
Integration or Fatal Embrace? The Uneasy Relationship between Indigenous and Western Medicine

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The relationship between western medicine and other medical traditions is bound to remain a controversial and confused item for discussion. During the past five to ten years a spate of publications¹⁻¹³ have advocated some form of cooperation while at the same time warning of certain pitfalls. B. Velimirovic's recent provocative article¹⁴ denouncing the WHO's policy toward an integration of western and indigenous medicine has certainly intensified the debate. In this brief note, I want to draw attention to three aspects of the problem which have remained largely unnoticed: First of all, the WHO policy seems more rhetorical than real; secondly, an effective integration of modern and traditional would probably lead to a speedy eclipse of indigenous medical traditions, and, thirdly, outside the auspices of the WHO and national ministries of health indigenous health practitioners are often engaged in an informal process of 'integration' with western medicine. My argument will both endorse and criticize Velimirovic's point of view.

In a survey of the literature Pillsbury¹⁵ has summed up the reasons why cooperation between western-trained practitioners and indigenous healers seems logical and necessary. The most important reason is well expressed in the title of one of her earlier publications⁷: "Reaching the rural poor: indigenous health practitioners are there already". Western medicine is not able to meet the demand for health care facilities in the rural areas where the majority of the third world population lives. It is said, probably with some exaggeration, that 70 to 80 percent of that rural population has hardly any access to 'modern' health care. Governments will not be able to solve this problem in the foreseeable future by training more doctors and other medical personnel, and by building more facilities. Moreover, those who have already been trained often try to get away from the rural areas. Statistics show that the unequal division of medical workers over urban and rural areas is almost universal. To cite one impressive example: In North Yemen over half of the number of doctors and nurses are found in the three largest towns where only seven percent of the population is living. In such a situation an appeal to traditional practitioners seems

a very logical step to take. The problem of doctors and nurses leaving the countryside would be resolved at the same time, because the town has comparatively little attraction for traditional practitioners. They depend on the local flora for their medical herbs, but there are more factors which bind them to their original place of living, for example the social prestige they enjoy in the village community, the land they cultivate, and the fact that their therapies are often addressed to ancestors and deities whose range of influence may be limited to certain localities. A further reason is the cost-saving effect of such a policy. Preparing a traditional healer for a function in the national health care system will probably cost over a hundred times less than the training of a doctor and also much less than training a nurse. The interest in indigenous medicine further increased with the growing emphasis on primary health care. One of the main objectives of primary health care is to encourage people's self-reliance in the field of health and health care. Where possible, dependence on external services should make room for the use of domestic resources. An appeal to indigenous healers fits in this philosophy.

Anthropologists have always stressed the importance of cultural 'kinship' between indigenous healers and patients. The sharing by patient and practitioner of a common idea about the origin, the meaning, and the best cure of an illness is an essential requisite for effective treatment. The lack of such cultural agreement is regarded by many a critic as the root cause of the sometimes limited effects of western medicine in developing countries. However, the most important reason why official medicine should perhaps make overtures toward indigenous medicine has not yet been mentioned. I am referring to the unique value of the various indigenous medical traditions. The conviction that these medical traditions contain valuable insights and therapeutic techniques which are unknown in western medicine could indeed be a reason to seek for cooperation and exchange of ideas.

Velimirovic's critique: It is exactly on this point that Velimirovic criticises the WHO. The unique value

of many indigenous cultural traditions has not yet been *proven*, but only *assumed*, apparently for diplomatic reasons. He even goes further claiming that "Traditional medicine is that part of culture least worthy of protection (as compared with language, art, music, oral tradition, poetry, etc. which must be protected by all means)" (p. 66)¹⁴.

