Healing Mind: Mental health, Indigenous healers and Traditional Medicine

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Abstract

Mental illnesses and other psychosocial disabilities are main source of burden for the family. About 13.7 per cent of general population of India has issues of mental illness or disorders and 10.6 per cent of these people need immediate intervention for the treatment followed by 10 per cent of the population has common mental disorders with 1.9 per cent people suffers with severe mental disorders. The mental morbidity is very high in urban areas. There is a higher prevalence of neurotic or stress-related disorders, schizophrenia and mood disorders. This situation may be due to fast-life styles, experiencing stress, complexities of living, a breakdown of support systems and challenges of economic instability. There are few population-level insights into the use of traditional healers and other forms of alternative care for the treatment of common mental disorders in our country as well as in South Asian and sub-Saharan Africa countries. Paper examines the extent to which alternative practitioners are consulted, and predictors of traditional healer visits for various neuropsychiatric diseases. Further it illuminates studies and national survey conducted on mental health on tribal communities and the role of traditional healers in the country. Paper raised the issue of mental illnesses as prevalent in the country and questions that do indigenous healing matters in healing the mind for better mental health in our country in first part of the paper besides analyzing recent survey, NMHS-2014. Then illuminates various mind healing ways and put it in question whether we can protect these healers and their medicines in existing IPR in part-II followed by traditional knowledge, medicines, National policy and cases of Indian patents and Intellectual Property Rights (IPR) in the last part where we conclude countries like Canada, South Africa or New Zeeland have supported for integration of traditional healers with main stream health care system. There are fears also generated for example in Canada that increasing acceptance of traditional healing may result into sea change. The lessons of these countries may be useful for our planning for integration of healers and their medicine in our country for effective resources utilization of the traditional healers and their medicines.

Keywords: *Mental Illness, Traditional Healers, IPR.*

1. Introduction

Mental illnesses and other psychosocial disabilities are main source of burden in the family. About 13.7 per cent of general population of India has issues of mental illness or disorders and 10.6 per cent of these people need immediate intervention for treatment followed by 10 per cent of population has common mental disorders with 1.9 per cent people suffers with severe mental disorders. The mental morbidity is very high in urban areas. There is a higher prevalence of neurotic or stress-related disorders, schizophrenia and mood disorders. This is situation may be due to fast-lifestyles, experiencing stress, complexities of living, a breakdown of support systems and challenges of economic instability. There are few population-level insights into the use of traditional healers and other forms of alternative care for the treatment of common mental disorders in our country as well as in South Asian and sub-Saharan Africa countries. Traditional Indian medicines-ayurveda, Chinese medicine, and Arabic unani medicine, as well as to various forms of Indigenous medicine around the world are grouped to together as Traditional medicine (WHO, 2002). Indigenous healing are treatment procedures used in the folk healing or rather traditional healing in traditional medicine.Traditional medicine accounts for approximately 40 per cent of health care in China, and 80 per cent in Africa, with methods including herbal medicines, the use of animal parts and/or minerals, manual therapies and spiritual therapies to maintain well-being, to diagnose and treat illness. In this paper we raise the issue of mental illnesses as prevalent in our country and question that do traditional healing matters in healing the mind for better mental health in our country in first part of the paper besides analyzing recent survey, NMHS-2014. Then illuminates various mind healing ways and put it in question whether we can protect these healers and medicines in existing IPR in part-II followed by traditional knowledge, medicines, National policy and cases of Indian patents and Intellectual Property Rights (IPR)in the last part.

2. Mental health: towards healing mind

Do we really look for solution in the mental health surveys? Or do we just enumerate the gravity of the mental health problems, i.e. how many people are suffering with which mental illness? Survey only shows gravity of the problem, not the solution and plan to control for these illnesses. Nobody tells how best can be prevented these illnesses. Most of the professional tell intensity of these diseases, but do not

chalk out the effective planning resulting intoappropriate solution. Let see the recent mental health survey, NMHS-2014 and its findings, followed by some case studies and relevance of participation of people in mental health awareness programme.

2.1. Mental illnesses- Situational analysis, DHMP, Mental health bill: *Where is cure or remedy?*

About 13.7 per cent of general population of India has issues of mental illness or disorders and 10.6 per cent of these people need immediate intervention for the treatment followed by 10 per cent of the population has common mental disorders with 1.9 per cent people suffers with severe mental disorders (Table-1). The mental morbidity is very high in urban areas. There is a higher prevalence of neurotic or stress-related disorders, schizophrenia and mood disorders. This situation is alarming, may be due to fast-lifestyles, experiencing stress, complexities of living, a breakdown of support systems and challenges of economic instability mentions the recent survey. A pilot study was conducted in Kolar district, Karnataka where 3,190 individuals were screened for the mental illnesses. Further NMHS-2014 was extended in13 States viz. Punjab, Jharkhand, West Bengal, Rajasthan, Rajasthan, Gujarat, UP, Tamil Nadu, Kerala, Madhya Pradesh, Chhattisgrah, Assam and Manipur.Assam, Uttar Pradesh and Gujarat reported prevalence rates of mental illnesses less than 10 per cent and in eight of the 12 States, the prevalence varied between 10.7 per cent and 14.1 per cent (see Yasmeen, 2016, NMHS-2014)

Table 1: Prevalence of Mental Disorders in Different Sates

Sl. No.	States of India	Percentage
1	Manipur	14.1
2.	Madhya Pradesh	13.9
3.	Punjab	13.4
4.	West Bengal	13.0
5.	Tamil Naidu	11.8
6.	Chattisgrah	11.7
7.	Kerala	11.4
8.	Jharkhand	11.1
9.	Rajasthan	10.7
10.	Gujarat	7.4
11.	Uttar Pradesh	6.1
12.	Assam	5.8

Table 2: Major Mental Illnesses in India

Mental Disorders	No. of people suffer	Symptoms of Mental Illness
Schizphrenia	3,737,481	Person suffers from delusion, hallucination
Mood disorders	19,933,232	Include depression and bipolar disorder, marked by alternating episodes of mania and depression
Cannabis users	9,966,616	Addicted to intoxicating hallucinogenic drugs
Mental retardation	1,245,827	A condition due to incomplete growth of brain, characterised by impaired cognitive, language, motor and social abilities
Child, adolescent disorders	30,896,510	
Geriatric disorders	3,089,651	Mental illness that onsets with aging
Dementia	1,893,657	Deterioration of an individuals' intellectual, emotional and judgmental abilities; can occur with aging or injury to brain
Common mental disorders	24,916,540	Describe a state of deeper psychological distress; includes anxiety disorders, dissociative disorders, phobia and somatoform pain or acute false pain
Epilepsy	11,212,443	Neurological disorder with convulsive seizure
Alcohol Dependency	12,458,270	Compulsive use of Alcohol

(Source: NMHS-2014).

3. National Mental Health Survey -2014: A brief

An important finding in this survey is that there are huge gaps in treatment of these illnesses. Further there three out of four persons (3/4) people are experiencing severe mental disorders in our country. Apart from epilepsy, the treatment gap for all mental health disorders is more than 60 percent. The economic burden of mental disorders is very high affecting families as they have to spend nearly Rs.1000-Rs.1500 a month mainly for treatment and to access care. Nearly 80 per cent of those with mental disorders had not received any treatment despite being ill for over 12 months due to the stigma of mental disorders mentions' the survey. Poor implementation of schemes under the National Mental Health Programme is the main responsible reason for this treatment gap. There is also a paucity of mental health specialists, pointing out that mental disorders are a low priority in the public health agenda in our country. The health information system itself does not priorities mental health. Recommending that mental health financing needs to be streamlined, he says that there is a need to constitute a national commission on mental health comprising professionals from mental health, public health, social sciences and the judiciary to oversee, facilitate support and monitor and review mental health policies (*Ibid*).

