners in the 1970s – integration would mean they would be controlled by competitors whose interest lay in putting them out of business (Kleinman, 1978:84). This control could now be expressed in calls for strict market regulation based on “benign” and “neutral” safety and efficacy grounds, in the patient’s best interests. This easily combined with economic rationalist concerns to fund only clearly demonstrated efficacious and cost-effective treatments from the public purse.

In the 1980s CAM had been criticised as “unscientific” by the British Medical Association (Fairfoot, 1987; Saks, 1998:207; Sharma, 2000:214), but in the 1990s the stance was moderated. In 1993, the British Medical Association released a report on CAM which proposed that biomedical practitioners improve their knowledge of CAM. However, it also argued for increased professional regulation of the sphere, continuing biomedical responsibility for the patient, greater biomedical input into courses on CAM and no
additional research funding (Saks, 1998:211). The report stressed the authority of biomedical doctors to assist the community to evaluate the competing claims of CAM (Sharma, 2000:215).

The new interest in and scrutiny of CAM by the biomedical profession was reflected in a surge of articles on this field in mainstream medical literature (Barnes et al., 1999:938; Barrett et al., 2003). Annual MEDLINE citations of CAM increased progressively from 156 in 1990, to 906 in 1999 (Barrett et al., 2003:938). Barnes et al. conducted a systematic search of medical literature to see if there was a growth of interest by the professional scientific community in areas of alternative medicine, traditional medicine, acupuncture, homeopathy and chiropractic (Barnes et al., 1999). They found that from 1966 to 1996 the total number of articles rose significantly to a peak of 400 000 additions per annum in 1996. The proportion of clinical trial-type alternative medicine articles was low but increased significantly from 1987 to 1996. They suggested that the plateau of new articles reached in 1996 could reflect a reduction in the rate of submission to more specialised CAM journals or a reluctance of mainstream medical journals to devote more coverage to the issue.

At the same time, there was a massive increase in the promotion of biomedical primary resources demonstrated by the rising proportion of expenditure in advertising. Whereas in 1989 the spending on advertising of pharmaceuticals in the US was US$12 million, in 1999 it had jumped to US$13 billion (Jobst, 1999:107). While heavily promoting their own primary resources, the biomedical profession also began to modify professional association rules and paradigms to enable the selective absorption or the exclusion of CAM/TRM. The biomedical paradigm was modified in two significant ways in the 1990s, the first being with the adoption of “evidence based medicine” already mentioned. This enabled scientific methods to determine efficacy to become the standard criteria to assess validity of treatment modalities. Therapies or that did not have an adequate scientific evidence base could thus be dismissed or excluded from “legitimate” medical practice or formal health care services.

The second paradigm shift was in the development of a new school of thought, reflected in new biomedical terminology that became prevalent in the 1990s such as “mind-body medicine” and integrative or integrated medicine (using biomedicine with selected facets of TRM/CAM such as acupuncture or medicinal plants) (see Anderson, 1999; Barrett, 2003; Eskinazi & Mindes, 2001:23).
Barrett et al., 2003; Dacher, 1999; Featherstone & Forsyth, 1997; Giordano et al., 2002; Leckridge, 2004; Michaeli & Relman, 2000; Park, 2006; Rees & Weil, 2001; Rifaat, 1997; Sabatino, 1993; Wayland, 2003; Weil, 2001; Weil & Relman, 1999). These new schools of thought developed rapidly, overcoming the mind-body split inherent in the biomedical Cartesian conceptual foundations and evolving from Engel’s *bio-psycho-social* model of health care (Engel, 1977). It was sometimes referred to as *psycho-neuro-immunology* (the study of mind-body interaction) (Easthope, 1993:295; Macdonald, 2005; Tataryn, 2002:884), which clinically validated some of the premises of TRM/CAM.94

Historically, the paradigms of traditional knowledge systems have been viewed as ‘primitive’ by modern or Western science, including [bio]medicine. However, recent advances in environmental sciences, in immunology, medical botany and pharmacognosy have led to a new appreciation of the precise descriptive nature and efficacy of the treatments employed (Bodeker, 1994b:6).

The modification of biomedical conceptual and professional boundaries to enable selective absorption of TRM/CAM was concurrent with an increase in scientific validation, and the dropping of professional restrictions against practice or collaboration (Saks, 2003a:144). It was recognised by some that such developments, fostering selective incorporation of TRM/CAM into the biomedical sphere, were primarily motivated by economic considerations – an effort to “expand market share in a competitive environment” (Kaptchuk & Miller, 2005:288) and a response to growing demand which provided an opportunity to expand responsibilities and seize profits (Gilbert, 2004). This occurred in the 1990s (as Unschuld theorised) when it was recognised that using the primary resources of competing medical systems would be advantageous to secure more secondary resources such as economic benefits, status or prestige (Unschuld, 1976b:8). The requirement for secondary resources to encourage co-operation was expressed in the *World Health Forum Journal*:

> Doctors should be rewarded with salary increments for collaborating with ethnomedical practitioners [economic benefits], who in turn should be rewarded for their collaboration … with training courses, equipment, certificates and diplomas [status, prestige] (Bastien, 1994:136).

Therefore, biomedicine still demonstrated a reluctance to accept aspects of CAM/TRM without economic incentives (secondary resources), but were more receptive to accepting

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94 Psycho-neuro-immunology (PNI) was “attractive to [biomedical] doctors because it enables them to continue to legitimate occupational closure using a rhetoric of science. That rhetoric is central to their occupational claim to monopoly and professional status … PNI appears to offer the possibility of incorporating the insights of alternative practitioners and social science about the contextual nature of illness without abandoning the biomedical scientific model …” (Easthope, 1993:295).
those treatments or therapies that demonstrated scientific validity and profitability such as acupuncture (Easthope & Tranter, 2000; Saks, 1992b, 1994, 1995a). For other aspects of TRM/CAM “[t]here is a lack of desire to research complementary and alternative therapies because often the therapeutic entity cannot be patented, and therefore no commercial profitability exists” (Giordano et al., 2002:902). There is no commercial incentive to produce drugs that use natural ingredients (Bodeker, 1994b:102; Jobst, 1999:107), unless patent protection (exclusive access to secondary resources) can be obtained from locating, extracting, synthesising and modifying the natural substance.

5.5.1:3 Interest group: TRM/CAM practitioners

In the 1990s, TRM/CAM practitioners were simultaneously presented with both a threat and an opportunity. Their primary resource base was adopted by consumers, and this surge of interest necessitated increased public sphere oversight and regulation. Suddenly, small scale local production was being subsumed by mass production on a global scale and their primary resources were moving into previously foreign markets (Jagtenberg & Evans, 2003). Competition to secure contested resources was expressed in forums such as the WTO and TRIPS (patent disputes and ownership claims) and in the biomedical sphere by recourse to demands for scientific validation and safety and efficacy agendas.

By the mid-1990s, a sense of dissatisfaction with the WHO approach to TRM was being articulated, such as the focus on TRM use only in PHC and only on clinically efficacious remedies. At a meeting in 1996 of TRM practitioners and advocates, “[t]here was reluctance to accept the apparent WHO restriction of [TRM] to primary health care” (Bodeker & Bichan, 1996:393) and TRM practitioners in Africa sought greater inclusion in state health programmes and called for a global representative council to be formed (editorial, 2002a). In seeking greater secondary resources, they were still keen to share the primary resources of biomedicine:

The healers did want to come to the hospital and work hand in hand … the traditional healers would be very, very happy. Most of them thought they would have power and the Ministry of Health would pay them [secondary resources] (Upvall 1992:34).

During the 1990s, TRM and CAM practitioners realised the economic value of their primary resource base and began to quickly lay claim to ownership. This was mainly visible with tactics of professionalisation and the adoption of scientific discourse. While these tactics
were employed, they were not free of controversy and difficulties in application and as Lee (1982) argued, they may hasten the absorption of TRM/CAM into the biomedical sphere.

The most obvious activity was in the area of professionalisation. Wahlberg (2006) mentions a number of studies that indicated various forms of TRM and CAM were undergoing rapid professionalisation, “involving the creation of practitioner associations, registers, ethical codes of conduct and disciplinary committees, not unlike those found in the biomedical profession” (2006:127). The acceleration of professionalisation was evident in Africa (Kagwanja, 1997; Last & Chavunduka, 1986), Europe (Saks, 1992a, 2003b; Sharma, 1992), Asia (Kim & Lim, 2003; Wahlberg, 2006), and North America (Baer et al., 1998; Kelnner et al., 2004; Welsh et al., 2004). However, the professional development of TRM was hindered in some countries by a lack of legal recognition of TRM practitioners (Okoth-Owiro, 1994:53).

The intensification of professional activity was also reflected with an increase in journals, articles, conferences and other publications related to TRM/CAM, accreditation of courses and formalisation of training and education. The attitudes of biomedical stakeholders to the professionalisation of CAM in Canada were analysed by Kelnner et al. (2004). They noted that several strategies were adopted by the biomedical coalition to constrain the professional development and jurisdiction of CAM. These strategies included demanding scientific evidence of safety and efficacy; redefining what integration was (blocking and controlling the process of integration); and opposing government funding being allocated for research. Such strategies were deemed to protect the dominant position of biomedicine and maintain existing “jurisdictional boundaries” (Kelnner et al., 2004), and were evident elsewhere, such as the US (Fontanarosa & Lundberg, 1998), UK (Saks, 1998) and Australia (Easthope, 1993).

These findings are consistent with Lee’s assertion that both professionalisation and the use of scientific discourse were key aspects in obtaining or maintaining structural dominance (Lee, 1982). Biomedicine can use these techniques to block or control integration (structural recognition of TRM/CAM) and TRM/CAM can use them to increase leverage. For example, the use of both scientific discourse and professionalisation was demonstrated by acupuncture. The World Federation of Acupuncture-Moxibustion Societies was formed in 1987 and boasted nearly 60 000 members – however, 70% of these members (35 000) were either biomedical doctors or had graduated from an accredited institution recognised by national government (WHO, 2002e:40). Secondary resources were obtained by acupuncture through the use of these techniques but also enabled biomedicine to dominate/absorb it via
professional organisations (or the development of them), the translation of the knowledge base into biomedical scientific terminology, and adopting it as an adjunct to biomedical practice.

While some embraced the concept of professionalising to gain official recognition, others did not want to be included in official health care plans and were still reluctant to rationalise their primary resources (via demonstrating safety and efficacy, accumulating an evidence base and adopting scientific discourse) or professionalisation (regulatory standards and accreditation for training and education, codes of conduct and official oversight). For some, this process meant set fees and taxation, meeting state requirements for lodging official paperwork and so on (Kale, 1995; Young, 1994:67). The inherent dangers of both professionalisation and adoption of biomedical scientific discourse loomed large – specifically the threat of co-option (losing control over primary resources) (see Eby 1998, Jagtenberg & Evans 2003).

The need to demonstrate efficacy and validity in scientific terms in particular presented dilemmas for CAM/TRM (Dalen, 1998; Thorne et al., 2002:128; Wahlberg, 2006). Apart from lacking the funds or expertise for conducting such clinical research, and the inappropriateness of some of the measures – this discourse was foreign, and ceded control and authority to the biomedical fraternity. Some argued that “scientific proof” was a biomedical construct that ignored valuable methods of healing and treatment and ignored many TRM/CAM therapeutic techniques: “Perversely, modern medicine has often acted as if nature could be ignored and the answers to all that ails humanity could be found in the laboratory” (Akerele, 1993:393). Others felt that scientific research was “unnecessary, wasteful and sometimes even harmful” (Elkadi, 1994:172).

The stringent needs for clinical testing and demonstrable efficacy (and the required funds and expertise to undertake this) were seen by some to be so onerous as to be impossible to meet, and even beyond what biomedicine itself could demonstrate (Dalen, 1998; Janes, 1999:1808). For example, many simple herbal remedies have been used over thousands of years yet may not be able to satisfy the requirements of evidence based medicine (Chang, 1999:183). The lengthy and costly processes for clinical testing prevented the adoption of such herbal remedies despite “proven” therapeutic effectiveness based on practical rather than clinical grounds.

95 “It is clear that many of the therapies prescribed by Western-trained (biomedical) physicians are not evidence based as currently defined” (Dalen, 1998:2130).
...it is also reasonable to ask what the point of such research might be from the perspective of the country of origin. After all Ayurveda is already an official health care system within India. Is research evidence a realistic basis for the formal acceptance of specific Ayurvedic medicines and therapies when so many thousands of these exist? Clearly it would be impossible to evaluate them all clinically (Bodeker, 2001a:391).

Calls for the testing requirements to be relaxed or modified were met with the WHO eventually agreeing that if a traditional medicine is in customary use with no reported side effects, a fast-track toxicology regime (testing on two species of animal for a six-week period) with documentation was an adequate basis for starting Phase III clinical trials. However, many major Northern funding bodies and peer reviewers rejected this approach (Burford et al., 2000:11). In the US in 1996, a research centre was established to co-ordinate and facilitate the evidence base of CAM, although it was acknowledged that a language bias may exist in the information as much scientific research was published in other languages (Ezzo et al., 1998), and a substantial body of research into toxicity and efficacy had already been produced in languages other than English that was being overlooked by the biomedical and scientific community (Bodeker, 1994b:13-14).

While debating or criticising the limits of scientific validation (Gerke & Jacobson, 1996; Waldram, 2000) or lamenting the lack of ability of TRM/CAM to develop suitable scientific methods (Godik & Friedman, 1998), the need for scientific validation to meet WHO and state endorsed “safety and efficacy” agendas was pressing. If TRM/CAM practitioners wished to be formally included in health systems and obtain the economic and professional privileges (secondary resources) of operating fully in the public sphere, then they needed to adopt the necessary discourse and form professional associations for political representation. Despite difficulties presented by the requirements of “evidence based medicine”, a growing body of literature demonstrating clinical efficacy was being established throughout the decade, and CAM increasingly resorted to scientific concepts and methods to describe their practices (Cant & Sharma, 2000:434).

Policy discourse in this arena is still conducted by appeals to evidence and causal inference. The success of more ‘democratic’ therapies, like herbalism, depends on the successful use of this discourse: those who advocate alternatives to high technology medicine have to show they are better at curing sick people (Moran & Alexander, 1997:593).

The views on the safety and efficacy agenda were not shared across the entire spectrum of TRM/CAM. Various practitioners and groups had different perspectives, with some embracing it readily and others rejecting it outright. For example, the attitudes of three CAM groups were analysed in Canada (Kelner et al., 2002). Chiropractic, homeopathy and Reiki
practitioners were questioned on their beliefs and striking differences were found. “The chiropractors agreed that it was essential for their group to provide scientific evidence that their interventions work, are safe and cost-effective. The leaders of the homeopathic group were divided on these points and the Reiki respondents showed virtually no interest in undertaking such research” (Kelner et al., 2002:235).

Kelner et al. (2002) concluded that the CAM groups that are more formally organized are most likely to recognize the importance of scientific research to verify their practices and therapies. However, it could also be concluded that this demonstrates that both professionalisation and use of scientific discourse are dual methods used by TRM/CAM to obtain more political recognition and secure a role in health care systems (obtain secondary resources). The adoption of these methods may reflect the outcome of weighing up whether further secondary resources will be obtained from resorting to these measures (or whether primary resources will be threatened). TRM/CAM groups that may potentially gain secondary resources could be more willing to submit to the need to professionalise and scientifically validate their primary resource base.

The vexed problems of scientific validation and determination of safety and efficacy are explored further in the following chapter, which specifically focuses on how these and other issues were dealt with in the WHO TRM Strategy (WHO, 2002e). How some of these conflicts and issues were played out on national levels is discussed below, with reference to South Korea, Mexico, South Africa, and Tibet. The issues of defining primary resource bases and professionalisation are common themes on many national levels.

5.5.1:4 National examples of implementation

Korea provides a particularly vivid and interesting example of the resource model in action. TRM (Hanbang, practiced by hanuisas) had obtained an independent legal status parallel to biomedicine after many decades of struggle, and maintained a competitive position in the health system (Kim & Lim, 2003:1999). In 1975, some pharmacists began selling herbal remedies (TRM primary resources), and TRM practitioners petitioned the government to restrict this to the TRM profession only. As the market for herbal medicines expanded in the 1980s and 1990s and became more lucrative (increased secondary resources), biomedical pharmacists again began to seek access to TRM primary resources through seeking rights to

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96 In Korea, health insurance is available for TRM, and TRM practitioners typically earn more (greater secondary resources) than biomedical practitioners due to the popularity of Hanbang (Bodeker, 1994b:7).
prepare and dispense herbs (Cho, 2000a:506). In 1993, this led to the relevant legislation being amended to allow pharmacists to sell both biomedical and herbal preparations, which resulted in massive demonstrations by thousands of *hanuisas* (Cho, 2000a:506).

Following this conflict over the access to *Hanbang* primary resources, a period of negotiation commenced and a proposal was developed to allow only pharmacists who had already sold herbal remedies for a year and passed a qualifying exam to continue. However, when this proposal was incorporated into the legislation, pharmacists rejected the restrictions and called a national strike in which they were joined by biomedical doctors – who also protested a new government policy to support *Hanbang* medicine (Cho, 2000a:506-507). Specifically, biomedical practitioners opposed the creation of a separate administrative unit for TRM, funding for a research institute and other measures (increased secondary resources for TRM). This conflict lasted for several years, with *Hanbang* students particularly militant in resistance and calling a strike for over two years. This perhaps reflected the threat to their future secondary resources (economic benefits, prestige) if biomedical pharmacists succeeded in their bids to claim rights to dispense their primary resources (herbal remedies).

The main points of contention can be seen to revolve around the demarcation and control of primary and secondary resources: Would the new department of herbal drugs be affiliated with the College of Pharmacy, or the College of *Hanbang*? How would examiners for the qualifying pharmacists or *hanuisas* be selected? What would be the extent of pharmacists’ rights in prescribing and dispensing herbal remedies? (Cho, 2000a:507). The TRM practitioners took China as their model, rejecting claims that *Hanbang* was unscientific and that pharmacists’ biomedical knowledge was sufficient for dispensing herbs. The biomedical practitioners followed the Japanese example, asserting the unity of scientific knowledge and that *Hanbang* concepts and theories were obsolete but their herbs may yield empirical uses suitable for biomedical exploration (Cho, 2000a:508). Ultimately both sides won concessions in securing secondary resources – pharmacists managed to maintain their right to prescribe herbs while *hanuisas* received institutional recognition.²⁷

In *Mexico*, the potential for integration was explored by anthropologists (Kennedy & Olsson, 1996). They concluded there were significant differences in knowledge bases (primary resources), but still room for active co-operation. The authors concluded that there were two main obstacles to effective integration: the first was the assumption that scientific

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²⁷ For more detail on the manoeuvring of biomedical and TRM practitioners, and political/professional conflict over reform in the pharmaceutical industry see (Cho, 2000b; Kwon, 2003).
knowledge would inevitably replace traditional systems of knowledge – “when one adds the irresistible lure of high technology and the asymmetrical power relations common to the First World/Third World encounters, it is easy to understand why so few (in the South) have rushed to embrace integration.” The other obstacle was the chasm separating TRM/biomedicine in terms of theory and concepts; the former being rooted in the local and the latter claiming universality (1996:42).

Kennedy and Olsson (1996) proposed that the systems of knowledge should be viewed as equal, and offered jointly within community clinics. An experimental clinic had already been set up in 1988, and was supported enthusiastically by practitioners and patients but funding for this project was ceased by the Government (1996:42-43). Integration took place effectively at the consumer level, even if this did not occur in service delivery infrastructure. Sophisticated medical pluralism operated, with people using both TRM and biomedicine depending upon health condition (1996:43-44). Kennedy and Olsson claimed that effective integration could take place through mutual referral systems, which was endorsed by the community. They desired the ability to access either TRM or biomedicine at the same health care facility due to convenience. About half of the small sample of biomedical practitioners favoured this (1996:44-45).

In the post-apartheid phase of the early 1990s, South Africa found itself in a similar position to other countries which had undergone decolonisation in the 1970s. The role of TRM in formal health care systems was questioned in a similar vein to that in the previous decades elsewhere on the continent (Freeman & Motsei, 1992; Gilbert, 2004; Kale, 1995). TRM practitioners were banned by an Act of Parliament in 1974 which was not repealed until 2004 – a move greeted with enthusiasm by black parliamentarians (Sidley, 2004). In the meantime, many thousands of TRM healers practiced privately and had formed professional associations. The government found developing a dialogue with TRM practitioners difficult, which was also hindered due to rules of biomedical professional associations which precluded co-operation. One official asked at a meeting:

How do I distinguish between a [TRM practitioner] who [is trained] and one [who is bogus]? They said, ‘It is easy. You just find out whether he has slaughtered a goat.’ Now, I am a [bio]medical doctor, and all this tells me is that they work in a completely different sphere, and that we cannot have the same rules for them … To integrate them, and to give them the same status and privileges [secondary resources] as [bio]medically qualified doctors is just not on but we cannot ignore them, especially if we want to deal with problems like AIDS and HIV (Kale, 1995).

Thus, there were difficulties and tensions in professional recognition, and scarce evaluative information to guide the integration process in South Africa. Commonly, the neighbouring
countries of Zimbabwe, Mozambique, and Swaziland were considered, with few encouraging findings (Freeman & Motsei, 1992; Kale, 1995). Incorporating TRM at PHC level would mean that they would have to accept a “secondary role” and a limit their sphere of influence, as well as accepting the “superiority” of biomedicine, a reduction in status, and probably a reduction in income due to regulation and taxation (Kale, 1995). The government made no mention of TRM in PHC plans, the dangers of TRM primary resources were highlighted and only after the “weeding out” of the “charlatans” through professional regulation could it be determined if TRM was an “asset or a liability” in South Africa (Kale, 1995).

HIV/AIDS was a significant motivating factor in seeking to regulate TRM practitioners and one section of the South African 2004 law on TRM practitioners prohibited unregistered healers from claiming cures or relief for cancer or HIV/AIDS. Biomedical doctors were concerned that patients were being encouraged to try traditional methods, causing delays in the uptake of biomedical treatment (Sidley, 2004). Sidley notes that other motives were the desire to standardise and regulate TRM remedies, which was expected to meet with “fierce resistance” and a need to protect consumers from dangerous practices such as traditional circumcision (2004). The legislation can therefore be seen as a reactive and restrictive move by the government. It still caused some concern in the health insurance business, which is worth around US$7.8 billion annually, as they felt that their funds would be diminished by claims for treatment from TRM healers. The South African government is now identifying healers, categorising them, setting standards and registering them, which as Sidley notes is by definition a process of exclusion.

In Tibet, Janes has extensively studied medical pluralism, globalisation and the transformation of local healing practices (Janes, 1995; 1999; 2002). Janes presents a detailed history of TRM in Tibet, but developments in the 1990s are focussed on here. Health care reforms introduced in China in the mid-late 1980s affected Tibet mainly through financing, structure of and access to biomedical and PHC services (Janes, 1999:1813-1814). The main factory for TRM remedies became an independent fiscal entity and was encouraged to gear production to profit, with international and domestic demand placing pressure on production standards as well as supplies. Rural shortages became common by the late 1990s. However, a clinic for foreign tourists was opened in 1993, catering to increasing international demand for TRM:

With the expectation that the Tibetan hospitals and clinics generate more of their own revenue, these institutions are responding by diverting [primary] resources away from rural areas, where medicine is less profitable [minimal secondary resources exist] to the urban...
areas … Responding to the potential for profit represented by this vast [tourist/international] market … [they] are rushing to establish clinics and export medicines, all at a cost to health care in Tibet. The better doctors, the more expensive pills, are being diverted … medicine factories responding to increasing demand are raising prices. This results in local shortages … (Janes, 1999:1815).

Janes also discusses the role of scientific discourse as part of the rationalisation process that began in prior decades. “Scientism” is considered a powerful force in both Tibetan and Chinese societies, and TRM was now subject “via a host of avenues, to cosmopolitan, scientific principles” (Janes, 1999:1815). Reconciling these two bodies of knowledge had the consequences of the theories and concepts of Tibetan medicine being defined or explained according to modern physiology, and accepting scientific standards for evaluating efficacy (Janes, 1999:1815).

Research efforts also attempted to blend classical theory or texts with modern scientific methods, following the Chinese process. The motive for compiling inventories and descriptions of TRM medicines was to enable scientific scrutiny. However, Janes concludes that efforts to integrate TRM with biomedicine in Tibet have never been “systematic or sustained” and are more “rhetorical and symbolic” (1999:1816). The need to professionalise to maintain the “integrity” of TRM whilst also protecting standards for this from “narrow and competing interests” is also important in the Tibetan context (Janes, 1999:1817). The conundrums associated with the use of scientific discourse and professionalisation are clearly illustrated in the Tibetan case, in the face of globalisation (development of global markets and the pressure from economic imperatives).

5.6 Conclusion

In the 1990s, the broader context again re-shaped the policy of integration of TRM in formal health care systems. As in previous decades, political, social and economic trends filtered through to international and national health policy agendas. This influenced the case of TRM in a variety of complex ways and served to push TRM back onto the policy agenda and entrench it as a matter of priority. The main global themes and problems of the decade were environmental conservation and sustainable development. In development efforts, indigenous knowledge systems came under closer appraisal as offering techniques that could be harnessed in establishing sustainable income generation and export markets.

TRM featured prominently in this new focus, because the use of plants, herbs and other primary resources of TRM systems became a largely unregulated massive international
market, and medicinal plants offered a lucrative resource as cash-crops to meet the rapidly expanding demand for TRM/CAM in the North. This demand presented an environmental concern related to protecting biodiversity. Medicinal plants were in danger of extinction through over-harvesting and environmental degradation, representing a serious threat. In implementing measures to protect the environment (such as cultivation schemes), medicinal plants also simultaneously offered economic benefits to indigenous communities. TRM could therefore be fortuitously tied to several high profile and popular concepts on the international policy agenda – efforts to protect biodiversity and promote conservation, protection and recognition of indigenous knowledge, and sustainable development/local capacity building.

This new focus was a marked shift from the emphasis prevalent in the 1970s which had been the development of low cost health care in the form of PHC. While this had been a paramount issue initially promoting TRM on the health policy agenda, in the 1990s environmental and economic factors caused the problem to be reframed. This was reflected in the presentation of TRM as a valuable resource, TRM practitioners as custodians of indigenous knowledge, and plants as having a quantifiable economic value. The environmental and economic value of TRM (specifically medicinal plants) therefore became prominent in policy and programme documents, anchoring TRM firmly to the broader political and economic agenda.

To capitalise on market growth, regulatory aspects urgently needed to be addressed (for example, standardisation, quality control, industrial production and cultivation). The WHO facilitated this, by publishing guidelines on use, assessment and manufacture (WHO, 1996c, 1996d, 1998b), clinical research (WHO, 1998a, 2000b), and quality, safety and efficacy (WHO, 1991a, 1993a, 1998e). The technical, clinical and tightly restricted focus of these issues suited their new organisational climate. In the 1990s, the WHO was overwhelmed with financial, administrative and political turmoil and experienced mounting criticism over failures in major policy goals such as HFA and PHC (which TRM had originally been aligned with). Under these conditions, the WHO scaled back its commitment to revolutionising health systems development and instead concentrated on narrow, technical issues guided by neo-liberal economic principles such as effectiveness and efficiency.

As the WHO objectives of HFA and PHC became less relevant on the health policy agenda, the terminology and jargon associated with them gradually disappeared or became less significant in TRM policy and programme documents. Throughout the 1990s, the emphasis of the WHO in the TRM arena became one of mostly guiding strictly clinical and technical
aspects of production and manufacture of medicinal plants, and standardisation of
acupuncture, as part of the global health market. This direction in policy and programme
development was expressed by the co-ordinator of the WHO TRM Programme (Zhang,
1999; Zhang, 2001:22):

With the tremendous expansion of traditional medicine worldwide, safety and efficacy, as
well as the quality control of herbal remedies and … therapies, have become important
concerns … Various traditional medicine practices have been developed in different cultures
in different regions without a parallel development of international standards and
appropriate methods of evaluation. The challenge now is to ensure that traditional medicine
is used properly and to determine how research and evaluation should be carried out. WHO
will continue to elaborate technical guidelines and support global information exchange
(Zhang, 2001:22, emphasis added).

While TRM was still obviously a health issue (Zhang, 1999), the economic and
environmental aspects of TRM/CAM overshadowed it and became central policy concerns.
These issues are formally beyond the scope of the WHO and other international bodies
stepped into the breach. The World Bank, World Trade Organisation, United Nations
Conference on Trade and Development, and World Intellectual Property Organisation were
the lead organisations for issues of trade, development, and intellectual property; and other
bodies such as the World Conservation Union and World Wide Fund for Nature addressed
matters such as conservation and biodiversity.98

The new environmental and economic catalysts also compelled state governments and
interest groups to act. National level regulation, especially regarding intellectual property
(WHO, 2000c), became more important as international conventions did little to protect
countries from economic exploitation of medicinal plant resources (Bodeker, 2000; Mbeva,
2000) and TRM knowledge was being “appropriated, adapted and patented by scientists and
industry, with little or no compensation [secondary resources] to its original custodians”

TRM/CAM and biomedicine professional groups needed to modify their strategies to cope
with the new context. While consolidating their power and protecting their primary resource
base through professionalisation and the use of scientific discourse presented an avenue of
control and power for TRM/CAM (such as access to international markets and state
recognition), it also presented the danger of having to conform to and be co-opted by
biomedical interests. Once scientific legitimacy was demonstrated, the biomedical coalition

98 See (WHO, 2002e39-41) for a list of some of the myriad international bodies, non-governmental organisations
and professional associations involved in the policy arena.
could absorb the primary resources and claim secondary resources that flowed from them (for example, in the case of acupuncture).

The progression of the policy on integration of TRM/CAM can be seen as a rational outcome of interest group interaction, with both exploiting openings in the problem or politics streams. Attaching the policy proposal of integration to emerging problems took advantage of windows opening in the problem or politics streams. However, existing power relations ultimately influenced their ability to promote or defend their interests as biomedicine had entrenched structural control of and authority in the formal health care sphere. Incrementally, biomedical interests consolidated their authority (for example, through applying rhetoric of evidence based medicine, safety and efficacy) and TRM either had to conform to biomedical structural dominance to claim secondary resources or be marginalised and exploited.

In the following chapter, the WHO policy on traditional medicine – culminating after an approximately 25 year gestation, is analysed. This policy document represents the end point of the policy process from inception in the 1970s to final outcome in 2002. As the foregoing analysis has demonstrated, the history of this policy has been long and complex, over an extended timeframe and with many intervening and changing political, economic and social forces. Whilst it appeared to atrophy in the 1980s and stagnate in advancement, new vigour was brought back to the policy concept during the 1990s. However, the lack of policy activity in the 1980s now meant that many pressing issues were inadequately resolved and the need to formalise the role of TRM/CAM became urgent. How best to do this, according to the WHO, forms the basis of the TRM Strategy (WHO, 2002e) (chapter 6).
6. WHO TRM Strategy 2002-2005

As we enter the new millennium, the promise of the traditional medicine system has never had greater potential or a greater burden attached to it. It should not be a competition between ‘scientific’ modern biomedicine and traditional medicine. Both have their place, role and value.

(Kronenberg, 2001:29)

In 2002, the WHO released the *Traditional Medicine Strategy 2002-2005* (WHO, 2002e), which defined its role in TRM/CAM and guided member states on formulation of policy. The articulation of this strategy followed efforts to ascertain the global regulatory (WHO, 1998f) and legal status (WHO, 2001b) of TRM/CAM, which found wide variations in national level legal recognition and regulatory frameworks. The *TRM Strategy* (WHO, 2002e) built on discussions held as part of consultations on *Methodologies for Research and Evaluation of Traditional Medicine* (WHO, 2000b) and was the result of repeated requests from member states for guidelines and assistance on TRM/CAM policy issues (WHO, 2002e:19).

The release of the *TRM Strategy* (WHO, 2002e) by WHO headquarters was preceded by increasing regional activity on policy and regulatory aspects of TRM. All of these documents explored various conceptual and regulatory challenges in using TRM/CAM in formal health care systems. The Western Pacific Regional Office published *Development of National Policy on Traditional Medicine* (WHO, 2000a), *Traditional and Modern Medicine: Harmonizing the Two Approaches* (WHO, 2000d) and *Regional Strategy for Traditional Medicine in the Western Pacific* (WHO, 2002c), while the WHO Kobe Centre for Health Development published the proceedings of meetings exploring policy, services and utilisation of TRM (WHO, 2000e, 2001a, 2001c).

The increasing public demand for TRM/CAM forced a range of issues on the policy agenda. By the turn of the century, social and economic trends had produced a range of health policy issues in relation to TRM/CAM that had yet to be adequately addressed. The failure to reorient health care systems towards an emphasis on PHC, and incorporate TRM as envisioned in the 1970s, resulted in the policy process coming full circle by 2002. TRM was thrust back under the spotlight from the sheer weight of consumer utilisation, which had created an unregulated and informal integration in the health services sphere.
There had been a convergence in the North and the South of demand for TRM/CAM, for totally different reasons. Those in the North sought alternatives, as deficiencies in biomedical conceptual foundations and techniques (primary resources) led to unsatisfactory therapeutic experiences and outcomes. Meanwhile those in the South continued to patronise TRM due to deficiencies in biomedical primary resource distribution and supply. Dimensions of the biomedical system were found wanting in both cases and “the public are voting with their wallets in the industrialized countries and with their feet in developing countries” (Bodeker, 1996:325).

The wealthier sectors of Western societies are switching to natural approaches to health care, [but] there is little policy or public awareness that the poorer sectors of the world’s population are turning more and more to [TRM] … for entirely different reasons. The trends converge as a global demand for natural health care as well as in the environmental pressures that are associated with the growing demand for medicinal plants … (Bodeker, 1996:324).

The WHO must have been aware of these converging trends and how they forced the need for attention, reflected in the increasing volume of publications regarding policy at regional levels. By 2002, it could no longer remain silent at headquarters, especially as other international agencies as well as national governments worldwide were taking an interest in TRM/CAM. In what appeared to be a reactive rather than proactive initiative (as it had also been with other policy issues, such as tuberculosis (Ogden, Walt, & Lush, 2003) where other agencies had taken the lead), the global TRM Strategy (WHO, 2002e) was launched – revealing some disquieting statistics. For example, over two decades after its conception, the objective of formalising the role of TRM in healthcare had only been acted upon in 25 countries. This was only around one-sixth of the replication or transfer rate achieved by the essential drugs scheme.

