The role of "Ethnomedizin" in health planning in developing countries. Preliminary considerations for a concept.

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"Ethnomedizin" has to play a clear role in health planning in developing countries. Advice and research in health planning is part of the mandate of our Institute of Tropical Hygiene and Public Health of the South Asia Institute of Heidelberg University.

When we deal with *Ethnomedizin* we are dealing roughly with the same area of work that in the English language is labelled "medical anthropology". Thus, our own medical system as a cultural construction is included in our concern. Theory and epistemology are still a problem of sorts, and beyond the intent of this paper.

In the context of this paper the term *Ethnomedizin* is being used without exception in the sense of a cultural anthropological approach to medicine. It refers basically to the systematic study of the cultural context of health, ill-health, and efforts to restore health, but also to observation of changes in, and transcultural comparison of, health care systems, their elements, functions, and related meanings.

The first role of *Ethnomedizin* in the context of health planning was that it provided here and there some description of aspects of traditional health systems. One of the most cited introductions of the subject was Benjamin D. PAUL's *Health, Culture and Community*, 1955. However, when modern health care and health planning care became a global fact, the existing knowledge of traditional health systems was far too scanty to be relevant for consideration in the health planning approach. In addition, there is in fact the science's bias in the modern health profession which was prohibitive to considering traditional medicine at all.

Thus, medical anthropological knowledge had no chance and still has little chance to be included in the health planning approach.

We are well aware that each and every culture has developed its own health system and also that interaction between health systems as between cultures has been a fact for ages. However, there has never been a time when the system of one culture virtually influenced globally all other cultures, as we are witnessing today. There are differences in which scholars look at *Ethnomedizin* according to their scientific background, be they anthropologists or physicians. We will comment here on the need for "ethnomedical" knowledge and expertease needed by physicians and health scientists in health planning. They are applying scientists, and they have met stupendous problems of communication and efficiency as well as effectiveness, working in developing countries. One lesson definitely learnt in the process is that *Ethnomedizin* is a tool of great potential, indispensible for mastering the task of health care, disease care, and health planning in the third world.

What is true in medical health care in developing countries is as much true in medical and health care in our own societies and world-wide. Modern physicians and health planners from our societies who have worked in developing countries and who have seen the results of their efforts falling far short of their ambitions, recognize and accept that *Ethnomedizin* must become part of medical sciences in teaching, research, and medical practice in order to balance the present shortcomings. However, we are here confronted with a central and almost unsolvable interdisciplinary problem. The tools of modern public health as well as of modern curative medicine are well developed and systematized for teaching and practice. This is not so for the cultural anthropological approach to medicine and health planning. In addition, we experience the problems of coming to grips with different conceptual approaches in both fields when we try to work for the practical solution of a problem in health planning. Our own experiences in Heidelberg demonstrate how, under the prevailing circumstances, we try to make use of "ethnomedical" scientific approaches in modern health planning and health systems research.

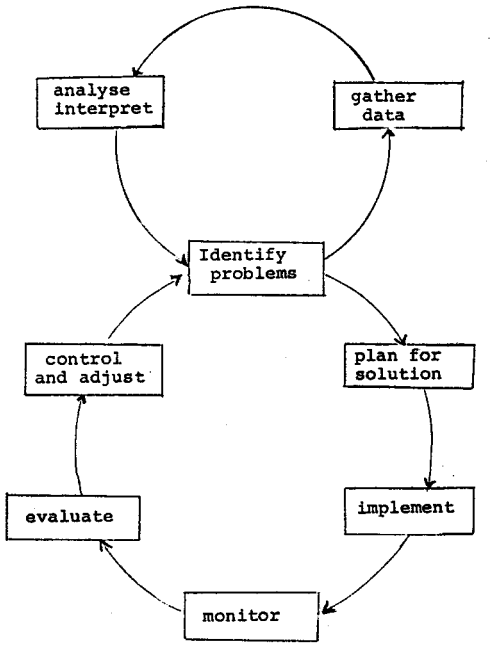
Our interest in this approach began as early as 1973, when our institute held a symposium together with the "German foundation for international development (DSE)" in Berlin on "Community Health and Health Motivation in South East Asia"[1]. At that time, the role of traditional medicine in modern health-care was discussed extensively with representatives of universities and health ministries of eleven South and South East Asian countries. This was five

years prior to the WHO's official recognition of the role that traditional health systems have in health care in countries of the third world. Since 1974 *Ethnomedizin* is integral part of our postgraduate training curriculum for medical doctors and other health personel preparing for volunteer services overseas. Since 1979, we provide "ethnomedical" courses for undergraduate students of medicine and anthropology. It is definitely easier to provide for "ethnomedical" education that to use *Ethnomedizin* as a research, implementing and evaluation tool in health planning. However, we are extending our efforts in both directions.