3. 1. Main findings

Most common illnesses were: depression, anxiety and substance abuse in this NMHS-2014.These were 10 percent to the total population studied. Most of the females in the age-group 40-49 years suffer from depression and it is almost 1 in 20 persons. 22.4 per cent of the population above 18 years suffers from substance use disorder. The highest was contributed by tobacco and alcohol use disorder. Nearly 1.9 per cent of the population is affected by severe mental disorders. These are detected more among males in urban areas. While prevalence of mental illness is higher among males (13.9 per cent) as compared to females (7.5 per cent), certain specific mental illnesses like mood disorders (depression, neurotic disorders, phobic anxiety disorders etc) are more in females. Neurosis and stress related illness is also seen to be more in women. Prevalence in teenagers aged between 13 and 17 years is 7.3 per cent (Table-2) (Ibid).

4. Healing mind

The following cases highlight the real picture of the common people (Mrinal, 2018). These reveals how they meet front line healers in the local areas. Ideally NMHP was launched 1982 with the hope of providing treatment at primary or district health centers. But real situation of DMHP-Sheohar, MP exposes their functioning at grassroot level in Sheohar.

> *Case-1: Jagat Ram's Sister*
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> He had been traveling from Hapur, UP to Institute for medicines for his younger sister. She suffers from depression, a common mental illness in the country. He tells about his sister illness: "It all began at her in-laws' place where she uses to complain of torture," recalls the 35-year-old. In 2007, she lost her newborn and it pushed her into shock. It was another addition, as blow, to her already existing problems in her marriage. She turned quiet, lost interest in doing household chores, personal care for her appearance and even stopped bathing. Her in-laws used to accuse her of acting to gain attention and did not think of her treatment. Her condition continued to deteriorate and then Jagat Ram forcibly brought her back their home. Jagat Ram spent money on costly private treatment in his native place for one year. But she showed no improvement. It was by chance that the family brought her to Institute. Here she is under treatment now and being recovering. He adds further that "We now have to keep her away from negative thoughts". Though I still spend money on travel and take frequent leaves from office whenever it is required (Mrinal, 2018 c.f. Varsheny,2013).

> *Case -2: Sanju*
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> Sanju is a tribal boy from a village in Jhabua district of Madhya Pradesh. He shows symptoms of depression. Ratan Singh, his father, believes that he is under the spell of evil spirits, because he was fine till two years ago. But his behavior suddenly changed. He stopped responding to calls and did not even care for himself. He would cry for no reason. In past two years, Ratan Singh and his wife have travelled several times to the Baba Dongar temple atop a hill, hoping that God would cure Sanju. They also promised to sacrifice cocks at the temple, if Sanju showed improvement. Though the boy did not show any sign of improvement. Baba Dongar is their only hope. When asked why he does not take Sanju to a doctor, a bewildered Ratan Singh says Sanju does not have any health problem. (Mrinal, 2018 c.f. Varsheny,2013).

4.1. National mental health programme(NMHP)

The Government of India launched National Mental Health Programme (NMHP)in 1982. One of its objectives was to integrate mental healthcare in general healthcare by introducing mental health centers through Primary and Community health Centers in each district. These centers are headed by psychiatrists who travel to interior parts of the district and provide treatment to patients. It is very interesting to observe the real field situation at the district level where how do the mental health professional work and encounter the everyday problems? The DMHP functioning the in-MP district reveals the issues at their level.

4.2. DMHP in Madhya Pradesh

The Sehore is a district in MP. There is has one DMHP centre which is not able to handle the load of patients in the area. It is the only hospital, other than the Mental Hospital, Indore and Gwalior Mental Hospital, to cater to the mentally ill people of Madhya Pradesh. Between 1996 and 2007, the Central government had sanctioned four DMHP centres in Shivpuri, Dewas, Mandala and Satna districts in the MP. But none is functional. The Sehore DHMP centre is under-staffed as people do not wish join. There is also shortage of psychiatrists and psychologists in the entire MP because there are no PG courses on these subjects in any of the six medical colleges of the state. Secretary of the Madhya Pradesh State Mental Health Authority says DMHP failed in the state because it is not a priority for the authority. The money sanctioned for Satna and Jabalpur centres was returned to the Centre because the district authorities were not interested in the programme.

Further adds "proposals have been sent to revive the defunct centres and begin DMHP in five new districts more than a year ago. But the proposals were never forwarded to the Centre," he says. The situation is no better in other states. The programme has made little headway in the past three decades (Varsheny,2013). One of the leading head of district mental hospital observes "*Very few patients visit the doctor,*" and adds further

> "While some fear social stigma, the rest are superstitious. We are planning to take the help of tantriks to bring mentally ill patients to the centre. Traditional or Indigenous healers, Tantriks, deal with many such patients and could be helpful to bring them here. They would perform their rituals and after that ask patients to visit the centre,"

In Madhya Pradesh theDMHP should beactive in 123 districts (of 652 districts), it is barely functional in most districts," mentionsStates Mental Health Policy Group, established in May 2011 to create a mental health policy for the country and provide recommendations to improve DMHP in the 12th Five-Year Plan. The group submitted its report in June 2012. It says "…*barring islands of good performance, the DMHP is yet to achieve its objectives,*" says the group. Inconsistent fund flow, lack of trained staff, lack of coordination between departments and non-availability of psychotropic drugs and psychological treatment are plaguing the programme. The group's report indicates that states are reluctant to take over funding of DMHP. As per the guidelines, the Centre will fund DMHPs for five years, after which the respective state governments shall take over the programme. A clinical psychologist working with advocacy group Public Health Foundation of India highlights another flaw in the programme design. "*NMHP is the only public health programme in the country where finances are routed through the Directorate of Medical Education,*" he says. "The deans of medical colleges are busy training psychiatrists and are not concerned about public healthcare whose foundation rests on awareness and reduction of stigma."

In the 12th Five Year Plan, the government plans to redesign the programme and expand it to all the districts in the country. But will it be effective given that India has never undertaken an official mental health survey? Several analysts are skeptical. A similar effort in 2002 to revamp NMHP and expand it to 22 districts had significantly changed the scope of the programme (Varsheny,2013). "The new policy reduced emphasis on access to services and community participation (which were the prime aim of the 1982 policy) and moved towards provision and distribution of psychotropic medication," (Jain and Jadhav,2009 c.f. Varsheny,2013).). The authorities revamped the programme without analysing the problems that were ailing NMHP. "...there is no indication of who was involved in this (consultation) process and what resulted from it," it notes. The study holds lessons for Union Ministry of Health and Family Welfare, which plans to revamp its mental healthcare system. It has drafted a Mental Health Care Bill to replace the Mental Health Act of 1987.

4.3. Mental illness: is it a biological reality?

Recent advancements in technology have established it well. With the advancement of technology, we could attribute emergence of mental illnesses to several factors:genetic inheritance, exposure to brain-damaging chemicals, conditions that beset people, such as work pressure, death of loved ones or even romantic rejection, which can trigger dysfunction of the brain and lead to mental disorders. The brain dysfunction may occur due to problems with neurotransmitters, where the level of the neurotransmitter serotonin is lowered in individuals who suffer from depression. Similarly, schizophrenia is linked to the disruption in neurotransmitters, dopamine, glutamate and norepinephrine.

Biological psychiatry is now an established branch of psychiatry and uses imaging techniques like psycho-pharmacology and neuro-immuno-chemistry to pinpoint the problem. Such understanding helps in the development of drugs to treat the problem.Using these techniques, researchers, in the past five years, have identified genes that influence susceptibility to five common psychiatric disorders, including bipolar disorder. Their finding was published in medical journal The Lancet. Using the technology, researchers at the National Institute of Mental Health in the USA are developing a classification system that would help differentiate the structure and function of a mentally ill brain from that of a healthy one. This will help researchers understand why a traumatic event leads to post-traumatic stress disorder, neurology of hallucinations and how drug addiction rewires the brain.There is still a long way to go. Scientists are not close to understand the brain the way they understand heart, kidneys and other parts of the body.