The information presented in the TRM Strategy (WHO, 2002e) could be viewed as an indictment on the lack of guidance, direction and funding provided by the WHO to member states to formulate policy frameworks over the previous decades, despite the fact that this was one of the main objectives of the TRM Programme. While the Collaborating Centres had been busy clinically and scientifically investigating TRM medicinal plants, very little work had been done on legal or regulatory aspects. This trend was clear in the 1980s when it was noted that not a single Centre had terms of reference related to policy and legislation (WHO, 1988:10) but was still not addressed by the mid-1990s (WHO, 1996e).
By the 1990s, the singular focus on scientific and biomedical evaluation had only become more marked. This distortion in research priorities meant that when the use of TRM/CAM surged in the 1990s, most countries were unprepared from a regulatory or health systems development aspect, with many still not monitoring even basic aspects of TRM/CAM use and scope. For example, the WHO headquarters review of legal status of TRM/CAM took nearly a decade to finish due to insufficient collection of data, and even then was not complete (WHO, 2001b:ix).

The TRM Strategy (WHO, 2002e) was produced within the Department of Essential Drugs and Medicine Policy, and made no reference to the long policy evolution of TRM within the organisation. It was presented in a manner that was divorced from any historical context, perhaps because in doing so the failures (PHC, HFA, TRM policy) and lack of priority accorded to TRM within the WHO may have been revealed. While it was specifically titled a TRM strategy, it made reference to CAM within the body of the report and grouped them together as one on the global level. TRM/CAM was presented as a health care “choice” for the consumer, and TRM/CAM sources of health care that could have their “potential maximised” if the objectives of the TRM Strategy were addressed – echoing the sentiments of “new universalism”.

Just as the initial technical report on TRM (WHO, 1978b) and WHO support of integration had attracted criticism (Velimirovic, 1984b, 1990), the release of the policy was not universally welcomed. Some criticised the inference that by endorsing integration, the WHO was encouraging the use of “non-scientific” systems of health and allowing potential economic gains (secondary resources) to be made without sufficient evidence to support health claims.

99 “Folk beliefs may influence the willingness of people to cooperate with licensed practitioners offering science-based treatments. It is important for scientifically oriented caregivers to respect the folk beliefs of their patients, not in order to encourage the preservation of their beliefs, but to build patient-provider relationships based on cooperation. Without showing respectful attitudes, many patients will reject science-based care and restrict themselves to using the charms, spells and rituals ingramed in their cultures for invoking the supernatural … In the health marketplace … we must require healthcare providers and health-product promoters to be accountable to their customers regarding issues of safety and effectiveness. We must ensure sellers meet the standards of manufacturing practice and professionalism. Promoters of treatments with superstitious or implausible rationales deserve no exclusion from this burden. Whenever a traditional practice is commercialized through advertising, sales, promotion, or labelling with implicit or explicit medical claims not backed by objective supportive evidence, it is neither complementary nor alternative. It’s quackery.” (editorial, 2002b)
6.1 TRM Strategy objectives

The *TRM Strategy* (WHO, 2002e) objectives bore a striking similarity to the original essential drugs list (WHO, 1977), which was driven by the need to promote rational use and access. The principle characteristics of essential drugs as defined in that report were safety, efficacy, need and affordability (Walt & Harnmeijer, 1992:27). The four objectives of the TRM strategy were policy development; safety, efficacy and quality; access (availability and affordability); and rational use.

While these objectives may be fairly clear (although still problematic) in relation to rationalising and regulating biomedical pharmaceuticals, in application to TRM/CAM they present a multitude of anomalies and inherent contradictions. Many of these are related to global-local tensions and conceptual differences between biomedicine and TRM (Jagtenberg & Evans, 2003). The international movement of TRM and wider transfer led to “problems of interpretation and application” in interaction with other cultures and biomedicine (WHO, 2002e:22). These are exposed when the objectives of the TRM strategy are assessed, with the inappropriateness of the underlying biomedical concepts becoming evident. As previously mentioned, the WHO is composed largely of biomedical professionals, and so can be seen to align with the biomedical coalition in perception and orientation. The application of these principles is therefore a natural outcome of the administrative focus. The objectives and some of the difficulties they raise are discussed below (6.1.1. policy development; 6.1.2. safety, efficacy and quality; 6.1.3. access (availability and affordability); and 6.1.4. rational use).

6.1.1 Policy development

The first objective was policy development to enable TRM/CAM to be integrated in national health care systems “as appropriate”, and the WHO defined its role as facilitating this (WHO, 2002e:5) most urgently in the South where populations depend upon TRM for health care needs. Apart from the obvious question of why large segments of entire populations still lacked access to basic biomedical health care, the reasons why relatively few of the member states had developed a policy were not considered, nor were the reasons why only Communist/Socialist countries had achieved “fully” integrated systems commented on. The WHO had been advocating integration for at least twenty-five years, so would have been some insight into the difficulties this concept presented from a political and economic perspective.
However, evaluating organisational policy performance or the policy implementation issues on national levels did not feature in the TRM Strategy. The tenor and substance of the policy document suggested that integration was conceived as a purely a technical issue, a matter of administration, something to be bureaucratically organised and achieved through regulation. The attainment of “integrative” systems was presented as a natural evolution, and all countries with an inclusive system (parallel) were ultimately expected to achieve this (WHO, 2002c:9). The notion that integrative systems would ultimately evolve worldwide was expressed in other policy documents – “Worldwide only four countries have integrative systems … In the future [countries with inclusive systems] will be classified as having integrative systems … As the exclusive [monopolistic] system is almost nonexistent, it will not be mentioned” (WHO, 2001c:20-22).

The information presented reflected the asymmetric power relationship between biomedicine and TRM in policy and programme development. For example, of 25 African countries, only 16 had a legal framework and 8 a national budget allocation for TRM. The WHO was therefore advocating national biomedical collaboration with systems of medicine that may not even be legally recognised, and which had negligible funds apportioned for any of the safety, efficacy or quality “prerequisites” for this incorporation. While advocating policy development appeared straightforward, it disregarded any lesson drawing from the policy history of integration, cost-burdens of the recommended approach, practical realities based on the economic position of countries in the South, and political position of TRM/CAM in national health care systems (especially power differentials, and conflict and resistance exhibited between groups of health care professionals). These difficulties in formulation and obstacles in implementation had become increasingly apparent over the previous two decades (WHO, 1986a:54-66; 1988:31; 1995b:43-45; 1996e; 2000a:11), but the TRM Strategy was presented in a manner divorced from political, historical and cultural context.

### 6.1.2 Safety, efficacy and quality

The WHO proposed to promote this objective by developing and promoting an evidence base, regulatory systems and guidelines. However, once the use of TRM moved beyond its local boundaries and into the international global health marketplace; safety, efficacy and quality issues changed fundamentally in nature and necessitated different considerations. These objectives can actually be seen to constrain and prevent the radical formal reorganisation of TRM/biomedical health care resources that integration may otherwise entail.
Many safety concerns emerge from the use of TRM remedies in situations far removed from their original contexts. For example, for different uses, in concentrated extracts, produced in larger volumes or using different techniques, and mixed with an increasing range of biomedical pharmaceuticals by consumers in the North. For example, Kava (Piper methysticum) has been used ceremonially in the Pacific Islands for more than two millennia with no recorded adverse impact. When used for stress and anxiety in Europe, it resulted in cases of liver toxicity (Moulds & Malani, 2003). Ma Haung (Ephedra sinica), used in China as a tea for asthma amongst other conditions, was used in the US in concentrated forms for weight reduction and to improve athletic performance. Risks from these uses of ephedra included nervous system problems, seizure, stroke and heart attack (Shekelle et al., 2003). Garlic may lose cholesterol lowering effects if produced in certain ways (WHO, 2002e:26), while ginseng and St Johns wort can interact negatively with particular pharmaceuticals (WHO, 2002c:27). Aside from problems posed by such interactions, industrially produced herbal medicines may pose new safety risks such as contamination, misidentification and counterfeiting (Wahlberg, 2006:135).

In localised contexts and with traditional modes of production and consumption (distribution and supply), safety issues are arguably minimal. Therefore, while safety is clearly important there appears to be conflicting needs and divergent priorities at the local and global levels. Safety can also be considered a flexible and value-laden judgement. As mentioned previously, the dangers presented by many biomedical primary resources are equally, if not more, serious than those safety concerns presented by TRM/CAM primary resources (Bodeker, 1994b; Ernst, 2003:14). Therefore, an adequate safety and evidence base for biomedicine is equally important, and is not already clearly established (Airhihenbuwa, 1995; Dalen, 1998; Last, 1986:4; Peabody et al., 1999:127; Smith, 1991), as implied by the TRM Strategy.

It could be argued that stringent adherence to safety and toxicity studies retarded the development of the herbal product industry, impeded integration and absorbed limited

100 According to Lock (1990), iatrogenesis associated with herbal medicines in Japan only appeared when TRM was appropriated and rationalised by biomedicine, which raises questions as to whether biomedical production and distribution systems that have an important role in iatrogenesis.

101 “Even though herbal medicines are not devoid of risk, they could still be safer than synthetic drugs. Between 1968 and 1997, the [WHO] collected 8985 reports of adverse events associated with herbal medicines from 55 countries. Although this number may seem impressively high, it amounts to only a tiny fraction of adverse events associated with [biomedical] drugs held in the same database... At present the relative safety of herbal medicines is undefinable, but many of the existing data indicate that adverse events, particularly serious ones, occur less often than with prescription drugs.” (Ernst, 2003) Barsh concludes that clinical studies suggest that a majority of remedies used in traditional medicine are effective and require careful preparation to have strong, selective and non-toxic impacts (Barsh, 1997:32).
research funds. The Guidelines on the Appropriate Use of Herbal Medicines recognised that safety requirements may be onerous and unnecessary in many cases, and that the history of use should be adequate evidence of safety (WHO 1998:56). However, this moderation of the stance on clinical assessment of safety was not reflected in the TRM Strategy in 2002, and instead it was recommended that scientific research on safety and efficacy be stepped up. The lack of adverse effects reported from herbal medicines were reported as potentially a reflection of poor monitoring rather than indicating that few adverse effects actually exist (2002:24).

**Efficacy** is an extremely tricky area to navigate objectively, and difficulties associated with the concept of efficacy in relation to TRM/CAM have been mentioned in previous chapters. Medical anthropology has grappled with this for decades, and some of the problems determining, isolating and measuring efficacy are related to the cultural and social dimension of healing (Fabrega, 2002; Waldram, 2000). Efficacy may even be compromised by removing the TRM/CAM system from its localised context and transforming it into a marketable product, or using modern methods of production.

Industrial processing and production to increase volume actually changes the nature of the original remedy and totally removes or modifies the patient-healer therapeutic relationship – which may be a key in the healing process (Berliner & Salmon, 1980a:544; Thorne et al., 2002:911). Individual preparation is often considered a significant aspect of the healer-patient encounter. In Tibetan medicine, consecration of raw materials and blessings are seen as essential contributions to the remedy (Gerke & Jacobson, 1996), which is also a major feature of African TRM (Koumare, 1983:26).

The therapeutic effectiveness of some remedies therefore cannot be reduced to strictly biological terms. For example, secrecy is sometimes considered a key factor in efficacy – if the secrecy is compromised, the efficacy or potency of the remedy is deemed to be diminished (Perara, 1985:95; van der Geest, 1997:905). The subtleties of TRM/CAM systems are sacrificed during the commodification process. The scientist (positivist) fails to recognise the value of the relationship between patient-healer, healer-herb or herb-place (Jagtenberg & Evans, 2003:327), and these subtleties must be disregarded to enable larger-scale production and distribution.

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102 In terms of Unschuld’s concept of professionalisation, the safety and efficacy agenda can be viewed as a strategy to block the professionalisation of TRM/CAM by biomedical coalition, as they were determining when it was appropriate or permitted to apply TRM/CAM knowledge and techniques.
The narrow biomedical concept of efficacy is premised on the notion of a single therapeutic agent that can be identified, and that isolating this molecule verifies clinical validity. In contrast, TRM belief systems often use more than one plant, and process them in complicated ways to produce a compound that may differ greatly from that found in each individual plant. Biological catalysts used in herbal remedies may have obscure biochemical mechanisms that are difficult to clinically isolate or identify (Barsh, 1997:32). The plant or plant parts in their natural form are also considered important, and extracting certain molecules from them may reduce ultimate effectiveness (Bodeker, 1994b:11-12; Scarpa, 1981). Taking the raw forms of herbs may be far more effective than consuming a concentrated or processed extract. For example, a study on Ayurvedic medicine in Sri Lanka found herbal drugs brewed in a simple clay pot were more powerful than the version produced en masse and in a much briefer span of time in a high-tech, stainless steel machine (Anonymous, 2001).

Strength or potency of herbs or plants varies widely between specimen (Chang, 1999:185; Chaudhury, 1992) and according to locale, soil, season, time picked and other factors including the type of vessel the remedy is prepared in, what it is mixed with, temperature and preparation processes (see for example Jagtenberg & Evans, 2003:327). This local knowledge of bioactive fluctuations and interactions has been clinically verified (Bannerman, 1982:10; Barsh, 1997:31-32). Biochemical mechanisms may therefore remain unclear, and the effect of a drug may be influenced by other factors such as diet (Barsh, 1997:32).

The focus on proof of efficacy removes the potential role of placebos, which have been dismissed from a biomedical standpoint as having no legitimate role in health care provision, but which may actually be extremely potent and powerful resources from a practitioner standpoint. Placebo action does not indicate ineffectiveness, on the contrary it is simply a “residual category” for what scientific discourse cannot explain (Berliner & Salmon, 1980a:543). Placebos work, but biomedical doctors and scientists don’t know why or how (Moerman, 2002). It remains one of the intriguing areas of mind-body interaction beyond the realm of scientific measurement. Some pharmaceuticals (biomedical primary resources) have been found to be no more effective than placebos. Many biomedical practitioners (up to two thirds) regularly use placebos although publicly disapproving of their use and 94% felt

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103 This also has economic imperatives. A single ingredient that can replicated, synthesised, patented and mass produced is necessary for commercial purposes (Bodeker, 1994b:11); this requires a synthetic analogue and marketing (Kumar, 2000b:7).

104 German doctors admitted that around 40% of drug prescriptions were unnecessary, ineffective or harmful (Xingzhu, 2003:6).
they were generally or occasionally effective. The use of placebos is not only frequent, but rising and may have a genuine role in patient care (Lichtenberg, 2004).

Techniques used to scientifically evaluate efficacy of TRM/CAM may be difficult to apply in practice (Bodeker, 2001c; Fabrega, 2002; Jonas, 1999; Kronenberg, 2001; Patel, 1987; Shankar & Unnikrishnan, 2004; Vickers, 1996) – with particular difficulties presented by the randomised controlled trial which is promoted as the standard methodology for evidence based medicine (Easthope, 2003; Thorne et al., 2002). Randomisation, blinding and the use of placebos in experiments present ethical and practical problems, with the philosophical origins of TRM/CAM making them “inappropriate for simple (randomised controlled trials) testing and, if such trials are conducted, can render the results meaningless” (Thorne et al., 2002:910-911). Other criteria for scientific research can also present hurdles. For example, research ethics that require that biomedical treatments be given to all subjects means that TRM remedies can not be evaluated in isolation, limiting the ability to assess the full therapeutic potential of TRM (Bodeker & Kronenberg, 2002).

Prevention is the main focus of many forms of TRM/CAM, with diet and nutrition as well as forms of exercise (e.g., yoga, tai chi) and stress reduction used to promote balanced health and well being. This presents research difficulties as it is a longer-term, methodologically difficult, and usually expensive process – however, benefits could be substantial (Bodeker & Kronenberg, 2002). The ease with which biomedical, curative treatments can demonstrate and quantify results in comparison to preventative methods is one reason it obtained preference in health delivery (Foster, 1977:530). The conceptual and philosophical approaches to maintaining health and preventing disease are a vital and valuable part of TRM/CAM, and are overlooked when an emphasis is placed on products (Eskinazi & Mindes, 2001:22), or on specific, isolated remedies and their clinical efficacy. A narrow focus on efficacy may lead to “botanical medicine being used in the same manner as conventional drugs, as ‘magic bullets’ for the treatment of specific medical conditions” (Eskinazi & Mindes, 2001:22).

There is no “singular view of efficacy” and the notion is “shifting and fluid” (Waldram, 2000:619). In addition to theoretical and methodological difficulties, and costs involved in establishing efficacy, the ultimate objective of only demonstrating efficacy neglects the social and cultural dimensions of healing. Although these are not able to be clinically demonstrated or verified, they still have an important and valuable role to play. TRM/CAM is most often used for symptomatic relief in treating chronic diseases that biomedicine offers no cure for, and provides patient satisfaction comparable to biomedical treatments (Peabody
et al., 1999:127). Efficacy as the only criteria for determining the validity of a remedy is therefore problematic, if the social, psychological and cultural dimension of healing also has a legitimate place.

While some local remedies may be [clinically] nonefficacious, their use constitutes a coping strategy … Now deaths from pneumonia, diarrhoea, malaria and even AIDS are reduced to ‘outside’ social, economic and political explanations. Although locally meaningful remedies have existed, they are simply no longer being provided (Zielinski Gutierrez & Kendall, 2000:95).

And finally, quality is also an issue which is value laden and open to interpretation. The unique individual reaction to TRM/CAM treatments, idiosyncratic variation in provision of treatments and the natural variations in plant and herb products all tend to prevent standardised regulation based on particular “quality” considerations. This need to standardise systems based on externally imposed quality standards is again a fraught exercise that serves to enable regulation and mass production (Jagtenberg & Evans, 2003). As Berliner and Salmon explored, the intrinsic nature of TRM/CAM in itself defies such categorisations:

Subjective nature of response to therapy tends to frustrate quality control … Since they are purportedly objective, [biomedical] therapies can be standardized … by their very nature and self-definition, holistic-styled modalities cannot (Berliner & Salmon, 1980a:539).

The issues of safety, efficacy and quality are therefore not as straightforward or neutral as they appear and raise a number of stubborn philosophical and practical dilemmas in application to TRM/CAM systems. Resolving such issues are political activities, and practitioner interest groups have much at stake in the outcomes. Applying similar standards for determining efficacy and safety across all forms of TRM/CAM may be inappropriate or inequitable (Thorne et al., 2002:912). The notion of “evidence” in support of efficacy, safety or quality is also contested – the questions of “What evidence?” and “Whose evidence?” need to be asked (Wahlberg, 2006:128). TRM/CAM may be more appropriately studied and evaluated on its own terms as coherent knowledge systems, rather than being driven by how much scientific-biomedical knowledge can be “salvaged” from such practices (Pearce, 1986:255). Wahlberg (2006) argues that the focus on safe, proper and appropriate forms of TRM is actually a:

… continuation of the bio-medical hegemony of the colonial days in a different guise, that herbal medicine in Vietnam has been “scientifically colonized” or co-opted, stripped of its original value as a “natural”, “eastern” or epistemologically distinct form of medicine … [TRM] is currently being bio-politicized – i.e. appropriated by expert bodies of knowledge that make authoritative and often contested claims as to what constitute the most “appropriate”, “effective”, “safe” and “responsible” ways of practising and utilizing it in the service of public health (Wahlberg, 2006:140).
6.1.3 Access

Access is considered only in the context of TRM in the discussion (WHO, 2002e:24-25), and making it both available and affordable. This appears an odd objective as in the South, it could be argued that full access already existed and the service delivery problem related to the dearth of biomedical services. For example, in Africa TRM was “perhaps the only health service that is accessible to everyone” (Airhihenbuwa, 1995:47). It may have also been important to address access to CAM in the North, considering that most practitioners work in the private sector (Saks, 2003a:145).

Tied to this objective were the safety, efficacy and quality imperatives. In other words, TRM was to be more extensively monitored and scrutinised to ensure that “quality” services that were safe and effective were delivered. Increased provision of “appropriate” TRM/CAM in health services, the development of associations for TRM/CAM, and criteria and indicators to measure cost-effectiveness were expected outcomes of this objective (WHO, 2002e:45).

The trends of efficiency and effectiveness (economic rationalism) in delivery of health services were applied to TRM in this context. As governments considered the role of TRM/CAM “the question inevitably arises as to whether these will result in cost savings and whether consumers will be willing to pay for such services” (Bodeker, 2001c:53). Economic policies and regulatory mechanisms that affect access to health services (such as insurance schemes) may undermine the role of TRM “as serving as the first and last resort for available health care for the poor” (Bodeker, 2001c:55).

Access to affordable TRM is jeopardised by the rapidly increasing global demand (which encourages over harvesting from wild sources) and also from environmental degradation (Schokman, 2004; WHO, 2002e:25). Domestic supply of and access to TRM products and services at the PHC level may therefore be diverted to meet foreign markets, and the commercial appropriation of TRM knowledge and primary resources threatened to reduce access to TRM at community levels. Unresolved intellectual property rights therefore remained a contentious problem (WHO, 2002e:25) and needed to be addressed in legal frameworks. The issue of access illustrates the complexities of interaction and interdependencies of economic, environmental, trade, legal and health care policies and how these affect access to and utilisation of services.

The WHO did not directly confront or mention issues such poverty, education, or the economic reform of health services that impact on access issues to both biomedical and
TRM services. It encouraged the improving and upgrading TRM/CAM practitioner skills and the conservation and sustainable use of medicinal plants (WHO, 2002e:25, 45). However, the WHO emphasised that increasing or improving access to TRM should not supplant the existing biomedical services or priorities in using biomedicine:

Evidently, increasing access to safe and effective [traditional medicine] should not mean displacing programmes to increase access to allopathic medicine [biomedicine]. Rather opportunities to improve co-operation between [TRM] practitioners and allopathic medicine practitioners, should be created, to enable patients to draw upon both [TRM] and allopathic therapies to best meet their needs  (WHO, 2002e:25).

6.1.4 Rational use

Rational use of TRM/CAM was to be facilitated via qualifications and licensing of practitioners, “proper use” of products of “assured quality”, provision of scientific information and guidance for the public, and information exchange between biomedical and TRM/CAM practitioners (WHO, 2002e:26). Such measures were to “promote the therapeutically sound use of appropriate TRM/CAM” (WHO, 2002e:45).

Rationality in the use of health care resources is another extremely contentious issue. It is generally taken to mean the use of the most effective resource at lowest cost. However, consumers are considered unable to distinguish between the effectiveness and quality of various resources and services, or weigh up various benefits and costs – which is used to justify state intervention in filtering the health resources accessible to the public (Coulter, 2006; Palmer & Short, 2000:24) and the use of biomedical authority to guide consumers (Hufford, 1995).

Rationality and its application to health care services and systems is confused by the fact that many people (it has been estimated up to 70-80%) seek medical care for conditions that have no known biological origin (Good et al., 1979:150), and many conditions (perhaps more than 50%) spontaneously heal regardless of the type of intervention offered (Glasser, 1988:1462; Scarpa, 1981:323). The production, prescription, use and transaction of health care resources has both symbolic and social functions, that provide healing with meaning – and this is common to both biomedical and TRM systems (van der Geest & Reynolds Whyte, 1989; van der Geest, Reynolds Whyte, & Hardon, 1996), although is rarely acknowledged within biomedicine.
This symbolic social and cultural dimension of health care may produce what appears to be an inherent “irrationality” in resource utilisation. However, it can be argued that patients are able to make rational decisions and actually have exclusive access to information in weighing up the benefits of various services. For example, Hufford (1995) claims that biomedical practitioners may be able to assess probable outcomes, physical risks, amount of pain and so on, but only the patient can give weights to those outcomes, and only the patient can say what effect the treatment had (1995:59). Hufford proposes that the mixing of biomedical and TRM/CAM resources by consumers are efforts to “place reasonable limits on [bio]medical authority and to maximise overall resources for dealing with illness” (1995:59). Therefore, despite appearing “irrational” from a biomedical standpoint, the use of TRM/CAM can fulfil functions that may not be immediately apparent and be a reasonable and pragmatic use of health care resources.

The selection and organisation of different health resources varies between individuals and according to health conditions, and can be considered as rational problem solving (Hufford, 1995:60). Such decision making is sophisticated, and may include economic cost-benefits but also goes beyond considerations of cost or scientific evidence of validity, to include symbolic, social, and cultural values (Craig, 2000; Crandon-Malamud, 1991; Wayland, 2004). This strategy objective implies that there is, and can be a universal “rational” use of such resources (tied to the problematic efficacy and quality objectives), when rationality is a socio-culturally constructed phenomenon (Kanji & Hardon, 1992:102-103).

Just as the WHO’s definition of essential drugs were tied to financial and biomedical terms, this objective in TRM/CAM use overlooks that “people have their own rationalities for deciding on therapies. Irrationality, defined from a [bio]medical view, may be totally rational from the consumer’s point of view” (Kanji & Hardon, 1992:102-103). Kanji and Hardon describe many beliefs and behaviours rooted in TRM concepts, including diverging notions of efficacy and the individualised nature of therapy. What is rational treatment for one person in these contexts may not be rational for another. They also point to economic factors that guide (and sometimes force) resource selection. In doing so, saving both time and money is paramount and may conflict with “rationality” from a biomedical perspective.

Rationality in health care can be seen to vary depending upon who the stakeholder is. What is completely rational from a biomedical conceptual perspective may be irrational from a TRM/CAM one. Rationality in service provision is undermined by the rational drive for TRM/biomedical practitioners to provide or supply primary resources to consumers if that ensures secondary resources, regardless of “efficacy”, “validity” or “equity” considerations.
Rationality in drug production and supply is driven by rational economic considerations of pharmaceutical industry stakeholders. It is similarly rational for consumers to mix primary resources of different medical systems in complicated patterns. This depends on different variables including income, age, gender, education, ethnicity, religion, location and health condition amongst others (Barrett, 2003:418) that affect access to, knowledge of and choice of primary resources.

This concern with rationality raises the question that Nichter asks when he notes that the present pattern of drug production and sales don’t match the epidemiological profile in India: “rational for whom and rational in what contexts? Given the social and microeconomic environment in which … practitioners function, clinically irrational practices may make economic sense” (Nichter, 1996:252). Rationality is therefore not a singular concept – there are multitudes of rationalities that conflict and/or coalesce, producing irrationalities depending on perspective at the health service distribution, supply, and access and/or utilisation levels.

6.2 Discussion and conclusions

All of the objectives of the TRM Strategy clearly express underlying biomedical conceptual foundations, values and bias. Navarro criticised the original adoption of integration based on a modified barefoot doctor approach, as a profoundly political experience that was stripped of its political significance – the de-politicisation of that being in itself political (Navarro, 1984:469). The same could be said of the TRM Strategy, in that social, economic, cultural and ethical issues were conflated into a scientific and economic rationalist framework (implicitly “value free”) which has political outcomes.

The inherent hegemony of the biomedical profession within health care was unquestioned, and ultimately reproduced and perpetuated through the values embedded in the objectives. What Lee had anticipated twenty years previously – that the WHO promoting TRM could accelerate the process of the structural absorption of TRM/CAM within biomedical systems (Lee, 1982:639)105 was now manifesting. The WHO was promoting certain values and serving particular interests, and the TRM Strategy aims were considered:

105 “In view of the world-wide movement of modernization through science, the [promotion of TRM by WHO, amongst other forces] might turn out to accelerate the absorption, both technically and organizationally, of the numerous alternative approaches into the scientific biomedical system … which will keep on strengthening the structural status … of biomedicine” (Lee, 1982:639).
eloquent proof of the need for urgent consideration of the consequences of globalization on herbal medicine … The assumptions underlying this approach seem to promote the interests of a global herbal industry over the protection of local traditional practice (Jagtenberg & Evans, 2003:322).

If the seed of this Strategy is taken to be the first resolution of the World Health Assembly that referred to TRM in 1969, it is not surprising that when it finally fully germinated as a global policy, it reflected the inherent principles of rationalisation of TRM through science and the structural superiority of biomedicine. Resolution WHA22.54 (1969) concerned the establishment of pharmaceutical production in developing countries, and while “being aware of the differences in the development of therapeutic practices” it expressed concern about the “hazards and economic wastage connected with the empirical use of [TRM] as long as their efficacy and safety have not been established.” However, this was with the awareness that “scientific research in this field may yield valuable pharmaceutical products.” The principles of scientific validation, safety and efficacy, and biomedical authority guiding this process, continued throughout the rest of the century and were prominent themes in many WHO policy and programme documents between the 1970s and 2002.

Reissland and Burghart (1989) noted in reference to the original technical report on TRM (WHO, 1978b), that the formulators of the policy acted as “agents of [bio]medicine” and “rigidly circumscribed the terms of integration” and this role was maintained in the TRM Strategy (WHO, 2002e). However, biomedical scientific views intrinsic to the TRM Strategy on the valid production, application and acquisition of medical knowledge and techniques contrast sharply with the philosophy and practices of many TRM/CAM systems (see Fabrega, 2002; Pearce, 1986; Reynolds, 1986).

The policy circle had come full circle by 2002, and even narrowed its ambit despite substantial research into medical pluralism, health economics and the function and operation of TRM/CAM systems. In 1970s, it had been stressed that the tendency to give the impression that TRM was limited to medicinal plants exclusively in the health-giving process must not be allowed to continue (WHO, 1978b:10). However, aside from the addition of acupuncture, the WHO had concentrated activities largely on medicinal plants, scientific validation and standardisation. This may be because the WHO accepts the notion

106 “Certain features of [TRM], such as the use of native drugs, were thought to be of benefit but only after their efficacy had been proven by the methods of science … [TRM] works, but only [bio]medicine knows why” (Reissland & Burghart, 1989:43).
contended by the biomedical profession – the belief that scientific inquiry produces ideology free knowledge, which is one of the most influential beliefs of our times (Young, 1981:379).

Allopathic [biomedical] practitioners emphasize the scientific approach of allopathic medicine, and contend that it is free of cultural values. [TRM systems] have developed rather differently, having been very much influenced by the culture and historical conditions within which they first evolved (WHO, 2002d:2, emphasis added).

TRM was eventually forced back onto the agenda in order to address the interests of stakeholders, and it appears to mainly serve dominant ones. A very different policy scope and objectives may have resulted if TRM/CAM and biomedicine were more equitably weighted in deliberations. For example, Peabody et al., concluded in their review of health policy and system development in Asia that maximising TRM resources at PHC level and biomedical at secondary and tertiary levels could be appropriate (see Peabody et al., 1999:252). This proposal rationalises health care resources and service structure, but would be met with strong resistance from the biomedical group, as relinquishing primary resources (such as antibiotics) would entail the loss of secondary resources.¹⁰⁷

For many elements of primary care, such as prevention, health promotion, and psychosocial support, the evidence suggests [TRM] is comparable and sometimes superior to [biomedicine]. For curative care of acute illnesses, [biomedicine] is superior in many areas but [TRM] could be substantially enhanced by training [TRM] providers in the appropriate use of antibiotics [transferring biomedical primary resources to TRM] (Peabody et al., 1999:129).

The WHO TRM Strategy (WHO, 2002e) demonstrates subtle management and control of the policy domain by the biomedical profession, who have determined the parameters and priorities of activity. The manipulation of policy formulation was facilitated by biomedical structural dominance in formal health care systems, and organisational domination within the WHO. The principles of biomedicine permeated the ethos of the organisation – biomedicine underlies the foundation of the WHO and steered its role from inception as a modernising health development body of the UN. Biomedical values and concepts were a clear factor influencing policy and programme development on integration between the 1970s and 2002, illustrated by the focus on TRM as an adjunct to biomedicine (initially to extend health care services and later as primarily sources for pharmaceuticals), the application of scientific discourse to the TRM realm and sanctioning biomedical authority in the integration process.

¹⁰⁷ Skirmishes over the rights to prescribe or dispense biomedical primary resources are ongoing, and do not only involve TRM practitioners. For example, in Australia in 2003 biomedical practitioners strongly resisted government reforms which enabled pharmacists to directly dispense emergency contraceptives, circumventing a consultation with a general practitioner.
The following chapter considers the implementation of the integration policy in more detail on a national level. A case study of Sri Lanka explores the global-local transfer of the policy on integration, how the concept of integration of TRM has been interpreted and applied, what the outcomes are, and how interest groups have influenced or responded to the process.
7. National Case Study: Sri Lanka

It may be interesting to see how the indigenous medicine is gradually disappearing in Sri Lanka, even though it has a fully established official status as such. The process of its demise is so subtle enough to go unnoticed. The dominant factor is, of course, the advent of the western culture. However, though there are many dedicated souls who are making desperate attempts to preserve and practice it, subtle manoeuvrings can be seen in operation showing the nefarious and potent nature of the antagonistic forces.

(Dharmasiri, 1997:178)

The model of agenda setting developed by Kingdon (1984) is based on three process streams, and their coupling or intersection, which enables particular policy issues to arise on the political agenda. This was explained in more detail in the introduction. Kingdon proposes that this model can be applied to any decision making unit, whether an organisation or a national government. Previous chapters have explored the operation of these streams within an organisation (World Health Organisation), and how their movements have influenced the destiny of WHO traditional medicine policy and its implementation at national levels. The shifting fortunes of that policy within the organisation can be related to the shifting ebbs and flows of the politics, problems and policies streams.

This chapter explores these streams at a national level. This analysis aims to offer insight into the transfer of policy concepts from the international to national level, and to demonstrate how the framework formed for analysis from the synthesis of political science and anthropology theories is valid at both macro (international) and micro (national) levels. In doing so, it becomes immediately apparent that a potential obstacle in policy transfer is the difference in streams at the international and national levels. The factors shaping and influencing those streams at a national level may vary markedly from that at the international level, resulting in diverse and even conflicting agendas. What appears to be a feasible policy internationally may not transfer coherently at the national level.

As mentioned previously, the combination of the theories and frameworks described in the methodology – primarily Unschuld (1975; 1976b) and Kingdon (1984), but also drawing on Lee (1982); allows this policy issue to be considered as an intrinsically political exercise that has been stimulated by global social and economic forces. A critical relationship is focused on – biomedical and TRM practitioner groups, who operate as interest groups within both the
politics and policy streams. These groups are motivated by a desire to maintain and increase access to primary and secondary resources, apart from their common goal of providing health care to the community. Tactics to preserve and increase access to secondary resources include professionalisation and the use of scientific discourse.

The politics, problems and policy streams surrounding traditional medicine in Sri Lanka are charted in this chapter, again with an emphasis on the politics stream (specifically the interaction between interest groups). While the focus is on the current situation, some history is necessary to place it in context. As Kingdon also noted, the role of entrepreneurs (advocates) and catalysts are factors and will be considered. The detailed assessment of the situation in Sri Lanka helps illuminate the difficulties in formulating and implementing a policy on integration of TRM, and offers insight into why an apparent “rational” policy goal is beset with complications and obstacles despite enthusiastic Government statements of support.