Velimirovic vigorously denounces traditional medicine, thus contradicting himself in two respects: In the first place because he has just emphasized that traditional medicine has not yet been seriously evaluated; secondly, because he has pointed out that it is inadmissible to speak of 'traditional medicine' in general. Africa in particular, he points out, has "a vast variety of different beliefs and practices" (p. 64).¹⁴ Velimirovic seems to have reached the conclusion that indeed traditional medicine all over the world does not measure up to the standards of western medicine. At best, it may be innocuous, and some isolated techniques (bone-setting, for example) may even be as effective as those performed by western practitioners, but on the whole the balance is extremely negative, and he calls for "a change in beliefs of disease causation and treatments" (p. 66).

Velimirovic's remark that the WHO's change in policy is premature and not based on serious research is highly important. It is, however, regrettable that he too is led to draw premature conclusions and to give sweeping, highly biased statements about traditional medicine. A call for in-depth research on indigenous medical traditions before embarking on a policy would have been a more logical conclusion. But his account is ethnocentric in yet another respect. The main weakness of traditional medicine, he writes, is that it has "no built-in correction mechanism". It is not able "to carry out a permanent revision and critical reassessment" (p. 65). I largely agree with this statement, but disagree with the implication that western medicine does have such a "built-in correction mechanism". I am afraid that he grossly overestimates its ability to question its own premises. Various authors have cogently argued that medical scientists are often caught in their own assumptions and are not able to take alternative ways of reasoning seriously¹⁶⁻²¹. One of the first to point out that scientific theories are less 'scientific' than they claim to be was of course Kuhn²².

WHO's Lipservice: Velimirovic's concern about a precipitate integration of western and indigenous

medical practices seems however somewhat precipitate itself. The fact that the WHO has published a number of statements favouring 'cooperation', 'integration' or 'articulation' of western and indigenous medicine does not yet mean that such is really going to happen. The fact that the movement toward indigenous medicine is mainly based upon political considerations, as Velimirovic himself remarks, could very well suggest that one should not expect a firm practical policy towards integration.

A recent volume¹³ published by the WHO shows an impressive list of committees, institutes, reports and policy statements announcing a reevaluation of indigenous medicine, but it is as yet unclear what the effect of all these will be in the near future. Is it perhaps a new way of speaking? The anthropologist Charles Leslie writes in the same volume (p. 316):¹³ "One of the paradoxes of life is that we must have rules to have a society, but we cannot have a society without breaking rules. People must be able to do one thing and to say something else, for we must often make a normative system work by pretending that it works, and by adapting rules to circumstances." It seems that Leslie's remark can also be applied to the discussion on integration. That discussion could very well camouflage the fact that there is hardly any real rapprochement of western and indigenous medicine going on.

A striking example is shown in the film *Bono Medicines* which reports on the well-known project of 'integration' in Techiman, Ghana. The film starts with shots of dancing priest-healers in a state of trance. Some time later we see a medical officer of the hospital instructing a number of indigenous healers how to treat a wound. An American peace-corps volunteer examines the knowledge of the healers. We never see western-trained doctors or nurses in the position of listener, let alone of learner. The so-called integration proves to be an entirely one-directional affair. Indigenous practitioners learn the alphabet of western medicine and become primary health workers in the western tradition. If the Techiman example is representative for other integration projects, Velimirovic does not need to be concerned. The attitude to indigenous medicine has hardly changed. Pillsbury, in her evaluation¹⁵, reaches a similar conclusion. She writes that so-called integration projects usually boil down to simple co-existence of various medical traditions. Where real cooperation takes place, this concerns in many cases only traditional

birth attendants. Traditional healers proved much less en vogue. The literature she was able to study showed that in only sixteen countries (China included) cooperation with traditional healers was practised. Nearly always, these healers prove to be herbalists, that is healers who, as the birth attendants, have much affinity with the practical approach of western medicine. Shamans, diviners, priest-healers, etc. are nearly absent. In China they are explicitly forbidden. Velimirovic even denies that the Chinese example can be called cooperation between western-trained and indigenous practitioners because the so-called barefoot doctors "are not a traditional but a new category of health personnel" (p. 69)⁴.

Pillsbury further points out that the existing integration projects are nearly always *pilot projects* involving only a handful of indigenous healers. Whether China should be called a gigantic exception is debatable, as we have seen.