5. National Commission on Macroeconomics and Health (NCMH)

The National Commission on Macroeconomics and Health (NCMH) report was published in 2005. It is most reliable and often quoted figure that provides some sense of prevalence of the illness. According to NCMH, at least 6.5 per cent of the Indian population-more than 80 million people-suffer from serious mental disorders, such as schizophrenia, bipolar disorder and obsessive compulsive disorder, with no discernible rural-urban difference. The share of mental illnesses is 8.5 per cent of the total burden of diseases in the country. These figures will grow substantially with increase in population. Poverty, gender discrimination, alcohol use, stress of modern life, conflicts and natural disasters—most of the identified risk factors for mental illness are common in India. But in the absence of an official mental health survey, there is little data on the number of people who suffer from the illness. Suicides cases have increased more than 22% in the last one decade.

Tamanna, 30-year-old lives a life of rejection (*Case-3*), is not the only one who has been ostracised because of mental illness. A warden at the hospital, who did not wish to be named, says she has witnessed at least 12 such cases in the past two years where family members refused to take back their wards even after doctors certified complete recovery. More often than not women face institutionalization and desertion. Indore Mental Hospital alone has more than 40 women inmates compared to 20-odd men. More than 50 per cent of patients admitted to a mental hospital often end up staying there for five years or more. The most unfortunate aspect of this problem is that these patients have been in the hospital for years not because of treatment-related reasons but because their families have abandoned them. Prolonged hospitalisation has further impaired their socio-vocational skill, points out the National Human Rights Commission (NHRC) in its report submitted to the Supreme Court in February this year. NHRC has been reviewing mental health institutions in the country since 1997. That year the apex court had asked it to monitor mental health hospitals at Agra, Ranchi and Gwalior following complaints of human rights violation.

Table-3: Depressing growth- suicide cases in the country

Year	Number of People	Rate of Suicide
2003	110,851	10.4
2004	113,697	10.5
2005	113,914	10.3
2006	118,112	10.5
2007	122,638	10.8
2008	127,017	10.8
2009	127,151	10.9
2010	134,599	11.4
2011	135,585	11.2
2012	135,445	11.2

(Source: National Crime Records Bureau).

Case-3: Tamanna
Thirty-year-old Tamanna lives a life of rejection. Last year, her husband and his family brought her to Indore Mental Hospital. Doctors diagnosed her with bipolar disorder and admitted her to hospital. Within a couple of months, they declared her healthy and asked her family to take her back home. But no one wanted to take her back. Tamanna kept writing to her family for six months, but there was no response. Even her mother did not respond. Finally, the hospital administration had no choice but to shift Tamanna to a nearby shelter home with due permission of the Chief Judicial Magistrate (Mrinal, 2018, c.f. Varsheny,2013).

When to see a doctor: How do we know that there is need to consult the Psychiatrist? Here the standard procedure, American Psychiatric Association, has suggested following: When there is marked personality change in the person; inability to cope with problems and daily activities; strange or grandiose ideas; excessive anxiety; prolonged depression and apathy; marked changes in eating or sleeping patterns; extreme highs and lows; abuse of alcohol or drugs; andexcessive anger, hostility or violent behavior. In such cases we must see the specialist, psychiatrist.

6. *Dava* and *Dua* project (DDP): a community based project for better Mental Health

The shrine of Hazrat Sayed Ali Mira Datar, a General of Ahmedabad Sultan Mahmud Begada, has attracted devotees for over 500 years. It is one of the many places of worship in India where thousands of mentally ill patients seek divine remedy. The fabled power to cure mental illness, which has a huge stigma attached to it, also draws Hindus who consist of 50% of the visitors.

But today, the shrine is now known for dua as well as for dava. The Dava and Dua Project (DDP), was initiated in 2008, which has ensured that almost half of the visitors to the shrine also consult a psychiatrist and accept an amalgamation of faith and science to treat their mental illnesses. This is one of the pioneering initiatives in which traditional faith healers work in close association with psychiatrists and

psychologists, creating a model of social psychiatry that has attracted the attention of organizations such as the World Health Organization and the National Human Rights Commission. The organizations have even recommended the project's replication in other places. The model has already been implemented at shrines in Erwadi district in Tamil Nadu and Hyderabad in Telangana. Another shrine in Nagpur, Maharashtra, will be part of the DDP later this year.Few years ago n Erwadi, 25 persons in shackles had died in a 2001 fire accident.The tragedy had stoked outrage and spurred a nationwide drive to prevent practices such as chaining patients and beating them up to cure mental illness. The Unava is a shrine sharing a number of such practices.

The going was tough as mujawar, faith healers, vehemently protested when a team of doctors and others tried to inspect the premises in 2002, and police had to intervene. The medical practitioners did not lose hope and succeeded in starting the DDP formally in 2008. Managing trustee of Ahmedabad-based *Altruist*, a voluntary organization that manages the DDP informs in last eight years they have treated 38,500 patients who would not have gone to doctors anyway.Further adds that mental illness is stigmatized in India. So studies estimate that 82% patients of common and 47% of severe mental disorders never come into contact with medical practitioners. In such a situation, places like Mira Datar provide an opportunity us to reach out. According to the figures released by Altruist — the NGO running the *Dava* and *Dua* Project- most patients were diagnosed for depression followed by schizophrenia, epilepsy, somatoform disorders, mental retardation, and general medical conditions. In eight years, the DDP has reached out to an average of 400 patients per month. In 2015-16, patients from Rajasthan, Maharashtra, Madhya Pradesh, Karnataka and West Bengal formed a major part of the visitor population, apart from those from Gujarat. In all, patients from 17 states had benefited from the DDP.

Case-4

Neeti, 26-year-old from Dhuliya, Maharashtra suffering with mental illness that hadcome for treatment with her brother to Mira DatarDarah shrine, which is located in Mehsana district. It is 100 km away from Ahmedabad. The shrine is famed for its capacity to cure illnesses and 'possessions'. Thousands people across the country visit it to for the treatment.Neeti's brother tells that she was chained as she would smash things and beat up people. Neeti's family spends four months every year at Unava for her treatment. We consulted doctors but nothing worked. Now, she has become much calmer.The bouts still erupt but they last, at the most, for ten minutes (Mrinal, 2018).

It is clearly visible that DDP success is because of the integration of the traditional healers who holds people's faith and trust. Similarly government should think to induct them in their main stream of health care system.

7. Do we still need effective the mental health policy? missing participation of people and community

An officer of PHFI-Public Health Foundation of India expressed that public sector is small and the private sector provides most of the services. Therefore, the policy should focus on strengthening the public healthcare system. Simultaneously, it should regulate the role of private mental healthcare providers. Dependence on psychiatrists should be reduced as in the case of TB programme where not all diagnosis and treatment are done by specialists. Like HIV/AIDS programmes, mental healthcare system needs counsellors. The evaluation mechanism has also to be built in the policy.

Similarly *Snehi*, a Delhi based NGO suggests instead of devising a separate mental health policy, the government should make it part of the pending national health policies. Further a former director of NIMHANS expressed that we need to make mental healthcare accessible, affordable and acceptable to the patient. For this he suggests a three-pronged approach: involve community, integrate mental healthcare with general healthcare system so that mental illness is dealt along with other illnesses, and bring about a change in the attitude of specialist doctors who are not willing to accept that non-specialists could provide care.

Adding more the existing system is controlled by the pharmaceutical industry and the private sector lobby. Instead the government should focus on spreading awareness about mental illness. People should know what to do when they are mentally sick. Unfortunately, India does not have a diagnostic manual of mental disorders. For creating awareness the government should use standard methods such as posters, radio and TV shows, street plays and social media. Mental illness-related information can be made available in the form of questionnaires, narratives or life stories of survivors. Networks of survivors can help patients combat the illness. The awareness would go a long way in reducing social stigma and ensuring early diagnosis. An early diagnosis is the key to fight mental illness.