As described in more detail in the methodology (chapter 2), the implementation of “integration” and attitudes of stakeholders was explored mainly via an assessment of legislation; resource allocation; policy and programme documents; activities of professional, research and education/training organisations; and interviews. Appendix 2 (page 354) lists the people interviewed. Information was also gathered from papers given at various conferences, seminars and workshops; and journals, books and newspapers.
7.1 Sri Lanka - Background

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data</th>
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<tbody>
<tr>
<td>Population</td>
<td>18.7 million</td>
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<tr>
<td>Life expectancy</td>
<td>70.7 years (male) 75.4 years (female)</td>
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<tr>
<td>Maternal mortality</td>
<td>46.88 per 100 000 live births</td>
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<tr>
<td>Infant mortality</td>
<td>12.2 per 1000 live births</td>
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<tr>
<td>Crude birth rate</td>
<td>18.9 per 1000</td>
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<tr>
<td>Crude death rate</td>
<td>5.9 per 1000</td>
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<tr>
<td>Literacy</td>
<td>92.5% (male) 87.9% (female)</td>
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<tr>
<td>Health expenditure</td>
<td>1.65% of GNP 108</td>
</tr>
</tbody>
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TRM systems: Ayurveda, indigenous medicine (*Desiya Chikitsa*), Unani, Siddha, plus a variety of specialists (e.g. bone-setters, those who treat snake bites, burns, mental health, skin diseases). Ayurveda is currently the official umbrella term for all indigenous forms of medicine. Homeopathy and traditional Chinese medicine are also practiced.

Use of TRM: Informally estimated to be 75-80% of population at least occasionally; 30% first choice (Abeysekera, interview, 25/3/2003). The figure of 75-80% was also cited by others (Samarasekera, interview, 25/3/2003; Wijesekera, interview, 31/3/2003)(Machiko, 1996).

While these figures provide a partial and basic overview of Sri Lanka, statistics on health, such as these, are almost meaningless in isolation. Despite a low national income, the population of Sri Lanka enjoys a relatively high status of health in comparison to other countries in the South, especially in mortality, lifespan and social indicators (Perera, 1985:94). For this reason, it has been the subject of some curiosity particularly in the matter of constructing low cost health services (Caldwell et al., 1989; Halstead, Walsh, & Warren, 1985) and was considered by the WHO (1978b) in their initial assessment of TRM in health systems. The biomedical health infrastructure was established under British rule, and the fact that it is universal and free has been considered a major contributory factor to the good

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108 Statistics were sourced from the "Sri Lanka Health Atlas" (WHO, 2003d). Accurate statistics are difficult to obtain due to a lack of official record keeping and data collection, and the frequent omission of figures from North/Eastern provinces.
health indices (see Caldwell et al., 1989). There is a particularly strong emphasis on maternal and child health at the community level, with a broad network of nurses/midwives.

Commitment to a variety of social democratic principles (such as compulsory, free education; voluntary family planning; some subsidised food items) means that it is actually very difficult to isolate the factors responsible for the impressive health gains evident between independence in 1948 and the 1980s – was it due to the biomedical infrastructure, the fact it is free, the midwives at community level, the education system, declining fertility levels, the mixing of TRM and biomedicine or some other factor/s? Others also questioned the causal relationship between these factors – for example the decrease in infant mortality may not have simply been due to supervision during birth:

Why claimed that it was solely because births were professionally supervised that infant mortality decreased in Sri Lanka? If there were a road and a school, as well as a maternity ward, how known that they, and nutrition, had nothing to do with the improvement? (Mackenzie, 1978:118)

The civil war between Tamil separatists and the majority Sinhalese in the North and East of Sri Lanka over the past three decades has diverted funds from social policy to military and defence (see UNDP, 2004). The universal biomedical infrastructure has suffered partly as a consequence, particularly in the war afflicted North and East regions (Hsiao, 2000:88-89), which represents approximately one quarter to one third of the land mass. Outside of urban areas, the biomedical infrastructure is unevenly distributed. In contrast, the traditional system of medicine (Ayurveda) is widespread, with a practitioner in almost every village (Schokman, 2004). Ayurvedic and biomedical services are provided in a parallel form by the Government, at no charge. However, the formal Ayurvedic service is much smaller in comparison and the majority of Ayurvedic practitioners operate in the private sphere.

In their study of the factors responsible for the health indices in Sri Lanka, Caldwell et. al. (1989) argued that this was more or less solely due to the density of the universal provision of biomedical care, and the education system which enabled effective utilisation of health services. The only role that Ayurveda was deemed to have played was in paving the way for more ready acceptance of biomedicine and providing a receptive audience to public health

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109 Sri Lanka (along with Costa Rica, China and Cuba) achieved exceptional health indices despite being a low income country and investing comparatively small amounts in health. Mortality and morbidity statistics, population growth rates and literacy are above average for South Asia. However, these improvements appeared to plateau by the end of the century (Jayasinghe, 2002:8).

110 For example – there are only 3.1 government hospital beds per 100 000 people in Sri Lanka. The three large, urban districts (Colombo, Kandy, Jaffna) have a higher percentage of beds, while in Vavuniya district the bed strength is only 1.7 per 100 000. Fifteen districts have no facilities for hospitalised care of psychiatric patients (WHO, 2003d:29). See also (Jayasinghe & Mendis, 2002) for an overview of the operation of the health system. However, Hsiao (2000:83) concluded it is “highly efficient” in its use of resources from an international perspective.
measures (as in Kerala, India - which also enjoyed unusually low mortality indicators, a high level of literacy and female education, and a strong tradition of Ayurveda) (Caldwell et al., 1989:366). The “massive and continuing” trend towards the utilisation of biomedicine was despite the “financial and moral support” given by the Government to Ayurveda (Caldwell et al., 1989:373). While this observation implied a naturally evolving preference for biomedicine, the differential and lesser status of Governmental support accorded to indigenous systems of medicine was not acknowledged.

The study by Caldwell et. al. is extremely comprehensive, but has drawn some conclusions which may be arguable. For example, it was noted that treatments employed usually consisted of both home remedies and biomedicine, although home remedies were not considered part of TRM knowledge systems. This was despite the fact that these are based on Ayurvedic pharmacopeia known in families, and utilised more frequently than biomedicine as a first resort. Also, factors that may have influenced the behaviour noted and health outcomes achieved - such as dietary and lifestyle habits/beliefs, and the recognition of sickness symptoms that prompted fast treatment were not traced to the influence of Ayurveda. Ayurveda has detailed knowledge systems and principles on these, amongst other health issues. However, the fact that TRM is an inextricable part of the social and cultural fabric makes it very difficult to determine and measure its influence.111

Despite some anomalies in data collection (such as the ambiguous distinction between home remedies and Ayurveda) which may have led to an overestimation of the role of biomedicine and underestimation of TRM, the Caldwell study (1989:377) provides an overview of utilisation of health services in the 1980s. The finding that biomedical services were cheaper and more accessible than TRM may not be current in light of the ongoing civil war, and subsequent fragmentation of social services outside of urban areas. The study clearly demonstrates the complexity of isolating factors responsible for good health, the difficulties of analysing data, the complicated patterns of health care utilisation where TRM and biomedicine co-exist, and causal directions or proportionate roles when a cluster of social services are provided. For example, while it is concluded that the biomedical services were responsible for the health outcomes, it was also concluded that this system would not have been “very effective on its own” (Caldwell et al., 1989:377).

As well as providing a model of parallel integration of TRM, Sri Lanka also presented an early example of an “essential drugs” programme prior to the adoption of this scheme by the

111 See (Obeyesekere, 1976) for more information on indigenous medicine in Sri Lanka.
WHO in 1977. It may therefore have presented an inspiration or model to the international community for both the utilisation of TRM as well as the adoption of an essential drugs approach. Sri Lanka was very progressive in both areas. Strictly speaking, the Sri Lankan case cannot be considered an example of policy transfer between global-local levels as the policy on traditional medicine already existed domestically prior to international endorsement, although in a different form to that promoted by the WHO (parallel, not integrative) and not extensively articulated.\textsuperscript{112}

The reform of the pharmaceutical industry in the 1970s did not go unchallenged (Lall & Bibile, 1978), and proved ominously prophetic for the later experiences of the WHO and other nations who attempted to emulate this scheme (see Chowdary, 1995; Kanji et al., 1992; Reich, 1987). Just as witnessed later with the essential drugs scheme, in Sri Lanka the biomedical profession and pharmaceutical companies strongly resisted reform throughout the 1970s. Those observing the implementation of the program to rationalise the production and distribution of pharmaceuticals in order to reduce costs warned others to “proceed with great care and immense caution” (Lall & Bibile, 1978:299) and drew some very salient conclusions (Lall & Bibile, 1978:324-326). This included noting that it was difficult to foresee genuine reform of this sector being undertaken “without a long term and powerful socialist ideology base” (Lall & Bibile, 1978:325) and an assessment that very few countries actually met the requirements to successfully launch such a concept (Lall & Bibile, 1978:326).

It is interesting that the commitment to the provision of social services has often been tied to Buddhist principles (not socialist ideology) in commentary by some Sri Lankan nationals. For example, Obeyeskere (in Mackenzie, 1978:118) referred to the Buddhist notion of providing these services to the poor as “meritorious” and Perara (1985) similarly traced the establishment of health care to Buddhism. The culture of Sri Lanka is thus tightly linked to and identified with Buddhism, the protection and promotion of which was enshrined in the controversial 1972 Constitution. There also appears to be a strong link between Buddhism and TRM systems of health care (see Liyanaratne, 1999). For example, temples and clergy have an historical and contemporary role in the preservation of Ayurvedic knowledge; as authors, teachers and practitioners; in the provision of some services, awareness and education campaigns; and distribution of some TRM remedies and herbal preparations (which is supported by the Government).

\textsuperscript{112} The concept of global-local transfer could more accurately be considered local-global transfer, as models or concepts appear to be inspired from one or more locations, adopted at an international level and then translated and implemented in a variety of other contexts globally. Essential Drugs, PHC and TRM policies all display this pattern.
According to the Government, Ayurveda is an umbrella term that includes all systems of indigenous medicine (such as *Siddha*, *Unani* and *Desiya Chikitsa*) as well as any medicine practiced in Asia, so is broader in scope than the normal definition of Ayurveda. This reflects the heterogenous context of multiple TRM systems in Sri Lanka, which is partly an outcome of ancient trading routes. The indigenous system (*Desiya Chikitsa*) resulted from blending North Indian (*Ayurvedic*) South Indian (*Siddha*) and Arabic (*Unani*) traditions (Ranaweera, undated:2-4). This flexibility in definition also allows other systems of medicine (e.g. traditional Chinese medicine) to be included in the ambit of officially recognised TRM – or indigenous systems of medicine (ISM) as it is referred to in Sri Lanka. There is currently a proposal to restrictively re-define “Ayurveda” and make the broader and more representative “ISM” an umbrella term instead.

Ayurveda itself is more accurately divided into two groups who compete with each other (Kasturaratchi, interview 1/12/04). *Desiya Chikitsa* can be seen as a localised form of Ayurveda, while Ayurveda itself is Indian in origin and more formalised in education and practice. While all systems of medicine mentioned have a role in health care, this analysis considers only Ayurveda in the strictest sense – that form of TRM which originated in India and is taught in state recognised institutions. This is for purposes of clarity, due to limitations of time and space, and also because Ayurveda is the most direct and strongest competitor to biomedicine in Sri Lankan health policy. Therefore, Ayurveda is the focus of this analysis and the main form of TRM considered whilst acknowledging that a simple dichotomy between Ayurveda and biomedicine does not exist in Sri Lanka.

In the national health care system, while indigenous and biomedical systems operate in parallel form and there is consumer utilisation of both, it does not mean this relationship is necessarily harmonious. As in other countries, while the conflict and competition between medical systems may be covert it is evident in policy and programme development. This subtle battle may not be clearly articulated or apparent to those observing the interaction of medical systems at practitioner levels – for example, Waxler (1984) concluded there was no competition. This idealistic conclusion developed in the era when anthropologists were assessing the operation of pluralistic medical systems, and may have led to a premature assumption of an amicable relationship.

The development, forms and use of TRM in Sri Lanka have been studied by several anthropologists besides Waxler (1984; 1988) including Wolffers (1988; 1989) and Nordstrom (1988). Sri Lanka is considered an “interesting laboratory” to examine pluralistic
medical systems, as Ayurveda and biomedicine formally coexist (Waxler-Morrison, 1988:531). The focus of this research is on the institutional relationship between the two systems of medicine and TRM policy and programme development, rather than the dynamics and rationales of consumer utilisation or the functioning of individual practitioners. Therefore, the political relationship between medical systems as expressed in government policy and health system development is concentrated on, with reference to practitioners and professional representative bodies as relevant interest groups.

7.1.1 Development and status of TRM in formal health care

Sri Lanka was subject to continuous colonisation for over 400 years – firstly from the Portuguese (from 1505), later the Dutch (from 1658) and then British (1796-1948). Under colonial rule, Ayurveda was neglected and biomedicine became structurally dominant (see Dharmasiri, 1997; Perera, 1985; Pieris, 2001), almost crushing TRM “out of existence” (Goonewardene, 2004).

This was an anomalous situation. The modern system of medicine which was adopted and encouraged by the government catered to only a small fraction of the population. The indigenous system which a great majority of the population practiced was not given due recognition. There was very little awareness at least among the ruling classes and the elite of the value of Ayurveda as a science. The higher classes in society, faithfully imitating the West, looked down upon indigenous culture as something inferior. Even the practitioners of Ayurveda medicine were referred to by a term generally considered to be derogatory – quite in contrast to the position that prevailed some centuries previously (Wanninayaka, 1982:9).

However, as a corollary to the “freedom movement” to obtain independence, indigenous systems of medicine were promoted (Ranaweera, 2001:13). Along with agitation for political independence, some concessions were made for the development of Ayurveda (Wanninayaka, 1982:11). The timeline of significant events in relation to TRM (appendix 9; page 366) reveals three phases of development: 1900-1940s was a period of lobbying, assessment and obtaining official recognition; 1950-1960 was a period of apparent inactivity at the regulatory and legislative level (perhaps a consolidation of previous gains made and a reflection of political effort and resources being devoted to independence activities); 1960s-2000 was a period of gradual expansion and enhancement of professional status and official recognition. This activity rapidly increased at the turn of the century. These approximate epochs are of course generalised, as the status of TRM waxed and waned throughout and the course of progress was not smooth.
After independence, formal legislative recognition was achieved and a parallel infrastructure developed under a Department of Ayurveda within the Ministry of Health. In 1980, a Ministry was created (without Cabinet representation) giving Sri Lanka the distinction of being the only country in the world with a Minister of Indigenous Medicine (Wolffers, 1988:545). However, this Ministry did not always operate as a discrete body and its fortunes were closely tied to the political complexion of the government of the day.

While a distinct department for indigenous medicine was a political asset, being placed within the Ministry of Health allowed for continuing structural domination by biomedicine. Ayurveda was alluded to as the “Cinderella” (Wijesekera, interview, 31/3/2003) or “poor brother” (Abeysekera, interview, 25/3/2003) whenever it was placed alongside the biomedical fraternity in the Ministry of Health. In any statute or regulation regarding Ayurveda, the term “Minister” always meant the Minister of Health (not the Minister of Indigenous Medicine), who was also responsible for appointments to Ayurvedic statutory bodies (Wanninayaka, 1982:13). Administratively and politically, the dominance of biomedicine was embedded in the regulatory mechanisms governing the Ayurvedic sector.

Bureaucratically, there has been an ongoing struggle for funds and status (secondary resources) and Ayurveda was moved between Ministries according to the government of the day. In 2000, a separate Cabinet Ministry for Indigenous Medicine (IM) was created. This meant that at Cabinet level, for the first time, Ayurveda had independent status and was not within the general health portfolio or any other Ministry. This increasing political power corresponded with a rapid increase in power of the Janatha Vimukthi Peramuna (JVP) party, with a socialist and nationalistic agenda. However, although nationalistic sentiment gained strength, it is not clear if there is a direct correlation between this and the establishment of an independent Ayurvedic portfolio. The growing economic strength (secondary resources) of this sector may also have been an impetus. By the late 1990s, the potential value of the rapidly increasing export market had been realised and Ayurveda acquired an elevated status attached to the newly acquired foreign demand.

The Indigenous Medicine Cabinet Ministry was short lived, and after 10 months there was a Cabinet re-shuffle and Ayurveda was placed into a new Ministry of Health, Nutrition and Welfare. This constant re-shuffling continued due to political instability, with Indigenous Medicine being placed with Disaster Relief (2003) before again achieving an independent Ministry in 2004. The lack of political power and status of Ayurveda within government is illustrated by the fact that in the six year period between 1998 and 2003, there were as many changes at Ministry level, with new Ministers, and/or new portfolios. While Ayurveda was
recognised as an important part of Sri Lankan heritage and health care provision, the portfolio seemed precarious, and appeared to be moved on whim according to political sentiment which could rapidly change. This was assisted by the fact that it was not compulsory to appoint a Minister for Indigenous Medicine and so Ayurveda could “float” between Ministries, and not all Ministers achieved Cabinet representation.

The history and operation of the formal indigenous medicine sector demonstrates that the politics and problems streams (such as changes of government, manoeuvring within parliament, the development of new issues such as environmental conservation and economic growth of the sector) directly affected the status and fortune of TRM at the national level. Status and resources allocated to the sector were closely related to the contemporary political situation, from the time of official recognition earlier in the century aligned with the independence movement, right through to the more recent changes of fortune. The political instability of the national government continued to affect the formal and consistent development of the TRM sector.

For example, with each successive ministerial change, there were corresponding budgetary and administrative changes which meant that policy and programme development was delayed or interrupted. Legislative development was also hindered by this insecurity and volatility at Central Government level. In 1998, amendments to the Ayurveda Act of 1961 were drafted. This was to take into account the growth of markets (requiring standardisation of herbal remedies) and the new tourism based activity which could not be regulated under the auspices of the original legislation. Therefore, the growth of secondary resources (economic benefits) attached to the TRM sector necessitated increased regulation and oversight.

It was considered easier and faster to amend the 1961 Act than to repeal it and draft a new legislative code. A new Act was also drafted for Ayurvedic Drugs, Cosmetics and Devices which meant Ayurveda was covered by two Acts (one for practitioners, one for drugs), as well as a code for intellectual property. However, although this had almost reached approval stage in 1998, in 1999 there was a change in Government and for one year it remained in limbo with no action taken. The subsequent Minister appointed then re-considered it, subjected it to further review and made some changes before another change of Government and cabinet shuffle. Responsibility for drafting the legislation on intellectual property was then transferred from the Ministry of Indigenous Medicine to the Ministry of Commerce and then Trade, reflecting the shifting focus of this issue from one of health to one of economics.
Currently, this legislation is still pending finalisation and Cabinet approval. The further development of Ayurveda is impeded by the lagging policy formulation and implementation, and delayed regulatory frameworks. It was estimated that it would receive cabinet approval in the first quarter of 2005, but it is still being finalised. Alongside this increasing legislative and regulatory status is an anticipated increase in fiscal appropriation, in recognition of both recent policy formulation undertaken and tourism and industry growth. The government was willing to allocate more resources to the sector as it became clearer that this sector can generate income (indicating that resources will be provided if secondary resources such as economic benefits are returned) (Abeysekera, interview, 25/03/03; Somaratne, interview, 30/11/04; Amarasinghe, interview, 19/11/04; Karunasena, interview, 25/10/04).

As demonstrated on the global level in the case of the WHO, the budgetary position and power of TRM in central decision making aspects of health policy is minimal. However, status in policy making has been enhanced with economic leverage (such as the potential for secondary resources to be generated via health tourism and commercial cultivation) and with heightened nationalistic sentiment. Policy formulation and implementation were also highly dependant upon specific entrepreneurs (advocates) who guided or pushed the policy process further, as well as receptiveness at senior bureaucratic levels. This is similar to the development of TRM policy on an international level within the WHO, where similar obstacles and impetus were observed.

The changing political fortunes of Ayurveda at central government level can often be linked to certain people or policy platforms of particular parties. For example, particular Ministers (Lokubandara, Soysa, Bandranaike) or Presidents (Kumaratunga) who are favourable or sympathetic to TRM are often cited as being responsible for improved status and support. The initial establishment of the Indigenous Medicine Department in 1980 was the result of a push from a senior parliamentarian who was an Ayurvedic practitioner (WHO, 2001b:139). President Kumaratunga urged provincial councils to establish medicinal herb gardens and Ayurvedic laboratories to increase the production of Ayurvedic medicines (Schokman, 2004). Just as Mahler was crucial in the WHO at the international level, certain entrepreneurs (advocates) and catalysts were essential to promote such policies within the Sri Lankan government.

While appealing to popular sentiment is unproblematic, transforming the platitudes to substantial programme development backed with budgetary commitment is more difficult. For example, in early 2003, the Minister for Indigenous Medicine and Disaster Relief (Rajakaruna) announced an initiative where all hospitals would have an Ayurvedic ward.
staffed by an Ayurvedic practitioner (Gampaha group correspondent, 2003). However, by late 2004 no steps had been taken to implement this initiative and it appeared to be a discarded political gesture. Another example of this type of gesture occurred in 2004 when an Ayurvedic clinic was opened in the national Parliament at the instigation of the speaker (Lokubandara) – who was also a previous Minister for Indigenous Medicine. Such symbolic rather than practical measures may be resorted to in order to gain constituent support, yet avoid politically contentious or sensitive resource reallocation issues.

Officially, the Ayurvedic sector is usually overlooked. Most policy and planning documents regarding health refer only to biomedicine. For example, the most recent WHO country plan for Sri Lanka makes no mention of traditional medicine. The Health Atlas, an official overview of health infrastructure and status, likewise does not recognise Ayurveda. On the basis of such documents, it could easily be concluded that no form of TRM exists in Sri Lanka, and that the thousands of practitioners are not officially considered health care personnel. Despite political recognition, TRM has limited structural strength in the health care system. Health development in Sri Lanka is generally restricted to the narrow ambit of those areas that fall within the purview of the Department of Health (such as disease control and prevention), and strictly to biomedicine (Wanasinghe, 2002:12).

7.1.2 Current organisation and distribution

Sri Lanka operates with central, provincial (8) and district (22) levels of government. Within each district, local government areas operate. Functions vary between levels of government, with both biomedical and Ayurvedic hospitals and dispensaries universally provided free of charge. Biomedicine dominates the health care system structurally and absorbs around 96-98% of the health care budget. About 85% of total expenditure is absorbed in tertiary care (hospital based) (de Mel, 2002:70). This budgetary allocation is a clear indicator of structural strength and power of the sectors in the formal health care system.

Under the constitution, Ayurveda is devolved to provincial level, although the Central government retains responsibility for some functions (e.g. research, education and training). There are 3 central government teaching hospitals, 46 provincial council hospitals, 121 provincial council dispensaries and 230 local government dispensaries. There are also four herbal gardens, a drug production facility and a research institute. An organisational chart for Ayurvedic public sector administration is attached (appendix 10; page 367). This complicated administrative arrangement may have led to what can be considered a lack of
cohesiveness between training and service delivery, an uneven distribution of facilities, and a lack of clear responsibility for co-ordination.

Table 4: Public sector health sector facilities (Sri Lanka)

<table>
<thead>
<tr>
<th></th>
<th>No. of facilities</th>
<th>No. of beds</th>
<th>No. treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedicine</td>
<td>855</td>
<td>48 632</td>
<td>40 066 528</td>
</tr>
<tr>
<td>Ayurveda</td>
<td>147</td>
<td>2 203</td>
<td>957 932</td>
</tr>
</tbody>
</table>

Table reproduced from (Liyanage, 2002:114)

Table 5: Budget allocation for Ayurvedic sector (in Sri Lankan rupees, 000)

<table>
<thead>
<tr>
<th></th>
<th>Health (total)</th>
<th>Ayurveda</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1998</td>
<td>1999</td>
</tr>
<tr>
<td>Biomedicine</td>
<td>11135</td>
<td>16668</td>
</tr>
<tr>
<td>Ayurveda</td>
<td>172</td>
<td>213</td>
</tr>
</tbody>
</table>

Table reproduced from (Ranaweera, 2001:8)

It can be seen from the above tables that the formal, public Ayurvedic sector is dwarfed by the biomedical sector. It should be noted that the private Ayurvedic sector is much larger than the public sector, although accurate data on both the public and private sectors is difficult to obtain. For example, statistics and figures vary widely between documents as to the number of public Ayurvedic institutions and patients treated. Ranaweera (2001), when Secretary of Indigenous Medicine, quoted figures of over 400 indigenous medical health institutions (including both dispensaries and hospitals) treating over 4 million patients. However, it is acknowledged that indigenous medicine is largely in the private sector and mainly home and community based (MoH, 2003:6.39).

Regardless of varied statistics, it is clear that there is a very skeletal formal Ayurvedic sector, with an ongoing struggle to maintain services and resources. The government assessment of Ayurvedic infrastructure acknowledges that the facilities are unevenly spread across regions, and that there is a need for more resources and more effective networking (MoH, 2003:6.24). Furthermore, the draft health master plan concedes that TRM in the public sector has not been fully utilised for health care delivery, and that demands for TRM have not been adequately met (MoH, 2003:6.29). So, while biomedicine is absorbing the vast majority of funds and dominating service delivery, TRM infrastructure has been neglected to the detriment of sufficient supply.
The budgetary allocation to indigenous medicine has significantly increased (Table 5), especially in 2000 when Ayurveda achieved Ministry status. This new political power appeared to enable a larger appropriation, and funds allocated more than doubled from the previous year. In proportion to the total health budget, Ayurveda was allocated 1.54% in 1998, and then nearly doubled to 2.91% in 2000 before climbing to 4.27% in 2001. Despite rapidly increasing, the proportion of secondary resources allocated to Ayurveda is still quite small and the vast amount of health expenditure is dedicated to biomedicine. Most people interviewed who mentioned the budget for Ayurveda provided a figure of 2% or less (Jayasinghe, interview, 20/12/04; Samarasekera, interview, 25/03/03).

In terms of personnel, there is approximately double the number of Ayurvedic practitioners than biomedical practitioners. However, many more practitioners (both Ayurvedic and biomedical) are not registered. It is estimated that there are 6800 government biomedical doctors (about half of which may be engaged in private practice after working hours), and 600-800 full time private biomedical practitioners. There are 15000 registered Ayurvedic practitioners (Jayasuriya, 2002:66). This figure is disputed by some, who believe the figure may be inflated by the registration of Ayurvedic doctors who are not fully qualified (Kasturaratchi, interview 1/12/04).

The variety of TRM systems operating within Sri Lanka adds considerable complexity to the situation. While all systems of TRM are represented by the Ayurveda Act 1961, they are not administratively equal. The hierarchy and domination by Ayurveda is most obviously reflected in the nomenclature used to describe TRM – Ayurveda as an umbrella term is neither accurate nor universally accepted. The suggestion to change the umbrella term to “indigenous systems of medicine” is considered a political manoeuvre as it allows the inclusion or exclusion of various groups according to political whim (Kasturaratchi, interview 1/12/04). The majority of resources within the TRM sector are also allocated to Ayurveda. The small budgetary allocation to TRM is therefore apportioned internally along political lines. It is unclear whether Ayurveda is the largest TRM practitioner group compared to Desiya Chikitsa, but formal government support has enabled the structural expansion of it and subsequent domination over other indigenous systems.

It is interesting (although not unexpected) to find that the various systems of TRM within that sector form a hierarchy of power. This reflects their ethnic/class origins and the corresponding size of their constituent community and its political and economic power. Ayurveda dominates followed by Desiya Chikitsa (Sinhalese), Siddha (Tamils) and Unani (Muslims) (D. Perera, interview, 9/12/2004). Besides these more formalised systems are
various specialties (often hereditary in professional lineage) – the lowest in ranking of power and prestige due to their fragmentation, diffusion, lack of organisation and institutionalisation. This includes bone-setters and those who treat snake bites, burns, mental health, and skin conditions.

As the theory developed by Unschuld proposes, power relations and conflict for resources between medical systems can be seen to distort health system development not only in relation to Ayurveda and biomedicine (between sectors), but within the TRM sector as well. There is a perpetual struggle to secure primary and secondary resources, the success of which is directly related to the political power enjoyed by that sector – seen here as parallel to that of the ethnic group from which the system originates. The hierarchy of power and status is thus clearly defined (biomedicine, Ayurveda, Desiya Chikitsa, Siddha, Unani) and directly linked to the proportion of secondary resources secured (status, funding).

Another example of how power relations between ethnic groups influence the interaction between the indigenous systems of medicine is obvious in relation to Ayurveda and Siddha (which is practiced mainly by Tamils). After communal riots in 1983, the Siddha teaching faculty at Colombo University was transferred to the Jaffna campus in the Tamil dominated Northern region. This can be seen as a form of educational partition, and Siddha receives far less formal support than Ayurveda. The interaction and exchange of information between these systems is limited and difficult (D. Perera, interview 9/12/2004), reflecting the tensions between Tamil and Sinhalese ethnic groups more broadly.

Currently, the organisation and distribution of the health care system suffers from a variety of challenges including under-funding, a lack of strategic policy development, and administrative confusion as a result of devolution (Hsiao, 2000:89-90). Such factors have contributed to sub-optimal functioning, which is also impeded by a lack of reliable information, fragmented financing, poor regulatory structures and inadequate responses to emerging needs (Jayasinghe & Mendis, 2002:124-126). Biomedical structural domination of the health care system has enabled it to secure the vast majority of secondary resources, and has distorted the development of integrated delivery incorporating TRM. The dominant ideology is biomedical and the funding is biased towards the curative/tertiary sectors (Jayasinghe & Mendis, 2002:126) regardless of stated government support for TRM over several decades, and despite the fact that it offers a cost effective approach for long term care management (MoH, 2003:6.39).
7.1.3 National policy and programme development

Policy and programme development in relation to Ayurveda has been impeded by a lack of political commitment and resources. The current organisational structure of Ayurvedic services has also hindered effective co-ordination and operation. The government has been criticised for paying “lip service” to the promotion and development of TRM (Wijesekera, interview, 31/3/2003). Policy often takes a more symbolic than practical dimension, with the first national policy proposed in 2004. This is still in draft form. Despite the international support for this concept and continuing national government statements of support for integration, progress is slow and the national TRM policy is still in embryonic stages.

The difficulty of political instability and lack of will is compounded by a lack of human and financial resources, and historically weak strategic policy ability within the Ministry of Indigenous Medicine. For example, it lacked a planning and development unit until 2004. In addition, the multidimensional nature of TRM means that issues are often split between or across portfolios. For example, agriculture, environment, science and technology, trade and tourism now all have a role in TRM, and central co-ordination is vital. As long as the Indigenous Medicine Ministry lacks political power and financial and manpower resources, this is beyond its capacity operationally. As at the global level, TRM is being pulled in different directions by different interests, making local (community level) development problematic.

In government planning documents, the integration of TRM and biomedicine is still referred to as a vague concept, a future activity, and cautiously worded:

Integration of the services of both allopathic [biomedical] and indigenous sectors is expected to be carefully done in relevant areas with the understanding and consent of both sectors based purely on the benefit of the patients without contradictions in the basic concepts of both systems of medicine (MoH, 2003:6.30).

Such ambiguous statements hint at the practical difficulties in formalising the role of TRM in the health care sector in an equitable manner. It is also a covert recognition of the lack of progress in integration since the 1970s. The piecemeal and symbolic formal development of the Ayurvedic sector is recognised by academics and commentators as well as other organisations. For example, Dharmasiri notes “The government … is said to support [Ayurveda]. But it is minimal and nominal” (1997:160) and Edirisinghe comments that “the gulf between the policy support and the actual task of putting into practice the policy decisions remain as wide as ever” (1987:168). The World Bank (1997:4) considered the
weakness of policy and programme implementation, and lack of resource commitment, to result from an emphasis on other political and economic priorities.

The Health Master Plan, which was drafted by the Government in 2003, regarded the highest priority in the TRM sector to be the administrative restructuring of the Ministry of Indigenous Medicine (MoH, 2003). This included the establishment of policy, project management, legislation and intellectual property rights sections. Such structural changes would improve institutional capacity to develop the appropriate programmes and ensure regulatory frameworks were adequate. Also high on the list of priorities was developing an Ayurvedic formulary to guide the manufacture, quality control and formulation of products under specified standards. This reflects the need to address rapid market growth.

Over the last decade, numerous Ayurvedic clinics catering to increasing foreign demand for natural health treatments have been established. This market has grown concurrently with an export market for herbal products. Around 60% of raw materials for Ayurvedic remedies are imported from India or Nepal and supply is failing to meet current demand for both domestic and international markets (MIM, 2001:20-21; Schokman, 2004). This has been compounded by international environmental conventions (e.g. Convention on International Trade of Endangered Species) which prohibit trade in threatened species. India is gradually introducing restrictions on the export of raw herbs, which may seriously affect the Sri Lankan market (MIM, 2001:21). For example, red sandalwood can no longer be sourced from India and saplings planted to make up the shortfall will take around 4 decades to mature. The resource base of TRM is thus under extreme pressure, and there is a need to effectively balance and prioritise environmental, economic and local health matters.

Between 1995 and 2000, the sales of Ayurvedic medicinal products approximately doubled (see table 6). The middle column of table 6 was unlabelled, but it may be the volume of production. Production reached an optimal level in 2000 under current facilities, and cannot expand further without equipment upgrade and improvements in the supply of raw material (MIM, 2001:19-23). The main problem encountered by the Ayurvedic Drugs Corporation is inability to supply demand, with only around 70% of the demand from the public sector met and a large portion of the open market remaining unserved (MIM, 2001:20, 21). In order to address problems in supply of raw materials, the Ministry proposed to promote the cultivation of herbs as an economic crop (MIM, 2001:21). This corresponds with international trends from the mid to late 1990s to commercialise TRM.
Table 6: Value of production of Ayurvedic medicinal products (rs. million)

<table>
<thead>
<tr>
<th>Year</th>
<th>Sales</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>46</td>
</tr>
<tr>
<td>1996</td>
<td>66.12</td>
</tr>
<tr>
<td>1997</td>
<td>84.34</td>
</tr>
<tr>
<td>1998</td>
<td>89.19</td>
</tr>
<tr>
<td>1999</td>
<td>100.04</td>
</tr>
<tr>
<td>2000</td>
<td>100.53</td>
</tr>
</tbody>
</table>

Table reproduced from (MIM, 2001:19)

The rapid increase in sales was fuelled by a surge in demand from foreigners – a market growth that was stretching the domestic production capacity. This unanticipated market development opened a window of opportunity for Ayurveda on the domestic political agenda. More government support for the Ayurvedic sector could be garnered when economic returns (secondary resources) were assured (Abeysekera, interview, 25/03/03; Somaratne, interview, 30/11/04; Amarasinghe, interview, 19/11/04; Karunasena, interview, 25/10/04; Malimage, interview, 25/10/04). Therefore, increased funding was directed to the indigenous medical sector in order to improve production capacity and develop the required regulatory frameworks. This accounts for more than a quadrupling of funding between 1998 (when the accelerating value of the export market was realised) and 2001 (see table 5).

