Role of traditional medicine in third world countries

Overview

According to the National Aboriginal Health Organisation (NAHO, 2003), the term ‘ traditional’ was introduced by the British during the colonial era and often rejected by many indigenous peoples. Authorities in the industrialised world used the term ‘ traditional medicine’ to distinguish between Western medicine and medical knowledge and practices that were local to indigenous tribes in Africa, South East Asia and other parts of the third world. Today traditional medicine is also referred to as Complementary and Alternative Medicine (CAM) (Shaikh & Hatcher, 2005). Chronic social, economic and political problems in many third world countries means that the vast majority of their populations have little or no access to modern medical resources. By contrast, traditional medicine is often available to the masses and may constitute the only available health care resource. This essay discusses the role of traditional medicine as an essential resource in the third world, with specific reference to Nigeria and Pakistan.

Traditional Medicine

There is no universally accepted and unambiguous definition of traditional medicine, largely because of differences in culture, language, and medical products and practices across the third world. However, the World Health Organisation defines traditional medicine as “ health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being” (WHO, 2003). Traditional medicine generally refers to any medicinal knowledge and practices that aren’t within the domain of

modern day Western medicine. Like modern medicine the ultimate goal of the traditional healer is to improve the well being of individuals who present with some undesirable physical or psychological malady (Shaikh & Hatcher, 2005). However, traditional medicine is unique in that improvements in well-being may incorporate spiritual healing, and whereas western medicine largely relies on science-based knowledge and procedures, traditional medicine is based on local rituals, herbs, and superstitions indigenous to the local community (NAHO, 2003).

Traditional medicine may incorporate different fields of expertise. NAHO (2003) identifies several types of specialists, including the spiritualist, herbalist, medicine man/woman, and healer. Spiritualists specialise in spiritual healing, for example by communicating with dead ancestors and performing ritualised sacrifices (e. g. killing a chicken). They often enjoy a certain degree of authority within local communities, serving as mentors for individuals or families. Herbalists are perhaps equivalent to pharmacists and pharmacologists in western medicine. They are experts on the medicinal properties of local plants and are typically called upon to prepare various medicinal concoctions to cure specific ailments. Such preparations may be in the form of a meal, drink, or even special soap for bathing. Healers are individuals with a natural talent for healing, often through spiritual or other means, perhaps similar to the ‘ psychic’ in Western society. Indeed, there seems to be a high degree of overlap between healers, and spiritualists, albeit this is debatable and culture-specific. Finally, the medicine man/woman is a traditional healer usually involved in ceremonial activity, such as a funeral. They often carry a lot of material effects, such as

mysterious ‘ bundles’, bones, and other effects. Chronic shortages of modern health care resources in the third world has led to renewed interest in the role that CAM could play in reducing premature morbidity and mortality.

Health care in the third word

Populations living in third world countries are plagued by a variety of health problems. These include childbirth problems such as low birth weight (Arif & Arif, 1999), nutritional problems, notably malnutrition, hypoglycaemia and hypothermia (Bhan et al, 2003), kidney disease (SantaCruz, 2003), degenerative psychiatric illnesses such as Hodgkin’s disease (Hu et al, 1988), hypertension (Galie & Rubin, 2004), tobacco-related illness (Tomlinson, 1997), and so on. The prevailing economic, political, social and environmental conditions aren’t ideal for maintaining good health (Cooper, 1984). Socio-economic inequalities caused by flawed economic policies and political corruption has meant that modern medicine is beyond the reach of the suffering masses. Environmental decadence manifests in poor sanitary conditions, itself a result (at least in part) of weak economic infrastructure, and political leadership. Governments in many third world countries often spend only a fraction of their gross domestic product (GDP) on health care, so that there is a chronic shortage of both primary and secondary health resources such as clinics, hospitals, staff, and drugs. Health care policies are either absent, inadequate or poorly implemented. Lack of adequate funding stifles research and development, not withstanding positive side effects like increased creativity (Coloma & Harris, 2004).