It is indispensible today to sensitize medical professionals who are going to work overseas to the fact that they are not going to work in a medical care vacuum, but in very different and very diversified systems of pluralistic health care, and also that people there definitely have different views of health and illness, of disease causation and healing than a western trained doctor, be he national or expatriate. The difficult question of acceptance, rejection or collaboration of various health care systems is not just a scientific one. It is an ongoing process in all cultures. However, where modern medicine was already introduced, where a modern health care delivery system was already established, it often becomes a highly delicate professional and a very sensitive political issue to introduce the medical anthropological approaches into health care planning.

We are only referring to the highly controversial statement of WHO concerning traditional medicine within the goal for "Health for all by the year 2000" through primary health care and the reactions from politicians and health professionals. And there are also warning voices from medical anthropologists that integration of traditional medicine into modern health planning may result in a deadly embrace.

The integration of *Ethnomedizin*-knowledge and philosophy in health care planning for the third world is beset with overwhelming difficulties. The lack of knowledge of non-western health care systems, traditional as well as transitional, in terms of motivations, concepts, behaviour, functions, roles, interactions, etc. is desperate. The lack of communication between the medical and the anthropological profession is also problematic. Yet, only together can we work at the issue of ethic criteria on which sound, culturally adapted, health planning in the third world should be based.



We want to introduce here the problem solving cycle adapted from John BRYANT:[2]

The upper circle demonstrates the independant collection and interpretation of cultural anthropological and health sciences data of the system. At each step we can demonstrate the need for either medical anthropological data collection or medical anthropological expertease in data interpretation. At the center where both circles meet we have then the "identification of health care problems", the first most important interdisciplinary step.

1. Identification of health care problems:

– *modern medicine:* Here we have the need of analysis of disease patterns by clinical and epidemiological parameters, anthropometrical and population parameters;
– *medical anthropology:* Here we have the need for documentation and analysis of local health behavior, customs , resources, concepts of health care and locally perceived needs;
– *cooperation of both:* The challenge for an integrated approach to health planning is to identify health problems from the health care and the cultural an-

thropological point of view and to plan for a solution that integrates both perceptions.

Ideally of each culture in which we work we should have fundamental background knowledge of the cultural system of medicine in traditional and transitional terms with all their aspects. We rarely have this information to begin with, nor do we have the funds or capacity to conduct the necessary profound studies. Therefore, we usually have to be satisfied with the possibilities of studying concepts of health and disease and perceiving the health needs of the local population in relation to what we are trying to accomplish. But we must be aware of the problem that if we change the system at one point, everything changes without us being capable of documenting and evaluating these changes with respect to their impact on total health (= physical, psychological and social well-being).

The greater challenge would be to strive for health planning approaches that consider their impacts on the culture as a whole and the improvement of health of people not only in biomedical but also in cultural, terms.

2. Planning of a particular or general health problem:

We are restricted in our efforts to develop cultural anthropological approaches to health planning by factors mentioned above. However, when we plan for the solution of a particular or general health problem
– in the area of primary *preventive health care* (= basic needs, strategy or general development for health);
– *secondary preventive* health care (= preventive medicine in the strict sense);
– *tertiary preventive* health care (= curative and rehabilitative medicine).
We are aware of this problem.

Looking beyond the present practices, needs and dilemmas that we face at our institute, we can say that we face a challenge worldwide: to enable and enpower "ethnomedical" research, knowledge and expertease to contribute on par with the biomedical and public health sciences to the development of primary health care. This includes most of all an analysis of the eight elements of primary health care concept in each culture while developing the seven principles of primary health care in cultural anthropological terms (see overleaf).

Inherent in the primary health care approach is a great challenge for cooperation between health sciences and *Ethnomedizin* and a great need for the development of applied "ethnomedical" knowledge and expertise so that its capacity can be included on par in the development of planning, implementaton monitoring and evaluation of health programs also from the cultural anthropological point of view.

3. Implementation and monitoring programme

When implementing a programme, close monitoring of the process and the outcome has to be considered from the beginning, as well as local participation (participating, observation and monitoring). This should include cultural anthropological indicators as well as public health and biomedical indicators. So far we know of no program in which cultural indicators have yet successfully been included in program monitoring.