A burgeoning export market exposed the weaknesses in existing policy, manufacturing and research programmes. While the production and use of Ayurvedic medicines for local use did not have to conform to strict regulations (NSTC, 2002:11) such as quality control, labelling and packaging requirements, handling, storage and so on – export markets were a different matter. This new imperative to industrialise and commercialise medicinal plant crops was dependant upon establishing scientific validation of safety and efficacy as well as resolving issues such as intellectual property rights. The assessment of industry capacity in 2002 repeatedly emphasised medicinal plants as source of foreign exchange and the need to meet international standards to capitalise on foreign markets (NSTC, 2002: 1, 2, 4, 6, 10, 11, 14, 15, 31, 41).

Scientific validation was also deemed essential to adequately integrate TRM into the health care system, as stated in both the Health Master Plan (2003) and draft National Policy on Indigenous Medicine (2004). Strengthening the research capacity of the sector was crucial in order to “make the ISM sector more scientifically evidenced based” and this data is required for effective integration (MoH, 2003:6.58).
There is an urgent need to establish the safety and efficacy of ISM therapies and drugs on the basis of experimental evidence for the ISM to be integrated into the healthcare system in modern Sri Lanka (MIM, 2004)

The neglect of such research had therefore hindered both the integration of TRM on the domestic level and also now threatened the ability to respond to and develop an export market. As Lee (1982) argued, the role of scientific discourse is crucial in order to gain structural strength in the modern state. Scientific validation provides credibility and a rationale for resource allocation. In this case, the adoption of scientific ideology and values is directly linked to the global market evolving for the products. The catalyst was economic and related to the generation of lucrative secondary resources. Hence, increased activity in the policy arena for TRM was visible in the late 1990s and from 2000 including drafting a national policy and attempting to resolve intellectual property rights issues. This corresponded with the situation observed on an international level within the WHO as well as in a variety other countries with a history of traditional medicine.

While progress in policy and programme development had been tardy in the period between the 1970s and mid 1990s, it was suddenly propelled by the international growth in demand for herbal health care products in the mid-late 1990s. To develop export markets necessitated an intensification of activity in domestic policy, and a range of activities across a variety of portfolios. Therefore, resources were finally allocated and policies to address pressing issues were drafted. This also tied in with international conservation and environmental agendas. The politics stream became conducive to developing the sector nationally, and the international demand for such products was acknowledged as a factor at the forefront of political activity. The politics, problems and policy streams therefore merged and TRM was elevated on the political agenda. This was evident with Indigenous Medicine achieving Cabinet representation in 2000, the rapid increases in funding allocated to the sector and the drafting of policy and legislation in relation to TRM.

7.2 WHO Activities

It is difficult to effectively gauge the activities of the WHO in relation to TRM in Sri Lanka. It does not appear to be a priority or to be even taken into account in policy and programme development. The WHO is dominated by the biomedical profession and considered inactive in the field of TRM (Dharmasiri, interview, 14/12/04). For example, there is no WHO officer responsible for TRM, even as a partial task. The WHO library in Colombo has very few
documents on TRM, including none of the key documents issued by Headquarters. In contrast to reference sections dedicated to particular diseases or health issues (such as tobacco use) there was no corollary for TRM. The WHO country documents on Sri Lanka also made no reference to TRM. The exclusively biomedical focus (and continuing emphasis on vertical interventions) was clearly reflected in staffing, structure, funding allocation and information resources.

At country level, the resolutions of the World Health Assembly may therefore not be accorded high status or implemented fully. However, in the 1980s some initiatives were undertaken which reflected the international interest in and commitment to TRM practitioners as “human resources” to expand the PHC effort. Phase 1 of a WHO/UNDP project for the development of TRM was undertaken between 1985 and 1988. This project emphasised human resource development and focussed on developing the teaching skills of 8 instructors of TRM, and the ability of over 1000 practitioners to provide community advice on the preventive and promotive aspects of PHC and treating common ailments (WHO, 2001b:140). Details on phase 2 of this project, or any outcomes and evaluations, are not available.

The same project provided incentives to establish the National Institute of Traditional Medicine, which carries out educational and training programmes for traditional and Ayurvedic practitioners, school children, and the general public. The Institute does not offer opportunities for advanced training or postgraduate education, so in 1993 the Department of Ayurveda began to provide alternative resources for Ayurvedic Medical Officers to obtain postgraduate qualifications through the Institute of Indigenous Medicine at the University of Colombo, Rajagiriya (WHO, 2001b:140).

The WHO has been involved in minor programmes, such as assisting with the training of TRM practitioners in biomedical anatomy and basic technology in diagnosing diseases (MIM, 2001:13). As can be seen from these examples, the emphasis of the WHO has been on manpower training and education and not on service delivery or policy development. In addition, the training has taken the form of basic biomedical theory being taught to TRM practitioners, rather than a collaborative cross sector education or transfer of information. Recently the WHO was approached by the Ministry of Indigenous Medicine seeking assistance to draft the national policy and translate it into Sinhala (Karunasena, interview, 25/10/2004).
While it is difficult to locate information on WHO activities in the sphere of TRM in Sri Lanka, budget allocations in 1998 provide an indication of emphasis within the organisation. While the entire annual allocation for TRM totalled US$37 000, this was about half the amount allocated to the programme on essential drugs (US$70 000) and similar to the proportion given to the promotion of a healthy lifestyle (US$32 000). However, this information was not provided in WHO documents but in the *Action Plan for the Development of the Health Sector* by the Government of Sri Lanka, Ministry of Health which listed foreign aided projects (1998:92). It is not clear how the funds were spent, again reflecting a lack of transparent and consistent record of data on the TRM sector as well as the fragmentation between agencies and bodies with an interest in or responsibility for traditional medicine.

In terms of the WHO, it is apparent that while there was a strongly articulated global policy promoting the use of TRM at headquarters, on the national level there was only a vague and incoherent strategy. In contrast, biomedicine was clearly dominant in policy formulation and programme implementation, and little co-ordination or co-operation between the sectors had been developed or promoted by the WHO. TRM had a minimal status and was not included in mainstream programme activity in any form. Unfortunately, it appeared that the directives of headquarters and resolutions of the World Health Assembly in relation to TRM were not practically adhered to on the national level by the WHO in Sri Lanka and were effectively ignored or overlooked.

### 7.3 World Bank activities

As happened on the global level, the World Bank took the lead in policy and programme development in the sphere of TRM and became actively involved in project development in Sri Lanka. Whereas the WHO barely showed any formal recognition of the sector beyond some piecemeal small scale training on national levels, the World Bank invested millions of dollars in development of the sector. It filled the vacuum left by the WHO and focussed on Sri Lanka as offering a potentially lucrative commercial opportunity.

The impetus for this was not for health service delivery but for a combination of economic and environmental reasons. Reflecting the broader mandate of the World Bank, the rapid international market growth for herbal health care products in the 1990s created an opportunity for commercial development that it quickly attempted to capitalise on. The global commodification of herbal medicines had created a massive demand that had not been
met, and was projected to increase. The Convention on Biological Diversity (CBD) had been signed in 1992, establishing an atmosphere of heightened sensitivity to environmental issues while “sustainable development” was the new economic agenda.

In 1997, at the peak of the World Bank interest in the medicinal plant and herb market and when it recognised that the use of indigenous knowledge could play a pivotal role in economic development (Lambert, Srivastava, & Vietmeyer, 1997; Srivastava, Lambert, & Vietmeyer, 1996), it announced a project in Sri Lanka called the “Conservation and Sustainable Development of Medicinal Plants”. This five year project was allocated US$4.57 million with the aim of developing a programme that preserved and cultivated specific medicinal plants.

This project neatly tied in with the international objectives current at the time of sustainable development, environmental preservation and protection of biodiversity. Therefore, it can be argued that these problem streams on the international agenda enabled such a project to gain legitimacy on the national agenda of Sri Lanka. This was a fortuitous coincidence for the TRM sector and allowed an unprecedented provision of secondary resources (both status/prestige and economic benefits). The window of opportunity had opened, and the process streams (problems, politics and policies) merged to allow the project to gain political prominence and economic support on the national agenda. The problems were developing sustainable industries, preserving the environment and protecting biodiversity – and the solution (policy) was the project for the development of sustainable use of medicinal plants. This simultaneously addressed several pressing problems and provided a solution that conveniently garnered support from a variety of interests who had diverse objectives.

This project provides an interesting example of some of the practical difficulties in implementing such a programme as well as priorities on the agenda. It was primarily considered an environmental and poverty alleviation project, not a health services development scheme. At the time of approval, the World Bank gave “priority to promoting the ‘western model’ of health care” (World Bank, 2004:2) and emphasised the environmental and income generating potential of the scheme. While dependency on TRM for health care (especially amongst the poor and rural populations) was recognised, the objectives of the project were not related to access to health services. Instead, the objective was couched in purely developmental and environmental terms – protection of natural resources and generation of income (World Bank, 2004:2-3).
The presentation of the issue as an environmental and agricultural one was politically expedient for both the World Bank and the government of Sri Lanka. A focus on this perspective allowed the funds to be accessed from the recently created GEF (Global Environment Facility, of which the World Bank was an implementing agency) and also avoided contentious and complex issues related to the health system structure and development of the TRM sector. It seemed incidental that these plants were used for health care – the outcomes of the project were presented as exclusively environmentally or developmentally related. The fact that they were part of the TRM system only increased their economic value. Medicinal plants were basically a cash crop, but one that needed to be managed sensitively for environmental reasons. This correlated with the economic rationalist trend in health policy the World Bank had promoted in 1993 with the report *Investing in Health* (World Bank, 1993).

Despite the World Bank changing directions in the 1990s and embracing the concept of a “human face of development” (which emphasised issues such as the environment, health and education as keys to future economic growth), the Conservation and Sustainable Development of Medicinal Plants project seemed to remain purely economic rationalist in tone and content. For example, the links between health and development were not directly referred to, even in this project which had a clear health component. The jargon of the World Bank in the 1990s did not appear to match the practical activities, which enabled it to avoid complex social and political problems in borrowing countries. The GEF and World Bank priorities were evident in the scope and language of the project, which concentrated exclusively on easily measurable economic objectives guided by environmental conservation.

The medicinal plants project also illustrated a problem previously mentioned in relation to policy transfer from the international to national levels. While an international consensus had been agreed in relation to the environment, this did not always match the agenda on national levels. Just as the global PHC and integration of TRM policies suffered in implementation when national level priorities diverged, the project on medicinal plants demonstrated that international agencies and national governments may not have corresponding concerns. This point was raised in the project evaluation – despite a strong international consensus on the

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For example, in the project description provided by the World Bank public information centre, benefits were listed for the global, national and local levels. At the global level, this included conservation of medicinal plants and preservation of unique ecosystems and knowledge on cultivation and use. At the national level benefits were improved supply of medicinal plants, market analysis to improve efficient production and distribution and sustainable use of resources. At the local level, increased choices of livelihood and opportunities, income generation, employment, equitable sharing of natural resources and resource management were listed. Health care did not feature directly in any of the outcomes or benefits.
environmental agenda “the national development agenda and institutional structures … may not have been fully prepared to absorb such initiatives” (World Bank, 2004:18). Agendas are not always synchronised. Problems identified and their solutions may not be the same for international and national bodies, or proposed solutions may not have the institutional and administrative capacity to implement (e.g. legal and regulatory frameworks).

While the World Bank and other institutions such as IUCN may have been eager, political and economic realities in Sri Lanka presented a stumbling block to smooth implementation of the project. Factors impeding the project included: political volatility (which led to ministerial changes as well as changes in the senior administration of the responsible government unit); the lack of a legislative framework for the protection of intellectual property in relation to TRM; and administrative and institutional weaknesses. This meant the international “issues and agenda for action … were not totally in phase with the institutional capacity” (World Bank, 2004:12).

The divergence between global and local priorities and the problems mentioned above meant that external bodies took a disproportionate control over the project and national government determination and ownership of the project was diminished (World Bank, 2004:12) and the project appeared driven by external interests:

The high degree of international advocacy of biodiversity conservation in the “global interest” also fuelled national public debate over the prospects of the loss of national control over indigenous knowledge and bio-resources. The impact of this was to further reduce the perception of national ownership and national interest in the project … (World Bank, 2004:12).

While the large provision of funds was significant, it was not directed to improving service delivery or alleviating the fragmentary nature of Ayurvedic institutional infrastructure and training, and the project was not clearly defined as a TRM or a health project as such. Initially (as hinted at above) it was not even welcomed in the sector or by target communities who instead considered it a neo-colonial attempt to steal indigenous plant knowledge (D. Perera, interview, 1/4/03). This was compounded by the lack of clear regulatory mechanisms which safeguarded intellectual property, and identified the beneficiaries of any commercial application or use of such knowledge.

Therefore, the project further demonstrated that external agendas or priorities which are agreed at the global level by funding or advisory bodies can be difficult to implement on national levels (as also illustrated in the PHC case and the WHO). This project was both a practical example of the World Bank taking a strategic lead in policy development in TRM,
and reflects some of the barriers to implementation experienced with international priorities in national settings. For example, the implementation of the project preceded the necessary national regulatory frameworks. Therefore, on national levels, the institutional capacity and legal frameworks to implement internationally endorsed programmes may be lacking or inadequately established.

Political volatility and other factors impeded the development of essential legislation in this case, which the World Bank had mistakenly assumed would be addressed in a timely manner. This may have been a result of underestimating the contentious yet subtle political position of TRM in the health care sector, and inadequately assessing the historical administration of indigenous medicine. In addition, issues surrounding the professional status of practitioners and the development of the sector may have been insufficiently canvassed. An exclusive focus on economic and environmental factors and a lack of assessment of social and political issues, may have given an unrealistic impression of the ease of implementation and achievable outcomes of the project.

7.4 Professional interaction

Despite the international growth of demand for TRM products and services and the heavy reliance nationally on this sector for health care, Ranaweera when Secretary of the Ministry of Indigenous Medicine considered that at best the current relationship between biomedicine and indigenous medicine was an “uneasy truce” (Ranaweera, 2001:13, Ranaweera, undated:11, emphasis added). In contrast to Waxler (1984; 1988), who concluded that the division of labour between biomedical and TRM sectors involved little conflict, it was eloquently described by Dr. Ranasinghe (an Ayurvedic practitioner) as a battlefield:

Today … Ayurveda having acquired most of the valuable techniques of the age-old traditional systems faces boldly the modern, so called scientific medicine for its last battle. There was a time for Ayurveda, we may say, its golden era when no other system of healing posed a threat to its existence, much less to its principles. That period has receded to the past never to return. Ayurveda having rejuvenated during the period of renaissance tries to recover the ground it had lost. Nevertheless [biomedicine] not only does not yield an inch of its acquired territory but engages in its normal advance hurling ever increasingly its new armoury in the face of Ayurveda. Thus an ideological confrontation has set in. A confrontation that was raging ever since Ayurveda recovered from its hibernation … (Ranasinghe, 1987:115, emphasis added).

The conflict between the sectors is therefore more subtle than that visible at practitioner level, and can be more clearly discerned at research, education, and policy and/or programme development areas. Competition, jealousy, and tension are recognised between practitioners (Somaratne, interview, 30/11/04) and a lack of co-operation is evident.
(Goonerwardene, interview, 15/12/04). Whereas on the surface the medical systems may appear to function and interact in harmony, the parallel system operates on a historical base of mutual distrust and rivalry (Aluwihare, 1986). This becomes clearer when the current professional interaction between biomedical and Ayurvedic sectors is considered more closely.

The power imbalance evident between biomedicine and Ayurveda reflects the colonial origins of biomedicine, which continues to overshadow the relationship today (Jayawardhana, interview, 17/12/04; Jayansinghe, interview, 20/12/04; Dharmasiri, interview, 14/12/04). “The attitude which glorified western medicine almost to the exclusion of other medicines persists to a large extent today ... It’s going to be a hard grind to turn it around” (Goonewardene, 2004). The relationship between these sectors is discussed in more detail below, with a section on each system to elaborate on professional attitudes and interaction.

**7.4.1 Biomedical profession**

As in other countries, the biomedical profession is strongly organised and enjoys a high social and economic status. A thorough background and history of the biomedical profession in Sri Lanka is provided by Pieris (2001). Her study commences with the introduction of biomedicine in Sri Lanka and the subsequent professional development of practitioners. The Sri Lankan Medical Association (SLMA) is the professional representative body, which was originally a branch of the British Medical Association. It has operated for 117 years and currently has around 2000 members (Epa, interview, 5/12/04).

**7.4.1.1 Relations with Ayurveda**

According to Ranaweera (2001:13), the lack of understanding and respect between the systems is exemplified by the Sri Lankan Medical Council (SLMC), a body responsible for the registration and professional conduct/discipline of biomedical doctors. In the early 1990s, the SLMC passed a resolution which prohibited biomedical doctors from practising other systems of medicine or healing modalities, or collaborating with such practitioners, under the
threat of de-registration. While this has never been enforced (Panditharatne, interview, 20/12/04), it acts as a powerful symbolic deterrent.\textsuperscript{114}

This resolution has never been imposed according to the SLMC as it first requires a complaint by a member of the public against the biomedical professional concerned. The fact that no member of the public has ever complained, and the resolution was not initially instigated due to public complaint, indicates that the issue of professional interaction is more a professional concern of the biomedical group, rather than one related to public safety or quality of care. It mainly acts as a formal barrier to collaboration, and a strong commitment to the principle of non-integration drives the continued adherence to this regulation. It is an adamant position of the SLMC that there is no mixing between medical systems in any form and that a parallel and not integrated system operates (Panditharatne, interview, 20/12/04).

The current registrar of the SLMC argues that biomedical practitioners should not practice Ayurveda and Ayurvedic practitioners should not practice biomedicine, as any type of integration will inevitably lead to the death of one system. In this case, TRM is presumed to be vulnerable to demise as the superiority of biomedicine will be demonstrated in treatment. Therefore the measure is promoted as protective of indigenous forms of medicine (Panditharatne, interview, 20/12/04). Regardless of government policy on integration, professional associations or representative bodies have therefore exerted a strong influence on the implementation of this goal through enacting misconduct rules that bar integration in a practical sense.

Another practical barrier to integration is in place at the level of practitioner education. In addition to barring biomedical doctors from practising Ayurveda or collaborating with these doctors, they are also prevented from teaching any biomedical subjects at Ayurvedic tertiary institutions. Therefore, while Ayurvedic students desire to learn biomedical subjects such as anatomy and physiology, they are not allowed to be taught by a registered biomedical practitioner. There is very strong hostility within the biomedical profession to including any biomedical subjects in the Ayurvedic curriculum (Kasturaratchi, interview 1/12/04). This necessitates recourse to biomedical doctors who are not registered with the SLMC and who

\textsuperscript{114} Some people referred to the famous case of Dr. Jayasuriya as a practical outcome of this prohibition. He was a well known biomedical doctor who was de-registered by the SLMC in 2001. It is suspected (and reported) that his popular acupuncture practise was the reason for this, although the official reason was that he failed to respond to SLMC correspondence or provide a current residential address thus breaching professional misconduct rules (Panditharatne, interview, 20/12/04; Jayasuriya, interview, 7/12/04). Dr Jayasuriya ran an acupuncture clinic in a government biomedical hospital until his death in 2005. He was also a very strong and outspoken proponent of integrated medicine, at the practitioner level. It is interesting to note his acupuncture students have adopted some biomedical primary resources, such as white coats and stethoscopes – a practice noted by biomedical practitioners (Goonewardene, interview, 15/12/04).
have trained as teachers overseas in India, China or the former USSR (Somaratne, interview, 30/11/04).

In contrast to the desire of Ayurvedic students to learn biomedical subjects, there is not great enthusiasm amongst biomedical students to learn Ayurveda. Recently, this option has been included in biomedical curriculum, but is not compulsory. The most popular subject is *panca karma*, practical physical therapies (Somaratne, interview, 30/11/04). There seems to be little genuine interest in learning about Ayurveda, except as a “curiosity” similar to a museum relic, and to enable them to discredit it. It provides them with sufficient knowledge of Ayurveda to give them the “weapons” to later destroy it (Kasturaratchi, interview 1/12/04).

Again, this ban on teaching is a powerful symbolic statement that reinforces the boundaries between the professions. “The battleground for integration of medicines is in the training of students” (Goonewardene, 2004). Some believe the real fear of the SLMC is that Ayurvedic graduates will use their biomedical knowledge (Jayansinghe, interview, 20/12/04; D. Perera, interview, 01/04/03), thus presenting an economic threat to biomedical doctors (C. Fonseka, interview, 15/12/04; Somaratne, interview, 30/11/04). There is an underlying concern that Ayurvedic doctors will prescribe biomedical drugs (use biomedical primary resources, therefore obtaining secondary resources) (Panditharatne, interview, 20/12/04; Kasturaratchi, interview, 1/12/04).

The actions by the SLMC to prevent or deter biomedical doctors from sharing primary resources (knowledge, facilities) is therefore clearly linked to preserving existing secondary resources (economic benefits, status, prestige). Such responses by the SLMC are a formalised outcome of professional resistance to the concept of integration, and are methods to control, restrict and re-define the process of integration. Staunch opposition to integration exists amongst the biomedical fraternity (Epa, interview, 5/12/04). As integration provides secondary resources (status, prestige, economic benefits), this reluctance is not unexpected and has also been demonstrated elsewhere (as mentioned in previous chapters).

A final example of biomedical aversion to the concept of integration and sharing primary resources (facilities, techniques, knowledge) relates to hospital facilities. It can be assumed that the proposed initiative of an Ayurvedic ward in every hospital (that did not eventuate) would have met with opposition. Around the same time, an assessment of hospital facilities revealed that some were underutilised. In an effort to rationalise resources, it was suggested that a biomedical hospital could be transferred to the Government Ayurvedic sector.
However, this idea did not meet with approval of the biomedical profession (Epa, interview, 5/12/04).

These are all examples of the biomedical profession protecting primary resources with the intent of preserving secondary resources. According to C. Fonseka, they are reflective of a broader class struggle (interview, 15/12/04). While Ayurveda engages in a struggle to seek greater status and resources, biomedicine actively resists such efforts. Dr Epa proposes the struggle is more over status than economic benefits (interview, 5/12/04), but it is recognised by many that there is a reluctance to share secondary resources whether of the tangible or intangible variety (Wijesekera, interview, 31/3/2003; Goonerwardene, interview, 15/12/04; Kasturaratchi, interview, 1/12/04; C. Fonseka, interview, 15/12/04). Dr. C. Fonseka believes that the biomedical profession will continue to exert professional leverage to prevent integration unless there is strong political pressure. He anticipates that the SLMC may make some concessions because of the rapidly increasing power of the Janatha Vimukthi Peramuna (JVP) Party which has a policy of improving health care services and promoting Ayurveda.

7.4.1:2 Professional recognition

The resistance of the biomedical profession to practical integration is further exemplified by the fact that no official links or formal relationships exist between the SLMC and any organisations that represent Ayurveda or other systems of medicine. The objective of the SLMC is to prevent association of any type – administratively, professionally, or in education and training. This barrier to professional recognition of TRM extends to the Ceylon Medical Journal, which had few references to Ayurveda or other forms of indigenous medicine. In approximately 15 years of publication, only several passing references were made to Ayurveda and it would be natural to conclude from this publication that no system of medicine other than biomedicine exists in Sri Lanka.

One comment made clearly illustrates the status of Ayurveda in relation to biomedicine. A doctor wrote about his biomedical education and on being discovered reading a specialised section of a biomedical textbook by a lecturer who was a senior surgeon:

… he said that I have read the most irrelevant section in the book, and added that since I am only interested in rare things, I should read on indigenous medicine, meet all the veda mahattayas [Ayurvedic doctors] in the area, and present in class what I had found … (Bulugahapitiya, 2002:136).
This anecdote reflects the sentiment prevailing at the time, based on modernisation and development discourses – TRM and Ayurveda were outmoded relics of an uncivilised era and practitioners were objects of curiosity rather than respect. In this journal, as was the case with Government and WHO documents, overviews and commentary on the health system exclusively focused on biomedicine.\textsuperscript{115} However, one article did acknowledge the importance of Ayurveda whilst not including it in the health sector analysis:

\begin{quote}
I have left out much that is important in health care in our country. Ayurvedic and other indigenous forms of medicine enjoy an important place in our health care system but constraints of time available and my unfamiliarity with this subject prevents me from including these (De Silva, 1990:100-101).
\end{quote}

Any references to Ayurveda or TRM in the \textit{Ceylon Medical Journal} were scarce and incidental, which also describes biomedical referral patterns to TRM. None of the biomedical doctors interviewed acknowledged referring patients to Ayurvedic practitioners. Some acknowledged that referrals did occur, but very rarely and usually in response to a direct patient request (Epa, interview 5/12/04) or to a specific doctor for psychosomatic complaints (Weerasekera, interview, 7/12/04). It is extremely uncommon for a biomedical doctor to prescribe Ayurvedic drugs, except perhaps to recommend the use of some balms or oils (Jayansinghe, interview, 20/12/04).

The irony of this situation was noted by several interviewees, considering that biomedical practitioners may personally use Ayurvedic medicines (Wijesekera, interview, 31/3/2003; Jayasinghe, interview, 20/12/04; D. Perera, interview, 01/04/03; Jayawardhana, interview, 17/12/04). While professionally they may ignore or disparage Ayurvedic drugs, personally they may resort to them, or have relatives who are TRM practitioners. There appears to be no conflict in this approach of personal use/professional criticism, again reflecting Ayurveda as an inherent part of the culture even if professional training and rivalry later excludes their serious consideration for use as practitioners.

Despite this professional blindness to Ayurveda, the biomedical profession has recently begun to more critically examine their model of health, and become more receptive to other modes of healing and broader determinants of health. This reflects international trends in the 1990s to realign biomedical conceptual paradigms. For example, the Sri Lanka Medical Association (SLMA) annual conference in 2003 was on \textit{Spiritual Health – A New Dimension}.

\textsuperscript{115} Pieris noted that the local folk healers did not pose a threat to biomedicine and therefore attracted no comment at all in medical journals. However, Ayurveda, Siddha, Unani and Desiya Chikitsa did have their own theories of disease and prescriptions for healing and therefore provided competition (Pieris, 2001:75).
in Health. This radical departure from strictly biomedical parameters was in response to a growing body of evidence linking emotional and spiritual factors to health status. Epa, the then President of the SLMA, gave a paper at the conference on mind-body interaction, which he acknowledged was an “unusual topic for a scientific forum”. An article on the same theme was also published in the Ceylon Medical Journal (Epa, 2003) and the development was reported in newspapers (Karunaratne, 2003; Malawaraarchchi, 2003).

While the SLMA Conference may have broken new ground in discussing emotional and spiritual aspects of health, it did not go as far as recognising this as an inherent aspect of indigenous systems of medicine (TRM). While religious activity and rituals, and meditation were mentioned, the fact that these are often components of indigenous Sri Lankan healing systems was not. Some questions from the floor addressed this anomaly – why had mind-body interactions only recently been discovered and acknowledged by biomedicine when it has been an important part of Sri Lankan culture for decades? Why are indigenous models of health which incorporate a mind, body, spirit connection (such as Ayurveda) overlooked? Unfortunately, these questions were not fully discussed by the panel apart from mentioning that the biomedical mode of education has previously precluded such an understanding developing.

Maybe a good place to start would be right here at home with the Eastern philosophy that [linked mind, body, spirituality] several thousand years ago. Can we overcome our need to get the answer from a Western, “modern” source? How high has the killing rate got to get before we shed our colonial awe of the “white man” as the font of all wisdom and technological advance? (Karunaratne, 2003).

The reason for this lack of direct acknowledgment of Ayurveda or other forms of TRM appears to be the extreme nature of the departure from the biomedical model and the necessity to abandon long held and deep seated beliefs about the inferiority of such medical systems entrenched during colonisation (Jayasinghe, interview, 20/12/04). Openly acknowledging the advantages of Ayurveda or TRM is a drastic move from formally ignoring or suppressing it and also gives secondary resources (status, prestige) to their professional competitor. Once the mind-body link is well established in the biomedical field, the biomedical profession may be more receptive to exploring indigenous traditions that exist locally (Epa, interview, 5/12/04). However, wide professional acceptance of the mind-body link is a pre-requisite, from which greater biomedical interest in Ayurveda may develop in the coming years. Growing interest in the West in Ayurveda (enhancing its status, secondary resources) may gradually increase biomedical support and respect for it domestically (Epa, interview, 5/12/04; Goonerwardene, interview, 15/12/04).
Generally, it appears that any increased support and interest in Ayurveda due to foreign demand is from the government rather than from biomedical practitioners (Epa, interview 5/12/04; Somaratne, interview, 30/11/04). It may be that secondary resources generated by Ayurveda are not significant enough to stimulate biomedical interest in their primary resources, or that this recognition is taking some time to filter through and accommodate professionally. There is also little government support and lack of research to scientifically validate the benefits and validity of TRM (Goonerwardene, interview, 15/12/04).

TRM mainly serves the poor and rural populations and foreign demand for TRM is still minimal – meanwhile, domestic health service provision is still overwhelmingly biomedical. So while a small niche tourist market has recently developed, income and benefits from this are not yet significant enough to encourage biomedical professional interest (Kasturaratchi, interview 1/12/04). Biomedicine retains structural control, and significant status and economic benefits from the current organisational domination of the formal health sphere.

7.4.2 Ayurvedic profession

The Ayurvedic profession in Sri Lanka has an ambiguous position. While Ayurveda enjoys the honour and respect of being part of the valued heritage of the country, it is also considered an anachronism in some senses and often a “second choice” as a profession to biomedicine (Jayawardhana, interview, 17/12/04) because the privileges and status of biomedical practice (secondary resources) are greater than those available in the Ayurvedic sphere (Jayasinghe, interview, 20/12/04). The history of relations between Ayurveda and biomedicine has been one of an ongoing struggle by the Ayurvedic sector to place it firmly alongside biomedicine and obtain the same status and benefits as the biomedical profession. The complex historical relations and active competition between these sectors is detailed by Pieris (2001), who describes the sustained efforts by Ayurveda to elevate its status and the poor professional image of practitioners (2001:79-98).

7.4.2:1 Professionalisation & scientific discourse

One explanation for the low official status of the Ayurvedic profession may be the lack of organisation and discipline within it (Pieris, 2001:84). The heterogenous nature of the group prevented an easy professional formalisation. As early as 1947 and at the time of independence, the Commission of Inquiry into Indigenous Medicine recommended the organisation of the Ayurvedic sector along lines that resembled the biomedical sector and
found formal education of poor quality with the profession “despised” and ridiculed. It suggested the formation of professional associations and publication of journals to improve the status of the profession (Pieris, 2001:87).

Following independence the greatest opposition to traditional medicine came from the western educated medical men of Sri Lanka. The commonest allegation was that traditional systems of medicine were unscientific, based on assumptions ... Counter arguments of the followers of traditional medicine were ineffective due to the power and influence the western educated possessed at that time (Edirisinghe, 1987:167).

However, the formal professional status of Ayurveda changed when (as proposed by Unschuld), the process of professionalisation in order to secure resources gathered pace in the TRM sector in 2003. Professional activity prior to this had also occurred, for example with the publication of journals, institutionalisation of education and delivery of services, registration of practitioners and development of professional conduct rules. However, Ayurvedic doctors formed a professional association in 2003 to strengthen their lobbying ability with the Government and enhance their professional strength.

While the biomedical profession formed such an association over one hundred years ago, the Ayurvedic sector lagged considerably behind it and only formed a corresponding body in 2003. The Sri Lankan Ayurvedic Medical Association aims to enhance dialogue with government and biomedical bodies (D. Perera, interview, 1/4/03) and met with its biomedical counterpart (the SLMC) for the first time in 2004. It was agreed at that meeting to form a joint committee to review the causes of the poor relations between the sectors and how to improve them (D. Perera, interview, 19/12/04).

Further evidence of professionalisation beyond the formation of a representative body is the establishment of a group to promote the interests of the TRM sector. An alliance was formed in 2004 called the Action Committee for Ayurvedic and Indigenous Medical Education and Professional Development. The main impetus for this alliance was to protest against a government ordinance which meant as a profession, they were isolated, discriminated against and neglected (D. Perera, interview, 9/12/04). Membership is a broad spectrum of various professional bodies and associations, forming a coalition of about 8 organisations.¹¹⁶

¹¹⁶ Members of the Alliance include the Alumina Association of the Institute of Indigenous Medicine University of Colombo; Alumina Association of Gampaha Wickramarachchi Ayurveda Institute of University of Kelaniya; Gampaha Siddhayurveda Medical Association; Gampaha Wickramarachchi Ayurveda Medical Association; All Ceylon Ayurveda Congress; Government Ayurveda Medical Officers’ Association; Indigenous Medical Practitioners’ Association; Indigenous Medical Association.
The most contentious regulation that the Action Committee is protesting is Medical Ordinance (chapter 105, number 34) which states that:

In any written law, whether passed or made before or after the commencement of this Ordinance, the words ‘legally qualified medical practitioner’ or ‘duly qualified medical practitioner’ or ‘registered medical practitioner’ or any words importing a person recognized by law as a practitioner in medicine or surgery shall be construed as meaning a medical practitioner registered under this Ordinance.

The outcome of this ordinance is that Ayurvedic doctors are not legally recognised as medical practitioners, and that this status is reserved for biomedical doctors only. Therefore, the alliance was formed to secure secondary resources including the status of formal recognition as medical practitioners (Jayawardhana, interview, 17/12/04) allowing them to have the same responsibilities as biomedical doctors including issuing medical certificates (D. Perera, interview, 9/12/04).

The alliance is also protesting against a monopolistic health system which it argues is the result of a colonial heritage and is now a neo-colonial outcome of globalisation. In 2004, this newly formed alliance launched a massive publicity campaign involving the distribution of thousands of protest posters. These posters argued that Sri Lanka had a variety of medical systems in the health sector, and that the pluralistic system should be adequately recognised in official health care policy as well as with modification to colonial health legislation. They were placed in prominent locations throughout Colombo, including in front of the Health Ministry (which is biomedical in orientation and composition).