7.1. Treatment is beyond pills: Are pills solution for mental illness?

Today we are concern over the excess dependence on medicines. But pharmaceuticals have already changed the character of National Mental Health Programme (NHPM). They studied the role of psychotropic medication in NHPM and found that instead of being a symbol of accessibility to healthcare, the pill ends up being a method of administering a discrete treatment. Thus, instead of empowering the community, the pill silences community voices and re-enforces the existing barriers to care (Jain and Jadhav,2009). Pharmaceutical industries have dominated the mental health care system in India. In 2007, the psychiatrists and pharmaceutical company nexus in the US reportedly resulted in growing use of new antipsychotics in children. Between 2000 and 2005, the industry's payments to Minnesota psychiatrists rose more than six-fold. During the period, prescriptions of antipsychotics for children under the state's insurance programme rose more than nine-fold (Varsheny, 2013).

The US psychiatrists are prescribing six times more antipsychotics to children and adolescents than in the UK. More than 30 million Americans take antidepressants. Another example of this unholy nexus is the recently released Diagnostic and Statistical Manual of Mental Disorders prepared by American Psychiatric Association. The manual turns even common ailments into mental illnesses. For example, it terms common experiences like grief as clinical depression, and binge eating a new category of illness. It is alleged that the manual aims at pleasing the pharma industry (*Ibid*).

Here it clear these Pharmaceutical industries controlled the political economy to make their ways of profits. As already said the everyday problems are being medicalised and there is standard book where they have added as mental diseases with appropriate symptoms and their treatment strategy.Now we resume the mind, its healing ways and mental health in the indigenous healers and their healing section.

II

8. Indigenous Healers and their healing

There are many definitions of indigenous or aboriginal healing, but we are giving a brief analysis of various definitions of indigenous healing or aboriginal healing practices. These healing ways have a more holistic approach to health than the approach taken in most western medical models (Hewson 1998; Horn 2008; Smith 2009) and aboriginal contexts (Adelson and Lipinski 2008; Fiske 2008; Fletcher and Denham 2008; Waldram 2008) most have common elements, found on different continents where Aboriginal populations have been colonised, e.g.in North and South America to Africa and Australasia.They also mention spiritual and emotional issues in addition to mental and physical health (Moran and Fitzpatrick 2008). They focus on the frequent reference to 'balance' and/or 'harmony' (Chansonneuve 2005; Ross 2008); place emphasis on families and communities as well as on individuals (Lane et al. 2002) and include references to nature or aspects of the environment. In many cases these explicitly refer to healing from the trauma caused by aspects of colonisation, such as forced removals from family and incarceration in residential schools (Castellano 2006).There may be a deviation from western models, there are many examples which mention the healing required by those who have hurt others, as well as those who have been injured (Archibald 2006; Correctional Service of Canada 2008). In Australia the Aboriginal and Torres Strait Islander Healing Foundation Team (2009), state that healing is 'a spiritual process that includes addictions recovery, therapeutic change and cultural renewal'. The Team goes further to explain that:*...therapeutic change means dealing with trauma in a safe and culturally-appropriate environment. Cultural renewal means strengthening and reconnecting with identity, which may include language, dance and song* (seeWilliam, Guenther and Arnott, 2011).

Most of the Tribal or indigenous people undergo through trauma byforcible removal from theirlands, the break-up of societies and families and the removal of children away from their cultural heritage and often into situations of cultural, physical and sexual abuse in Australia as well as in other countriesof the world. Such trauma needs the healing at different level- at individual, family and community as means of alternative care (William, Guenther and Arnott, 2011).

8.1. Healing traditions

Healing traditions are the methods which are learned and passed down from generation to generation. It also includes the "experientially informed" healers when a healer gains through self-motivated skills in dealing with their own trauma or problems which can be helpful to other people. They may be called as indigenous or aboriginal healers. Let us see an example of traditional healing among the Navajo. The Navajo *hataali* spend years studying and working with a master healer to learn their craft of singing healing ceremonies. These chants are long and any mistake in words is considered dangerous and the potential healers are selected for their work ethic and seriousness, and must be prepared to spend years working on their craft and paying for what they are learning (Iris 1998; Sandner 1979). There are other forms of healing in Navajo communities, which may be practiced by men or women with diagnostic skills or knowledge of herbal remedies (Iris 1998), but they do not enjoy the level of status given to hataali. Similarly, there are long-established healing methods in east Arnhem which are still practised by Yolngu healers, and which require specialized training and experience to use (Wearne and Muller 2009).

There are Communities whose experiences have devastated transmission of cultural knowledge during the post-colonial period and unlikely to retain the degree of healing knowledge required for such extensive and rigorous ceremonies (Phillips 2003). The use of traditional healing practices may be more common than is realized, at least in both South America and North America:

> In some areas of the country [Canada, in this case] and within some Aboriginal communities, traditional healing practices remain very strong. There are traditional "treatment centres" which are being run with no external funding, no staffing or administrative structures and which are undocumented, often at the homes of healers. Many people, both within the literature and anecdotally ascribe their healing to participation in traditional cultural practices (Lane et al. 2002)

8.2. Healing methods

There are many methods in traditional indigenous healing which are normally employed. A healer tries almost every modality for healing someone. Often almost everything works for someone, and nothing works for everyone. It is clear that specific modalities are less important than the context in which they take place (Lane et al. 2002).Medicinal plants are often an important component (Dobson 2007; Swan and Raphael 1995) but ceremonies and other healing modalities are typically even more important, and most often there is a mix of healing methods, even in the most traditional healing modalities.

A list of healing methods may include: chants, cleansing and smoke rituals, counselling, healing circles, bush trips to special sites, painting and other forms of art therapy, vision quests, massage, residential treatment and many more, often used in various combinations (Fiske 2008; Smith 2009; Swan and Raphael 1995). Some approaches appear to be particularly effective, particularly the common emphasis on group healing involvement rather individual sessions, and the emphasis on cultural recovery. Healing circles were often cited as effective, compared to more standard western healing models:

> I probably could have gotten help [from a professional therapist], but what scared me was, I got in touch with my rage and for the first time, I became aware of how terrifying it was. I couldn't make myself go back to a therapist, because I'm going to be there alone, and I am going to be touching this terrible thing inside me, and I'm going to be walking away alone. I can't do any work through the western methods. It's just too much. I have to do my work through the traditional way. I have to use the circle. I have to have people that care about me and know they care about me. I want them there to help me through whatever it is I have to deal with. I can't do it any other way (Bushie 2008cf.William, Guenther and Arnott, 2011).

Perhaps the single strongest claim in the literature is the importance of re-connecting to one's own cultural traditions; indeed, in many cases it appears that 'recovery' is equivalent to recovery of one's lost cultural identity and that this is vital to healing. *The answer to improving the health of indigenous people may lay less in increasing their access to modern health services and more in their rediscovering cultural values and ways (Smith, 2003).*

Probably for such reasons, Canadian Aboriginal communities are increasingly adopting the 'Culture as Treatment' healing model across that country, sometimes in favour of more traditional local approaches, due to their perception of its special effectiveness (Lane et al. 2002: 30).

8.3. Healing places-Where to heal?

Indigenous healers generally do heal in their home.But there are examples in other countries where there are 'Aboriginal healing centre' where it takes place. This healing is used in many different senses ranging from frankly entrepreneurial centers that combine New Age techniques with Aboriginal healing practices. A Healing place may or may not be headed by an Aboriginal person, to centers specializing in western style medicine but in a facility designed for use by Aboriginal clients, to places offering solely traditional healing practices. In many cases, traditional healing may be offered in private homes or in community buildings not necessarily called 'healing centres' (Lane et al. 2002).

Hospital and clinics owned and operated by Aboriginal people may offer western medical equipment and procedures, but the facility is often designed to look and operate different from a mainstream hospital or clinic, perhaps with family spaces (for extended family of well of over a dozen people), 'talking rooms', incorporating local motifs, open spaces that do not separate healers from patients, and other culturally friendly features (Belfrage 2007; Finke 2009; Towne 2009). Iris (1998) noted that:

> Today… it is not unusual for a Navajo healer to perform some piece of a healing ceremony in the clinical setting, and many Navajo people are engaged as community health representatives, nurses, and interpreters, among others, in the health delivery system on the Navajo Nation.