The evaluation of a program again has to consider the "ethnomedical" aspects. This should include at least an informed understanding of the changes within the systems of health care as they affect everyday life of individuals and communities in health and illness in behavioral terms. In this context *Ethnomedizin* should become an applied sister science to plan, implement and monitor changes in health care in a culturally appropriate manner that is, to avoid unnecessary trauma and tension but yet improving the health status of the population.

There are many health development programs in the third world. So far they are rarely being utilised for cultural anthropological approaches not only to contribute its present expertease but also for the benefit of Ethmomedizin proper, that is also to develop intervention-monitoring tools from the cultural anthropological point of view. The principle ideas for cooperation between health sciences and *Ethnomedizin* have been formulated long ago by many researchers but the tools for this interdisciplinary approach are depending as much on qualified health information as on qualified "ethnomedical" information. Their development depends on qualified interdisciplinary discussions and planning and they have to be properly developed and tested in the field of applied research and practical health planning.

Sieben Grundsätze zur Primärversorgung, Genf (WHO) 3.8-3.10:S. 32

1. Die medizinische Primärversorgung sollte an den Lebensgewohnheiten und Lebensstilen der Bevölkerung, der sie dient, orientiert sein und sollte sich an den Bedürfnissen der Gemeinschaft ausrichten.

2. Der Basisgesundheitsdienst soll integraler Bestandteil des nationalen Gesundheitssystems sein. Die weitere Auffächerung der Dienste sollte den Notwendigkeiten entsprechen, die sich an der Basis ergeben; dies betrifft insbesondere die Verfügbarkeit technischer Möglichkeiten sowie Aufgaben der Überwachung und Beratung.

3. Die Aktivitäten einer medizinischen Primärversorgung sollten voll integriert sein in die anderen Sektoren, die es mit der Entwicklung des Gemeinwesens zu tun haben (Landwirtschaft, Erziehung und Ausbildung, öffentliche Dienste, Wohnungs- und Kommunikationsfragen).

4. Die Bevölkerung am Ort sollte sowohl an der Formulierung der Aufgaben als auch an den Bemühungen um die Problemlösungen im Gesundheitsbereich aktiv beteiligt werden, so daß der Gesundheitsdienst mit den jeweiligen örtlichen Bedürfnissen und Prioritäten zur Deckung gebracht werden kann. Entscheidungen darüber, welche die Nöte der Gemeinschaft sind, die einer Lösung bedürfen, sollten sich auf den beständigen Dialog zwischen den Leuten an der Basis und den Mitarbeitern der Gesundheitsdienste gründen.

5. Die angebotenen Gesundheitsdienste sollten größtmöglichen Gebrauch machen von den in der jeweiligen Gemeinschaft vorhandenen Ressourcen. Dabei sollten besonders die Möglichkeiten berücksichtigt werden, die bisher nicht in Anspruch genommen wurden; die angebotenen Gesundheitsdienste sollten ferner die zwingenden Grenzen für die Kosten achten, die es jeweils im Lande gibt.

6. Basisgesundheitsdienste sollten sich um den Ansatz bemühen, in dem präventive und kurative Maßnahmen ebenso wie der Rehabilitation und der Gesundheitsförderung dienende Programme gleichzeitig und in gleichem Umfange aus- und aufgebaut werden, und zwar zugleich im Blick auf Individuum, Familie und Gemeinschaft. Das Verhältnis, in dem diese einzelnen Dienste zueinander stehen, sollte sich je nach den Bedürfnissen des Gemeinwesens einpendeln, dabei mag es im Laufe der Zeit durchaus Veränderungen geben.

7. Der größte Teil von der Gesundheit dienenden Aktivitäten sollte auf der jeweils am dichtesten an der Basis angesiedelten Ebene, auf der sie noch praktizierbar sind, geschehen und von Mitarbeitern ausgeführt werden, die für die jeweils erforderliche Maßnahme am besten ausgebildet sind.

WHO off. Rec.No.226,
Annex 15, p. 116,

THE SEVEN BASIC PRINCIPLES OF PRIMARY HEALTH CARE

- Primary health care should be shaped around the life patterns of the population it is to serve and should meet the needs of the community.
- Primary health care should be an integral part of the national health system, and other echelons of service should be designed in support of the needs of the peripheral level, especially with regard to technical supply, supervisory, and referral support.
- Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing, and communications).
- The local population should be actively involved in the formulation and implementation of health care activities, so that health care can be brought into line with local needs and priorities. Decisions as to the community's needs should be based on a continuing dialogue between the people and the services.
- Health care offered should place maximum reliance on available community resources, especially those that have hitherto remained untapped, and should remain within the strictest cost limitations.
- Primary health care should use an integrated approach of preventive, promotive, curative, and rehabilitative services for the individual, family, and community. The balance between these services should vary according to community needs and may well change in the course of time.
- The majority of health interventions should be undertaken at the most peripheral level possible of the health services by those workers most suitably trained to perform these activities.