The entrenched structural control of biomedicine in the formal health care system has given the previously loosely associated bodies a common goal and allowed them to unite in order to secure more government funding and recognition (secondary resources). The formation of the professional association and an alliance are significant political steps and an essential requirement to securing status in negotiations over resources. The colonial legacy which enabled biomedicine to secure domination of the health care system and degraded the status of indigenous medical systems is considered a form of colonisation of the mind (Fanon, 1978), which is extremely difficult to overcome and enables asymmetric power relations to be maintained. The consciousness that biomedicine is inherently superior, and a symbol of progress and modernisation is pervasive and ingrained (but also resisted):

The White Male has trained and indoctrinated their acolytes in our countries, the doctors, to brand our own medical system as primitive and quackery ... Thus our natives lose all their sense of self-respect and their own potential creativity as our people. They lose their very soul and become mere puppets of their colonial masters ... [We] do not know that instead of being apes of the White Man, our tradition has the potentiality to teach the white male who is digging his own grave in the name of western medicine (Dharmasiri, 1997:162).
Biomedical domination is embedded in regulatory and administrative structures. The biomedical sector always assumes control or oversight of the TRM sector, as well as almost total allocation of resources. For example, some key administrative positions in Ayurvedic institutions are filled by biomedical doctors – such as the head of the Institute of Indigenous Medicine at Colombo University. There is currently a proposal made by the Ayurvedic sector for the Ayurvedic Research Institute and National Institute of Traditional Medicine (which are both primarily research and education organisations) to become independent statutory bodies (D. Perera, interview, 01/04/03). Independence from biomedical control in administrative and legal arrangements is crucial to the TRM sector in asserting professional power and status as a medical system in its own right and with equitable weight in health sector development.

The Ayurvedic sector is aware that it is not respected by the biomedical profession because it is “unscientific” (Amarasinghe, interview, 19/11/04; Malimage, interview, 25/10/04), despite having scientific research bodies undertaking development of the sector. The research bodies (Ayurvedic Research Institute, and the National Institute of Traditional Medicine) have the objective of scientifically testing and developing Ayurvedic products, but the research output has been sporadic and piecemeal. For example, there has been no organised plan or research policy regarding priority areas (Edirisinghe, 1987:168). Organised cultivation and propagation of medicinal plants and herbs to prevent wild stocks being over harvested has been on a small and limited scale (Schokman, 2004). The research bodies may have been restricted in operation by a lack of adequate resources, expertise, co-ordination with other research bodies, the professional biomedical restrictions on collaboration and education of Ayurvedic practitioners, and low political commitment. There appears to be more status, prestige and economic benefits for scientists to work in the biomedical or technology sector.

It is ironic that the scientific development of Ayurveda in terms of an evidence base has been hindered by the restrictions placed on the training of practitioners (mentioned above). This means that skills and knowledge such as scientific methods are not taught comprehensively in Ayurvedic tertiary institutions and there is a lack of qualified staff with both a scientific and Ayurvedic knowledge base. This restriction is partly due to the fear of the biomedical profession that Ayurvedic doctors actually have a “fundamental desire” to be biomedical practitioners, and that those who fail to qualify for biomedical training instead undertake Ayurvedic education (Pandutharatne, interview, 20/12/04; D. Perera interview, 3/12/04).
Therefore, the desire to learn biomedical and scientific subjects is perceived as a technique to become quasi-biomedical practitioners that is market driven (Kasturaratchi, interview 1/12/04). The adoption of biomedical techniques and jargon (primary resources) by TRM practitioners is viewed as an overt threat. Training in biomedical anatomy and basic technology in diagnosing diseases has proven popular among TRM practitioners (MIM, 2001:13). One medical anthropologist claims that this extends to Ayurvedic practitioners “overwhelmingly” prescribing biomedical drugs (Waxler-Morrison, 1988). However, most Ayurvedic doctors interviewed state they do not use biomedical pharmaceuticals or refer patients to biomedical services except in emergencies of acute conditions (Somaratne, 30/11/04, N. Fonseka, interview, 9/12/04; J. Perara, interview, 29/10/04). This is estimated to represent approximately 10-15% of cases (Amarasinghe, interview, 19/11/04).

The adoption of scientific discourse has therefore been impeded by professional restrictions placed on biomedical practitioners which prevents the teaching of and direct professional collaboration with Ayurvedic practitioners. However, as mentioned previously, rapid market growth now necessitates documentation of safety and efficacy, and has promoted the “scientific” development of the sector. Adopting scientific jargon and scientifically evaluating remedies and treatments is increasing amongst the Ayurvedic profession. For example, the professional journal *Ayurveda Sameekshawa* is dominated by clinical studies and scientific assessment of the efficacy of certain remedies for particular conditions. Another research journal, *Ayurveda Pradeepika* also clearly reflected the influence of Western scientific method in research designs and terminology (Pieris, 2001:86).

As mentioned in the methodology (chapter 2), the adoption of scientific discourse and professionalisation to secure legitimacy and power in formal health care spheres is a pattern recognised in other TRM/CAM systems including osteopathy (Baer, 1981; Berliner & Salmon, 1980a:544), homoeopathy (Cant & Sharma, 1995, 1996; Lee, 1982; Taylor, 1979a:83), chiropractic (Coburn & Biggs, 1986), acupuncture (Baer et al., 1998) and naturopathy (Gort & Coburn, 1988).

7.4.2:2 Growth in secondary resources

Ayurveda has increased in political and economic status with an increase in international interest and therefore foreign income. Increasing government support can be discerned with this rapidly growing market and source of foreign exchange (Jayasinghe, interview 20/12/04; Amarasinghe, interview, 19/11/04; Goonerwardene, interview, 15/12/04). The international
interest in and demand for Ayurveda became particularly evident from the mid 1990s, especially from Germany (Somaratne, interview, 30/11/04). This correlated with international trends for citizens to seek CAM/TRM as an alternative or adjunct to biomedicine.

However, this increased foreign interest has not translated into increased professional recognition for Ayurveda within Sri Lanka by biomedical doctors (Somaratne, interview, 30/11/04) and biomedicine still displays a lack of professional respect for TRM (Chandralatha, interview, 25/03/03). According to biomedical professional attitudes, Ayurveda is still a marginal health care system that offers little to modern health sector development and is generally formally ignored. As previously mentioned, secondary resources generated by Ayurveda may not yet be significant enough to stimulate biomedical interest in their primary resources, and biomedicine currently enjoys large secondary resources from its organisational domination of the formal health sphere (which has not been effectively threatened by Ayurveda, in terms of diverting secondary resources from biomedicine).

Regardless of this lack of secondary resources in the form of local professional status or prestige, Ayurveda did manage to secure rapidly increasing economic allocations domestically and from foreign funding bodies such as the World Bank. The budgetary allocation to indigenous medicine has significantly increased, however the proportion dedicated to Ayurveda is still quite small and the vast amount of health expenditure is absorbed by biomedicine. Despite being a minimal fraction of the total health budget the increasing allocation is still a significant milestone and represents a rapid and unprecedented accumulation of resources – government budget allocations nearly tripled between 1998 and 2001. Combined with funding from the GEF/World Bank project on the conservation and cultivation of medicinal plants, the TRM sector secured an extraordinary financial commitment to the development of the sector and enhanced visibility, and thus an increase in a range of secondary resources (economic benefits, status, prestige).

The massive growth of secondary resources for the Ayurvedic sector due to the new Western interest in natural therapies can be illustrated with reference to an individual practice (J. Perera, interview, 29/10/04). After graduation, Dr Jaanaki Perara was a resident Ayurvedic doctor at the Hotel Paragon in Unawatunu catering mainly for foreign tourists. She established her own clinic in the popular resort town of Hikkaduwa in 1999. Dr Perara now operates three clinics there, employing four doctors as well as therapists and assistants. In 2003 she began expanding her business further along the coastal tourist strip and now has a
chain of eight clinics in total. This expansion has been partly funded by German business partners, and German tourists make up a large proportion of her foreign clientele.

Although she has several clinics in the small coastal town of Hikkaduwa, her business does not have a monopoly on supply of Ayurvedic services. In an approximately 2-3km strip, she estimates there are around fifteen Ayurvedic doctors practising and there are at least half a dozen shop fronts advertising treatments. These clinics compete to capture the seasonal influx of tourists. At the main clinic in Hikkaduwa, Dr Perera says she has consultations with 15-20 local people per day and 20-30 tourists during the tourist season. She estimates overall that the number of foreigners treated is *double* that of locals. The main conditions they sought treatment for are vague chronic categories like low energy, poor immunity and also beauty therapies. Throughout the 1990s Ayurveda was obtaining increasing secondary resources from both the private sector and the government.

If the value of Ayurvedic primary resources was unrecognised or not perceived as a credible threat to the status of the biomedical profession in the formal health sector, it was not being ignored by external interests. Sri Lanka experienced the first recorded case of biopiracy in 1999 (see Samath, 1999b). The export of medicinal plants or their extracts is banned in Sri Lanka, however bio-piracy was increasing and the high profile case of a university professor being detained for bio-piracy and charged with smuggling gained much prominence (Sriyananda, 2004). A lack of adequate intellectual property law and frameworks for the protection of indigenous knowledge, as well as insufficient inventories of rare medicinal plants (Kumar, 2000b; Samath, 1999a; Schokman, 2004; Sriyananda, 2004) enabled the exploitation of TRM primary resources by foreign pharmaceutical (scientific and biomedical) interests:

> Loopholes in existing laws and other legal snags are robbing the country of millions of dollars that is rightfully ours … since the country does not have the hi-tech scientific equipment to analyze chemical components of indigenous plants or the capacity to pay the international patent fee of $60,000, wealthy countries are taking advantage (Samath quoting Sirimal Premakumara, a scientist at the Ceylon Institute of Scientific and Industrial Research) (Samath, 1999a)\(^{117}\)

The rapid growth in secondary resources, mainly spurred by foreign interest in TRM, therefore fuelled the professional development and political leverage of Ayurveda in Sri Lanka.

\(^{117}\) *Many other patents, like from the plant Weniwalgeta - used effectively as a herbal remedy for fever, coughs and colds - have been registered by Japanese, European and U.S. pharmaceutical manufacturers … although the law requires that a patent can be obtained only if it is an economically valuable invention created through a methodology, most multinationals have somehow obtained patents for products used in our country for thousands of years.* (Samath, 1999a)
Lanka. Legislative frameworks to protect intellectual property, a national policy on indigenous medicine and updated regulations were all required to accommodate the sudden market growth. The catalyst of environmental conservation and preservation of biodiversity also enhanced the role of TRM on the policy agenda, and around the turn of the century it had achieved unprecedented secondary resources. Concurrent with this growth in secondary resources was an increase in professional activity and adoption of scientific discourse.

7.5 Conclusion

The policy developments in Sri Lanka regarding the integration of TRM have mirrored broader global trends and patterns. This is evident historically and in contemporary developments – from the suppression and exclusion of indigenous medicine in the colonial era, the adoption and promotion of biomedicine as a modernising agent, to the re-emergence of TRM as an expression of cultural heritage with independence, the commercialisation of the TRM sector during 1990s, and the increasing pressure to address policy and regulatory aspects to meet market growth from mid-late 1990s.

While TRM is officially sanctioned and promoted as part of government health policy and is functionally strong, it has been formally marginalised and dominated by biomedicine which still secures structural control in Sri Lankan health care system and policy development. Formal recognition of TRM has not translated into power or status in the formal health services sphere, or an equitable distribution of resources or representation in health policy.

The country case study has demonstrated in more detail the operation of the analytical framework on a national level. The hypotheses put forward by Kingdon (1984), Unschuld (1975; 1976b), and Lee (1982) can be seen to be operating in the policy domain of indigenous medicine in Sri Lanka. The policy notion of integration floated around on the domestic political agenda for several decades and gained some advances at politically opportune moments – when the politics or problem streams were conducive to pushing it onto the agenda. This is most evident at independence and in the 1990s when a foreign market developed for TRM therapies and remedies.

However, as Unschuld proposed, medical systems usually do not co-operate voluntarily to share resources (Unschuld, 1976b:8). In this case, interest group interaction may have impeded the agreed government goal of integrating indigenous medicine into the formal health care system. While a type of parallel system has been established and operates
effectively, it is a hierarchical system which reflects asymmetric power relations. This power imbalance was established during colonisation and persists to this day, reflected in the distorted and subordinated development of the indigenous medical sector which is dominated administratively, structurally, politically and economically by the biomedical field.

Power and political manoeuvring is exerted in health policy formulation, service infrastructure and in education and training, by professional organisations in the competition to secure or maintain resources. The biomedical profession has implemented barriers to integration and co-operation at practitioner level through restrictions on practice and education. These professional restrictions impede practical integration despite political recognition of Ayurveda and state expressions of support. The “unscientific” nature of Ayurveda is one factor in the biomedical professional rejection and exclusion of it from health services development, and competition appears to be another. However, the biomedical profession also recently began to modify conceptual paradigms to incorporate spiritual and psychological dimensions of health (an implicit recognition of primary resources of TRM).

The Ayurvedic profession formed a representative professional body in 2003 and has adopted scientific discourse at an increasing rate. These strategies facilitate the acquisition of structural strength. Professionalisation and adoption of scientific discourse allows TRM primary resources to be legally identified, verified, and promoted, therefore allowing institutionalisation, funding, status and commercialisation (secondary resources). The techniques used by the biomedical profession to constrain and control the integration process, and by the TRM sector to secure more status and benefits (secondary resources) in Sri Lanka are common themes demonstrated elsewhere in biomedical and TRM/CAM relations.
8: Discussion and Conclusions

8.1 Introduction

This research analysed the contested issue of integrating TRM in formal health care systems, and explored the history of policy development in this field in an international health organisation (WHO). This was prompted by the intriguing development of the policy on TRM which appeared to lack consistent progress within the WHO as an organisation, and weak implementation on national levels. The release of the TRM Strategy by the WHO in 2002 presented a unique opportunity to examine a complete life cycle of the TRM policy from the first inception of the concept in the 1970s (WHO, 1978b) to its culmination as an articulated global strategy in 2002 (WHO, 2002c).

While the benefits of formalising the TRM in health care systems had been established by 1978 (WHO, 1978b), by 2003 “systematic efforts have not yet been made to achieve integration of TRM/CAM with conventional health care delivery for the wider benefit of communities” (WHO, 2003c:97). This was despite almost universal recognition “that unless traditional health practitioners are properly recognized, utilized and articulated within the national health system, countries will never be able to achieve adequate health coverage for all their people” (Roh, 2004:170).

The anomalous situation of widespread recognition and support for the policy concept of integration, yet lack of tangible implementation, appeared to be irrational – as what was proposed seemed to offer a feasible solution to addressing health care needs in the South, as well as accommodating increasing consumer demand in the North. Formalising the role of TRM/CAM in health care seemed to rationalise health care resources in a manner which would benefit key stakeholders such as citizens and the state. Therefore, lagging national policy formulation and implementation of the concept of integration hinted at peculiar difficulties such a policy may face.

8.2 Conclusions about the main research questions

The central questions of why the issue of integration first arose on the international policy agenda in the 1970s, why it seemed to languish and be resistant to implementation in the 1980s, why it was regenerated in the 1990s and then reappeared in 2002 as a global policy constituted the main field of inquiry. This investigation explores the lifecycle of the policy of integration and traces its changing fortunes on the international health agenda.
In addressing this question, it became apparent that standard methods of policy analysis were not suited to providing an adequate explanation for the peculiarities of the policy history. The intricacies of health policy and of TRM specifically meant that what appeared to be a straightforward question was soon overwhelmed with complexities from a range of diverse fields such as anthropology, political science, sociology, health sciences and economics. Each field represents a huge body of literature and encompasses complicated issues. Therefore it quickly became apparent that not only did standard methods of policy analysis present difficulties, but also that evaluation would require some broad generalisations or abstractions to enable a simplification of data gathering and assessment.

As mentioned in the methodology chapter, these broad generalisations were used to facilitate a more coherent and structured analysis, despite being based on “artificial” dichotomies that some may reject as simplistic. The first is in the use of North and South. The other is in the use of TRM/CAM and biomedicine. These generalisations were theoretical abstractions which enabled both a macro (international) and micro (national) level analysis, over a long term period of approximately thirty years during rapid globalisation (1970s-2002). Over this time frame, a range of social and economic forces began operating and interacting in complex ways which affected the policy domain. A policy analysis tool developed by Kingdon (1984) was used to hypothesise that these forces were affecting the initial appearance and disappearance, and then re-appearance of TRM/CAM on the international agenda.

### 8.2.1 Kingdon’s multiple streams model

Kingdon’s (1984) “multiple-stream” theory provided one way of interpreting the life cycle of the policy on integration. The multiple streams are problems, politics and policies. According to this policy analysis tool, the appearance of TRM/CAM on the health policy agenda must be due to the “coupling” of these streams when “windows” of opportunity open. Therefore, in the 1970s when it first appeared and in 2002 when it re-emerged, there would be evidence of the problem, politics and policy streams merging. This was borne out in the analysis of literature over this period. It required a systematic assessment of the broader political, social and economic environment over three distinct eras (1970s, 1980s and 1990s). Many different factors came into play, and it can be concluded that the history of this policy within the WHO was not fortuitous but the result of the linking of these streams in a variety of ways.
In the 1970s the political climate was very conducive to the concept of integration. There had been an awakening of nationalistic sentiment following a surge of independence in previously colonised states. Expressions of culture which had been repressed or neglected under colonial expansion were embraced and celebrated, including indigenous systems of medicine. These newly independent nations gained membership to international bodies such as the WHO, and began to form blocs to promote their own economic and social interests. The 1970s therefore represented a decade where the South achieved an unprecedented level of representation at the international level.

At the same time, modernisation theories and the path of “development” were being questioned. Modern technology, such as that represented by biomedicine, was failing to meet the needs of populations in the South. Academics began pointing out the limits of biomedicine, and critically exploring the links between biomedicine and colonisation. Human rights, equal opportunity and social justice became prominent themes. The problem of equitably delivering basic social services in resource poor countries became paramount, as the era was also characterised by concern with longer term resource management.

In relation to the WHO, these broader trends were reflected in the problem of providing basic universal health care in the form of “Health for All” (HFA) and the policies of providing primary health care (PHC) and essential drugs were endorsed on a global level. Attached to these policies was the concept of utilising the manpower and resources of TRM, as a form of delivering more comprehensive health care at a community level. The use of TRM was promoted by new members of the WHO with China providing what was seen to be an inspiring model. It was an optimistic and idealistic era, and many believed that using TRM was a practical and feasible solution to the problems of cost and access to biomedical services. Therefore, the policy of using TRM met an identified problem and the politics stream was amenable to the idea. The streams coupled and the issue gained prominence and support on the international health agenda.

In the 1980s, these streams drifted apart and the window of opportunity closed. A paramount issue was the global recession, which forced a scaling back of expenditure and caused attention to be diverted from social policy issues to one of economic imperatives. The role of the government in providing social welfare programmes such as health and education was questioned. Neoliberal economic rationalism gained hold of the policy agenda and with it such concepts as cost recovery, “user pays” and privatisation. In addition, other concerns such as environmental issues took priority later in the decade. In this new political context, the problems became one of financing public services, resource management, increasing the
effectiveness and efficiency of existing programmes, and addressing the impacts of recession such as unemployment.

TRM managed to stay afloat during the 1980s by attaching itself to newly emerging problems such as HIV/AIDS and environmental conservation. This approach was explicitly encouraged by the WHO TRM programme director, who exhorted that “pragmatism should be encouraged and opportunities for linkages with other interests must be seized” (Akerele, 1988:358). However, despite attempts to attach it to high profile problems and contemporary issues, TRM suffered on the policy agenda as the primary programmes it was related to (PHC, HFA) floundered in implementation.

The political and economic climate favoured more easily evaluated and implemented vertical interventions. Difficulties were presented by a climate of financial stringency and confusion as to how to effectively integrate TRM into health care systems. There was a lack of clarity as to how to implement such a goal, and ambiguities surrounding differences in the paradigms of TRM and biomedicine. It presented many problems in practical application, and the politics stream was clouded with debate and uncertainty as to how to proceed on national levels. Lacking financial and political commitment, TRM took a subordinate role on the agenda and little progress was made.

In the 1990s, the problem stream changed rapidly in unforeseen ways and TRM again arose on the agenda. New problems were recognised and gained in importance – such as protection of the environment and biodiversity, sustainable development (including the role of indigenous knowledge), and the rapid and unregulated increase in the use of CAM in countries in the North. All these problems bore a strong relationship to TRM, and this merger of high profile agenda issues focussed attention back onto TRM and formalising its role in health care systems. Whereas in the 1970s access to health care and provision of low cost health services had been the paramount problem, in the 1990s, the problems became more closely tied to environmental protection, income generation for indigenous communities (sustainable development) as well as the provision of affordable health care services. The concept of using TRM was again suddenly pulled out of the policy stream in 2002 as it represented a solution to a variety of politically recognised pressing dilemmas.

Over the twenty-five year history of the policy of formalising TRM in health care systems, it can be seen to flow on and off the agenda according to surrounding political, economic and social climates. The policy content and objectives were also shaped and influenced by the politics and problems streams. This history illustrates the premise of Kingdon’s theory
(1984) that the policy process is like a “primeval soup” and the conception, survival and parameters of a policy are dependant upon the climate it evolves within. If a policy achieves great prominence on the agenda, then either one or both of the surrounding problem and politics streams must have coupled to enable it to gain weight at the political level. These problems may even vary over time, but the policy solution can remain the same. The fate of a policy may be dependant upon its ability (guided by its entrepreneurs or advocates) to quickly attach itself to emerging problems, to present itself as a feasible solution that appeals to current political, economic or social situations.

While the evolution and final outcome of this policy initially appeared ambiguous and intriguing, using Kingdon’s (1984) multiple streams approach allows the history of this policy to be perceived as rational. It presented a practical solution to current problems of the day, and the political climate was right for change at those points in time. So while in 1978 the rising use of CAM in the North had never been envisaged, and trying to replicate a barefoot doctor scheme in the South seemed to be a worthwhile and achievable goal, by 2002 TRM had become a massive business with huge economic weight and regulating trade and protecting the environment rose to the fore as the key issues.

The first technical report produced by the WHO on TRM in 1978 and the global TRM Strategy in 2002 seem worlds apart in scope, but match in their language and intent with the broader political and economic environments. The policy had evolved and survived, re-emerging from the “primeval soup” – adapting to the surrounding political, economic and social milieu and rising to the top of the policy agenda again nearly three decades after its initial conception.

8.2.2 Interest group interaction

The WHO proposed in the global TRM Strategy (2002) that monopolistic health care systems had ceased to exist and that “ultimately countries operating as inclusive (parallel) system can be expected to attain an integrative system” (WHO, 2002e:9). However, this assessment may fail to adequately take into account the politics stream, specifically interest group activity. Professional interest groups and the manner in which they interact have an impact on how the policy on integration is shaped, developed and implemented.

While incorporating interest group interaction adds complexity to analysing the issue, it also offers an explanation for the fate of the policy on TRM and provides further depth to understanding why it arose on the agenda in 1978, disappeared in the 1980s and then gained
prominence again in 2002. It enables greater detail to be added to the framework provided by Kingdon (1984) as it offers motives for the behaviour of significant interest groups. How this operated is summarised in a generalised form below, and worked in combination with the factors described above operating in the problem and politics streams. The motives of interest groups were only one factor in the politics stream, but a crucial one.

Using a synthesis of theories developed by Unschuld (1975; 1976b) and Lee (1982), biomedical and TRM/CAM interest groups can be perceived to be in competition with each other to secure resources. Unschuld (1975; 1976b) argued that these groups embark on a process of professionalisation in order to secure a monopoly on their primary resources and therefore gain exclusive right to the secondary resources that accumulate from their use. Lee (1982) proposed that the use of scientific discourse was also an important variable in this process, as discussed in the methodology. Therefore, these groups can be seen to compete to gain or maintain structural strength (secondary resources) in health care systems through techniques associated with professionalisation and scientific discourse.

Lee hypothesised that certain social forces had emerged that encouraged the development of TRM/CAM such as the publicity given to Chinese medicine, the rise of nationalism, the advocacy of PHC and the promotion of TRM by the WHO (Lee, 1982:639). According to Lee, “in view of the world-wide movement of modernization through science, the above various forces might turn out to accelerate the absorption of [TRM/CAM] into biomedicine” (1982:639). This hypothesis was also tested, by applying the theories provided by Unschuld and Lee within the framework offered by Kingdon. If these theories were correct, increasing professionalisation and the application and use of scientific discourse would be observed over the timeframe, and competition for both primary and secondary resources would have a role in the formulation and implementation of TRM policy.

These professional groups operate within a broader policy environment. Economic, social and political contexts influence their ability to promote or protect their interests and access to resources. The relationship of exchanging and transferring primary resources between medical systems has occurred throughout history (as described by Unschuld 1976:3-5), however colonisation, modernisation and globalisation have created a range of forces that have influenced this process, redefined the rules of engagement and presented particular obstacles and opportunities.

In the 1970s biomedical primary resources were seen to be both ineffective and expensive to treat common health conditions in the South. The primary resources of TRM were seen to
offer a feasible alternative. While this idea gained support, it threatened biomedical interests as it endorsed the use of primary resources of competing medical systems and therefore sanctioned secondary resources to TRM. In addition, the use of TRM as proposed in the 1970s implicitly promoted the use of manpower to deliver biomedical primary resources or extend basic biomedical services.

As a result, tensions arose between interest groups in the 1980s and a stalemate ensued. The biomedical profession was reluctant to cede either primary or secondary resources to their rivals. They acted instead as gatekeepers to the integration process, demanding scientific validation of TRM and rejecting the use of manpower as auxiliary personnel in biomedical health care delivery systems. The biomedical primary resource base was reasserted as offering the safest and most effective way to provide health care.

TRM practitioners were likewise unwilling to work in the limited or subordinated capacity of health care auxiliaries without an increase in secondary resources. While enthusiastic to access biomedical primary resources, they were not as willing to provide unlimited biomedical access to their own primary resource base. In the absence of any clear gain of secondary resources from the integration process, they obtained more from continuing to operate in the unregulated and informal private sphere.

In the 1990s, their functional strength rapidly increased as consumers in the North embraced TRM/CAM. Secondary resources accorded to TRM/CAM experienced a massive growth spurt, and the practitioners were anxious to protect them. To do so, they needed to secure control over their primary resource base by professionalising and also conforming to demands to scientifically validate it. This was due to the need to identify, document, verify, and institutionalise primary resources in order to secure state recognition, funding, status and access to markets (secondary resources). Industrial production and distribution depends upon factors including regulation, standardisation and quality control. In the 1990s scientific discourse was therefore adopted with more frequency, and widespread professionalisation in the form of associations, conferences, journals and standards for training and education gathered pace.

The unanticipated establishment of a global market for TRM/CAM in the 1990s is a vital development, as it generated and intensified competition for control over primary resources and access to secondary resources. The growth of markets provided economic incentives (secondary resources) to practitioners for integration. Shifting primary resources (knowledge, techniques, drugs) from one group to another is possible once it is “recognised
that these resources will be of use in gaining access to more secondary resources” (Unschuld, 1976b:8). Some TRM/CAM practitioners accepted that in order to secure increased secondary resources (status, prestige, and economic benefits), scientific (biomedical) vocabulary and methods might have to be adopted. In seeking increased structural strength and dialogue with the state (and the WHO), they needed to conform to dominant paradigms.

While some medical anthropologists may view the adoption of biomedical discourse as “an unplanned and unconscious process of cultural imitation” (Anderson, 1999:165), critical medical anthropologists would look more closely at the political and economic imperatives and antecedents of this trend. Accommodation on the part of TRM/CAM to reductionist biomedical concepts is compatible with capitalist ideology (Baer, 1989) and the commercialisation of TRM is facilitated by institutionalisation (Lock, 1990).

Accepting a scientific agenda (for example, safety and efficacy) and undergoing professionalisation processes allows access to markets and state support (enhanced secondary resources) for TRM/CAM but facilitates its absorption into the biomedical coalition. Mass production, standardisation and regulation (commodification) within commercial and rational-legal frameworks that are attuned to biomedical, corporate philosophies also undermine core TRM/CAM principles. Therefore, in seeking to maintain or increase secondary resources and structural strength, their primary resources may ultimately be compromised and/or appropriated by the biomedical profession.

As the secondary resources of TRM/CAM grew in the 1990s, biomedical practitioners began to see advantages in selective incorporation of TRM/CAM primary resources as this could provide them with secondary resources (economic benefits, prestige). They therefore modified the biomedical paradigm, imposed “evidence based medicine” requirements, developed “mind-body” medicine, and began practising “integrative medicine”. These techniques can be interpreted as efforts to consolidate and maintain their structural monopoly in health care systems as this facilitates absorption and subordination of TRM/CAM.

Biomedical stakeholders dominated the integration policy process through the application of western scientific discourse. This extends their structural dominance in health systems through limiting the primary resources (and therefore flow-on secondary resources) available to TRM/CAM whilst inflating their own. The biomedical coalition attempted to restrict secondary resources of TRM/CAM by first emphasising safety/danger of their primary resources and by later strengthening calls for effectiveness and efficiency to be
demonstrated. This can be seen as moves to block and control the integration process and legitimation of TRM/CAM primary resources.

The lifecycle of the WHO policy of integration from the 1970s to the present can be seen as part of the “dance between biomedicine and [CAM/TRM] … evidence of the still incomplete hegemony of biomedicine in its efforts to eliminate or control the competition” that Waldram describes as occurring in North America (2000:618). Saks refers to this manoeuvring as a “fluid battleground” where biomedicine preserves and enhances their position in health care using ideology, disciplinary and/or other levers (Saks, 1998:202-203). The dance or fluid battle revolves around constructing, preserving and extending the boundaries of primary resources, and attempting to maximise the secondary resources that accumulate from it. The policy agenda on integration on both an international and a national level can therefore be viewed as being manipulated by interest groups (stakeholders), who are motivated to secure resources – the rights to use various primary resources, as well as gain power, money, status and authority (secondary resources).

The long gestation and delayed implementation of the WHO policy on integration may therefore be partly explained by competition between different medical systems (interest groups), which required economic incentives (secondary resources) to overcome. Development of a global market, combined with demographic and health transitions, changed the nature of the problem stream, allowing the policy of formalising the role of TRM to gain more influence and be revived on the international agenda in 2002.

This synthesised conceptual model based on Kingdon (1984), Unschuld (1975; 1976b) and Lee (1982) allows us to see that the process of integration in formal health care systems is not neutral or technical, but political in nature. It involves allocating benefits to certain groups, and mediating the knowledge and authority of different medical systems in state funded health services. The timing of this issue on the agenda was not co-incidental; it was the outcome of particular social, economic and political forces operating in tandem with interest group activity. These forces intensified with globalisation and resulted in TRM coming to the fore on the agenda of international organisations like the World Bank and the WHO. The WHO and other UN bodies play a significant role in this process by setting policy guidelines and priorities in relation to TRM/CAM. Through international bodies, various interests and values are mediated and ultimately legitimised.
8.2.3 The politics of medical pluralism

If the state attempts to formalise the role of TRM/CAM (or TRM/CAM seek a formal role), then norms and principles for training, registration and practice require standardisation and conformity to rational-legal state frameworks. Integration requires some level of professionalisation, which permits state involvement in defining or restricting access to the TRM/CAM primary resource base. For example, certain criteria may be required for qualification as a practitioner, which may exclude traditional training methods. Accreditation, validation and standardisation (rationalisation) of education and training redefines the scope of practice and the knowledge base (primary resources).

Setting standards for education in TRM/CAM can be interpreted as an expression of “biomedical dominance” or a reflection of “turf wars”, and play an important role in market control and exclusionary strategies (Shahjahan, 2004:409). Just as formalising education and training can present inherent difficulties, the process of professionalisation is also not universally considered a positive development in the context of TRM/CAM (DeJong, 1991; Feierman, 1986; Kagwanja, 1997; Kleinman, 1984; MacCormack, 1986; Saks, 2003b:152). Like their CAM cousins in the North (Cant & Sharma, 1995:744), TRM may only reluctantly professionalise and jettison aspects and modes of their practice (such as those that cannot be scientifically verified) in a bargaining strategy with the state and biomedicine.

Some of the TRM/CAM groups appear to use strategies in seeking structural strength that facilitate co-option by and subordination to biomedicine. Why do they lust for this “fatal embrace”? (van der Geest, 1985). Adopting these strategies may be “rational” as there is only one process available to gain structural strength and secure further secondary resources, such as access to markets and state funding: entering into dialogue with the state which necessitates unity/cohesion (identifying themselves as a profession or a group, documenting and codifying their primary resource base) and speaking a common language (scientific discourse). In practise, this is almost impossible, and such codification can serve as a means to exert or maintain control and authority. Once scientific discourse is adopted and training, education and practice is standardised and regulated (rationalised) TRM/CAM primary resources can be automatically co-opted by the biomedical profession. The new “profession”

\footnote{For example, Kleinman considers that “professionalisation tends to distance practitioners from patients, and prioritizes “concern for disease ahead of interest in illness” (1984:147). Others note that it extends authority and control, and redefines the boundaries of the healing system.}
can then be subsumed or marginalised within the lower echelons of the biomedical sphere and/or adopted as an adjunct to biomedical practice.

Therefore, the strategies used by TRM/CAM to obtain secondary resources – professionalisation and adoption of scientific discourse, may paradoxically serve to threaten and weaken control over their primary resources. These tactics can eventually act against the interests of TRM/CAM, as they do not result in an equitable sharing of secondary resources and result in limited structural strength (and may even weaken functional strength by alienating citizens), ultimately serving mainly biomedical, corporate and/or other interests (see Cant & Sharma, 1995; 1996 for a description of this process with osteopathy). However, competitors to biomedicine appear to continually enlist these strategies while seeking structural strength, sacrificing aspects of their primary resource base in the process and becoming subordinate or captive to biomedical/corporate/state interests.

Resisting professionalisation and scientific discourse could be seen as a counter-hegemonic strategy, but one less often pursued probably due to the sacrifice of potentially substantial secondary resources. For example, aromatherapists and reflexologists have not made efforts to professionalise (Saks, 2003a:144) and Reiki shows no interest in scientifically demonstrating efficacy and safety (Kelner et al., 2002). In doing so, these therapies will continue to be marginalised in the formal health care sector (will never gain structural strength) but will maintain the integrity of primary resources. Not all practitioner groups are likely to accept organising themselves, and formalising practices and education, which will pose a challenge to the policy of integrated health care services (Thorne et al., 2002:912).