Although there are facilities specifically designed to offer traditional healing, these are probably a minority; few of the Canadian Aboriginal Healing Foundations grants, for example, went to such facilities, with most going to programs that would be operated out of other facilities and perhaps incorporated into other programs (Aboriginal Healing Foundation 2008). Lists of different types of Aboriginal healing places can be found in Canada (Aboriginal Healing and Wellness Strategy Management 2003; Aboriginal Healing Foundation 2008) but no comprehensive national lists exist, likely due in large part to the difficulty of determining what exactly should qualify as an *'Aboriginal healing centre'*.

New Zealand provides relatively comprehensive national lists of services that 'deliver health and disability services to predominantly… although certainly not exclusively… Māori clients [within a]…. delivery framework which is distinctively Māori' and seeks to keep the lists comprehensive and updated (Cripps and McGlade 2008). In America, it is easy to find lists of services offered through the Indian Health Service for people living on recognised tribal lands, but it is difficult to find lists of services outside this system, and urban Aboriginal Americans in particular have great difficulty in accessing suitable healthcare (Young 2007). It has proven difficult to find good sources listing Australian Aboriginal healing centres. Even discussion papers and reports on the potential for Aboriginal healing provide little in the way of such information (Aboriginal and Torres Strait Islander Healing Foundation Development Team 2009; Phillips and Bamblett 2009). This may again in part reflect the difficulty of defining an 'Aboriginal healing place' but may also reflect the lack of strategic attention to date paid to such facilities at a national level.

9. Healers

The literature offers far more on the healing experience from patients' perspectives than can be found on healing from the traditional healers' perspective. However, a number of important themes emerge, including contrasts between the approaches taken by traditional healers and most modern doctors, the need to sustain Aboriginal healing knowledge by passing on information, the need to care for healers, and to importance of distinguishing between genuine healers and self-proclaimed 'healer' charlatans. The relationship between patients and their Indigenous and traditional healers differs from the patient/doctor relationship in most modern western practices. As Hewson (1998) notes, traditional healers may not distinguish between 'curing and caring', or between *subjective* and *objective* symptoms.

> "Traditional healers probe deeply into the patient's social and psychological well-being in addition to the history of the present illness. They already know or are prepared to learn about the context of the patient's life, such as his or her social and economic status, attitudes, beliefs, hopes, and fears"(Hewson (1998), c.f. William, Guenther and Arnott, 2011)

It is also important to explore -where these healers heal? There is a significant relationship of these two. Here Dobson (2007) elaborates it among Arrente women that power of healing comes from the country of whoever chosen to be healer. Further Trudgen (2000) also illuminates the relationship between healing and traditional laws among Yolngu and context of Arnhem Land. He says further that 'health matters' he concludes that:

> All this knowledge and the correct procedures pertaining to health and healing are encapsulated in the Yolngu law, the Madayin. (c.f.William, Guenther and Arnott, 2011, p-13)

Ganesharajah (2009) explains complex relationships on the healing, country and sharing intergenerational cultural knowledge in Canada. He pointed to need for 'recognition of the central importance of land to Indigenous peoples' identity, spirituality, community and culture'. In Canada, the sharing healing knowledge is also an important issue for lateral knowledge transfer as well as for intergenerational transfer. The following quote from a Canadian context confirms.

> Talk of "knowledge transfer" and the "exchange of best practices" has become, of late, very much the talk of the town [but] the prospect that useful knowledge might flow "up-hill," or even laterally from community to community is ordinarily excluded from the realm of conceivable or legitimate possibilities…(see Chandler and Lalonde 2006 c.f. William, Guenther and Arnott, 2011)

Healers are trying to improve opportunities for 'side-by-side learning' to ensure transfer of information by those who possess healing knowledge before the healers pass on. The intergenerational transmission of healing knowledge is also an important issue because such knowledge is guarded in many traditional societies. It is not shared with others. Similarly such situations have emerged in well-established healing traditions. The Navajo Nation where healers are finding it difficult to get young healers interested to learn and put in their years for acquiring skills to become a qualified traditional healer. In this endeavor a school for traditional healers was set up with the support of Cornell University bur it could not produced the desired results.(Iris 1998). Similarly, the Maori system of healing in New Zealand has been incorporated into mainstream health delivery system, interactive workshops with traditional healers revealed their difficulties with overwork and their ageing. Maori traditional healers are therefore currently looking at practice-based training with suitable candidates selected by older Maori practitioners and posing a problem in caring the older Maori healers. Here the caring of Maori older healers has becomes an important issue.

In Canada, the situation of aboriginal healers is similar to Maori healers. Aboriginal healing foundation and other similar organizations have helped to support these healers having serious issues of self care and traumatic experiences in Canada. Further the problem of distinction between qualified and non-qualified healers' remains. But such situation is being controlled by the membership of the formal

organizations, recently developed, which automatically declare them as qualified healers in South Arica and New Zealand. Today healers in these countries are facing their own problems of – self-injuries, ageing and unresolved legal issues (William, Guenther and Arnott, 2011 p-14).

10.   Integration of Traditional Healers and their Medicines: Experiences of some countries

Most of the countries of the world are using traditional medicines and about 80percent people in rural areas in developing countries rely on these medicines for primary care. In contrast developed countries mostly used western medicines for their day-to-day sicknesses. These developed countries are using similar medicines in their colonies and traditional healers or aboriginals' people also use same medicines seldom. However traditional medicines men do have their own medicines for such illnesses. In such countries- New Zealand, South Africa, Australia, Canada, and USA, the policies for the best care practices are still evolving. Government in these countries is using two strategies for increase the number of aboriginal healers /indigenous healers working in the main stream of health care. These people increase Aboriginal workforce without enabling the incorporation of traditional practices can lead to high turnover in Aboriginal staff. One registered Nurse Emmy Mitchell(1998)expressed her concern as follows.

> *Emmy Mitchell… looks at every elder as if they were her grandparents and strongly believes in the natural way of healing. To her that means hands-on healing; massage therapy, traditional medicines, soaking the elders' feet, talking to them in their own language and other comfort measures. Working first as a Licensed Practical Nurse, then as a Registered Nurse, Emmy clashed over and over again with doctors and nursing directors who believed in giving the elders muscle relaxants, sleeping pills and antidepressant pills… "As I passed and graduated the RN course, it was supposed to be big celebration, but it was not because the more I learned about medication and its side effectsthat our people are suffering from, it turned me away from being a nurse (Emmy Mitchell, 1998)*

Now let's see how these Countries look at such issues of traditional medicine and its healers? Can their integration to mainstream be a best way for them? In South Africa, some countries are colonized which are less in numbers, so they are in minority, as compare to aboriginal people living in these areas' priory to colonial rules.Here colonial government has evolved an attitude of curbing them as their medicine too.

They made legislation, *Witchcraft Suppression Act-*1957 forbidding traditional healing practices. But *Witchcraft Suppression Amendment Act-1970* replaced an attempt to partnership.

> In rural South Africa, over 60% of the population seeks health advice and treatment from traditional healers before visiting a medical doctor. Those that do seek formal health care also continue to visit a traditional healer… partnering with traditional healers and bringing them into the formal health system is vital to improving health in South Africa. Their potential as a resource and point-of-contact for both rural and urban communities cannot be ignored (African Medical and Research Foundation 2010).

WHO has also encouraged western medical practitioners for partnership with these healers' to control the problem of HIV/AIDS. Now these healers are making associations so that their services can be recognized by the South African department of Health. But there are issues related to medical ethics, on such partnership, between Traditional Healers and Medicines and mainstream health care system.