There are various reasons why the policy of integration has achieved so little; some of them are mentioned by Pillsbury. In the first place, there is no systematic evaluation of indigenous medicine, neither of its efficacy nor of the experiments of cooperation. Such evaluations are, however, necessary before a large-scale cooperation can be set up. Secondly, primary health care projects, where integration should be implemented primarily, often do not function well. Thirdly, financial problems delay implementation. Although integration is meant as a cost-saving measure, its implementation proves a costly affair. It sounds paradoxical, but it is not the first time that economizing measures cannot be taken because they are too expensive in the short run. A fourth reason is that policy-makers do not grant traditional medicine priority. Politicians are more interested in projects which extend their political power. Political support from the rural population is not won by giving them something they already have: traditional medicine, but by giving them resources they cannot produce themselves. Moreover, the interests of politicians are not served by making a population self-reliant, for self-reliance renders the state and the politicians superfluous. It is therefore not surprising that community-based initiatives of primary health care which indeed strengthen the people's autonomy, receive little assistance from the authorities or are even thwarted by them. Finally, we must face the wide gap in culture and medical paradigms between policy-makers and western-trained medical officers on the one hand

and indigenous healers on the other. However eloquently some prominent medical people and other functionaries may have pleaded for integration or cooperation, the majority of the medical profession remains not interested or against it, particularly where the indigenous tradition seems incompatible with western medicine.

Is integration possible? Asking whether integration of western and indigenous medicine would be possible and desirable makes no sense if the term 'integration' is not explained. I want to restrict the discussion to two ideal types of integration: one type which guarantees the preservation of the identity of indigenous medicine and one type which will lead to the loss of this identity. I hope to make clear that whenever integration is mentioned, this nearly always implies that the indigenous practitioner ceases to fulfill his own unique role and is reduced to a lowly qualified health worker in the western system.

It is ironical that the Chinese barefoot doctor is often presented as the example of a successful integration of western and indigenous. The barefoot doctor should rather be seen as an example of non-integration and fatal embrace. The Chinese system does not recognize the indigenous medical tradition in its own right. It only preserves isolated technical fragments from the old tradition, entrusting them to the barefoot doctor. Thus the tradition itself seems thoroughly destroyed, swallowed by the imported modern system. In a study of medical pluralism in Taiwan, Hongkong and the People's Republic of China, Lee²³ introduces the concepts 'structural superiority' and 'functional strength'. The former concept refers to a situation where a medical system has been able to acquire a superior position with the help of its greater control over disease, its social prestige and the support of dominant social groups and the authorities. The latter concept refers to the degree to which a medical system is spread among the population.

Lee remarks that the two qualities do not necessarily coincide. Often, a traditional indigenous system is better distributed, while the modern system is superior in social terms. When two different medical systems meet, whether this is peaceful or in competition, the quality of structural superiority produces most of the dominance. Lee shows that the western system, with its scientific ideology and its support among the social and political elite, continuously

moves to a dominant position which gradually leads to a process of 'medical absorption'. A confrontation may also lead to revivalism of the weaker system, but paradoxically even revivalist efforts often facilitate the process of medical absorption in the long run. In a situation of a hierarchically unequal medical pluralism, integration or cooperation which leaves the identity of either party intact seems impossible. Such 'integration' could be paralleled with the term 'political integration' which is often a euphemism for annexation and gradual annihilation. In an article on the development of the midwife in the United States, Cobb²⁴ uses the term 'cooptation' for the same phenomenon: By accepting certain practices of the midwife ('integration'), the dominant system appropriates them and absorbs the entire function of midwife.