Contrary to claims that the rising development and growth of CAM professions demonstrate that biomedicine was never “hegemonic” (hegemonic) (Coburn & Biggs, 1986), the outcomes of CAM/TRM demarcating primary resource boundaries in the pursuit of secondary resources demonstrate that biomedical hegemony and their strategic alliances can actually be augmented. This augmentation is a consequence of the automatic subordination of the new professions, and the appropriation and commodification of their primary resources. This ultimately serves to enlarge the biomedical primary resource base and channels secondary resources to the biomedical coalition, therefore enhancing and maintaining their structural strength.

This leaves the question asked by Janzen (1978): How can CAM/TRM groups form associations sufficiently powerful enough to engage in dialogue with state bodies, without being co-opted or losing distinctive boundaries in that process? (in Donahue, 1990:87). An
intrinsic problem is that the modern state only speaks rational-legal scientific language (in which biomedicine is fluent and uses to its advantage), does not recognise non-professionals, and has already formed historical alliances with biomedicine. Biomedicine has a legal structural monopoly on formal health care provision, and market domination (Freund, McGuire, & Podhurst, 2003:214; Kelner et al., 2004:917; Lee, 1982; Saks, 1998, 2003a; Waldram, 2000), which gives it much power and control in the health sphere and a status that is intimately linked to the modern state (Kleinman, 1995:39).

Regulatory recognition is therefore simultaneously a threat and opportunity, which is difficult to navigate in asymmetric power relationships. Values and ideologies cannot be divorced from the process of official incorporation of TRM/CAM into formal health care systems. The scope of integration policies, the manner in which issues are defined and programmes proposed to achieve this will enshrine particular beliefs. The values embedded in the policy process (reflected in content, consultation and resource allocation), usually represent the interests of dominant groups and the power relations between stakeholders: “even policy based on the best motives might yield unexpected and undesirable results: namely bringing [TRM/CAM] more under control of the biomedical profession” (Kleinman, 1984:159).

For example, as discussed throughout the body of the thesis, emphasising scientific validity, toxicity or safety and efficacy of TRM remedies may be seen as an effort by the structurally dominant biomedical profession to limit and control the resource base of TRM practitioners. Over-emphasising the safety of patients in regulating TRM/CAM disregards widespread errors in biomedical practice and impacts of pharmaceuticals that can result in serious health problems (Bodeker, 1994b:14; Ernst, 2003; Heggenhougan, 1981:97; Hitchen, 2006; Illich, 1975; Leape, 1994; Mayor, 2003; Steketee, 2003). Refusing to extend legitimacy to remedies that cannot conform to biomedical therapeutic models and demonstrate causality or efficacy restricts the scope of TRM/CAM practices.

As Elling notes, power relations determine what is defined as efficacious and acceptable (1981b:93). Scientific discourse is not neutral – it embodies social, political and economic values, and ideologies that reflect and reproduce power relations (Cunningham & Andrews, 1997; Navarro, 1980, 1984). Underneath claims of scientific authority and legitimacy/efficacy are political and economic interests which guide the interaction of

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119 Last (1986:4) regards assessing drugs for their safety and efficacy as an enormous task. In Britain, 11 000 out of the 43 000 drugs on the market have not been reviewed. The narrow, technical approach of biomedicine and its concept of efficacy is a standard that Janes observes biomedicine itself may not be able to meet (1999:1808).
medical systems (Janes, 2002:273). The orthodox biomedical paradigm is socially constructed (Dean, 2004), therefore it is “contextual” not “objective” (Jones, 2004), and scientific research is subject to bias and conflicts of interest (Quah, 2003).

Kelner et al. (2004) noted that the biomedical coalition constrained the professional development and jurisdiction of CAM in Canada by demanding scientific evidence of safety and efficacy; redefining what integration was; and opposing government funding being allocated for research. This protects the dominant position of biomedicine and maintains existing “jurisdictional boundaries” (Kelner et al., 2004). The tactics enlisted by the biomedical profession can be interpreted in Unschuld’s framework as having one goal: to preserve their primary and secondary resource base, in direct response to increasing CAM professionalisation.

The “jurisdictional boundaries” which Kelner et al. conclude are what is at stake in the relations between biomedicine and CAM can be considered demarcations between primary resource bases, and rights to secondary resources. Therefore, it is not surprising that the biomedical practitioners in the study by Kelner et al. (2004) refused to endorse or encourage the professionalisation of CAM and instead presented obstacles and stalling tactics. Similar tactics were evident elsewhere, in both the North and the South. Issues like efficacy and professionalism presented difficulties to structurally weaker medical systems gaining legitimacy (Kennedy & Olsson, 1996:42), and therefore an increased share of secondary resources. Likewise, Coburn and Biggs (1986) found that the main conflict between chiropractors and biomedical practitioners centred on such issues as the validity of chiropractic theory and philosophy, the efficacy of techniques, and their scope of practice (Coburn & Biggs, 1986:1042). TRM and CAM overtly threaten the “jurisdictional boundary” of biomedicine – the supremacy of their primary resource base and state sanctioned access to secondary resources.

Janes (1999) and Eeuwijk (2000) consider that biomedical dominance in defining acceptable health care is one aspect of the larger process of globalisation. They fear that this dominance will obliterate local healing modalities and decrease medical pluralism. TRM is reduced to “repositories of herbal concoctions where assumptions of efficacy rest in scientific understanding of biochemistry” (Janes, 1999:1804). Co-option via a process of scientific modernisation may even “strip” TRM/CAM of therapeutic value (Wahlberg, 2006:128). Scientific discourse tends to have a corrosive effect on competing traditions (Riley, 1977:551); it disaggregates, de-contextualises, and imposes a reductionist frame. Plans to “rationalise” medical systems in many countries share the same goal of:
… making local medical systems standardized components of a larger structure that is ultimately linked to a world wide system of [biomedicine]. This goal is a powerful force in modern history because it expresses the dream of a future good society in which modern science will be used benevolently and rationally to relieve human suffering and distress (Leslie, 1980:191).

8.3 Conclusions about supplementary questions

This case study on integration of TRM also aimed to illuminate some of the broader questions raised by researchers in relation to health policy and globalisation. These questions revolve around the processes of global health policy formulation and transfer, and cannot be fully answered on the basis of a single case study. However, they can be clarified in relation to a specific health policy issue (namely, the integration of TRM in formal health care networks) as this thesis has demonstrated.

8.3.1 How appropriate are universal policy models?

The global transfer of biomedical systems could be arguably one of the earliest examples of the use of universal policy models. In the 1970s, the application of the universal policy model of health care based solely on biomedicine was found to be unrealistic. In the South, formal health care systems built on biomedical primary resources were found to be inefficient and ineffective. The biomedical policy model was exported and entrenched with colonialism and imperialism, but foundered and by the mid-late twentieth century was replaced with a more pragmatic approach advocating traditional medicine:

By the late 1970s, national and international health managers were beginning to question the capacity and ability of Western medicine alone to deal with the health problems of the world. During the same period, Chinese and Indian traditional medicine systems were gaining popularity and prominence in the international arena. Hence, in 1978, the International Conference on Primary Health Care, held at Alma Ata … urged Member States to (recognise) traditional medicine (Mensah, 2000:300).

Therefore, it became clear throughout the twentieth century that a monopolistic biomedical policy model was not appropriate or feasible in all contexts – initially in resource constrained countries in the South, and later in countries in the North where new public health issues emerged and consumers embraced other health care modalities. The “superior” biomedical model which had been transplanted worldwide, partly with WHO’s advocacy and assistance (Lee, 1997) on the basis of “universality” and with the assumption it would inevitably replace all other systems of medicine and healthcare, was therefore revealed to be flawed and medical pluralism was instead recognised and endorsed.
The concept of integrating TRM into formal healthcare systems was based on a model offered by China, which had achieved great success in improving health indices and was considered a prototype by the WHO for other countries needing to construct basic, low cost health services. This model was especially appealing to countries experiencing the same problems faced by China, like many nations in Africa: “All the problems mentioned in connection with health care delivery systems and methods in China in the 1950s are with us in Nigeria today.” These included a shortage of manpower, mal-distribution of resources, and patterns of utilization (availability, accessibility, acceptability) (Ademuwagun, 1979 [1975]:159). That is, TRM was widely accessible and socially acceptable, and still extensively utilised in the informal health care sphere.

While the WHO later recognised that each country needs to take a unique approach to integration of TRM and that contexts would vary, it both explicitly and implicitly endorsed the model adopted by China. In the initial technical report on *The Promotion and Development of Traditional Medicine* (WHO, 1978b), the committee considered that China demonstrated “effective” integration, which was defined as a synthesis of traditional medicine and biomedicine “through the application of modern scientific knowledge and techniques” (WHO, 1978b:16). Whilst details of TRM in other countries had been included in deliberations, only China was specifically mentioned as having already achieved integration – while other countries such as Sri Lanka and India were still “advancing satisfactorily” (WHO, 1978b:12).

The term “integration” in the technical report (WHO, 1978b) was used in some places as a synonym for “synthesis”. As mentioned in the introduction (chapter 1), the formal integration of TRM in health care systems may take the form of an inclusive (or parallel) model where two or more systems of health and medical care co-exist. This is separate formal recognition and the systems maintain distinct institutions for practitioner education and service delivery, such as in India and Sri Lanka. The other method for integration is integrative (integrated) systems where biomedicine and TRM are merged in medical education and service delivery, and jointly practiced (China). The inclusive or parallel systems are considered to preserve the identity of TRM, while integrative approaches corrode it (van der Geest, 1985:12).

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120 “Traditional medicine should not be integrated into health care systems just because it is fashionable to do so or because other countries have adopted it. It has to be integrated into a country’s health system in the light of each country’s unique circumstances.” *Inaugural address by Nakajima (Director of the Western Pacific Regional Office) at the Second Meeting of the Directors of Collaborating Centres* (WHO, 1988:6).
The initial WHO consideration of formally incorporating TRM into healthcare systems in the most effective manner (WHO, 1978b) may have been clouded by the terminology, as integration appeared to have been equated with synthesis rather than simply formal recognition (which may take different forms). The notion that an integrative model was the superior form of integration may have also been heavily influenced by the information from China which dominated proceedings, and automatically linked to the impressive health gains they had achieved. China was the “shining example” of the “potential which lies in integration” (WHO, 1978b:17), “If China could succeed within one generation, then the whole world could likewise achieve some success in providing the entire population with adequate health care services” (WHO, 1978b:29).

The parallel system of integration as adopted by India and Sri Lanka was presented in the report as a less effective method. The main problem identified with parallel models was that “the practitioners … ‘borrow’ freely from one another when the health situation indicated that such a practice would be advantageous” (WHO, 1978b:16-17) and that the “need for integration then arose” (WHO, 1978b:17). Implicitly, parallel systems were deemed precursors to effective integration or “synthesis”, which is a position WHO appeared to maintain in the TRM Strategy: “ultimately countries operating an inclusive [parallel] system can be expected to attain an integrative system” (WHO, 2002e:9).

The notion that “integrative” systems are the natural evolution or the ultimate policy goal when integrating TRM/CAM is contentious. This form of integration is only one method used to formalise the operation of pluralistic medical systems, and has rarely been achieved. The WHO recognises that only China, the Democratic People’s Republic of Korea, the Republic of Korea and Vietnam have integrative systems (WHO, 2002e:9). Whether it is realistic or feasible to achieve equitable “integrative” systems globally, is also controversial (Islam, 1994:83; Young, 1994). For example, biomedicine dominates all organisational relationships between medical systems in formal health care, and many aspects of TRM are excluded (Leslie, 1983:316). For these reasons, monopolistic and integrative systems are very similar in practise (Young, 1994:66) despite the latter appearing to encompass medical pluralism.

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121 The terminology used by WHO is ambiguous, as “integrative” systems are only defined as systems where TRM/CAM are officially recognised and incorporated into all areas of health care provision (WHO, 2002e:8), yet this term is usually more specifically used in the literature to refer to merging in education and delivery. However, by using these countries as an example it can be inferred that the WHO is advocating their processes used to achieve integration. In most cases, it was not clear which concept of integration was being proposed but integrative and not parallel systems was generally implied (van der Geest, 1985:12).
Regardless of differences in the definition or application of the term “integrative” (that is, whether it means merging or synthesising disparate systems of medicine in delivery and practice, or whether it means recognising and incorporating different systems of medicine into all areas of healthcare provision), this goal is beset with a host of conceptual and practical difficulties. Addressing many of these questions is onerous and they cannot be easily resolved, and universally encouraging (or anticipating) all countries to adopt this policy concept is problematic. The actual rate and degree of integration will vary according to location, as well as political and economic forces and other factors including the values and attitudes of individuals holding key decision-making positions in government and healthcare institutions (Barrett et al., 2003:944; Saks, 2003b:162). Forecasting “how swiftly, to what extent, and in what forms integration will proceed” is very difficult (Barrett et al., 2003:944).

The path to development of formal services in TRM will vary from country to country according to many factors. These include the existing status of TRM and its relationship with the mainstream medicine sector; the level of political will within government to mobilize resources and accelerate change, often in the face of opposition from established health care professional groups; and a research and training infrastructure … If planned and developed appropriately for the national and cultural context, [TRM] can be an effective and cost-saving means of providing culturally meaningful health care … (Bodeker, 2001c:64).

The pursuit and adoption of simplistic models in the integration process was warned against very early in the policy development process (Good et al., 1979:152), and some forms of TRM may function more effectively outside of formal treatment settings (Kleinman, 1978). The process of “bureaucratization … may not only contribute little to biomedical care but undermine” specific forms of alternative healing (Kleinman, 1978:85). Fully integrative systems may not be viable in practice, and present a host of insurmountable difficulties in implementation. Feasible mechanisms for deciding which practices should be formalised and regulated and which are best left to private or informal spheres have yet to be created (Thorne et al., 2002:913).

The model eventually proposed by the WHO for integration of TRM was considered by some to be a replication of the Chinese system (Bibeau, 1985:943), and the initial technical report on TRM (WHO, 1978b) did appear to promote it as the pre-eminent example to follow. The supremacy of the Chinese model and the methods they had taken to achieve it – specifically and most prominently “modernisation” through science and technology, became embedded in WHO policy prescriptions on TRM. This was referred to numerous times throughout the technical report (WHO, 1978b:41,30), and the importance of applying
modern science and technology in research on traditional medicine was emphasised repeatedly from the 1970s onwards.

According to Bibeau (1985:940), the two main principles of the Chinese strategy were the development of TRM under the supervision of biomedicine, and a recognition of some technical aspects of TRM with a denial of the theoretical and conceptual foundations underlying it. These two principles formed an ideological prism and were also prominent guiding values evident in WHO policy and programme development. The WHO focussed mainly on biomedical scientific enquiry into TRM drugs and techniques. The safety, efficacy and quality of specific remedies and treatments were to be clinically verified by scientific methodology which was intrinsically held to be objective, superior and universally applicable.

However, many aspects of TRM are considered beyond the realm of science and are “theoretically inexplicable within the domain of scientific discourse” (Berliner & Salmon, 1980a:543; Wahlberg, 2006:128). The approach of legitimising TRM via scientific validation may be extremely challenging as well as ultimately detrimental to the integrity of TRM/CAM philosophy, as it encourages the assimilation of only certain aspects into biomedicine (Unschuld, 1993:53). The pressure to comply with official health regulations, and the “inability to succeed under the ethos of science” presented an onerous challenge to the traditional Chinese medicine community (Quah, 2003).

In addition, the model of integration adopted in China suppressed or ignored the magico-religious aspects of TRM, and shamans, diviners and spiritual healers were prohibited (Pearce, 1986:240; Pillsbury, 1982:1827; van der Geest, 1985:11). Ignoring and excluding the religious or spiritual dimension of TRM was also endorsed by WHO. Healers using supernatural or spiritual techniques were beyond the scope of policy formulation as “their methods and beliefs are so diverse as to preclude their incorporation in any formal system” (Akerele, 1986:9) and the WHO had an “objective and scientific approach” (WHO, 1986a:62).

Therefore, while avoiding directly articulating a specific policy model to adopt, the WHO did actively and universally promote integration with the aim to achieve “integrative” systems, and endorsed the basic parameters of the Chinese process of doing so. These parameters included the central role of science and technology to verify TRM according to biomedical constructs, the control and regulation of this process by biomedical practitioners, and a recognition of some aspects of TRM (such as herbs and some therapies) with a
rejection of underlying conceptual foundations (including religious or spiritual dimensions). These principles can be seen to accelerate the absorption process of TRM/CAM as Lee hypothesised (Lee, 1982:639), ultimately serving to amplify biomedical structural strength.

The universal policy goal of “integrative systems” driven by a top-down approach may prove elusive even over a very long timeframe. In a top-down approach “it is assumed that policy formulation occurs within national governments, or at the international level, between donors and national policy makers. Once devised it is largely a technical process to be implemented by administrative agencies …” (Walt, 1994:153). However, the integration of TRM/CAM is far from a simply technical process, and implementation crucially depends on a range of factors including interest group interaction. As demonstrated, the implementation of such a policy is fraught with obstacles. In contrast to a “top-down” approach, the policy of integration is actually driven by a “bottom-up” process. In bottom-up models, the implementers play a vital role in the implementation process and interest groups have a role in influencing the policy outcomes (Walt, 1994:155-156).

An integration policy driven by a top-down process which attempts to control implementation through regulatory mechanisms could therefore be impractical. Achieving “integrative systems” where TRM/CAM are officially recognised and incorporated into all areas of health care provision (WHO, 2002e:8) may not be technically or politically feasible, and overlooks the validity or appropriateness of informal integration already occurring at consumer and practitioner levels. Wolffers (1990:14-15) and van der Geest (1985:13) argue that formal efforts to integrate TRM into health care systems are pointless, as integration at the consumer level already exists and the interaction between medical systems is beyond regulatory control. The development of integrated systems involves “bottom up” processes, and the degree and form of integration achieved is partly the outcome of factors beyond direct bureaucratic command. Buse et al. caution against the widespread transfer and adoption of universal policy models driven by top-down approaches as they may be conceived from ideological preferences and lack an adequate evaluation of whether the policy works, and under what conditions (2002:267).

Top-down processes to achieve integration may be more effective in communist or socialist countries where authority is centralised and interest group activity is less able to intervene or influence policy formulation and implementation. For example, in communist and socialist countries the biomedical professional lobby often has much less power and autonomy (Maclean, 1986:16) and the governments “refuse to allow the battles of professionals over the carving up of the medical arena to interfere with the delivery of health” (McDonald,
According to Unschuld’s theory of medico-cultural conflict, biomedical and TRM practitioners require close government supervision or coercion to co-operate, unless they gain an advantage (secondary resource) from doing so (Unschuld, 1976b:8). The presence of close supervision and political pressure may therefore be a crucial factor that contributed to China, the Democratic People’s Republic of Korea, and Vietnam achieving integrative systems.

8.3.2 What are some of the forces behind convergence of policy proposals?

In relation to the policy proposal of integration of TRM into formal healthcare systems, a multitude of economic, social and political forces acted together to create the environment for policy convergence (see Bodeker, 1994a; Islam, 1994). This occurred twice, the first time in the 1970s when the use of TRM in delivering basic health care services was proposed for wider application in the South. The second time was in 2002, when the integration of TRM/CAM was proposed worldwide.

The economic, social, cultural and political forces varied in the North and South, but acted in a complementary manner to push the policy proposal of integration firmly onto the international health policy agenda. Many of these were mentioned above (8.2.1 Kingdon’s multiple stream model), which demonstrated how the problem and politics streams interacted over time. When the problems are shared across a variety of countries, or when different problems can be addressed by the same policy, there is a greater likelihood that policy proposals will converge. The same policy may offer promise in a range of different contexts and be adopted to address diverse problems. Different objectives may therefore exist in different settings despite common policy prescriptions (McPake, 2002).

Economic forces acted strongly in creating the climate for convergence. Resource constraints are highly relevant in the context of encouraging the need to consider low cost alternatives in health care delivery (Bodeker, 1994b:98). When restricting healthcare costs or working within limited budgets, TRM/CAM were able to gain more leverage on the policy agenda and were considered more seriously as policy solutions. Most countries in the South faced the situation of extremely limited budgets in the 1970s when the policy concept was first raised for transfer. At the turn of the 21st century countries in the North were faced with growing substantial costs related to chronic, lifestyle related conditions that were not effectively treated by biomedicine. For example, obesity and depression threatened to become major costs to the state by 2020 (Janes, 1999:1807).
The need to restrict health care budgets in an environment of fiscal stringency was one factor in the convergence of the policy of integration, as TRM/CAM can offer more cost effective ways to treat particular conditions and also place an emphasis on preventative measures. This emphasis on prevention, and benefits of therapeutic social relationships that many forms of TRM/CAM offer, presents both social and economic benefits to healthcare. Formally incorporating TRM/CAM can therefore expand the delivery of basic health services as well as reduce the burden on biomedical infrastructure.

A separate economic force also contributed to convergence of the policy concept of integration – the growth of a massive economic market for herbal remedies, and therapeutic products and services of TRM/CAM. This multi-billion dollar international market created regulatory pressures and gave weight to TRM/CAM on the policy agenda. Governments in the North could no longer ignore the informal health sector which more people were patronising and which was growing rapidly. Governments in the South also needed to act on this trend, as establishing intellectual property rights became crucial in order to protect economic profitability and access to markets. The rapid commodification of traditional knowledge and biological resources generated new revenue streams in the South, which required legal protection.

The growth of these international markets enabled new economic trends and development theories of the 1990s (sustainable development and the use of indigenous knowledge for furthering development efforts), to be put into practise. Generating income, encouraging self-reliance and self-sufficiency while conserving and protecting natural resources, were the main themes of sustainable development. Servicing markets in the North allowed the South to benefit from the notion of “sustainable development” as plants, herbs and biological resources could be developed as cash crops. Capitalising on the market growth for herbal products, which the World Bank projected would be worth US$3 trillion by the middle of the 21st century (Bodeker, 2000), became another incentive to formalise the role of TRM/CAM for a variety of interests in both the North and the South.

**Social** and **cultural** forces interacted with economic trends, to create a climate for convergence. In the 1970s in the South, the use and practice of TRM emerged as a valid cultural expression, linked to nationalistic sentiment and the preservation of heritage. The use of TRM had been sustained on social levels during the years of colonisation, and this public use in informal spheres was recognised and sanctioned when the policy concept of integration arose. Later, in the North, the new social trend of recourse to alternative forms of
health care created an increase in the use of TRM/CAM and the need to formally recognise
this. The surge in use of TRM/CAM correlated with a social movement of growing
environmental awareness and requirements to conserve biodiversity, and also created
pressure on existing biological resources. This encouraged closer management and
regulation of the use of TRM/CAM and the need to incorporate these considerations into
policy frameworks.

**Demographic** trends and associated epidemiological and public health issues reinforced the
need to consider TRM/CAM as health policy options internationally. In the South during the
1970s, family planning and maternal/child health issues were crucial matters, reflecting
carens of the day with population growth and infant mortality. Conditions that were
cauing high mortality rates were infectious and preventable (diarrhoea, malnutrition,
malaria), and did not require expensive biomedical technology to treat. Prevention, education
and public health measures were increasingly viewed as having more important roles to play.
Later, HIV/AIDS and malaria became significant public health concerns. In the North, diet
and lifestyle related conditions (such as obesity, depression, diabetes, heart disease, cancer)
as well as an increasingly elderly population emerged as serious health burdens.

All of these public health matters are complex problems that cannot be addressed or
managed with sole reliance on biomedical infrastructure. Technical, curative interventions
were increasingly ineffective to meet the emerging health needs of populations. Such
conditions require a focus on health education, prevention and/or psycho-social support
mechanisms. While clinical interventions may be necessary, prevention, education, diet and
support (of which TRM/CAM systems focus) are equally or more important aspects.
Intractable public health issues that are not readily resolved by biomedical measures
therefore created a need in the North and the South to review and incorporate other
approaches. All these economic, social and cultural forces interacted in complex ways:

… aging populations, suffering from degenerative and chronic diseases will turn increasingly
to non-biomedical alternatives for biomedical treatment. Yet the very same social and
historical processes that produce the health transition also entangle indigenous medicine in
social forces that seriously impede its ability to develop without complete accession to the
authority of Western science. Nations with viable and well developed indigenous systems
face the prospect of losing the core features of these systems, and in the process, losing the
elements of diagnosis, treatment and care that have been argued to comprise the greatest
benefit and which may provide highly desirable options under the current contexts of
neoliberal health reform (Janes, 1999:1817).

Social and economic forces were given **political** weight with widespread legal recognition of
TRM/CAM by the 1990s. In the 1970s, the revival of TRM was partly a political response to
post-colonial developments, and was related to asserting independence and validating nationalistic sentiment. Later in the North, political recognition of the popular demand for CAM encouraged the allocation of resources for research, and establishment of government sponsored institutions or inquiries dedicated to TRM/CAM. For example, political interventions played a significant role in the development of CAM in the US (Eskinazi & Mindes, 2001:21). Economic, social, cultural and political forces acted together to create a climate for convergence, although the nature of the forces differed temporally and geographically. By 2002 when the integration of TRM/CAM was proposed for global application, the variety of forces interacting in the North and South made the policy concept appear to be both a viable and desirable development worldwide.

8.3.3 What are the requirements for successful transfers of health policies?

One of the difficulties with successfully transferring health policies is that they are often indivisible from the broader political, social and economic environment from which they originated. What may appear promising in one country may not produce the same outcomes elsewhere, because a myriad of factors contribute to population health outcomes and specific health policies and programmes may only be one contributory factor. This is particularly evident with the case of integration of TRM, where some argued that the economic and political situation in China was unique, and that their particular health policies could not be simply transferred to other contexts (Blendon, 1979; Doyal, 1979:288; Good et al., 1979:152; Navarro, 1984:469; Rosenthal, 1981:612; Sanders & Carver, 1985:183). The health policies of China were like a “new species which have adapted precisely to a particular ecological niche” and were thus considered to be rarely (if ever) directly transplantable (Geiger in McQueen, 1985:934).

Whether health policies are broadly transferable therefore depends on the nature of the policy itself and the context within which it was initiated. The complication with this, as mentioned above, is being able to determine conclusively what the links are between the health policy or programme, and its outcomes in isolation from any other influencing factors. In some cases, particular enabling conditions are required for successful transplantation of a policy concept. These particular conditions may not always be apparent without sufficient time to observe and evaluate outcomes, or undertake comparative analysis. For example, using volunteer community health workers was considered unachievable in the absence of precise conditions (Walt, Perera, & Heggenhougan, 1989) and essential drugs schemes also had pre-requisites for implementation (Lall & Bibile, 1978). The circumstances for
successful transfer may be difficult to replicate and include distinctive social, cultural or political factors.

In looking at broader requirements for successful transfers of health policies, the factors that Hogwood and Gunn (1984) list for “perfect implementation” offer an indication of some of the pre-requisites (see also Walt, 1994:154-155). While they are referring to policy in general, the conditions are also applicable to health policy more specifically. Hogwood and Gunn emphasise that “perfect implementation” is unattainable, but that certain conditions act to increase the likelihood of success (1984:198-206). These include: circumstances external to the agency do not impose crippling constraints; adequate time and resources are available; the required combination of resources are available; the policy is based upon a valid theory of cause and effect; that the relationship between cause and effect is direct; that dependency relationships are minimal; there is an understanding and agreement of objectives; that the tasks are fully specified in correct sequence; there is perfect communication and co-ordination; and that those in authority can demand and obtain perfect compliance.

It can be seen that many of these conditions are difficult or even impossible to obtain. This is especially the case with regard to complex policy fields like health - where there are many participants, the relationships between cause and effect are sometimes obscure or indirect, and there are many agencies that contribute to outcomes observed. Some health policies may be easier to transfer than others, particularly those that match as closely as possible those factors mentioned above for “perfect implementation” (Hogwood & Gunn, 1984:198-206). Converting these conditions to health policies, would lead to clearly articulated, narrow, vertical (disease specific) interventions. Such policies have clear objectives, a set list of defined tasks or activities, are based upon a theory of cause and effect that is direct, and are implemented by single (or limited) agencies within a determined timeframe. Communication and co-ordination is therefore clearer, objectives agreed and measurable, authority usually hierarchical, and compliance easier to enforce and supervise.

This may be one reason why health policies and programmes that are based upon vertical interventions (or that are restrictive in scope) are more easily transferred than policies which are longer term, require major organisational restructuring and substantial allocations of funds. Narrowly defined and clearly articulated policies are easier to obtain agreement on, to determine and fund costs, and to implement and monitor. For example, the essential drugs (Chowdary, 1995) and tuberculosis (Ogden, Walt, & Lush, 2003) programmes achieved success in replication partly because they were specific problems with specific solutions. They also employed branding and marketing strategies, which were considered important.
factors for success (Ogden, Walt, & Lush, 2003:44; Walt & Harnmeijer, 1992). It is
unfortunate that most health problems are socially complex and cannot be addressed by such
narrow technical solutions, addressing single issues (or the “magic bullet” approach)

In contrast, broader concepts such as PHC and integration of TRM were hindered in their
transferability as they lacked clear strategies, there were wide divergences in definitions of
central terms which led to confusion about meaning, and the policy could be interpreted
differently by different actors in the policy process (van der Geest, Speckmann, &
Streefland, 1990:1025; Wolffers, 1990). Flexible and abstract notions like PHC and
integration are thus very difficult to translate and transfer successfully into workable
policies. Ambiguity may help achieve international consensus, but is not helpful in making
difficult decisions at national levels (Reich, 1987:49). In addition, such interventions require
close collaboration across health, economic and social sectors, and community level
participation and education. These types of interventions are less predictable in outcome, and
more laborious to implement (Zielinski Gutierrez & Kendall, 2000:86) and thus require high
levels of political support and allocation of substantial resources.

Therefore, it was a practical development for PHC to be redefined as “selective PHC”
(Walsh & Warren, 1980) in terms of the policy process, even though this may have
eventually undermined the ultimate goals of PHC (Macdonald, 1992:72; Newell, 1988:904;
Walt, 1993:137). While PHC advocated a decentralised, horizontal organisational structure;
selective PHC replicated a hierarchical vertical management. The programmes were run as
separate projects, with their own staff, facilities, logos and accounting systems (Walt,
2001:682). This approach appealed to bodies responsible for implementation as it strictly
defined activity; did not require radical re-organisation of health care systems; absorbed
designated resources and was easier to evaluate and monitor. As such, it was easier to garner
both economic and political support, and implementation was clearer and more direct.

In summary, the successful transfer of health policies firstly requires sufficient objective and
detailed comparative information, to determine the extent that other economic or social
policies may have produced or contributed to the observed health outcomes. If the health
policy in question was implemented at the same time as a cluster of policies or reforms
across sectors, this may affect the validity of the health policy or programme to achieve the
desired goals. Clearly observed cause and effect needs to be determined, and central terms of
the health policy clearly and unambiguously defined.
The common criteria between countries that have successfully adopted the policy need to be isolated, and whether this matches the conditions in countries where the policy is to be transferred need to be assessed. Whether the required legislative and regulatory frameworks exist for policy and programme development has to be determined (for example, in some countries TRM is still not legally recognised). Obstacles in execution, how these were overcome, and timeframes and costs to achieve full implementation are also relevant in assessing the practicality of replication elsewhere. Finally, political commitment, cooperation of key stakeholders, consistent guidance and support, and sufficient resources are required.

8.3.4 What is the impact of international initiatives at country levels?

The impact of international initiatives at country levels can vary widely. In relation to TRM, the impact at national levels could be argued to be minimal. For example, the critical indicators identified in the TRM Strategy 2002-2005 (2002e) demonstrate that very little progress had been made on national levels between the 1970s and the end of the century. Only 25 out of 191 member states had a TRM/CAM policy (13%), 65 member states had laws and regulations on herbal medicines (34%), and 19 member states had a national research institute for TRM/CAM (10%).

The international initiative to integrate TRM into health care systems in the 1970s therefore appears to have made nominal impact on national levels in the following decades. This may be partly related to the complexity and contentious nature of the policy issue (which was not purely technical in nature), but also because adoption of the policy as envisaged had onerous requirements that acted as a deterrent. For example, the facilities and resources required to undertake the scientific testing to determine safety and efficacy (which were considered prerequisites to incorporation) were lacking in countries in the South. Many countries were severely constrained by a lack of funds – for example, in Nigeria medicinal plants were not pharmacologically screened due to the lack of funds for extraction (WHO, 1996e:33), the Philippines were cautious in committing funds, and Kuwait argued that funds were not available to introduce TRM practices into their healthcare system (WHO, 1986a). Resources were therefore often unavailable or absorbed by other priorities.

One needs the facilities of pharmacological laboratories, which do not exist in most of the countries of the Third World, because multinational corporations are not doing any research work there or providing the necessary technology … (Said, 1982:22).
The primary requirement for integration, as articulated by WHO, was therefore a major stumbling block at national levels. The scientific expertise and technology needed to undertake inventories and assess clinical efficacy or determine “appropriateness” was simply unavailable, ironically in those countries that were to benefit the most from the development of low cost health care services. It was a paradox that although integration of TRM was a cost-saving strategy in the longer term, it could not be implemented due to expense incurred in the short term (van der Geest, 1985:11). The “low technology” solutions were being implemented through a very high technology approach, which may have been unrealistic to expect or demand from member states in the South.

The international initiatives of PHC and integration of TRM can be seen to have internally contradictory and conflicting philosophies. This may be one reason why they were unable to be effectively reconciled at national levels. For example, Welsch (1986) points out that the definition of PHC provided by the WHO had an emphasis on community participation and self determination, with a simultaneous demand for scientific soundness. This calls for the “bottom-up” development of health services, yet is structured as a “top-down” approach, where the experts oversee and guide the “uninformed” communities. Similarly, the principles provided by the WHO to guide and encourage the integration of TRM were resource intensive, and required scientific expertise that was lacking in target countries.

Many of the questions raised by the integration of TRM/CAM are conceptually complex, and there is little practical information to guide their resolution. While presented as straightforward by the WHO, all of the policy objectives of the TRM Strategy (WHO, 2002e) present inherent complications. For example, in achieving “integrative systems” where TRM/CAM is officially recognised and incorporated into all areas of health care provision (WHO, 2002e:8), raises the questions (amongst many others) of which types of TRM/CAM should be offered in public health delivery? How is that to be determined? What should be reimbursed under health insurance? What should be included in national drugs policy? What form should the education of practitioners take, and how does this accommodate non-conventional forms of training? Countries were still grappling with the considerable practical implications of integration in 2000 (see appendix 7, page 361, for an excerpt of a WHO (2000a) regional report).