Maori constitute 15 percent of the population in New Zealand and have high rate of incarceration, ill health early mortality or suicides than other people. Government has changed her attitude towards the Tohunga (the traditional healer in Maori) between 1907 and 1962.The Tohunga(Maori traditional healer) Suppression Act had the provision of penalties for using any type of sorcery or enchantment or to claim to leave super natural power for the treatment of diseases. Such provisions have led many Tohunga to go underground. But their methods of healing continue (Archibalds, 2006, c.f. William, Guenther and Arnott, 2011). Now New Zeeland government formally, including traditional healers in the formal health care system. This way the government is also increasing Maori work force in the main stream of health care. Through there are challenges remains i.e. to distinguish between legitimate and non -qualified healers, to meet patient care needs, are evaluating practices, training new healers, and protecting cultural and intellectuals property right of these healers(*Ibid*, p-16).

In USA, 1.5 percent people are American Indian, or Alaska nation, or often called "Native Americans", then two groups may be attributed on "aboriginal" as I feel indigenous equally co-notates same meaning for these two groups. The Dawes Act suppressed traditional healing practice for a long times these nation Americans. This act prevented dances and ceremonies in 1921 or it continued till 1978. But Freedom of Religion Act in 1978 gives same freedom for these dance and religion ceremonies. By 1960, tribal people and nation Americans become politically empowered or gave a birth to American Indian movement (see Witllstock and Salivas, 2006, c.f. William, 2011). There are 564 recognized tribes living on the reservation in 38 states of USA and all of them are entitled Indian health services funded by the federal government. Hospitals, health care's, community clinic or often services are operating under the supervision of federal or the tribal system. These services are dedicated to tribal peoples or aboriginal people. Though only one percent of these resources are dedicated to others tribal or aboriginal people living off their land in the urban cities (See Young 2007).

The Indian health services are being provided for more culturally appropriate spaces healing through significant process of de-medicalise space in their culture. A number of partnerships have also emerged between traditional healers or mainstream primary care system (Finke, 2009, Town, 2009). Through this arrangement people or patient can approach a number of healing traditions (Lamphere, 2000). They may either go to a western clinic for any ailment i.e. for a broken leg and may have traditional healing ceremony for it to after returning from such clinic, or they may approach to traditional healer for an effective healing directly. In USA, the government is developing a strategy for a healing model which has culture and spirituality at the base due to the increasing partnership with traditional healers are incorporation of traditional healing practice(see Smith,2009).

In Canada, there are three groups of aboriginal people viz, first Nation, Inuit and Metis, which together make 3.3 percent of Canada's populations. These aboriginal people have been suffering with ill health, high risk of suicide, colonial trauma of forced relocation to the long "residential school" era-where aboriginal children removed from their families and kept in these schools for further education(see William…p.17). In 1980, Aboriginal health movement began after the darkest phase between 1950 and 1980 in Canada. A re-emergence of aboriginal spirituality or culture, due to greater political empowerment developed some new initiative for this Aboriginal people. Gov-

ernment started "Addiction services" in 1982 for these people baser their cultural principles particularly target the Aboriginal communities (Beadman, 2009). As Beadman (2009) further write about them

> *Many communities have experienced the revival of old ceremonies, practices and teachings such as smudging, the sweat lodge, the use of the sacred pipe, fasting, vision quests, ceremonies for naming, healing, reconciliation, and personal or collective commitment. Some communities seemed to have forgotten their own ceremonies, and so whole generations of younger men and women travelled to other communities and tribes across the continent to find spiritual teachers who would help them recover something of their own aboriginal spiritual teachings and practices. Sometimes, as the teachings and songs of another tribe were introduced in a community, the elders would begin to share their own heritage which had been hidden away in their hearts for so many years* (Beadman 2009).

In Canada, there is federal system where provinces are entirely responsible for health care. Through central government of Canada is especially responsible for health of aboriginal people in all the provinces. They are living on reserves provisions made for them. The Ontario province has very well-developed health care policy for the traditional aboriginal healing and has developed the agreement with a number of Aboriginal nations in Ontario for incorporation of their practices and also ensured access to other health options. One of such centre in Ontario is providing the health services to aboriginal people on holistic health services, combining traditional and western practices. The Traditional Healing Program uses various traditional Aboriginal healing methods and

> *…a holistic approach to individual, family and community health and wellness. Services include confidential sessions with traditional healers, access to traditional activities, learning about natural medicines, stress management workshops using traditional methods, and cross-cultural awareness training. (*Aboriginal Healing and Wellness Strategy Management, 2003*).*

There are other initiatives taken by the other provinces in Canada. These are healing for offenders about to re-enter, communities, training or enabling the aboriginal to work in other parts of health care system (Lane et. al 2002, Lavalles, 2007).

The development of "Aboriginal Healing Foundation" has greatly influenced the aboriginal health care system or streamlined with other system. Initially it was set up for limited time period, but it continues to support the programm in healing legacy of Canadian residential school for emotional damage, violence or abuse by survivors, or their children. ((Adelson and Lipinski 2008; Archibald 2006; Castellano 2006; Chansonneuve 2005; KishkAnaquot Health Research 2006; Mussell 2005; Waldram 2008)..

In Australia, 2.4 percent of its people are aboriginal or Torres Strait Islanders based in northern territory. They are in pre-dominantly aboriginal. They are younger, less migratory, have higher fertility and mortality rate, high population growth and wide dispersed people as compare to aboriginal people. Main problem of these people is high suicide, violence, abuse, family breakdown, health problem, life expectancy.These are more in Torres Strait Islanders and other aboriginal in Canada, New Zealand and USA (Archibald, 2008).

As already mentions in other case that Australian government has adopted traditional healing practice into mainstreamhealth care. Through it does not support them. About Australian government, Devanesen (2000) writes:

> *"Traditional healers were employed by the Northern Territory Department of Health at various rural health centres in Central Australia in the early 1970's.... A training course to teach traditional healers about western medical practices was attempted in 1974. It was soon realised that it would be better to train a separate group as Aboriginal health workers and to leave the traditional healers to their vitally important roles… However, rural health centres continue to recognise and cooperate with traditional healers in the management of sick people… The Northern Territory Department of Health's first policy on Aboriginal health stated that "traditional medicine is a complementary and vital part of Aboriginal health care, and its value is recognised and supported".*

But recent documents, "Aboriginal Health and Families: a five year frame work for action"; it notes, understand and acknowledge the potential value of traditional healers:

> *...Increasingly the medical profession has recognised that 'health care belief systems are critical to the patient's healing process' and overseas studies have shown that the practice and advice of traditional healers is often valued more highly than the advice from western medical practitioners. These themes are repeated in recent decisions of the Australian Health Ministers' Advisory Council*(Northern Territory Department of Health and Community Services 2005)

Although, this document does not propose any effective programme for the healers as remains continue to improvement the western medicine with involvement of community and the cultural of activity. In contrast Dunlop (1988) mentions the importance of "Aboriginal traditional method and their community imitations given equal status to non-aboriginal medical practice"."Bringing them home" report expressed need for holistic approach to their healing, including the partnership with traditional healers. Through Australian government respect the traditional healing practices or cultural protocols; and also recognize potential role of community leaders, traditional healers, those working to resolve the community problem (see William, Guenther and Arnott, 2011, p-19).

Here, it appears Australian government makes ad-hoc plan which are inconsistent for traditional healers. Through more emphasizes have been given on the improvement of aboriginal housing for their general well-being rather than to address their trauma, grieving, and heading (Belfrange, 2007; Cummingham and Stanely, 2003). The government has encouraged the development of aboriginal or Torres Strait islander Healing Foundation. This Foundation is investigating intergenerational trauma and their strategy of healing methods, which are traditional and cultural healing practices, which can be: healing centre; family support and sources centers; ceremonies, going back to country, traditional healers; Elder support groups, support group for sexual assault survivors, leadership programme for youth; anger management groups etc.

There has been less emphasis on aboriginal traditional healing in Aboriginal traditional healing in Australia, aging of older traditional healing for training other healing; mainstream credibility of healing. There is little hope on healing families has been created to help or lead the Australian indigenous healing movement (see William. 2009 p-20). Besides, there are few issues remaining unsolved- integrating western or aboriginal healing modalities, building an evidences-based practices for Aboriginal healing and cultural or intellection property right issues and the main benefits of such aboriginal healing.