Genf 1975

Aus: Medizin in Entwicklungsländern 1. Aufl.

One reason for our difficulties is certainly the lack of theory and epistemology of *Ethnomedizin* as related to modern health care development needs. One other reason certainly is the dilemma of the different paradigmatic approaches in our different fields, although we are under the impression that there are promising developments in science research so that the paradigms problem may be more efficiently dealt with in not too distant a future for medicine also.

However, a related problem is, how the sciences and the development of third world countries are being supported. Strategies and priorities are decided upon in the political arena. They are depending on conditions of power relationships with which we have to deal at the present if we want to consider the development of applied *Ethnomedizin* for the need of health planning in third world countries.

Anmerkungen

1 DIESFELD H. J. 1977. Der Einbau traditioneller Gesundheitssysteme in den Rahmen nationaler Gesundheitsstrategien in Entwicklungslandern. In SCHRÖDER E. (Hg): *Faktoren des Gesundwerdens in Gruppen und Ethnien*. Beitrage zur Südasien-Forschung 30. Wiesbaden: Steiner, 79–83.

2 BRYANT J. H. 1969. Health and the Developing World, in HELLBERG J. J. *Community Health and the Church,* Genf, p. 44.

3 DIESFELD H.-J., SCHRÖDER E. (Hg) 1978. *Medizin in Entwicklungsländern.* Ein praxisorientierter Orientierungskurs für Ärzte, die erstmalig in Entwicklungsländern tätig werden. Ergänzende Skripten (Ringbuch). Heidelberg (im Auftrag der GIZ, Eschborn), 1. Auflage.

4 DIESFELD H.-J., WOLTER S. (Hg) 1984. *Medizin in Entwicklungsländern.* Handbuch zur praxisorientierten Vorbereitung für medizinische Entwicklungshelfer, 4. neu bearbeitete Auflage. Reihe Medizin in Entwicklungsländern. Schriftenreihe zur Medizin und zu Gesundheitsproblemen in Ländern der Dritten Welt, hrsg. v. Prof. Dr. med. HANS-JOCHEN DIESFELD, Heidelberg, in Fortführung der Schriftenreihe „Gesundheitsprobleme in Entwicklungsländern" der Lehranstalt für Allgemeine und Sozialhygiene an der Universität Hamburg, hrsg. von Prof. (em.) Dr. med. habil. Dr. phil. H. Harmsen, Bd. 19. Frankfurt am Main/Bern/New York/Nancy: Peter Lang.

Die 8 Elemente von Primary Health Care	
1. Erziehung zur Erkennung, Vorbeugung und Bekämpfung der örtlich vorherrschenden Gesundheitsprobleme 2. Nahrungsmittelversorgung und Sicherung der Ernährung 3. Trinkwasserversorgung und sanitäre Maßnahmen	Intersektoraler Bereich (Grundbedürfnisse) primäre Prävention
4. Mutter- und Kind-Gesundheitsversorgung einschließlich Familienplanung 5. Impfungen gegen die vorherrschenden Infektionskrankheiten 6. Verhütung und Bekämpfung der örtlichen endemischen Erkrankungen	Präventivmedizin integriert oder in vertikalen Programmen
7. Behandlung gewöhnlicher Erkrankungen und Verletzungen in angemessener Form 8. Versorgung mit essentiellen Medikamenten (entnommen aus der Deklaration von Alma Ata)	Kurative Medizin auf Dorfebene mit Referenzsystem

Quelle: DIESFELD, H.-J., WOLTER, S. (Hrsg.) 1984. Medizin in Entwicklungsländern, S. 230.

Nachlese und Kommentar zu dem Artikel: The Role of „Ethnomedizin" in Health Planning in Developing Countries.

Es ist eine besondere Herausforderung, einen eigenen Artikel aus 15 Jahren Abstand zu kommentieren und darauf hin zu untersuchen, wie man ihn aus diesem Abstand heute bewertet, und dies noch dazu als einer von damals zwei Autoren.