Even decades after the policy concept of integration was raised, the main difficulties facing national governments in implementation (according to the WHO) were a lack of mutual understanding between TRM and biomedical practitioners, a lack of communication between governments and TRM practitioners, a lack of evidence based on scientific research, and a
lack of funds and human resources as well as a lack of measures to protect intellectual properties and patents (WHO, 2000a:11). In 2000, non co-operation and a lack of understanding between practitioner groups was still evident and the same conceptual questions asked in the 1970s were again being raised – for example, whether “integrating the knowledge of traditional healers into the western system and vice versa was feasible” (WHO, 2000a:26).

To date, the most significant impact of the WHO policy of integration of TRM on national levels could be seen to be symbolic. A policy usually has two components – a verbal component (statement of purpose, pledge and intention), and an effectiveness component (regulatory rules, grants and resources). If a policy lacks the effectiveness component, it can be termed “symbolic” (Eyestone, 1978:15), and in the vast majority of member states no practical measures had been taken to implement a policy on integration policy even 30 years after it was initially proposed. Hours called this form of passive acceptance of TRM an “alibi” or “smokescreen” which costs very little but offered many institutional advantages (1986:48).

Regardless of practical outcomes, it was symbolically significant for the WHO to recognise TRM and later CAM. The biggest impact on one level could be seen as the recognition and validation of medical plurality, an acceptance of diverse healthcare traditions and alternative healthcare modalities. This was a turning point for the WHO as an organisation, which had previously only promoted biomedicine and the modernisation of health care through the adoption of biomedical models. However, despite this validation, it was also symbolically important that it maintained the rubric of biomedical ascendancy and thus perpetuated and reinforced the existing hierarchical and asymmetric power relationships between medical systems.

### 8.3.5 Is there “lesson-drawing” in health policy development?

The process of lesson-drawing “starts with scanning programmes in effect elsewhere, and ends with the prospective evaluation of what would happen if a programme already in effect elsewhere were transferred here in the future” (Rose, 1991:3). Lesson-drawing specifically refers to determining how practical and desirable it is to transfer policies. The critical analytical question is “[u]nder what circumstances and to what extent would a programme now in effect elsewhere also work here?” (Rose, 1991:4).
The WHO was lesson-drawing in the 1970s by “scanning” (or observing) programmes and policies that had addressed the problem of delivering basic healthcare services in environments of resource constraint. In the 1970s the WHO was actively seeking comparative information on how successful low cost health care services had been implemented, especially in those countries that had achieved good outcomes in health indices (Djukanovic & Mach, 1975; WHO, 1975). From these evaluations came the ideas of community health workers, primary health care, and integration of TRM (Gish, 1979:204; Janes, 1999:1811; Macdonald, 1992:18; Purcal, 1989:34). However, complete evaluation as part of a lesson-drawing process also involves determining likely success in other settings – how and why a programme works in one country and the likely success or failure in another country (Rose, 1991:23).

While such policy concepts and programmes as PHC and integration of TRM might have been desirable in other settings, whether they were practical was another matter. Distinguishing between desirability and practicality is an important aspect of lesson-drawing (Rose, 1991:25). According to Rose, the most interesting confrontation between political desire and technical expertise occurs when there is a highly desirable programme but the specific conditions for replication or transfer do not exist (Rose, 1991:26).

The attractiveness of a Japanese programme associated with its economic miracle may be as compelling to Western policy makers as the call of the female sirens was to sailors in Greek mythology. However, the siren call of mythology lured sailors onto rocks; the siren call of Japanese success may attract policy makers to a programme that is likely to fail, because the preconditions for effectiveness in Japan are not met elsewhere (Rose, 1991:26).

It could be argued that the Chinese model of integration and the use of community health workers in the form of barefoot doctors was an extremely strong “siren call” in the 1970s. These policy concepts were associated with the public health miracles achieved in China. For example, between 1952-1982 China’s average life expectancy increased from 35 to 68 years, and infant mortality was reduced from 250 to 40 deaths per 1000 live births (Hsiao, 1995:1047). These outstanding improvements were achieved with a large population, low per capita income, lack of professionally trained health personnel and limited biomedical infrastructure. The Chinese success was a result of a new way of organising and distributing limited resources, rather than of increasing expenditure (Cox, 1989:44).

The lure of achieving such striking positive health outcomes with restricted resources must have been incredibly strong to international health policy makers and in countries facing similar conditions to those experienced in China. While China offered a particularly inspiring or compelling example, the utility of the model may have had less validity in other
settings. Particular policy models may offer great incentive or stimulus, especially when other countries face similar problems. However, it may take some time to realistically assess what the outcomes of the policy were, and how effective it was independent of other social or economic policies.

In some respects, it could be argued that complete lesson-drawing did not occur in the WHO with regard to using TRM practitioners as community health workers, and the integration of TRM. While the desirability of policy transfer was considered, the required conditions and probability of replication was less prominent in analysis. Firstly, it was assumed that the impressive health gains witnessed in China had been achieved largely through the integration of TRM and the use of community health workers (barefoot doctors). Whilst these were undoubtedly factors, they were not solely or independently responsible for improvements in population health. A range of various economic and social policies contributed to overall improvements in health indices (Cox, 1989:44; Sanders & Carver, 1985:180-183; Sidel & Sidel, 1975:11).

Beyerstein and Sampson (1997:3) argue that the utility of barefoot doctors was exaggerated and they were really equivalent to “first aid attendants”. Herbal remedies and TCM therapies contributed much less to the improvement of population health than their efforts in communal health projects such as sanitation, access to safe drinking water, the control of several parasitic epidemics, containment of sexually transmitted diseases, and improvements in diet and immunisation rates (Beyerstein & Sampson, 1997:3). In addition, the equitable distribution of food, housing, and social services was a major contributing factor to improved health indices (Cox, 1989:44).

Has the use of large numbers of primary health workers – and particularly barefoot doctors – been responsible for the unparalleled advances in the health of the Chinese population? And can the barefoot doctor experience be somehow isolated from the social process in which it evolved and, by implication, be successfully transplanted to societies whose political and economic conditions are quite different?

The answer to the first … [is that there was] a wide range of health promoting interventions – many from outside the health sector … before the substantial strengthening of primary health care … As to the second question: the underlying answer rests in the fundamental change in the organisation of the Chinese economy [which enabled free, universal health care, and sanitation and immunisation programmes] (Sanders & Carver, 1985:180)

Secondly, there were unique conditions present in China that enabled successful implementation of the policy on integration and the use of barefoot doctors. The presence of very specific social and political conditions were found to be required for the introduction of successful volunteer community health worker schemes elsewhere (Walt, Perera, &
Heggenhougan, 1989). While the Chinese example provided inspiration and hope for other developing countries (Leslie, 1985b:929), they lacked some of the crucial pre-requisites that provided fertile ground there (Sanders & Carver, 1985:180-183). For example, particular economic factors (Blendon, 1979), an extremely strong political counterforce to the domination and resistance of the biomedical profession (Rosenthal, 1981:612), and a TRM profession that was highly organized and more unified and already partially institutionalised. Traditional Chinese Medicine was based on a written history and more uniform in theory and practice – whereas for example, the diversity of systems and standards of knowledge in Africa presented more challenges to incorporation (Oppong, 1989:609; Semali, 1986:95).

**Thirdly**, while the idea of barefoot doctors was seized upon as offering a potential solution to the delivery of low cost health care, it was simplified and modified in a manner which may have made it unworkable in practise or far more difficult to implement. Barefoot doctors were not TRM practitioners given basic training in biomedicine, but an entirely new volunteer manpower category (Pillsbury, 1982:1832; Velimirovic, 1984b:69). Creating a new and separate category of community health workers was a pragmatic method to overcome the difficult task of forging relations between biomedical and TRM practitioners (Pillsbury, 1982:1830). A distinctive attribute of the barefoot doctor scheme was the strongly altruistic and ideological commitment they displayed (Ronaghy & Solter 1974:1331 in Doyal, 1979:288).

However, the WHO instead determined that rather than create a new category of personnel trained in both systems to fill roles in the PHC sphere as the Chinese had done, the training and development of existing TRM manpower categories in basic biomedicine was preferred (WHO, 1978b:21). This objective overlooked the political tensions and strongly entrenched historical ambivalence between biomedical and TRM practitioners. It was also unrealistic to expect that health services could be extended at no cost using volunteers or TRM practitioners trained as community health workers. While these workers were unpaid in China, it was optimistic to anticipate that volunteers would be able to support the expansion of such programmes elsewhere. As articulated by Unschuld’s theory of contested resources (1975; 1976b), without any secondary resources (economic benefits, status) it would be very difficult to recruit and maintain TRM practitioners as PHC workers.

The WHO later recognised this, with the suggestion to offer some form of remuneration or reward (WHO, 1995a:11), as the lack of payment for undertaking extra PHC duties produced minimal incentives for participation. Constraints experienced on national levels in the implementation of community health worker schemes, and in using TRM practitioners in this...
role, reflected the lack of adequate “lesson-drawing” from either the Chinese experience or other countries. There was considered to be a lack of policy guidance and government commitment, lack of dialogue and co-operation between the two groups of practitioners, conflict between practices and paradigms of health, poorly defined roles, lack of organised representative groups for TRM practitioners, and little practical evaluation of existing programmes (WHO, 1995b:43-45).

Finally, the assumption that complete integration had been attained in China may have been inaccurate, and it would seem that the form of integration achieved was not universally supported. By the late 1980s, it was being argued that the integration of TRM had never been fully achieved (Chen 1989 in Janes, 1999:1812). Although China was often classified as demonstrating an integrated system (Bodeker, 2001b; Stepan, 1983; WHO, 2002e), Hesketh and Zhu (1997) described the status of the systems as one of “co-existence” with integration only a “possibility for the future” and conditional upon demonstrated clinical effectiveness. This was recognised by the Chinese government when it was noted that “[o]bviously, there is not complete integration: it is still too early to expect that … In effect, there are now three systems: traditional, Western and integrated” (WHO, 1986a:35).

The Chinese model institutionalised domination of TRM by biomedicine and there was not genuine equity between medical systems (van der Geest, 1985:12). The true synthesis of both systems of medicine was considered by some to be “doomed to failure” mainly due to the lack of conceptual compatibility (Unschuld, 1976a:315; Unschuld, 1976b:15). The achievement of “real” integration was therefore questionable, as a bias to biomedicine was inherent in the model and certain aspects of TRM were excluded. The approach of legitimising TCM via scientific validation can be eventually negative (Unschuld, 1993:53), despite enabling mass production, commercialisation and global export. The processes and impartiality of techniques used in China to achieve integration were critically questioned by academics and practitioners, and implementation found to be a very long and complicated process.

A difficulty with objective lesson-drawing in the case of integration of TRM was that there appeared to be a lag in critical analysis of the Chinese experience. While some early commentators were reflecting on the broader validity of the situation in China in the late 1970s (Blendon, 1979; Doyal, 1979:288; Good et al., 1979:152), it was not until the 1980s that more evaluative information began filtering through the policy community (Bibeau, 1985; Cox, 1989; Jingfeng, 1988; Pillsbury, 1982; Rosenthal, 1981; Sanders & Carver, 1985; van der Geest, 1985). The vast majority of information analysing the situation in China was
not produced until after it had been endorsed by the WHO as a model to emulate (WHO, 1978b). Perhaps the problems were so pressing and political sentiment on the issues of low cost health care so strong, that the practicalities of transfer may have been overlooked. The merits of integration and processes to achieve it may also have been overshadowed by a wave of nationalistic sentiment propelling TRM onto the agenda as an effective means to address health issues in the South.

China definitively reorientated the question of traditional medicine back to one of national pride. The Chinese had no intention of demanding or even passively accepting Western medicine as other developing nations had. They were instead emphatic about bringing their own health care practices into the world spotlight. Following the Chinese lead, during the World Health Assemblies of 1973 and 1974 delegations from Zaire, Dahomey, Congo, Guinea, the United Republic of Cameroon, Sri Lanka, India and Malawi, many of which had never before mentioned the topic, began speaking of their traditional medicine as a positive affirmation of their native cultures (Lee, 1997).

The nature of the WHO as an organisation may also have hindered its ability to effectively lesson-draw in the case of policies like the integration of TRM. The WHO is dominated by the biomedical profession, and it did not recruit sociologists or anthropologists (Foster, 1987; Godlee, 1994a:711; Walt, 1993:138, 139). Information from the social sciences that could have informed the policy formulation and evaluation process was thus peripheral to the focus of the WHO. The almost exclusively biomedical and technical boundaries of the WHO created an environment where integration was viewed as an administrative exercise, and contributing political and economic factors were ignored or overlooked. For example, conflict and tension between TRM and TRM practitioner groups was downplayed and only mentioned obliquely (if at all) in most policy and programme documents.122

The WHO attempts to maintain an “apolitical, neutral stand” (Chowdary, 1995:138) and refrains from directly commenting on political and economic policies that had an impact on health. It seemed to consider that the relationship between political systems and health system organisation was remote (Elling, 1981a:87) which may explain why, in relation to the situation of TRM in China, including the use of barefoot doctors, the political nature and significance of the exercise were overlooked (Navarro, 1984:469). This neglect of the political dimensions of the structure of health care systems, and avoidance of political issues and tensions in integration of TRM/CAM was also evident in the TRM Strategy (WHO, 2002e).

122 Science was upheld as the objective intermediary in any cases of discord: “Conflicts between the Western-trained doctor and the traditional practitioner are bound to occur, in any society, but [Vietnam] looks to science to resolve this problem. Let us use science wisely to test the values of the past.” (WHO, 1986a:34)
Whether the WHO actually is non-political and strictly concerned with technical health issues is discussed below. Remaining aloof from political issues is difficult (or even impossible) in the contested environment of health policy, and when health issues have an inherently political dimension – in spite of the fact that the WHO was based on and guided by the principle of “studiously (avoiding) political or cultural controversy” (Godlee, 1994a).

8.3.6 Are values transmitted through international organisations?

The WHO is usually considered to be an impartial agency, advising on technical health issues and is perceived to be “neutral” (Walt, 1994:131). The WHO secures much of its influence and legitimacy from the perception that it is a technical professional body that operates on a basis of apolitical scientific consensus (Peabody, 1995:737; Walt, 1994:134). Any country can join the WHO as long as it contributes financially according to an agreed formula (Walt, 1994:131), and there were 191 member states in 2002. However, the employees of this organisation do not always act objectively – they may be influenced by the government of their nation (Walt, 1994:133) or biased by professional affiliations (Lee, 1997). A significant amount of the WHO’s:

authority is derived from its professional core of medical doctors. Not only does the medical profession have a high status among other professions but it serves as an internationally cohesive group. Doctors have common bonds and common global standards (Walt, 1994:134).

According to Peabody, two key myths give the WHO strength as an organisation. The first is that it “is a politically neutral, technical agency that sets an international standard of social justice by improving health” and the other is that it “is uniquely qualified to improve health in the vast and complicated international arena of divergent populations besieged by overwhelming diseases” (Peabody, 1995:736). However, the biomedical basis of the WHO has created a homogenous work force operating within a rigid structure, viewing health issues through a “single lens” (Peabody, 1995:737). As many health issues are not amenable to technical-biomedical solutions, the WHO has limited capacity to address increasingly complex and multidisciplinary matters (Peabody, 1995:737-739). The narrow biomedical orientation thus influences and restricts the manner in which the WHO perceives and responds to health issues (Lee, 1997).

Navarro contends that the WHO, through its reports, reproduces ideologies and political positions (Navarro, 1984). How it interprets health issues, and the solutions proposed to
address them, therefore reproduce particular values and ideologies. In relation to the integration of TRM in formal health care, it has been demonstrated that a biomedical focus clearly influenced the development of this process, and that the biomedical paradigm was the dominant ideology promoted by the WHO. For example, within the policy of integration, biomedical concepts, scientific methodology and the supervisory position of biomedical expertise were assumed. A reductionist, secular frame was used in which herbs and plants (biological resources) were a prime focus, and clinical validity was a core concern.

Objectives that the WHO promoted and supported as neutral (such as safety, efficacy, quality, appropriateness, proper use) are in fact embedded with value judgements. As mentioned above (section 8.2.2), power relations determine what is defined as efficacious and acceptable (Elling, 1981b:93) and scientific discourse is not impartial, it embodies values and ideologies that reflect and reproduce power relations (Navarro, 1980, 1984). Claims of scientific authority and legitimacy/efficacy represent political and economic interests (Janes, 2002:273) and dismissing or approving of TRM on account of its “scientific” basis is motivated by ideological and political factors (Unschuld, 1976b:7). Scientific discourse is a medium through which power, domination, and control can be expressed and maintained.

By endorsing biomedical authority and expertise in the process of integration, the WHO was accelerating and institutionalising a movement that some contend is a part of a larger process of globalisation – that of biomedical dominance in defining acceptable health care (Eeuwijk, 2000; Janes, 1999; Wahlberg, 2006). The promotion of TRM by the WHO according to these strict parameters was therefore encouraging the subordinate absorption of TRM/CAM into biomedicine (Lee, 1982:639), and reproducing and entrenching hierarchical relations in medical pluralism.

8.4 Implications for theory

The implication of the “resource model” used for analysis in this thesis, is that it offers an alternative mechanism to scrutinise health policy formulation and implementation. It presents a mediating framework based on broader theory that is connected to a specific policy issue (Ham, 1993:183). The framework focuses on stakeholders and actors in the policy process, specifically interest groups. It assists in the generation of knowledge about actors (stakeholders, interest groups) in the policy process “so as to understand their behaviour, intentions, interrelations, agendas, interests” (Brugha & Varvasovszky, 2000:239). Such information can then be used to both guide or evaluate the policy process,
to develop strategies, facilitate implementation, understand the policy context and assess the feasibility of programmes and policies (Brugha & Varvasovszky, 2000:239).

Like other tools for policy analysis, such a framework provides descriptive, predictive and explanatory tools (Reich, 1996). As a descriptive tool, it enables the systematic collection and organisation of information about a specific health policy. It allows the content of the policy, goals and objectives, the positions of key players (interest groups or other actors) and the opportunities and obstacles to policy change to be assessed. As a prescriptive tool it provides a method to design strategies for implementation, assess the impact of policy and programme options and the feasibility of reform.

As an explanatory tool, it can explain health policy outcomes, and interest group responses, and identify underlying interests served by policy objectives or programme goals. Its efficacy in this regard has been demonstrated by its application to the policy of integration. As has been demonstrated, it has offered an explanation for why the policy goal of integration proved difficult to execute on national levels, despite apparent international consensus and support – the first aim of this study.

The use of the “resource model” as a framework for health policy analysis enables both a micro and macro level of assessment. The framework is flexible in application, so can be used at local (community) levels, national levels, or at organisational levels including international organisations. A micro-macro approach is facilitated by observing how power and authority are used to legitimate, structure and allocate health care resources (Janzen, 1978:124, emphasis added), making Unschuld’s theory of medico-cultural conflict (Unschuld, 1975, 1976b) based on contested resources particularly applicable in this context. It offers a way to conceptualise health care resources, and how these health care resources are defined, legitimised and allocated by the state and by interest groups in a medically pluralistic health care system.

This analytical framework combines political science tools of policy theory and interest group interaction, with anthropological insight into the interaction of medical systems. As a multidisciplinary tool, it offers a theoretical construct which may be useful in disciplines such as critical medical anthropology. Such a framework addresses an obstacle in the theoretical development of critical medical anthropology, as it provides a methodology to explore the political dimensions of medical pluralism. The use of macro-micro models to explore medical pluralism, that take into account broader political and economic contexts, have been encouraged by medical anthropologists (Janzen, 1978; Singer, 1986, 1990):
… critical medical anthropology struggles to synthesise the macro level understandings of the political economy of health with the micro level sensitivity and awareness of conventional medical anthropology (Singer, 1986:128).

In this way, the use of the “resource model” contributes to the understanding of policy processes within the complex, contradictory and contested health field – the second aim of this study.

8.5 Implications for further research

The “resource model” used for analysis in this thesis could be used in a variety of ways in future research. It could be applied at national levels to provide structure to the context of health policy formulation, implementation or evaluation. This may be with reference to policies of the integration of TRM/CAM, or more broadly to other health policies or programmes (such as primary health care, or essential drugs) or in relation to specific health conditions (e.g. malaria, HIV/AIDS). The analytical framework may offer particular promise as an explanatory tool for health policies or programmes that have been resistant to implementation. It can guide research that is historical in nature (assessing health policy development of a specific type or in a specific location), or assist in feasibility studies of different policy and programme options.

As limitations of space and the large timeframe covered necessitated a superficial analysis of many of the issues involved, the analytical framework could also be applied in more detail over specific epochs (such as each decade, or even prior to the 1970s), or to some of the subjects or themes raised (such as traditional medicine, intellectual property and TRIPS; the commodification and industrialisation of TRM; the World Bank projects on the conservation and sustainable use of medicinal plants; the export of specific TRM systems to new locations; evidence based medicine and TRM/CAM).
Appendices
Appendix 1: WHO ACTIVITIES – TRM
(resolutions, documents, meetings)

1969 World Health Assembly resolution 22.54 (establishment of pharmaceutical production)

1972 International survey of 20 countries and the use of TBAs

1973 Consultation on the role of the TBA in maternal and child health and family planning, Geneva
Organisational study on methods of promoting the development of basic health services Official Records No.2206 Geneva

1974 Interregional Seminars on the Training and Utilization of Traditional Birth Attendants in Maternal and Child Health (San Salvador 29 September – 5 Oct; Philippines 2-6 Dec).

1975 Verderese, M & Turnbull, L. The TBA in maternal and child health and family planning – A guide to her training and utilization. Offset publication no.18
Djukanovic, V., & Mach, E. Alternative approaches to meeting basic health needs in developing countries - A joint UNICEF/WHO study.
Newell, K (ed) Health by the People, Geneva
Executive Board Resolution 56R6
Consultation on TM, Geneva October

1976 World Health Assembly resolution 29.72 (health manpower and development)
African Regional Committee (Kampala) discussed official use of traditional healers by African governments
African Region (Brazzaville) formed a board of experts with the aim of proposing modes of co-operation between modern and traditional medicines
Working Group on TRM: headquarters, Geneva under leadership of Dr Bannerman
Taskforce established on indigenous plants for fertility regulation
Traditional Medicine and its role in the development of health services in Africa. WHO Regional Committee for Africa, 26th session, Kampala 8-15 September AFR/RC26/TD/1
Traditional Medicine and its role in the development of health services in South East Asia Region. SEA/OMC
African Traditional Medicine, WHO Regional Office for Africa, Brazzaville, Technical Report series 1
Selected Bibliography on Evaluation of Traditional Medicine for Safety and Efficacy (unpublished document OMH/76.3)

1977 World Health Assembly resolution 30.49 (promotion and development of training and research)
Regional seminar in Sri Lanka on the development of a programme in TRM
Special Issue of *World Health* on TRM

WHO/UNDPO trip to China

Working group proposed a program; approved by the Executive Board

International WHO meeting on TRM (report in 1978)

1978 World Health Assembly resolution 31.33 (medicinal plants)

International Conference on Primary Health Care, Alma Ata, USSR 6-12 September

Primary Health Care - Report of the International Conference on Primary Health Care, Alma Ata

The promotion and development of traditional medicine WHO Technical Report Series No. 622

Dental Health and the Development of Health Services in Africa. Traditional Medicine and its role in developing health services.

Johnson-Romauld, F. General Policies and practices in regard to medicinal products. Geneva (document A31 TD 8.5)

1979 32nd Regional Committee - assignment of consultants to study TRM

Executive Board recommendation 63.124

First Collaborating Centre for Traditional Medicine designated – Italy (Instituto Italo-Africano, Rome)

Traditional Birth Attendants: A Field Guide to their Training, Evaluation and articulation with Health Services. Offset publication No 44


1981 34th Regional Committee session discussed the topic of TRM

First Meeting of Directors of WHO Collaborating Centres for Traditional Medicine, Geneva, November (Document TRM/MTG/81.2 - report unpublished)


1982 35th Regional Committee, Regional seminar on the involvement and utilization of practitioners of TRM in PHC

1983 Bannerman et al (eds) Traditional Medicine and Healthcare coverage

Primary Health Care: the Chinese Experience. HMSO books for the WHO

1984 Standard Acupuncture Nomenclature, WHO Regional Publications, Western Pacific Series No. 1, WHO Regional Office for the Western Pacific, Manila

1985 Consultation on approaches for Policy Development for Traditional Health Practitioners, including Traditional Birth Attendants, New Delhi

Inter-Regional Workshop on The Selection and Use of Traditional Remedies in Primary Health Care

Inter-Regional Seminar (WHO in association with the Ministry of Public Health of the People's Republic of China) on The Role of Traditional Medicine in Primary Health Care in China; Guangdong Province and Guanxi Autonomous Region, China 9-21 October

Report of the consultation on approaches for Policy Development for Traditional Health Practitioners,
including Traditional Birth Attendants

1986
WHO/DANIDA Training Course: the Selection and Use of Traditional Remedies in Primary Health Care (Report of an Inter-Regional Workshop held in Bangkok, Thailand, 25 November - 4 December 1985), WHO/TRM/86.1

The Role of Traditional Medicine in Primary Health Care in China (Based on an Inter-Regional Seminar sponsored by the WHO in association with the Ministry of Public Health of the People's Republic of China, 9-21 October 1985), WHO/TRM/86.2

Maglacas, H & Simons, J. The potential of the traditional birth attendant Offset publication 95

Report, Regional Workshop on Training in Traditional Medicine convened by the Regional Office for the Western Pacific, Manila, Philippines, 25-28 Nov

Guidelines regulating use of herbal medicine discussed at Eastern Mediterranean Regional Office (Kuwait) and draft act for medicinal plants produced (WHO/EM/PHARM/119-E)

1987
World Health Assembly resolution 40.33 (optimal use of TRM practitioners and remedies)

Second Meeting of Directors of WHO Collaborating Centres for Traditional Medicine; Beijing, People's Republic of China, 16-20 November

1988
World Health Assembly resolution 41.19 (conservation of medicinal plants, substantially duplicating Chiang Mai Declaration)

Report of the Second Meeting of Directors of WHO Collaborating Centres for Traditional Medicine (Beijing, People's Republic of China, 16-20 November 1987), WHO/TRM/88.1

International Consultation on the Conservation of Medicinal Plants, Chiang Mai, Thailand, 21-27 March

1989
World Health Assembly resolution 42.43 (TRM and modern health care)


Medicinal plants in China. WHO Regional Publications, Western Pacific Series No. 2, WHO Regional Office for the Western Pacific, Manila

Intercountry Course on the Appropriate Methodology for the Selection and Use of Traditional Remedies in National Health Care Programme, Kadoma, Zimbabwe, 26 June - 6 July

1990
Report of a WHO Consultation on AIDS and Traditional Medicine: Prospects for Involving Traditional Health Practitioners (Francistown, Botswana, 23-27 July 1990), WHO/TRM/GPA/90.1

Report of a WHO Consultation on AIDS and Traditional Medicine: Clinical Evaluation of Traditional Medicines and Natural Products (Geneva, 26-28 September 1990), WHO/TRM/GPA/90.2

Medicinal plants in Viet Nam. WHO Regional Publications, Western Pacific Series No. 3, WHO Regional Office for the Western Pacific, Manila

The Use of Traditional Medicine in Primary Health Care

1991
Executive Board resolution 87.R24 (TRM and modern health care)

World Health Assembly resolution 44.34 (TRM and modern health care, medicinal plants, acupuncture)

Traditional Medicine and Modern Health Care: Progress Report by the Director General A44/10.22
Geneva

A proposed standard international acupuncture nomenclature: report of a WHO scientific group


STCMA (State Traditional Chinese Medicine Administration) and WHO jointly held The International Traditional Medicine Conference, and experts from over 40 countries and officials from more than 20 countries presented the meeting

Traditional Healers and Community Health (WHO/SHS/DHS/91.6) unpublished

Guidelines for Assessment of Herbal Medicine, WHO/TRM/91.4, WHO Geneva

1992

Symposium on Plants and Health for All: Scientific Advancement, Kobe, Japan, 26-28 August

Chaudhury, R. Herbal Medicine for Human Health WHO Regional Office for South East Asia, New Delhi.

Review of the Traditional Medicine Programme (TRM) AFR/RC 42.19 Brazzaville

Traditional Birth Attendants – A Joint WHO/UNFPA/UNICEF Statement

Training of Traditional Birth Attendants (TBAs): An Illustrated Guide for TBAs.

Training of Traditional Birth Attendants (TBAs): A Guide for Master Trainers


1993

Research guidelines for evaluating the safety and efficacy of herbal medicines WHO Regional Office for the Western Pacific, Manila

WHO/IUCN/WWF Guidelines on the Conservation of Medicinal Plants: a framework for the conservation and sustainable use of plants in medicine

Standard Acupuncture Nomenclature, Second Edition WHO Regional Office for the Western Pacific, Manila

1994

Guidelines for Formulation of National Policy on Herbal Medicines WHO Regional Office for the Eastern Mediterranean

Guidelines for Training Traditional Health Practitioners in Primary Health Care WHO/SHS/DHS/TRM/95.5

Traditional Practitioners as Primary Health Care Workers WHO/SHS/DHS/TRM/95.6

Guidelines for Clinical Research on Acupuncture WHO Regional Publications, Western Pacific Series No. 15, WHO Regional Office for the Western Pacific, Manila

Selection of Essential Medicinal Plants, Eastern Mediterranean Regional Office

Third Meeting of Directors of WHO Collaborating Centres for Traditional Medicine Beijing, People’s Republic of China, 23-26 October

1996


Good Manufacturing Practices: Supplementary guidelines for the Manufacture of Herbal Medicinal


97th Executive Board meeting reviews Programme on Traditional Medicine

1998

Quality Control Methods for Medicinal Plant Materials

Basic tests for drugs: pharmaceutical substances, medicinal plant materials and dosage forms

Guidelines for the Appropriate use of Herbal Medicines Western Pacific Series No. 23, WHO Regional Office for the Western Pacific, Manila

Regulatory Situation of Herbal Medicines: a worldwide review, WHO/TRM/98.1

Medicinal plants in the South Pacific WHO Regional Publications, Western Pacific Series No. 19, WHO Regional Office for the Western Pacific, Manila

Medicinal plants in the Republic of Korea WHO Regional Publications, Western Pacific Series No. 21, WHO Regional Office for the Western Pacific, Manila

1999

Workshop on development of national policy on traditional medicine, Western Pacific Region 11-15 October 1999, Beijing, China

Consultation Meeting on Traditional and Modern Medicine: Harmonizing the Two Approaches, 22-26 November 1999 Beijing, China

Training Package for Practitioners of TRM. Manila, WRPO

International Symposium on Traditional Medicine - Its contribution to human health development in the new century 6 November 1999, Kobe, Japan

WHO monographs on selected medicinal plants (Vol 1)

Guidelines on Basic Training and Safety in Acupuncture WHO/EDM/TRM/99.1

2000

General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine, WHO/EDM/TRM/2000.1

Traditional Health Systems in Latin America and the Caribbean: Baseline Information. Washington PAHO/WHO

Development of National Policy on Traditional Medicine. A report of the workshop on development of national policy on traditional medicine, 11-15 October 1999, Beijing, China, Western Pacific Region

Traditional and Modern Medicine: Harmonizing the Two Approaches. A report of the Consultation Meeting on Traditional and Modern Medicine: Harmonizing the Two Approaches, 22-26 November 1999 Beijing, China. Manila, WHO Regional Office for the Western Pacific

International Symposium on Traditional Medicine: better science, policy and services for human health development 11 - 13 September 2000, Awaji Island, Japan

WHO Regional Workshop on Regulation of Herbal Medicines, Jamaica

2001

WHO monographs on selected medicinal plants (Vol 2)


Apia Action Plan on Traditional Medicine in the Pacific Island Countries, Manila, WHO Regional Office for the Western Pacific

International Consultative Meeting on Global Information of Traditional/Complementary and Alternative Medicine Practices and Utilization 19 - 21 September 2001, Kobe, Japan

2002

Acupuncture: Review and analysis of reports on controlled clinical trials

Chaudhury, R & Rafei, U. Traditional Medicine in Asia WHO Regional Publications, Sth East Asia Series no 39

Some Traditional Herbal Medicines, Some Mycotoxins, Naphthalene and Styrene IARC monograph on the Carcinogenic Risks to Humans, IARC monographs volume 82

Regional Strategy for Traditional Medicine in the Western Pacific. Manila: Western Pacific Region

Traditional Medicine Strategy 2002-2005

Fact Sheet 271: Traditional and Alternative Medicine. Geneva

Traditional Medicine - Growing Needs and Potential (Policy Perspectives on Medicines No. 2). Geneva

Appendix 2: People interviewed (Sri Lanka)

Prof. A.M. Abeysekera (biomedical)  
Previous Director (2003)  
Ayurvedic Research Institute

Prof. A.P. Amarasinghe (Ayurvedic)  
Director – Ayurvedic Research Institute  
Consultant Paediatrician – Ayurveda

Ass. Prof. G. Dharmasiri  
Lecturer – Philosophy  
Perediniya University, Kandy

Dr. S. S. Epa (biomedical)  
President Sri Lanka Medical Association 2003  
Private biomedical practitioner

Dr. C. Fonseka (biomedical)  
Acting Head of Institute of Indigenous Medicine, Colombo University

Dr. N. I. Fonseka (Ayurvedic)  
Consultant Physician  
Borella Ayurvedic Hospital

Dr. R. Goonewardene (biomedical)  
Surgeon and Professor of CAM (retired)  
Speaker at Integrated Medicine Conference

Prof. S. Jayasinghe (biomedical)  
Associate Professor, Faculty of Medicine, University of Colombo  
Private Biomedical practitioner

Dr. A. Jayasuriya (biomedical)  
Practitioner of Integrated Medicine  
Kalubowila Hospital

Dr. G. Jayawardhana (Ayurvedic)  
Private Ayurvedic practitioner

W.A. Karunasena  
Secretary; Ministry of Indigenous Medicine

Dr. N. D. Kasturaratchi (biomedical)  
Senior Lecturer  
University of Peradeniya  
Faculty of Medicine

A. Malimage  
Additional Secretary; Ministry of Indigenous Medicine

Prof. P.S.S. Panditharatne (biomedical)  
Registrar  
Sri Lanka Medical Council

Dr. D. Perera (Ayurvedic)  
Registrar – Ayurvedic Medical Council  
Assistant Director (Technical) Planning  
Division Ministry of IM  
Previously – Ethnobotanist; World Bank  
Medicinal Plants Conservation Project

Dr. J. Perera (Ayurvedic)  
Private Ayurvedic Practitioner  
Littoral Ayurvedic Hospital  
Hikkaduwa

Dr. C. Samarasekera (Ayurvedic)  
Specialist Consultant Physician  
Senior Lecturer  
National Institute of Traditional Medicine

Dr. S. Somaratne (Ayurvedic)  
Senior Consultant Physician  
Borella Ayurvedic Hospital

Dr. D. Weerasekera (biomedical)  
Consultant Surgeon & Private Practitioner  
Kalubowila Hospital

R.O.B. Wijesekera  
Industrial Advisor – Medicinal Plants  
(previously with WHO Human Reproductive Programme 1975)
On the one hand we have the persistence in tens of millions of people of such diseases as cholera, malaria ... On the other we have we have the gigantic modern machinery geared up to the treatment of a whole range of disease up to the point of obfuscating the distinction between life and death. In one sophisticated city more than 70% of all so-called health expenditure is used on people who are going to die within the next twelve months. In another ... a network of sophisticated renal dialysis centres catering to the needs of a few hundred patients with chronic kidney disease was given priority over a network of rural health centres catering to the needs of hundreds and thousands of women and children. These examples reflect, in my opinion an obsessional concern of the medical profession – my own profession – with marginal disease and tend to pervert the very concept of health.