III

11.   Traditional Medicine and Traditional knowledge

Traditional medicine (TM) is well known in most of the world. Most of the people use it in Asian and African countries. Further 70 to 80 percent of the populations in developing countries use varieties of alternative or complementary medicine. It is the blend of social, cultural, and scientific values prevailing among the indigenous people. WHO has already recognized its importance in commercial and scientific areas (WHO, 2008). Traditional Knowledge (TK) refers, as WHO mention elsewhere, as the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention diagnosis, improvement or treatment of physical and mental illnesses (WHO, 2002).

The traditional knowledge has assumed a critical dimension in the area of intellectual property rights in developing countries. The phrase *"Traditional Knowledge"* implies the development and transmission of the knowledge from generation to generation within a system, held by local individuals, families, lineages or indigenous communities. These local people or communities have a store-house of knowledge about their geographical flora and fauna. However, the local individuals and communities do not have the means to safeguard their traditional knowledge in the increasing global process of extraction, exploitation and commercialization of the biodiversity of the Third World. It is a stark reality that globalization is threatening the biodiversity, bio-information and creativity of indigenous approaches into proprietary knowledge for the commercial profit of a few. The existing IPR agenda is oriented around the concept of private ownership and individual innovation which encourages the co-modification of traditional knowledge without benefit sharing to indigenous communities (Mishra, 2003).

Traditional knowledge and traditional medicines (WHO, 2008) make a very important contribution to the holders of traditional knowledge in the Committee though their representation is not made mandatory in the Act or Rules Health of a particular community. Most of the Asian and African countries depend on traditional medicine for primary health care (Ibid).In China, traditional medicine accounts for around 40% of all health care delivered. In Chile, 71% of the population and in Colombia 40% of the population use such medicine. In India, 65% of the population in rural area use Ayurveda and medicinal plants to help meet their primary healthcare needs. Traditional systems of medicine are based on traditional beliefs, norms and practices of old experiences at the household or community level normally passed through oral tradition (Carlos, 2002).

12.   National Policy on Traditional Medicine (1940)

India possesses rich heritage of traditional medicinal practices of Ayurveda, Unani and Siddha system. The knowledge of these systems is well documented and has been successfully practiced for centuries in our country (Venkataraman, and Swarna, 2008). The National Policy on Traditional Medicine was introduced in 1940 in the country. National laws and regulations were also issued in 1940, and updated in 1964, 1970 and 1982. The national office the Department of Medicine and Homeopathy was established in 1995 as part of the Ministry of Health and Family Welfare. There are a number of expert committees for different forms of traditional medicine; the earliest of which was established in 1962. There are also a number of national research institutes; the first being the Central Council of Indian Medicine, established in 1970. India also has two multivolume national pharmacopoeias, the Ayurvedic Pharmacopoeia of India and the Unani Pharmacopoeia of India. Both are considered to be legally binding.Regarding national monographs, several sources are used, including a national database on medical plants used in Ayurvedic medicine and monographs contained in the national pharmacopoeias. Safety requirements include those required for conventional pharmaceuticals, as well as special requirements of traditional use without demonstrated harmful effects and reference to documented scientific research on similar products. No control mechanism is used for these requirements, as the long standing use of herbal medicines in the Ayurveda, Unani and Siddha systems demonstrates their safety for human use (WHO,2005).The demand for protection of traditional medicine arose in the context of bio-piracy and patenting of new products based on traditional knowledge using biotechnology (Venkataraman and Swarna,2008). Western science has acknowledged the usefulness of traditional medicine for the development and commercialization of new pharmaceutical products.

13.   Traditional Medicine in Intellectual Property Rights(IPR) Perspective

Traditional Medicine (TM) plays a crucial role in health-care and serves the health needs of a vast majority of people in developing countries. Access to "modem" health care services and medicine may be limited in developing countries. TM becomes the only affordable treatment available to poor people and in remote communities. World Health Organization (WHO) defines traditional medicine as the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observations handed down from generation to generation, whether verbally or in writing. Health care providers worldwide including major pharmaceutical giants are turning to incorporate many of these into their mainstream activities. As traditional medicines are largely based on medicinal plants, indigenous to these countries, where the system has been in vogue for several centuries, the effort is on accessing them either directly or through the use of modem tools of breeding and cultivation, including tissue culture, cell culture and transgenic technology. IP issues linked to such endeavors remain unresolved (Mashelkar, 2001).

The protection of Traditional Medicine (TM) under intellectual property rights (IPRs) raises two types of issues. First, to what extent it is feasible to protect, existing IPR system. Certain aspects of TM may be covered by patents or other IPRs. There have also been many proposals to develop sui generis systems of protection. Such proposals are based on the logic that if innovators in the formal' system of innovation receive a compensation through IPRs, holders of traditional knowledge should be similarly treated. The codification of TM varies significantly. A distinction can be made, particularly in Asia, between the codified systems of 'traditional medicine' and non-codified medicinal knowledge, which includes 'folk', 'tribal' or 'indigenous' medicine.

In our country the folk traditions are transferred orally from generation to generation. The 'folk' medicine is based on traditional beliefs, norms and cultural practices, trials and errors, successes and failures at the household level. These are passed through oral tradition and may be called, 'people's health culture', home remedies or folk remedies.Healers use rituals as part of their traditional healing methods, which often allow them to monopolize their knowledge, despite disclosure of the photochemical products or techniques used. The codified tradition consists of medical knowledge with sophisticated foundations expressed in thousands of manuscripts covering all branches of medicine. Examples are *ayurveda, siddha, unani* and the *Tibetan tradition*. The grant of patents on non-original inno-

vations (particularly those linked to traditional medicines), which are based on what is already a part of the traditional knowledge of the developing world have been causing a great concern to the developing world (Ibid).

World Intellectual Property Organization (WIPO) has been sensitive to these concerns. In 1998, WIPO put forth an agenda for the future of IPR in the field of traditional medicines which prioritized activities in this area, namely, development of standards for the availability, scope and use of IPRs on traditional medicine in Asian countries, systematic documentation of traditional medicine for protection purposes, regional and inter-regional information exchange and compilation of the requisite databases, etc. Still this agenda needs to be implemented for saving the prevailing knowledge of healing traditions. There are following examples showing that how profit-making originations exploiting their healing traditions.

Amazon Rainforest Plant Patent

Traditional healers and religious leaders from the indigenous tribes of the Amazon used to collect a plant named Baniste-riopsiscaapi, and process it to produce a ceremonial drink - 'ayahausca', also called 'yage'. They used ayahausca in religious and healing ceremonies. According to tradition, ayahausca was prepared and administered only under the guidance of traditional healers[1]. Although the patent claimed to have identified a variety of the species with new and distinctive physical features, particularly the colour of the flower. This plant grew naturally throughout the Amazon basin. By law, plant patents cannot be awarded to plants 'found in an uncultivated state'.

Neem Oil Case

Similarly the US has been taking undue advantage of the low level of patent awareness and laxity in enforcement of law. The Neem tree is used in India in the areas of medicine, toiletries, contraception, timber, fuel and agriculture. Its uses have been developed over many centuries but never patented. Since the mid-1980s, US corporations have taken out over a dozen patents on Neem- based materials. When the US Patents Office (USPTO) granted patent for 'Neem oil' for antiseptic use, then Council of Scientific and Industrial Research (CSIR) urged for re-examination of the case, but failed. In this way, collective local knowledge developed by Indian researchers and indigenous communities has been expropriated by outsiders who have added very little to the process (Shiva and Bhar, 1993).