The question whether 'integration' is *possible* while preserving the identity of the structurally inferior system, can be answered with a clear no. The question if 'integration' leading to the loss of this identity (which is possible, as we have seen) is *desirable*, is more difficult to answer. The answer clearly depends on one's standpoint. Someone who is convinced of the superior quality of western medicine will undoubtedly applaud this kind of 'integration' and consider it as progress in human well-being. Velimirovic, however strongly he may resist integration, can be regarded as an advocate of this viewpoint. Someone who believes in the unique value of a particular indigenous medical tradition will reject such 'integration'. It is not unlikely, however, that advocates of an indigenous system strive for 'integration', hoping to restore its dignity, but in actual fact contribute to its disappearance. Conversely, as we have seen, opponents of indigenous medicine may bar its 'integration', thus helping it to survive, because one thing seems beyond doubt: If a non-western medical tradition wants to survive, it should stay out of the clutches of western medicine. Asking what is desirable is bound to be an ideological question. What people desire depends on what they regard as true, as good, depends on what they 'believe' in. It is tempting, therefore, to simply call for research into the qualities of the various indigenous medical systems; a call which Velimirovic apparently deems superfluous. Unfortunately, such objective research is not easy to realize. It is not only theological dogmas which are difficult to prove via scientific tests. The articles of faith in the various medical systems

(including the western system) also often escape the tests of scientific reasoning. Moreover, what we call 'scientific' already belongs to the domain of the western medical system, and cannot be regarded as an objective tool to measure the effectiveness and adequacy of both the western and another tradition. In other words, scientific research itself proves to be imbued with ideology. Researchers, therefore, face the impossible task of not letting themselves be influenced by their ideology. Without losing sight of this contradiction, one could at least recommend that balanced research into indigenous medicine should be undertaken, and that for the time being the various medical systems should be granted more living space.

Informal integration: Asking whether integration is desirable is not only ideological, it is also pretentious in that it suggests that planning and policy can either implement or prevent integration. Such a pretention may well prove an overestimation of the possibility of controlling social processes. Both patients and practitioners may follow their own course of action, without paying attention to paper proposals, policy statements, and speeches fabricated in ministries and other bureaucratic centres. Both parties, patients and practitioners, often prove extremely syncretistic. An increasing number of publications^{25, 26} show that so-called traditional healers eagerly adapt elements of western medicine, such as potent drugs, especially antibiotics, injection-treatment, and other paraphernalia. The hegemony of western medicine is so firmly established that this unplanned process of acculturation seems unavoidable. Some authors²⁷ have termed this new syncretism 'transitional medicine', as it constitutes a transitional state between the indigenous and the imported tradition. While the policy-makers discuss a formal 'integration', the informal integration has already sneaked in. Neither patients nor practitioners seem to be bothered by the paradigmatic incompatibility which, according to various researchers, renders integration impossible. History repeats itself. An old heritage is abandoned in exchange for the impressive products of the West. The commercial attraction of these products probably plays a major role in this development. The dangers of this process for the health and general well-being of the people involved have been repeatedly spelled out^{25, 28, 29}, but the process can probably not be halted.

Conclusion: Velimirovic rightly points out that the WHO policy towards recognition and integration of indigenous medicine is premature and unfounded. However, his own critique of indigenous medicine is equally premature. Velimirovic also takes the WHO policy too seriously. It is unlikely that some form of integration or cooperation will be implemented on a wide scale in the foreseeable future.

Velimirovic, moreover, does not seem aware of the possibility that integration of indigenous medicine may lead to its disappearance, and not to its maintenance, and that, conversely, a decision against integration may provide the best chances for indigenous traditions to survive. In other words, Velimirovic's plea against cooperation and integration may have the exactly opposite effect to what he wants to hap-

pen. Finally, to make things still more complex, it should be borne in mind that an unplanned and informal process of medical acculturation is taking place, regardless of what policy-makers decide, and that this process is likely to produce considerable health hazards.

Why all this fuss, one could ask, about integration? In their heads, clients of health care have already achieved an 'integration' of medical traditions. They have an elaborate arsenal of ideas as to which practitioner is capable of treating which illness. In their heads, a complex 'referral-system' between various medical institutions exists. Why not leave it at that? Is a peaceful-coexistence of medical traditions not the most felicitous form of 'integration'?

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