Global Health and Wellness: Integrating Public Health with Traditional and Complementary Health Practices

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Health care, medicine and public health are rooted in the concept of eradicating human suffering related to illness and disease. Despite many common features, each area offers unique perspectives into specific philosophies and approaches to curing disease, restoring and ensuring health, and promoting wellness.

In Africa, traditional medicine and other approaches including integrative, complementary and alternative methods intersect with public health in a number of ways. Mhame and colleagues have stated that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." (1) Optimal health and wellbeing depend on both having access to clinical services as well as individuals' behaviours and attitudes.

Between 2002 and 2005, the World Health Organization (WHO) included Traditional and Complementary Medicine (T&CM) in its overall health services strategies for the first time. More recently, WHO issued its strategies for the period 2014 through 2023 related to Traditional Medicine (2). The objectives of these strategies included the following goals:

- Build a knowledge base for management through policies.
- Strengthen quality assurance, safety, proper use and effectiveness through regulation.
- Promote universal health coverage by integration.

At the opening of the WHO Congress in 2008 in Beijing, Dr. Margaret Chan, Director-General of WHO, made the following statement about integrating T&CM into national health systems: "The two systems or traditional and western medicine need not clash. Within the context of primary health care, they can blend together in a beneficial harmony, using the best features of each system, and compensating for certain weaknesses in each." (3)

In May 2014, the 67th World Health Assembly adopted a resolution on Traditional Medicine (4) that outlined the following agenda:

- To adapt, adopt and implement, where appropriate, the WHO strategy as a basis for national T&CM programmes or work plans.
- To develop and implement working plans to integrate T&CM into health services particularly primary health services
- To report to WHO on progress in implementing the strategy.

This resolution (WHA67.18) requests that the Director-General of WHO facilitates Member States' implementation of the WHO strategy and to provide guidance for developing policies related to integrating T&CM services into health care systems.

Translating policy into action depends on a firm grasp of public health principles as well as a vision for future global health. I spoke with two specialists in international health about their

ideas on integrative approaches in South Africa. **Dr. Paul Kadetz** is the Director of the BSc Programme in Public Health at Xi'an Jiaotong-Liverpool University and Honorary Lecturer at the University of Liverpool. He is also a Research Associate at the Refugee Studies Centre at the University of Oxford and an Associate of the China Centre for Health and Humanity at University College in London. **Dr. Daniel Gallego-Perez** is a doctoral candidate in International Health at Boston University School of Public Health. He worked as a primary care physician in a refugee camp setting in Ghana for over four years. He has also written about use of indigenous herbs in his native Colòmbia.
Both Kadetz and Gallego are colleagues in our Integrative, Complementary and Traditional Health Practices' Section of the American Public Health Association.

Question: What are your experiences with T&CM in an international public health context?

Kadetz: From my research, I have found that the way in which people *use* health care *is* the actual health care system, regardless of the formal state (biomedical) representation of the health care system. Thus, the myriad health care practices and practitioners in any given group is very much part of the public health of that group. Public health is not merely biomedicine writ large, but all of the plural health activities of a group.

My doctoral research specifically concerned the actual outcomes of implementing WHO's policy for health care integration at local levels in the rural Philippines. I found that what is actually being done in the name of "integration" is the promotion of certain globally accepted T&CM practices (such as acupuncture and Chiropractic) to the detriment and marginalisation of existing local health practices and practitioners. Thus, top-down integration controlled by biomedical experts can result in a reduction of existing health care pluralism. Thereby, health care access may in turn be reduced. Furthermore, the purported logic of biomedical integration is that it is necessary to ensure the safety of health care and yet in my own research I found that imposed constructions of safety that are alien to a given group can result in both a) group resistance and b) increased health risks. Thus, non-biomedical practices and practitioners must be a visible and considered to be an element of public health despite biases to render them invisible.

Gallego: One of the most interesting experiences during my time in Ghana was the importance of not only being "culturally-sensitive" and attempting to understand the culture, but also actually respecting it and creating a space for it within the clinical encounters and public health practices. In many instances, for example, I engaged a local healer to help me with patients with whom I had "therapeutically failed" or for whom I really could not offer a meaningful culturally-relevant "treatment". For example, I had a few patients for whom I did several courses of various treatments for different dermatologic manifestations. They had in common that anything I would do would not really help them. Then I referred them to a local herbalist/healer and he was quite successful and their symptoms resolved. Thus, collaboration among different kinds of practitioners is very important in several contexts, particularly in contexts where systems such as the biomedical model do not count with a framework to interpret and treat conditions that are rooted or closely related with cultures and ways of living/being.

Another important aspect of this point is the relevance that T&CM has in resource-constrained contexts. For instance, in many cases, where it was not possible to access specialized care for

patients with severe conditions, I resorted to using T&CM methods with remarkable success. That is to say, T&CM techniques are useful in many cultural contexts, as long as they are accepted by the local culture. Often, limitations of resources could open the door to T&CM treatments that might be not favourably seen otherwise.