Der Artikel war die zusammenfassende Darstellung unserer damaligen Bemühungen, der *Ethnomedizin* ihren Stellenwert in Forschung und Lehre in dem von mir geleiteten Institut für Tropenhygiene und Öffentliches Gesundheitswesen der Universität Heidelberg zuzuschreiben und auch ihren Stellenwert bei der Entwicklung moderner Gesundheitssysteme in Entwicklungsländer zuzuordnen. Bei der nochmaligen Lektüre unseres Beitrags muß ich feststellen, dass wir uns wohl damals unserer Sache überhaupt nicht so sicher waren und diesen Bemühungen wenig Chance einräumten.

Unsere Ausgangshypothese war, und zu der stehe ich nach wie vor, dass jede Kultur, unsere westliche eingeschlossen, ihre eigenen Vorstellungen von Gesundheit, Krankheit und Heilung und ein darauf ausgerichtetes Medizinsystem entwickelt.

Wir sahen damals, dass der globale Gültigkeitsanspruch der „modernen, westlichen, naturwissenschaftlichen Medizin" die spezifischen Belange und medizinischen Systeme anderer Kulturen nicht berücksichtigte, sondern argumentativ, technisch, ökonomisch und, unterstützt durch seine Erfolgsstories, niederwalzte.

Wir hatten 1987 jedoch noch die Hoffnung, dass die WHO mit ihrem „weltgesundheitspolitischen Konzept von Primary Health Care" der späten 70er und frühen 80er Jahre dieser kulturanthropologischen Komponente der Medizin eine Chance geben würde. Es führte die Prinzipien einer partizipativen, kulturell angepassten, sozial verträglichen und ökonomisch machbaren Gesundheitsversorgung ein. Nach einer sehr monopolistischen, fremdbestimmten Medizin von oben-außen sahen die Entwicklungsländer hier eine Chance zu einem autochthonen Aufbruch. Wir sahen in diesem Ansatz auch eine Chance für die *Ethnomedizin* als Verstehens- und Verständigungsinstrument bei der Planung und Implementierung moderner Gesundheitsversorgung. Wir sahen aber auch damals den Mangel einer soliden Theorie, eines Konzepts und eines Konsens auf der Seite der Verfechter/innen dieses Anliegens.

Gleichwohl muß heute festgestellt werden, dass im Zuge der neuen Entwicklung, auch im Bereich der Gesundheitssystemforschung oder auch des TDR-Forschungsprogramms (Tropical Disease Research) der WHO die kulturspezifischen Krankheitsvorstellungen und Bedürfnisse der Bevölkerung und da mehr Beachtung fanden.

Wenn dies auch nicht „Ethnomedizin/Medical Anthropology" war, wie wir sie uns vorgestellt haben, so war und ist es bis heute ein Anliegen der Gesundheitsplaner und derjenigen, die Gesundheitspolitik auf der politischen und technischen Ebene umsetzen, diese Bedürfnisse der Bevölkerung genauer zu berücksichtigen.

Vielleicht können wir alle, die wir uns hierum bemüht haben, uns dies zu Gute halten, auch wenn heute außerhalb enger Fachzirkel weder von *Ethnomedizin* noch von „Primary Health Care" die Rede ist.

Vielleicht ist es auch nur die Erkenntnis, dass eine bankrottes Staatsgebilde seinen politischen Versprechungen nach einer „Gesundheitsversorgung für Alle" ohne eine massive finanzielle Beteiligung „Aller" nicht nachkommen kann.

In einer Zeit der „Globalisierung" und „Liberalisierung" des „Gesundheitsmarktes", der sogenannten „Gesundheitsreformen" allenthalben und der späten Erkenntnis, dass eine gesunde Wirtschaft einer gesunden Gesellschaft bedarf, geht es nicht ohne eine gewisse "Partizipation" Berücksichtigung kultureller Werte.

Die Erkenntnis, dass die meisten Krankheiten, in Entwicklungsländern zum mindesten, jenseits des offiziellen Gesundheitssystems behandelt werden, zwingt zu besseren Kenntnis des Gesundheits- und Heilungsverhalten der Bevölkerung und somit zu „medizin-anthropologischer" Forschung.

Nur auf dieser Grundlage wird eine Dezentralisation der Versorgungsstrukturen möglich werden. Dann wird vielleicht auch meine in unserem Artikel zitierte Vermutung wahr, dass dann erst die letzte Stunde der traditionellen Medizinsysteme geschlagen hat.

So würde „ethnomedizinische" Forschung zur Speerspitze der weiteren Globalisierung des internationalen Pharmamarktes, wie dereinst die Ethnologie die Speerspitze des Kolonialismus geworden war.

Hans-Jochen Diesfeld,
Starnberg im November 2001