These deplorable conditions have persisted despite massive financial investment by the World Bank. The organisation pays out an estimated $28 billion annually to third world countries, some of which is meant be used for the development of adequate health infrastructure (Pinker, 2000). But this has had little effect, partly because of government corruption, political instability, and crippling national debts. Moreover, technological change is so rapid that investment in essential medical equipment is not viable, unless there is a regular cash flow to finance replacements (Coloma & Harris, 2004). Much has been written about the problem of ‘ brain drain’ in which locally trained professionals flee their under-resourced and decaying health care systems to take up more lucrative jobs abroad (Fisher, 2003; Latif, 2003; Levy, 2003). Then there is the capitalist constraint. Private companies in the West that provide health services, pharmaceuticals, equipment, and other medical resources need to make a profit to stay in business. This means selling products to their clients (governments, health service organisations, the general public) at a cost-effective price, which third world countries simply cannot afford. Getting private companies to sell their health services and products at a loss, for example by provide cheap or free drugs, often requires government intervention and corporate will (Enserink, 2000), both of which are often lacking. In the midst of such adversity traditional medicine may provide the only viable source of health care.

Nigeria

Modern health care in Nigeria incorporates primary care provided by local government and privately owned clinics, secondary care dispensed by hospitals, and tertiary services (e. g. orthopaedics, psychiatry) provided by

specialist hospitals (WHO, 2002-2007). Like many third world countries the health infrastructure is severely under funded, with chronic equipment and staff shortages (Kadiri, 2005). Brain drain is a constant problem (Levy, 2003), and adequate health care is expensive and hence beyond the reach of the masses (WHO, 2002-2007). Traditional medicine operates side-by-side with modern health care. Most Nigerians have access to traditional healers, or ‘ medicine men’, especially in the rural areas where people lack local health infrastructure and transportation to travel to the nearest clinic or hospital. Thus, CAM is the only health resource available to most Nigerians (Mpyet et al, 2005). Nigeria is actually a ‘ melting’ pot of over 300 different tribes [1] , with remarkably different languages, cultures, lifestyles, religions and traditional governments (at local level). Thus, the practice of traditional medicine is quite varied across the country. Nevertheless, most medicine men are considered ‘ experts’ in the preparation and administration of various herbal medicines, and the prognosis for patients is often good. The use of herbal drugs remains very popular, especially amongst the older generation and/or less educated.

Recent evidence suggests that some Nigerians are suspicious of modern medical procedures and consequently fail to utilise services to which they have access. Raufu (2002) and Pincock (2004) both document a recent health crises in northern Nigeria in which parents refused to get their kids vaccinated against poliomyelitis. There was considerable scepticism about the vaccination campaign, with many parents fearing their children may become infected with the HIV, or worse become infertile, irrespective of what the health officials said. This incident seems to mirror a subtle nation-wide

cultural shift towards traditional medicine. For example, there have been calls for traditional healers to be involved in making referrals to secondary care services, along side professional medical doctors (Mpyet et al, 2005). The WHO has specifically encouraged research on traditional medicine in Nigeria, and the National Institute for Pharmaceutical Research and Development (NIPRD), located in Abuja, the capital city, has been identified as a possible location for such research. The NIPRD was set up to conduct research projects designed to improve, refine, and modernise traditional medicine, especially in terms of herbal remedies. The institute has successfully developed some herbal medicines including NIPRD AM-1, a herbal extract for treating malaria.

In other parts of the country steps have been taken to ‘ blend’ traditional medicine with modern medical procedures. The Fantsuam Foundation (IHDC, 2003), a women’s group founded in 1996 and based in northern Nigeria with over 80, 000 members, was set up to help rural women fight their way out of poverty. This organisation is not profit oriented, works in collaboration with local government, and uses modern computer resources, such as electronic commerce. The foundation recognises the value of CAM especially amongst women living in poor communities, and works to reconcile traditional practices with modern medicine. Women in this part of the country are plagued by a variety of health problems ranging from minor ailments (e. g. back pains) to more serious conditions (e. g. HIV/AIDS). Thus, there is an ever-present demand for appropriate health care. Traditional healers are very active, using various emollients and herbs to treat patients. More encouragingly, the Foundations’ work in the community has highlighted

several interesting points concerning the modernisation of traditional medicine. These include the following; Some aspects of traditional medicine can be improved for better health service provision; Traditional healers are open to modernisation initiatives provided there is a sense of partnership and intellectual property rights are protected; Traditional medicine as a body of knowledge can be preserved while simultaneously opening it up to reforms. Overall, the value of traditional medicine as a widely available health resource is universally recognised in Nigeria.