Question: Are there clear connections between public health and T&CM? What promotes understanding or connectedness? What are barriers to understanding or connectedness?

Kadetz: In many ways the public health framework is more akin to non-biomedical frameworks than to the biomedical paradigm. Does biomedicine consider the macro-level in terms of causality or treatment? Does a physician query a patient about their community or social world in taking the patient's history? I would argue that in biomedicine all issues of health are reduced to the micro-level of analysis, namely the physical human body. This may be understood to have affected the health management discourse of public health that similarly places all responsibility for health change on individual behaviour, regardless that the changes that are most needed are social and well beyond an individual's control.
Public health, by its very nature, is concerned with the relationship between people and their social and physical worlds. T&CM practices, such as Traditional Chinese Medicine, as well as many local practices understand the macro world as part of the micro world of the person. We call this kind of framework "holistic", because it is not reductive in that the person needs to be considered as a *part of* their world rather than *apart from* their world and somehow existing in a theoretical test tube. This holistic framework is exemplified by the myriad depictions of the mandala found in numerous healing systems; representing the restoration of the wholeness of the person in balance with the wholeness of their physical and social environments. So, yes, I would argue that the paradigm of public health by its very nature shares a paradigm that is similar to non-biomedical frameworks.

Gallego: I think there are very important connections between public health and T&CM in every context. Some of the drivers for that connectedness could include: cultural relevance, acceptability of practices, access to care. These three work in both directions, that is, both public health and T&CM need to be culturally relevant, acceptable and accessible. Often, T&CM methods are closer to people's ways of thinking and ways of living, thus more acceptable, and easier to access. Public health systems should use T&CM to create bridges with people for whom conventional medicine and public health interventions often seem way too remote from their world. Public health should engage T&CM practitioners in a constructive dialogue to create networks that could safely and effectively take care of people.
Barriers include social distance between university-trained health professionals and T&CM; mind-sets created at universities that promote separation; cultural believes; history of abuses on both sides.

Question: Because of the systematic exploitation and under-development of Africa by Europe in particular, as well as by the U.S., what is our role as public health professionals in partnership with Africa? How do we counter centuries of racism?

Kadetz: Though more subtle than actual colonialism, knowledge colonialism most definitely is a living and thriving form of colonialism. The imposition of high-tech biomedical health care

interventions and expertise, implemented in the name of doing what is best for a group, whilst ignoring cultural contexts and local knowledge, is a recipe for ineffective interventions at best and disaster at worst. To counter centuries of racism, high-income countries need to get off their paternalistic high horse of self-proclaimed expertise and start to dialogue with local knowledge in order to arrive at interventions that are not only inclusive of local expertise, but appropriate for local contexts. The reductionism that public health inherits from medicine has to be shed for complexity and holism that affords more realistic interventions pertinent and appropriate to a given context. This is as true for public health as any form of local "development". *Listening*, rather than *dictating* may be the first step in resolving the knowledge colonialism embedded in public health expertise.

Gallego: I think one of the most important things to consider are the recognition of the immaterial and intellectual property that T&CM practitioners and cultures should enjoy (I think there are treaties and documents about patents of traditional medicines, for example). Often, pharmaceutical companies have their eyes open to catch potentially exploitable uses of medicinal plants (particularly when related to isolation of potentially useful active ingredients for drug development). And then, local communities and practitioners receive nothing from that development.

Another important factor to consider is the sustainable use of resources. Plants/animals might become extinct if they are unsustainably harvested for medicinal purposes. Related to the previous point is the issue of conservation of native habitats that have not even been explored yet for potential medicinal purposes. Some potential remedies might become unavailable before we even get to know that they exist!

Then, of course, ways of living, systems of healing, and cultures do undergo pressures (particularly from globalization) and the wisdom of traditions might be lost if no adequate provisions are made by countries/communities.

Question: What is your vision for T&CM in Africa?

Gallego: Some African countries are quite active in recognizing the importance of and advancing the integration of T&CM into their healthcare systems. African countries are being more and more exposed to T&CM that are foreign to them. In Ghana, for example, they have a research institute on herbal medicine and they created a degree program in one of the biggest universities of the country to train herbal medicine doctors.

Kadetz: In her critique of normative development and foreign aid, the economist Dambisa Moyo argues that to receive no western aid is better than the dominant forms of foreign aid that perpetuate dependency and destroy self-sufficiency in Africa. I believe the same criterion is needed to assess public health interventions; are they fostering self-sufficiency or perpetuating dependency? We could argue that quite simply health aid or interventions that are dependent upon a continual flow of external expertise essentially create *need* rather than provide sustainable solutions. Whereas, sustainable solutions may be found by employing assets-based approaches to fostering the health care capital that already exists, but may be unfamiliar, or more likely, disregarded by biomedical expertise; such as found in local-level health care practices.

Working together to create sustainable solutions is one of our goals as part of a global public health movement. In the spirit of working collectively to shape a healthy future for all the World's children, we wish our South African colleagues success in their important work. We are honoured to work together with you.

References:

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