There is a problem on the grant of such patents linked to the indigenous knowledge of the developing world that needs to be addressed jointly by the developing and the developed world. We need to understand that there is a distinction between the patents that are granted based on modem research and patents, which can be categorized as traditional knowledge-based patents. A recent study by an Indian expert group examined randomly selected 762 US patents, which were granted under A61K35/78 and other IPC classes, having a direct relationship with medicinal plants in terms of their full text. Out of these patents, 374 patents were found to be based on traditional knowledge not that all of them were wrong. The Governments in the Third World as well as members of public are rightly concerned about the grant of patents for non-original inventions in the traditional knowledge systems of the developing world. At international level there is significant level of support for opposing the grant of patents on non-original inventions. For example, more than a dozen organizations from around the world to oppose the Neem patent and the entire process took five years. Such a process of opposition is understandably expensive and time consuming (Shiva and Bhar, 1993).

The issue of 'protection' of traditional knowledge needs to be looked at from two perspectives, the 'protection' may be granted to exclude the unauthorized use by third parties of the protected information. On the other hand, the 'protection' also means to preserve traditional knowledge from uses that may erode it or negatively affect the life or culture of the communities that have developed and applied it. Further, the protection also promotes self-respect and self-determination. While recognizing the market-based nature of IPRs, other non-market-based rights could be useful in developing models for a right to protect traditional knowledge, innovations and practices. To date, debate on IPRs and biodiversity has focused on patents and plant breeders' rights. Provisions under undisclosed information or trade secrets could be invoked to protect traditional knowledge not available in the public domain. Geographical indications and trademarks, or sui generis analogies, could also be the alternative tools for indigenous and local communities seeking to gain economic benefits from their traditional knowledge. The potential value of geographical indications and trademarks is in protecting plants and germplasms   that   are   specific   and   unique   to   geographical   regions.   They   could   protect and reward traditions while allowing innovation (Chauhan, 2004)New experiments are beginning to emerge on benefit-sharing models for indigenous innovation. An experience in India is worth sharing. It relates to a medicine that is based on the active ingredient in a plant, *Trichopuszeylanicus*, found in the tropical forests of southwestern India and collected by the Kani tribal people. Scientists at the Tropical Botanic Garden and Research Institute (TBGRI) in Kerala learned of the plant, which is claimed to bolster the immune system and provide additional energy, while on an expedition with the Kani in 1987. These scientists isolated and tested the ingredient and incorporated it into a compound, which they christened '*Jeevan*', the giver of life. The tonic is now being manufactured by a major Ayurvedic drug company in Kerala. TBGRI agreed to share the license fee and royalty with the tribal community on a fifty-fifty basis and formed a registered trust with an understanding that the interest accrued from this amount alone can be used for the welfare activities of the *Kani* tribe. It is significant to note that while the issue of material transfer and benefit sharing was discussed and debated after Convention on Biological Diversity (CBD), India has already pioneered one of the first models (Chauhan,2004).

Developing countries need a systematic documentation of traditional medicine for protection purposes, regional and inter-regional information exchange and compilation of the requisite databases etc. To mitigate this problem, the Indian Government has taken steps to create a Traditional Knowledge Digital Library (TKDL) on traditional medicinal plants and systems, which will also lead to a Traditional Knowledge Resource Classification (TKRC). Linking this to internationally accepted International Patent Classification (IPC) System will mean building the bridge between the knowledge contained in an old Sanskrit Shloka and the computer screen of a patent examiner in Washington. This will eliminate the problem of the grant of wrong patents since the Indian rights to that knowledge will be known to the examiner. It is right time that India must evolve a viable and effective mechanism to protect the biodiversity, bio-information and creativity of indigenous communities (Chauhan, 2004).

Indian Legal Frame for Protecting Traditional Medicine- *Indian Patent Act*

The terms of the Indian Biodiversity Act in some limited ways may help protect TM, owing to its focus on genetic resources and associated TK. However, since TM is an intricate combination of both tangible and intangible TK resources, the Biodiversity Act alone will not suffice to protect TM. So far as the intangible aspects of TK are considered, the Indian Patent Act (as amended in 2002) acknowledges its value and contains provisions that proscribe the patenting of TK. Under Section 3 (p) of the Indian Patent Act, an invention which in effect is traditional knowledge or which is an aggregation or duplication of known properties of traditionally known component or components is not patentable. This provision however does not prevent granting of patent to new products and process based on traditional knowledge. The Act also mandates the disclosure of the source and geographical origin of the biological material in the patent specifica-

tion when the invention claimed is based on biological material. There is also no reference to the provisions of the Biological Diversity Act in this regard at least in cases where the traditional knowledge is based on genetic materials. The Indian Patent Act acknowledges the oral tradition in TK and accordingly allows opposition to a patent application if the invention claimed in the application is anticipated having regard to the knowledge, oral or otherwise, available within any local or indigenous community in any country [Indian Patent Act, Section 25(k)]. Opposition to patent is also allowed where the complete specification does not disclose or wrongly mentions the source or geographical origin of biological material used for the invention [Indian Patent Act, Section 25(j)]. Similarly, a patent granted can also be revoked on the above said grounds [Indian Patent Act, Section 64(p) & (q)]. But here again there is no provision to oppose a patent application or revoke a patent granted on the ground that the traditional knowledge is used without the prior informed consent of the community or the patent owner failed to satisfy the terms and conditions including benefit sharing. Thus, the Act while treating the traditional knowledge as public domain property has failed to recognize the customary ownership and Right of the custodians of this knowledge (Gopalakrishnan,2004). Another legislation that has a very limited application in case of protection of traditional medicine is the Protection of Plant Varieties and Farmers' Right Act (PVFA)[2], 2001. The PVPA though primarily intended to protect new plant varieties also include provisions for the registration of existing varieties and payment of compensation and benefit sharing to the community. The law is useful for protection traditional medicine only if there are medicinal plant varieties. The benefit under this law is mainly targeted to the farming community. To protect the traditional knowledge of farming community the PVPA facilitates the registration of extant variety[3] and farmers' variety under the Act.

We now sum up in brief, as far as the integration of traditional healing or medicine in the western medicine is concern, there are successful attempts have been made in America, Canada, South Africa and in New Zeeland. Illness like trauma, loss of cultural identity, its common effects, substance abuses etc. often addressed through healing modality require concerned culture and their place or land. Through, sometimes aboriginal patient may visit western clinic for physical injuries and afterwards needs own cultural ceremonies in their community for a life. The main content of such ritual is "high emotional content". Some countries like Canada, South Africa or New Zeeland have supported for integration of traditional healers with main stream health care system. There are fears also generated for example in Canada that increasing acceptance of traditional healing may result into sea change. The lessons of these countries may be useful for our planning for integration of healers and their medicine in our country for effective resources utilization of the traditional healers and their medicines.

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End Notes:

1. A Plant Patent No. 5,751, issued to Loren Miller on 17 June 1986 by USPTO claimed rights over a supposed variety of B. caapi, which Miller dubbed 'Da Vine'. The challenge to this patent was made by the Center for International Environment Law (CIEL), on behalf of the Coordinating Body of Indigenous Organizations of the Amazon Basin (COICA) and the Coalition for Amazonian Peoples and Their Environment (Amazon Coalition). COICA is a coordinating body of more than 400 tribes. On re-examination, USPTO revoked this patent on 3 November 1999. However, the inventor was able to convince the USPTO on 17 April 2001, the original claims were reconfirmed and the patent rights restored to the innovator

2. The PVPA is India's sui generis legislation for the protection of plant varieties giving effect to Article 27(3(b) of the TRIPS Agreement. The Preamble to the Act outlines some of the basic objectives behind the PVP A. The Act is purportedly for the establishment of an effective system for protection of plant varieties, the Right of farmers and plant breeders and to encourage the development of new varieties of plants. The PVP A acknowledges the need to protect plant breeders Right to stimulate investment for research and development. The PVPA was also created for the purpose of facilitating the growth of the seed industry in India, which will ensure the availability of high-quality seeds and planting material to farmers.

3. The PVPA defines "extant variety" in Section 2(j), as a variety available in India which is

i)   Notified under Section 5 of the Seeds Act, 1966; or
ii)   Farmer's variety; or
iii) A variety about which there is common knowledge; or
iv)   Any other variety which is in public domain

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