Pakistan

Pakistan like other third world countries suffers from an under funded and under-resourced modern health care system. Poverty-related health problems are rife, including low birth weight (Bhutta et al, 2004), hepatitis (Yusufzai, 2004), sexually transmitted diseases (Wallerstein, 1998) and high infant mortality and malnutrition (Abbasi, 1999). The health care system is dichotomised into the public and private sectors. The former incorporates a mixture of mostly unregulated private hospitals, clinics, and traditional healers, while the public sector is made up of government run hospitals, mostly in very poor condition (Shaikh & Hatcher, 2005). Overall, Pakistan’s health service system does not compare favourably with its neighbours. Poverty, illiteracy and poor sanitation, as well as political instability compound the problem, with infant mortality and infectious disease particularly problematic (Abbasi, 1999; Zaidi et al, 2004). Historically CAM has been a permanent part of the health care landscape in Pakistan, practised in the form of ‘ Unani’, ‘ Ayurvedic’ and homeopathic systems (Shaikh & Hatcher, 2005). Unani medicine entails the use of natural

resources normally found in the body, such as clean and fresh water, whereas Ayurveda remedies are sensitive to a woman’s natural rhythms and cycles.

There is particular emphasis in Pakistan on the use of plant-based traditional medicines, albeit animal based products are sometimes used. In the midst of chronic and widespread socio-economic deprivation more and more Pakistanis are turning to traditional healers for their health care (Shaikh & Hatcher, 2005). Local ‘ hakeems’, religious leaders and medicine men regularly dispense traditional therapies. These individuals enjoy considerable public trust and respect, especially in the rural areas, and patients regularly present with a wide range of medical conditions including gynaecological problems. According to Jafry (1999) traditional medicine was officially acknowledged in Pakistan under the Unani, Ayurvedic and Homeopathic Practitioners’ Act of 1965. The practice of homeopathy in particular has become well established, with increases in the number of homeopathic (privately owned) schools, especially after the Homeopathic Board and National Council for Homeopathy (NCH) was set up. Currently there is an abundance of homeopathic clinics, pharmaceutical companies, and other related organisations in Pakistan. Interestingly, despite these advances Pakistan continues to import homeopathic medicines in large quantities and local drug prices remain high. Consequently many Pakistanis cannot afford homeopathic treatment. Like the modern health care system which is heavily under funded ((Abbasi, 1999), homeopathic medicine remains crippled by under investment (Jafry, 1999). Despite these drawbacks, CAM as a whole remains more accessible than modern health resources, and constitutes an

indispensable resource for the vast majority of the population (Shaikh & Hatcher, 2005).

Exploitation

NAHO (2003) has identified a number of important concerns that need to be recognised if CAM is to be successfully integrated with modern medicine in developing nations. Firstly it is essential to recognise the important role played by the elderly, who form the bulk of spiritual healers and medicine men. Less common in Western culture, high reverence for elders in many third world countries is a major reason traditional medicine enjoys considerable public endorsement. Secondly, there is the risk of exploitation by unscrupulous western private enterprise. In particular it would be wholly inappropriate in a cash economy for a private pharmaceutical company, concerned about making a quick profit, to offer symbolic but worthless ‘ gifts’ to a traditional healer in return for valuable knowledge on local medicines, ointments and herbs. Thirdly, there is the issue of intellectual property rights. These must be protected under any circumstances, again to avoid unfair exploitation and profiteering by private companies. Health care funding provided to third world governments by the WHO, World Bank, and other financial organisations should be conditional on the establishment and implementation of satisfactory protective policies. For example independent (e. g. WHO) officials can be used to supervise contracts that are drawn up between private enterprises and traditional healer groups.

Conclusions

As early as 1984 Cooper argued that Western medicine might not really be suitable for the third world (Cooper, 1984). Despite the rapid spread of modern medicine CAM remains an indispensable resource for providing adequate health care to the majority of individuals living in these countries. Socio-economic and political problems have severely limited access to modern health care. However, considerable progress has being made towards harness the potential of traditional medicine, for example by allowing traditional healers to make hospital referrals. Both the WHO and World Bank seem committed to promoting the development of CAM. Given the complexity and variability of health provision across the third world it may be necessary to tailor health care reform to the peculiar requirements of each country (Buch, 2005). Traditional medicine is firmly rooted in local culture and customs (NAHO, 2003), and therefore traditional health protocols cannot be generalised across nations. Additionally, concerns about equality, protection rights, and other ethical issues need to be addressed.

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Footnotes

[1] There are three major tribes; The Hausa, Ibo, and Yoruba.