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Opening the Closed Circle of Health in Asia

Most Asians today still live in primarily rural environments. In these situations, almost all of the people are deprived of certain basic goods and opportunities which are normally found in growing urban/industrial centers. This lack of access to the necessities of life and the means to buy or produce them shows the acuteness of their poverty.

This culture of poverty must not be seen only in its economic terms but also acknowledged in its social and political dimensions.

People are sick or children are malnourished because their parents do not have the money for treatment, or to buy or grow proper foodstuffs.

And why do the parents not have the money?

However, instead of giving more attention to such questions, the medical and health professions are tending to become increasingly inward looking and specialised. Inbreeding has become the norm, with everybody busy 'doing their own thing'.

This is not to suggest that all specialization is an unnecessary, or at best a necessary evil. The question is whether the areas of specialization are relevant to the particular problems of the society for which they are being pursued. It is only seldom that medical specialization is related to Asia's poverty situation. Medical researchers and health planners do not appear to be perturbed by symptoms like most Asians not being able to afford almost any form of medical treatment; the 'distance' of medical research and services from the poor in urban and rural areas, and the general lack of social concern on the part of the educated elite.

For a start, it is necessary that issues related to medical practice and research are not allowed to remain within a closed circle. These issues have very much to do with economics and politics and have relevance for preventive as well as curative medical care. Preventive measures against ill-health can, and often do, prove to be as out of reach from poor people as curative treatment that must always be followed-up with expensive drug prescriptions.

In recent years, attempts have been made to implement various preventive and public health programmes covering controlled water supply, nutrition, malaria control, immunization against communicable diseases, etc. These measures, laudable enough on the face of it, would have had greater impact had they been carried out simultaneously with land reform and other egalitarian changes in the pattern of assets and incomes of the people.

However, instead of concerning themselves with such problems and relating their work to the over-all problem of eradicating poverty, 'medicos' have found it more profitable to mind their own narrow business of health as a specialised occupation. In acting like this they have however only conformed to similar trends in other disciplines in the social and natural sciences.

Another point to take into consideration is that in developing societies, the primary responsibility for providing health care rests with governments. And the question can be asked as to whether government systems are capable of providing effective health care for the majority of their peoples.

The following articles try to give an overview of a few creative responses of Asian groups who are trying to cope with this health problem in close contact with local communities.

This issue also features the importance of indigineous systems of medicine as in the case of Ayurvedic medicine in India as well as the use of acupuncture in China. The importance of herbal medicines is also underscored, as seen in the Chinese experience.

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Special Issue on Health in Asia

Mantras and Medicine

(Excerpts from a report by David Drucker for the Mobile Training Scheme of the Economic and Social Commission for Asia and the Pacific of the U.N. David Drucker is a social scientist who is now working with the Asian Regional office of WHO, based in Delhi).

From the planner's eyeview in Kathmandu one constantly sees maps of Nepal scattered with measles-like dots (usually in red) which 'cover' the country. Coverage is usually expressed either as a ratio of 1 to so many of the population, or has a geographical significance.

It is clear to us that this coverage is graphic only. Only in rare situations reported to us do people travel any great distance for Health Post care and even in the Panchayats (or sometimes the actual village) where a Health Post is situated it cannot be said that real coverage actually takes place. Sometimes this is because the Health Post functions poorly, but more often there are impediments and barriers through which the people will not pass to use modern medicine. The question is often asked: "how can modern services (of all kinds, not just health) reach out into the villages?" The more meaningful question seems to be: "how can one assist and motivate the people to reach up to the realistic resources which are made available in a way the people want and understand?"

How Can We Eat Paper?

The impediments and barriers are sometimes straight forwardly economic in origin: "How can we eat paper?" the villager asks; he means that he is given a prescription for medicine which is often not available and if is, for which he has no money. Living in areas in which subsistence agriculture is the pattern, and not having entered into a cash economy from the barter system, it is more meaningful to him that the 'indigenous' healer expects (usually does not *asks* for) offerings of food or sacrifices of he-goats, chickens, ducks, etc. Not only is it possible for the villager to produce these 'offerings' but he is not expected to 'pay' until he is 'cured', unlike the medical practice of paying cash in advance.

It is clear that many village people see sickness not as a discrete condition, but related to a series of misfortunes that befall them. Ideas of causation are not often present, certainly not in terms of phenomena such as flies, drinking water, excreta, bacteria, virus, etc. The cause is not tackled so much as what needs to be done, *which* evil influence is to be bargained with, or which good influence is to be propitiated. Each requires an offering (usually of *food*).

The treatment of the *sickness*, the actual symptoms, seems to be of secondary importance and it is these that the medically trained person might be able to treat.

Two Areas of Phenomena

Thus it is that the indigenous healer appears to understand and to be able to deal with two areas of phenomena and has two sets of skills. The first is what might be called demonology and the second is medicine (treatment of signs and symptoms). The modern-trained medical practitioner, according to this view, has only *one* skill, and that is the lesser one anyway. Permission is commonly necessary from the indigenous healer before the patient or his family will dare approach the modern practitioner.

Although, of course, there are many variations, it would seem that the indigenous healers make some accommodations to modern practice (where it appears and becomes available). What is not clear is whether modern medicine has accommodating practices to make to the indigenous healer and his 'devotees' (patients?). For service delivery strategies, such a question is crucial. For example, it is reported to us that some school teachers are emphasising to the children "away with all this superstitious nonsense" in areas where no modern alternatives are actually available and when the school teacher falls sick he is pleased (privately) to receive what attention the indigenous healer can give him.

We have already commented how even in Kathmandu, sophisticated 'modern' people still use the old healers along with the new.

What seems to be required is some kind of set of strategies so that in any given area we can effectively introduce what modern medical technology can offer according to the social and conceptual condition of the community approached. Thus, in circumstances where modern resources are scarce or not available the indigenous healers should be seen as the major (if not *only*) resource and manpower, and attempts should be made to *organise* their service as effectively as possible, providing a framework for their cooperation between each other with whatever training or aids can be provided to them. The objective of such a strategy should be to ensure that one minimises the amount of harm they can do (e.g. cleaning of scythes before cutting umbilical cords, etc.) while gradually maximising the positive good. At a later stage such healers must be constructively involved in creating the conditions within which, whatever modern functionary we have, the resources to introduce will be positively received in the context of the indigenous healer's welcome and recommendation.