Countries further down the scale are busy imitating this kind of perversion. In a developing country, which constitutionally declares health a universal human right, you find in one province 80% of the health budget being used to support one teaching hospital, whereas in outlying parts complete coverage is supposed to be achieved by one general purpose dispensary for half a million people ... and the costs are spiralling ... over the last 20 years ... the cost of medical care rose by 300-500%. While in the same year period the population in such countries increased by 10-20%, hospital utilization rose by three and a half times that figure. Paradoxically, with such stupendous cost increases and disease addiction has gone increasing dissatisfaction with the health care system ... because serving champagne to the few while many do not get their daily bread is hardly promoting confidence.

(Elling, 1981b:90-91)
Appendix 4: China as a model

China provided an inspiration to the international community in the 1970s, and a main factor in the health gains achieved was deemed to be the novel incorporation of TRM into health service delivery. The prominence given to China’s experience is clearly reflected in the WHO original policy and programme development, and continues to the present day. For example, the Western Pacific Region of WHO (of which China is a part) has produced far more reports on TRM than any other region; the distribution of Collaborating Centres for TRM is weighted to China (in 2002 there were 7 centres in China alone compared to 1 for the entire South-East Asia Region); two of the three meetings of Directors of these Collaborating Centres were held in China, and WHO publications on TRM also have an emphasis on TCM, specifically acupuncture. A brief overview of the development of TRM and biomedicine, and the form of integration implemented in China is described below.

History 123

For over 2000 years, TCM 124 was both the functionally and structurally dominant medical system. In the 19th century, despite the import of biomedicine, TCM maintained structural and functional strength through continued social and political support. However, in the early 20th century, an epidemic of plague allowed biomedicine to assert superiority and claim structural dominance. The success of biomedicine in dealing quickly with this epidemic encouraged official recognition and support, and “made many social and political elites realize the urgency of medical modernization through science” (Lee, 1982:632).

In the first half of the 20th century, biomedicine became the structurally superior form of medical care in China. TCM strongly resisted their diminished reputation, and there was a lot of tension between medical systems throughout this period. A younger generation of intellectuals aided the increasing biomedical status, by rejecting TCM as a potent symbol of outmoded traditional culture that had to be eradicated to ensure China’s growth and development (Croizier, 1976:342).

The organisation of a national professional association of TCM in the early 20th century can be seen (according to Unschuld’s paradigm) as a direct response to the increasing structural competition from biomedicine. Biomedical doctors formed a National Medical Association in 1915, and successfully lobbied the government to promote biomedicine and restrict TCM (Lee, 1982:632). The Institute for National Medicine, founded in response to a Government resolution in 1927 to eliminate TCM, was able to block attempts to regulate and reduce its scope (Croizier, 1976:346).

However, although biomedicine was able to achieve structural strength it was never able to achieve functional dominance. Despite official recognition and support, it was not able to gain widespread social popularity beyond the elite – particularly in rural areas. A comprehensive biomedical infrastructure could not be effectively established, and the resource intensive nature and specialised training requirements for personnel were obstacles to this goal. In this period, neither TCM nor biomedicine were functionally strong, as many depended upon localised healing traditions (Lee, 1982:632-633).


124 TCM is the majority TRM system in China, but not the only one. It is a collective term that refers to many different systems created by different Chinese minorities. The term TCM usually refers to that used by the Han nationality, which accounts for up to 95% of the Chinese population (Cai, 2000:140). TCM is the traditional form of medicine developed and promoted in state institutions, post 1956 in mainland China (Taylor, 2004:98).
Incorporation of TRM in the formal health system

Following the Communist revolution in 1949, a main priority became improving the health of the population. Despite the communist emphasis on modernisation through science and technology, TCM became a central aspect of the health strategy (Sidel & Sidel, 1975). This was in line with the Maoist emphasis on using indigenous resources to achieve modern goals (Croizier, 1976:347), and self reliance. It also corresponded with the patriotic importance given to national heritage and customs, and desire to democratise health care. Integration was guided by the principle of modernisation of TRM through science and technology (Jingfeng, 1988; Taylor, 2004).

In the early period of Communist rule, the use of TCM was based on an expedient and pragmatic attitude of mobilising all medical resources, and it was promoted “because it was readily available, rather than because of any inherent value it had” (Bibeau, 1985:939). Initially, this urgent practical need to expand the resource base was the motivating force for government policy on the recognition of TCM (Chi, 1994:315) and it was considered a “stopgap” measure until the biomedical infrastructure could be expanded (Croizier, 1976:347). However, in the mid-1950s, this was augmented with an ideological commitment to China’s unique medical heritage as part of an upsurge of nationalistic sentiment (Bibeau, 1985; Croizier, 1976).

The health strategy used by the Chinese was to develop both TCM and biomedicine, and also integrate them at both the operational and theoretical levels (Lee, 1982). This was called a health policy of “walking on two legs” – using both biomedicine and TRM in health care. On a theoretical level, TCM theory was scrutinised using modern scientific techniques, in order to establish the efficacy of remedies. This clinical work was intensively undertaken in the 1950s and by 1958 both systems of medicine were officially accorded equal status in the health system (Hesketh & Zhu, 1997). At an operational level, thousands of new health workers were trained in both basic biomedical and TCM principles. These “barefoot doctors” were responsible at the village level for disease prevention and education, and were considered the showpiece of the Cultural Revolution in the mid-1960s. Biomedical and TCM doctors were also educated in the basic concepts of each others systems and encouraged to co-operate with each other, while TCM infrastructure was expanded.

Equity of TCM and biomedicine?

In practise, some commentators questioned the equity of TCM and biomedicine in the health care system and the extent of success in their synthesis. Lee comments that although resources were directed to TCM, biomedicine maintained power over health affairs and therefore remained structurally superior (1982:633-634). By the 1960s, although integration was still advocated, it appeared that TCM had been relegated to a “supplementary and … inferior position” (Croizier, 1976:350). In this period, biomedical doctors “regarded Chinese-trained doctors with condescension and contempt” (Bibeau, 1985:940). Unschuld states that by 1976, the pressure on biomedical practitioners to use TCM “vanished almost completely”(1993:52) and by the late 1970s, attempts to reconcile TCM with biomedical concepts had failed (1993:53). From the late 1970s, China commenced a program of international exchange emphasising science and technology fields, including biomedicine. Lee proposed that these efforts would continue to strengthen the structural position and functional strength of biomedicine in formal health care delivery in the future (Lee, 1982:634).

The true synthesis of both systems of medicine was considered by some to be “doomed to failure” mainly due to the lack of conceptual compatibility (Unschuld, 1976a:315; Unschuld, 1976b:15). Later,

125 Only a simplified outline of the complex history of TCM in health care has been presented here. Efforts to integrate TCM did not only emerge post Communist rule. Various strategies had been considered from the 19th century in response to the challenges presented by the import of biomedicine (Chi, 1994:315). Unschuld discusses three main approaches to legitimise the continued existence of TCM, and traces their origins and shifting emphasis from the 19th century throughout the 20th century. These were a “naive idea of combining the best practices of both traditions”; an effort to “join [TCM] to experimental science and Marxist dialectics”; and a strategy to “present [TCM] in a conceptually restructured version adapted to specific cognitive values of Western medicine” (1993:46-47).
proposals to merge the two systems were not politically supported. Instead, a parallel system was advocated with co-operation encouraged only where viable (Unschuld, 1993:52). This was promoted as “Three Roads”: the independent development of both systems (two separate roads), with them coming together (third road) where practicable. Therefore, the idea of merging primary resource bases of both systems was replaced by the concept of allowing each manpower group to use different primary resources while working within a single health care system (Unschuld, 1976b:15).

Others have questioned the contribution made by TCM to the health gains achieved, and considered the success of the barefoot doctor scheme as not directly attributable to dual training in both systems of medicine. Rather, their role in massive public health education campaigns and programs is considered more significant. Beyerstein and Sampson (1997:3) consider the training of barefoot doctors as equivalent to “first aid attendants” and argue that herbal remedies and TCM therapies contributed much less to the improvement of population health than their efforts in communal health projects such as sanitation, access to safe drinking water, the control of several parasitic epidemics, containment of sexually transmitted diseases, and improvements in diet and immunization rates. In addition, the equitable distribution of food, housing, and social services was a major contributing factor (Cox, 1989:44).

Integration?

Although some have classified China as effectively demonstrating an integrated system (Bodeker, 2001b; Stepan, 1983; WHO, 2002e), Hesketh and Zhu (1997) described the status of the systems as one of “co-existence” with integration only a “possibility for the future” and conditional upon demonstrated clinical effectiveness. According to Bibeau (1985:940), the two main principles of the Chinese strategy were the development of TRM under the supervision of biomedicine, and a recognition of some technical aspects with a denial of the theoretical foundations underlying it. The integrity of TCM was threatened by the approach of selectively choosing specific remedies (guided by biomedical principles) and neglecting conceptual foundations. “Genuine” integration was therefore questionable, as a bias to biomedicine was inherent in the model. It was not until 1999 that there was legal recognition of equal status of TRM and biomedical practitioners (WHO, 2000e:12).

This approach of using scientific methods to evaluate and “refine” TCM was considered by Chi as the “most fortuitous” of approaches, as it was less problematic than that experienced with earlier approaches or in other countries such as India (1994:315). In India in the mid-1960s, many schools that had been established to train practitioners in a synthesis of biomedicine and Ayurveda were closed by student riots. The unrest was due to the graduates wanting the same recognition and salary (secondary resources) as that provided to biomedical graduates. Most of the colleges converted to granting biomedical degrees, others reverted to teaching “pure Ayurveda” (Taylor, 1976:290).

Perhaps officially endorsing biomedical control in assessing the resource base of TCM removes potential for overt conflict between practitioners, and avoids addressing complex issues such as theoretical synthesis. In contrast, Unschuld considers the approach of legitimising TCM via scientific validation as ultimately detrimental, as it encouraged the assimilation of only certain aspects of TCM into biomedicine and the rejection of the rest (1993:53). This illustrates Lee’s argument (1982:640) that TRM may increase structural status through adopting a scientific basis and rationalising training and education, but this may ultimately facilitate the process of their selective absorption and subordination into biomedicine.

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126 Beyerstein and Sampson (1997) argue integration was a politically motivated and economically convenient move by Mao, who continued to use biomedicine for his personal health care. Mao stated in 1944: “We cannot solve our problems be merely relying on the doctors of the new [biomedical] school. Of course, the doctors of the new school are superior to those of the old [TCM] school; but they do not concern themselves about the sufferings of the people ...” (Bibeau, 1985:939).
Appendix 5: Extract from Traditional Birth Attendants - A field guide
to their training, evaluation, and articulation with health services (WHO, 1979b)

... Allusion has been made at times to the notion of ‘integrating’ the TBA into the organized health system. This has been viewed with mixed feelings of enthusiasm and trepidation. Integration has been openly enunciated and discussed in several countries, but as yet there is no known systematic framework for this. If by integration is meant that TBA’s should be so intimately connected to the organized health system that they might finally lose their identity as perceived in the traditional sense, this might well lead to conflict between TBAs and other categories of health personnel in the organized services, as well as between TBAs and the communities they would be expected to continue to serve.

Integration in this, the true, sense of the term should be avoided at all costs, since it would defeat the purpose of programmes to extend health services to underserved populations. In order to ensure that the identity of the TBA remains intact and that the TBA continues to serve the community, only informal and flexible links should be developed between her and the organized health system. Thus, the question should not be one of defining the role of the TBA in the modern system of health care delivery but one of defining the role that the modern system can play in helping TBAs to perform more safely those tasks they generally perform on the basis of the principles of mutual self-help and humanitarianism. In this context, the concern should not centre of integrating the TBA into the modern system but rather on ensuring that, within the TBA as a person, modern and traditional concepts and modes of practice are so integrated as to eliminate only traditional practices and rituals that are clearly shown to be harmful, and to instil only modern concepts and techniques that are absolutely essential to the safety of the persons under care of the TBA.

For the above-mentioned reason, those who have been closely involved in the preparation of this guide decided to use the term ‘articulation’ rather than ‘integration’. “Articulation” according to Webster’s Dictionary of Synonyms, implies “organization in which each part fits into another in a manner comparable to the fitting into each other of two bones at a moveable joint and a structure so built that it functions as a whole yet without any loss of flexibility or distinctness in any of its component units or without any conflict between them.

(WHO, 1979b:7-8)
Appendix 6: The Chiang Mai Declaration - Saving Lives by Saving Plants

We, the health professionals and the plant conservation specialists, who have come together for the first time at the WHO/IUCN/WWF International Consultation on Conservation of Medicinal Plants, held in Chiang Mai, 21-26 March 1988, do hereby reaffirm our commitment to the collective goal of "Health for All by the Year 2000" through the primary health care approach and the principles of conservation and sustainable development outlined in the World Conservation Strategy. We:

recognise that medicinal plants are essential in primary health care, both in self-medication and in national health services;

are alarmed at the consequences of loss of plant diversity around the world;

view with grave concern the fact that many of the plants that provide traditional and modern drugs are threatened;

draw the attention of the United Nations, its agencies and Member States, other international agencies and their members and non-governmental organisations to:

the vital importance of medicinal plants in health care;

the increasing and unacceptable loss of these medicinal plants due to habitat destruction and unsustainable harvesting practices;

the fact that plant resources in one country are often of critical importance to other countries;

the significant economic value of the medicinal plants used today and the great potential of the plant kingdom to provide new drugs;

the continuing disruption and loss of indigenous cultures, which often hold the key to finding new medicinal plants that may benefit the global community;

the urgent need for international co-operation and co-ordination to establish programmes for conservation of medicinal plants to ensure that adequate quantities are available for future generations.

We, the members of the Chiang Mai International Consultation, hereby call on all people to commit themselves to Save the Plants that Save Lives.

Chiang Mai, Thailand
26 March 1988

(http://users.ox.ac.uk/~wgtrr/chiang.htm; accessed 1 May 2004)
Appendix 7: Extract of national level reports

From: Development of National Policy on Traditional Medicine (WHO, 2000a)

The promotion and integration of traditional medicine encounter many hurdles in Asian countries. Cambodia, for one, is burdened by financial problems. In the Cook Islands, the lack of legislation for changes in the national health agenda has stifled traditional medicine in spite of the fact that majority of the population patronize it. It was, however, proposed that the Cook Islands situation could be solved through advocacy. The Fiji delegate recommended that a movement in traditional medicine should be initiated [professional association] and dialogues with government officials should be started. The issue of intellectual property rights remained controversial and according to the delegate from Fiji, this issue should be looked into. The report of the delegate from French Polynesia drew questions inquiring if criteria in selecting traditional healers existed. In Fiji there was none. The Malaysian delegate mentioned that the criteria were made by “God”[religious dimensions], thus, making it difficult to question their validity. The delegate from Hong Kong, China, added that criteria for traditional healers were important for accreditation and credibility. Malaysia faced a peculiar problem in that scientists involved in the research and development of herbal medicines did not want to share data and knowledge.

A question was raised about how strict legislation for traditional medicine should be in comparison to food legislation. The general opinion was that food legislation did not require such high standards as legislation on medicines did.

Dr Chen Ken gave a summary [of] the main difficulties [facing] governments:

• a lack of mutual understanding between [TRM] healers and modern medicine;

• a lack of communication between governments and healers;

• a lack of evidence based on scientific research; and

• a lack of funds and human resources as well as a lack of measures to protect intellectual properties and patents.

Creation of a better understanding between traditional healers and modern medicine seems to be one of the important goals. In many countries, traditional medicine is not accepted by the [bio]medical society (e.g. the Philippines). (WHO, 2000a:10-11). As a solution to the problem of lack of understanding of [TRM] and non co-operation between practitioners of Western and [TRM], it was discussed whether integrating the knowledge of traditional healers into the western system and vice versa was feasible. Introduction of [TRM] curricula in the western system has, however, only been possible in some countries, e.g. in China, but not in the Republic of Korea. For this reason the group proposed as a solution either to encourage practitioners to practise both systems of medicine to complement each other, where applicable, or to introduce traditional medicine curricula in the western system, where applicable. Furthermore, introduction of education and training to traditional health practitioners as well as an attempt to convince other health care providers that traditional medicine does not intend to compete but to safeguard public health could be potential options. (WHO, 2000a:26)
Appendix 8: Kava –Traditional resources as tradeable commodities

The example of kava encapsulates many of the complicating factors surrounding traditional plants and their use beyond original cultural, social and economic spheres. It is presented in detail to illustrate the intricacies of the issues, and can be seen as a microcosm of what was occurred with TRM and globalisation on the international level. This material is mainly from Pollock (2000), observations and information gathered during a visit to Vanuatu in November 2002, and from the Secretariat of the Pacific Community website. The botanical garden in Vanuatu has a large section dedicated totally to kava, including information on the cultivation, preparation, and socio-cultural aspects of use.

Background

Kava (Piper methysticum) is one among several closely related species selectively cultivated over thousands of years for use in Pacific Island communities as a beverage. It has a social (“ceremonial”) role in their lifestyle, which varies slightly in expression between Islands. It is highly significant as a symbol of social cohesion and a valued part of their heritage, inherently embedded in the cultural fabric of these nations and recalled in legends, songs and poems (Pollock, 2000:5). Today it is considered the “national drink” of Vanuatu and men gather to drink it at dusk in dimly lit and very quiet kava bars (nakamel), although women also consume it (less publicly and not as widely). Over the centuries, ritualised cultural expressions were attached to it and it evolved multifaceted social uses.

For example: the uses include as a symbolic gift; marking of particular occasions and expressing communal unity; it has special grinding plates for the roots, and bowls for mixing and serving it; huts for consuming it; servers to distribute it; seating, serving and consumption patterns indicating social status; and gestures and protocols that govern preparation and consumption, affecting its potency. Therefore, its use was regulated and controlled by traditional methods (traditional legitimacy) which were bound up with honour and respect and also imbued the drink with some of its physiological influences, as well as social and spiritual meaning.

Kava was banned by missionaries in the early 20th century, but made a strong return to use in Vanuatu after independence in 1978 (Pollock, 2000:3). With urbanisation and modernisation, some aspects of kava cultivation, preparation and usage were modified. For example, it was processed and pre-packaged in bags for mixing at home, usage broadened in the population, and there was simplification of the associated rituals. The expanding use with urbanisation was driven by the need of communities to preserve their ties to traditional heritage (Pollock, 2000:7).

Today, expatriate communities of Samoans in New Zealand particularly prize the whole root, which is treasured if they can get through quarantine (Pollock, 2000:5). The export market for it was partly driven by expatriate communities keen desire to maintain social and cultural meanings in new settings (Pollock, 2000:7). Kava is considered by anthropologists to have ritualised significance expressing power, unity and identity. During the failed Fijian coup in May 2000 to restore indigenous power in the perceived face of the growing ethnic Indian minority control, the leader (Speight) held nightly kava sessions for the entire two month occupation of the Parliament in Suva (Pollock, 2000:4).

Pharmaceutical interest

German pharmaceutical companies showed interest in Tonga’s kava in the late 19th century, and again late in 20th century (Pollock, 2000:4). The bioactive compound isolated in kava by scientists is kavalactones. They induce relaxation and assist sleep, and can be effective in reducing stress and anxiety. “These are the desirable qualities by western standards” (Pollock, 2000:2). European pharmaceutical companies manufactured the main bioactive component into more convenient pills, to meet the new demand in the 1990s for natural alternatives to synthetic biomedical drugs.
The Kava Growers Guide (SPC, 2001) provides a detailed description of the kava plant. Clinical trials with standardised kava extracts show pharmacological activity comparable to benzodiazepines (e.g. valium). Kava has been shown to have sedative, hypnotic, anticonvulsant, muscle relaxant, anaesthetic, antymycotic, and anxiolytic properties. Kava products are a natural substitute for these pharmaceuticals, and have fewer side effects and have not been shown to be addictive or to lead to dose tolerance. Kavalactones have little or no effect on cognitive performance and visuomotor tests, and do not linger on the breath, but may be detected by a blood or urine test (Pollock, 2000:6).

The chemical make-up of the plant is complex. Fifteen different kavalactones are present, each with a different physiological effect. Each part of the kava plant has a different mix of kavalactones. Kavalactone concentration, taste and action differs according to the part of the plant, soil it was grown in, moisture content, age (generally a minimum of 3 years is required for sufficient concentrations), type of preparation, and what is consumed with it. How you prepare the drink and even what you drink afterwards changes the physiological effect (for example, hot water magnifies effects). The harvesting, handling and drying of kava also impacts on quality. Kavalactones efficacy increases when they are given in combination, and not in isolation.

Efficacy is therefore not based on a single active substance, but from a blending of several kavalactones. Scientists have not been able to identify the mixture required to achieve a particular effect. Naturally produced kavalactones are still much stronger than the synthesised kavalactone, which do not induce the same physical results. This is significant as it means synthetically manufactured kavalactones are inferior to the natural source, and it’s difficult to reduce to a specific bioactive compound (and therefore it cannot be easily be patented or artificially mass produced) – a monopoly on production and IPR remains firmly with the traditional custodians by a chance of nature.

This scientific data demonstrates that the Islander population actually had highly specialised knowledge of particular kava varieties they were selectively cultivating, their efficacy and strengths, and that the rituals of preparation and consumption also had a "scientific basis" designed to enhance potency. Prior to international trade, information on quality of the kava was assessed purely from physical examination. A few simple tests could be performed, beyond appearance and odour, such as taste. However, trade necessitated standardisation and regulation. In the 1990s, plants were analysed and categorised according to their particular configuration of kavalactones, known as a chemotype. Particular varieties of kava could be classified by chemotype, which were of different values for pharmaceutical interests.

While the chemotype was not important for local use, the pharmaceutical industry in Europe only wanted kava with a particular chemotype and of a particular quality (which was difficult to standardise considering the natural variation in plants and plant parts). And they only wanted the raw material, to “value add” and “quality control” themselves; they did not want to invest in local processing facilities. The profit margins explain this: raw materials account for about 8% of the product’s final price, processing adds 17%, wholesale margin is 25% and retail margin is 50% (TF, 2002b). Therefore, in only taking the raw material, foreign pharmaceutical firms profits are maximised and most kava was sent off-shore for processing. Some products were being produced and trialled in Vanuatu, including water and fruit juices infused with kava, and kava confectionary.

The kava plant quickly became a lucrative cash crop. It became a major source of revenue for four Pacific Island nations, and land used for cultivating coconut was replaced with kava in some places. The Islanders in Pohnpei even encroached upon previously uncultivated land in the foothills to grow kava, arousing the ire of ecologists and environmentalists (Pollock, 2000:5). However, these nations had few sources of external revenue, and kava represented one of the only tradeable commodities available. The need for revenue in this case was difficult to balance with environmental concerns. Their environment presented an advantage as it was an indigenous plant that required unique growing conditions, and they were therefore able to form a natural monopoly on supply (effectively giving price control to Islanders). Despite that, Hawaii soon attempted to establish a kava industry cultivating only the preferred chemotypes of the pharmaceutical industry. The Pacific Islands went to considerable
lengths to inform and guide their growers on the cultivation needs according to new industrial demands (including production, harvesting, storing and drying), evidenced by the growers guide in 2001.

**Local versus global use**

In moving into global markets, kava raised interesting questions beyond environmental or sustainable development issues. The use of kava product internationally was in direct contrast and conflict with its customary usage as a ritual summons to the gods, and honorific of status (Pollock, 2000:1). It was also in forms (pills, powders) and for uses (stress, insomnia, anxiety, depression, premenstrual syndrome) beyond that in the local sphere. Therefore, classifying kava presented some conceptual difficulties. Is it a plant, drink, supplement, narcotic or medicine? It has to be one or the other to fit into rational-legal frameworks, and each category has associated conditions and regulatory requirements regarding processing, labelling, testing, quality control and claims made.

Or is kava simultaneously all of these, and yet none of them – and really a cultural or religious symbol that transcends all of these uses, but which becomes meaningless in the global market? Pollock comments that in the original communities, the use could be classified as more religious than medicinal, and notes that “Kava is a drink based on sharing and sociability, rather than as a pill to be popped by an individual” (Pollock, 2000:7). Differences in judgements about categorisation were reflected in international variations in classification. In France and Germany, kava was a prescription drug. In the US it was a non-prescription herbal remedy classified as a nutritional supplement (SPC, 2001).

Pollock questions the classification of kava as a drug (Pollock, 2000:6). According to the resource-model, debate around classification (food, plant, herb, drug) are about demarcating primary resources. If it is a drug, it has to conform to biomedical conceptual foundations (i.e. demonstrate causality, mechanisms of action and efficacy) and it is then a biomedical primary resource and with substantial increases attached to its secondary resources. If in any other category, it belongs to TRM/CAM with use as a dietary supplement or food/plant product.

The classification of this primary resource therefore depends entirely on who is looking at it and what use they have for it: from a biomedical gaze, it was a drug, a psycho-active compound, and it was used, packaged, labelled and promoted as such. But from an Islander perspective, it was a plant-drink; and the processed products, powders or pills stripped of the surrounding ritual and social aspects were something very different. Kava powder and pills had different strengths and potencies than the root in raw form, and locals called them NesKava (Pollock, 2000:7). The name is a simultaneous allusion to the multinational appropriation and instant fix/commodification approach of Western mindsets. As a commodity, it acquired new symbolic uses. It has been transformed and redefined within a Western, industrial, capitalist, biomedical framework. As Pollock notes, the use of kava was culturally constructed (Pollock, 2000:2), and this served various economic and social interests.

Pollock concludes by questioning whether this new market was just a temporary fad, and if it was sustainable over the longer-term (Pollock, 2000:6). Two parallel markets now existed - the local and the global. These markets were very different, with one based on localised, individual production and preparation and consumed in communal social settings (South); and the other processed, packaged and sold in a variety of forms for prescription or over the counter for individual self-medication (North). The market demand in the North was driving local production: of particular kava varieties, with higher and higher quality (strength) and locals had to balance the new demand with existing land uses and environmental issues, with limited arable land.
Trade and economic outcomes

This question soon proved to be irrelevant. In 2002, the global market collapsed. Trade bans and restrictions were placed on kava based on a single German report which had linked 32 cases of liver toxicity to kava. The clinical evidence of this was very tenuous, including double-counting and disregarding heavy alcohol consumption, other life-style factors, or the use of biomedical pharmaceuticals (TF, 2002a). In the UK, the Medicines Control Agency found “[t]here is no evidence to support a safe dose of kava” (Hopkins Tanne, 2004). The US had been concerned about the use of kava from at least 1999 (following a surge of use in 1998) when the US National Toxicology Programme announced that they would be testing aloe vera, ginseng, kava, and milk thistle for carcinogenic activity (Gottlieb, 1999). Once reports were made of toxicity, regulators moved quickly and without any warning or advice, almost immediately ceased import from the four main kava traders (Vanuatu, Samoa, Fiji, Tonga), and enforced bans, product recalls and issued consumer warnings and alerts.

These countries mobilised to fight the trade restrictions. They formed the Pacific Kava Crisis Committee, and asked Fiji to approach the WTO (as only Fiji had WTO membership, a compulsory pre-requisite to request action) and raise the matter under the auspices of provisions for technical barriers to trade or phyto-sanitary agreements. The strategy also included appealing to the Commonwealth Secretariat, trying to establish a brand for kava, obtaining funding in order to develop internationally accepted standards for kava and undertaking clinical research so that disputes over quality or safety could be refuted. This needed "expert neutral consideration" but a WHO expert suggested that “this approach would not achieve the desired outcome” (TF, 2002a). The Secretariat of the Pacific Community requested the WHO to help assess kava and establish an expert panel to assess the scientific validity of the adverse claims made (SPC, 2002b).

The WHO remained virtually silent on the issue. The WHO Kobe Centre lists kava and liver toxicity as an example for the need for safety guidelines in TRM, and kava was presented as a case study to illustrate safety issues related to herbal products in a WHO Pharmaceuticals Newsletter (WHO, 2003b). It was reported there that the Centre for Business Development in Brussels commissioned a study to explore the claims of toxicity and found only 4 out of a total of 76 reported cases were possibly linked to kava consumption. The pharmaceutical processing and use of different plant parts may have played a role in toxicity, and it was concluded that unbiased assessment and evaluation including extraction and processing methods of the kavalactones was needed (WHO, 2003b). The safety issues therefore seemed to point potentially to the pharmaceutical handing of the raw product than to the plant itself, and even to the disregard of expert traditional knowledge regarding concentration, consumption and preparation that had been determined over generations.

PUBLIC STATEMENT BY KAVA INDUSTRY REPRESENTATIVES AT THE PACIFIC HERBS BUSINESS FORUM

The Pacific Island Countries are growers and exporters of kava, and more importantly come from a tradition where kava has been consumed for many hundreds of years. Kava is very important to our tradition, to our ceremonies and to our economies. The amount of kava consumed in the Pacific Island Countries greatly exceeds the dose in herbal medicine, yet no pattern of liver disease has been linked over all those years to kava consumption. We believe that the medical authorities in some European countries have acted in haste without an adequate scientific basis for their decisions. We call upon these authorities to immediately conduct a scientific review of the alleged medical cases that led to this situation … We bring to your attention the fact that consumption in the Pacific Islands is many times the recommended dose in an herbal preparation, but this dose is taken in the form of the natural plant. The actions in Europe will not influence the kava drinkers of the Pacific Islands but our small vulnerable economies need all the export income that we can earn. The loss of export sales will impact on our economies and on the subsistence farmers for whom kava offers one of the few opportunities to generate a cash income (SPC, 2002a).
### Appendix 9: Timeline of significant events (TRM, Sri Lanka)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900-1920</td>
<td>Organisations formed to re-establish (rehabilitate) TRM</td>
</tr>
<tr>
<td>1919</td>
<td>Site offered to Oriental Medical Science Society for a hospital and college in Colombo, but they did not have funds to take up offer</td>
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<tr>
<td>1922</td>
<td>Supreme Court ruled that Ayurvedic practitioner could not use title “doctor”</td>
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<tr>
<td>1924</td>
<td>Oriental Science Medical Fund gazetted to send students for Ayurvedic education in India</td>
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<tr>
<td>1927</td>
<td>Constitutional Assembly establish a Committee to develop proposals for the incorporation of TRM into health care system; consider training of practitioners and medicinal value of remedies</td>
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<tr>
<td>1928</td>
<td>Board of Indigenous Medicine formed</td>
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<tr>
<td>1929</td>
<td>Ayurvedic Hospital, Pharmacy, College of Indigenous Medicine established in Colombo</td>
</tr>
<tr>
<td>1935</td>
<td>Ordinance 46: Ayurvedic Medical Council incorporated to prepare register of practitioners, hold examinations, issue certificates, develop code of regulations</td>
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<tr>
<td>1936</td>
<td>Committee appointed to report on Board of Indigenous Medicine and make recommendations for the administration of the College, Hospital, Pharmacy</td>
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<tr>
<td>Late 1930s</td>
<td>Local government councils begin to provide free Ayurvedic treatment</td>
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<tr>
<td>1941</td>
<td>Indigenous Medicine Ordinance 17: Board of Indigenous Medicine granted corporate status</td>
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<tr>
<td>1945</td>
<td>Indigenous Medicine Ordinance 27</td>
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<tr>
<td>1947</td>
<td>Commission of Inquiry into Indigenous Medicine – recommended organisation of Ayurvedic sector along lines that resembled biomedical sector; found education poor and profession “despised” and ridiculed. Suggested formation of professional associations and publication of journals</td>
</tr>
<tr>
<td>1949</td>
<td>Act No 49: College, Hospital, Pharmacy, Herbarium, Dispensary became government bodies</td>
</tr>
<tr>
<td>1950</td>
<td>Commission appointed to inquire into <em>Desiya Chikitsa</em>: requested separate hospital and separate medical council. Also request to learn use of biomedical tools and diagnostic techniques</td>
</tr>
<tr>
<td>Date</td>
<td>Indigenous Medical Advisory Council established to advise the State Council on promotion of TRM</td>
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<tr>
<td>unknown</td>
<td>Ayurveda Act No.31: Ayurveda Department est. - parallel system in health care</td>
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<tr>
<td>1961</td>
<td>Bandranaike Memorial Ayurvedic Institute established; devoted mainly to clinical research</td>
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<tr>
<td>1962</td>
<td>Committee appointed to inquire into salaries and conditions of Ayurvedic sector. Recommended increased wages but did not match biomedical scales.</td>
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<td>1969</td>
<td>Ayurveda Drugs Corporation established</td>
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<td>1971</td>
<td>The Ayurvedic Physicians Professional Conduct Rules made by the Ayurvedic Medical Council under Section 18 of the 1961 Act and approved by the Ministry of Health.</td>
</tr>
<tr>
<td>1972</td>
<td>Ayurveda College affiliated to the University of Sri Lanka</td>
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<tr>
<td>1980</td>
<td>Ministry of Indigenous Medicine (assumes responsibility for Dept of Ayurveda) but supervised by Department of Health</td>
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<tr>
<td>1996</td>
<td>Presidential Taskforce on National Health Policy</td>
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<tr>
<td>1998</td>
<td>New legislation drafted to Amend Act No.31 (1961)</td>
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<tr>
<td>2000</td>
<td>Creation of Cabinet Ministry for Indigenous Medicine – independent status</td>
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<tr>
<td>2003</td>
<td>Formation of professional association for Ayurvedic practitioners</td>
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<tr>
<td>2004</td>
<td>Action Committee for Ayurvedic and Indigenous Medical Education and Professional Development formed</td>
</tr>
<tr>
<td>Date</td>
<td>National policy drafted</td>
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</tbody>
</table>
Appendix 10: Organisational chart (TRM sector, Sri Lanka)

Source: Dr. D. Perera


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