

**The Representation and Practice of Healthcare Integration
alterity and the construction of healthcare integration in the Philippines**

*Thesis submitted in partial fulfilment of the requirements
for the Degree of Doctor of Philosophy*

by

Paul Kadetz

Word Count: 99,987

Department of International Development
Queen Elizabeth House

Green Templeton College
University of Oxford, January 13, 2012

I hereby certify that this thesis is the result of my own work except where otherwise indicated
and due acknowledgement is given

Paul Kadetz

13, January 2012

ABSTRACT

Non-biomedical practices and practitioners serve as the primary source of healthcare for a majority of populations in low-income countries. The World Health Organization (WHO) has prioritised the integration of local non-biomedical healthcare practices and practitioners into formal state healthcare systems since the Declaration of Alma Ata in 1978. Heretofore, both WHO's representation of healthcare integration and its discourse of beneficence have been reified, yet largely unexamined.

This research examines the processes of healthcare integration through qualitative research at multiple levels of analysis in the Philippines to better understand: what healthcare integration is; how stakeholders perceive healthcare integration; and how the practice of healthcare integration may differ from its discursive representation.

This research was conducted in communities of four municipalities of the Philippines over a period of 22 months. The sample of 1,023 informants consisted of community members, community leaders, healthcare providers, and policy actors who participated in semi-structured interviews, focus groups, and pile sorts. Participant experience was also conducted over a year-long period in both the Traditional Medicine Unit of The Western Pacific Region Office of the WHO and the Philippine Institute of Traditional and Alternative Healthcare of the Department of Health of the Philippines. The integration of local birth attendants through prohibition of their practices serves as a case example.

From this research, healthcare integration is understood as multiple independent and interdependent processes that occur simultaneously across global, state, and local levels of analysis, including the individual level. However, community level stakeholders were identified to resist healthcare integration practices, which they perceived as either inappropriate for their community and/or capable of compromising their access to healthcare.

These findings are presented in terms of the development studies discourses concerning appropriate knowledge/technology transfer, community agency, complex adaptive systems, health reform and administrative decentralisation, and the relevance of subjectivity in development interventions.

*In memory of my father, William Kadetz,
who taught me -as a boy living in Thailand- how we are also "the Other"*

ACKNOWLEDGEMENTS

There are many people to whom I am indebted for their assistance, time, and support which was essential to the completion of this research and dissertation. Firstly, I am most grateful to my Supervisors, Professor Dawn Chatty and Professor Gerard Bodeker for their imperative guidance, patience, and support through a very complex dissertation and research process. I am extremely grateful for their supervision.

I am also most grateful to Dr. Laura Rival who supervised me in my first year as a probate research student. Dr. Proochista Ariana was most instrumental in her generous guidance throughout this process, for which I am extremely grateful.

Also I would like to thank Dr. Katherine Morris, Professor Michael Freeden, Dr. Vivienne Lo, Ms. Gisela Robles Aguilar, Ms. Elisabeth Rahman, and especially Professor Elisabeth Hsu for their most generous time in meeting with me to discuss various aspects of this dissertation.

I would also like to thank the following for reading this dissertation and providing valuable comments in its various stages: Dr. Volker Scheid, Dr. Hugh MacPherson, Dr. Kaori O'Connor, Dr. Ayesha Ahmad, Dr. Ruben Caragay, Professor Ed Villegas, Ms. Alexandra Priebe, and most especially Dr. Janette Davies.

I would like to extend my sincere gratitude to the following for their imperative assistance in the field: Dr. Juvencio Ordon of PITAHC for arranging the research at the various research sites. I am also most grateful to Dr. Jenny Madamba of INAM; Dr. Ruben Caragay of the University of the Philippines; Dr. Jessica DeLeon and Dr. Penny Domogo.

I would like to thank Ms. Charlotte Strum for her valuable guidance in my research at The Rockefeller Archives; Ms. Gill Edwards for all of her valuable help as Green Templeton College Librarian in securing books I was unable to locate; Mr. Kim Small and Dr. Gerard Finin for their guidance whilst I was a Visiting Scholar at The East-West Center, and most especially Ms. Mary Smith at the University of Oxford Division of Social Sciences.

I am extremely grateful for the financial support I received from the following sources for this research including: The Department of International Development, University of Oxford for the Francis Stewart Award, Oxford Development Studies Grant, and various travel grants for research and conferences. Green Templeton College, University of Oxford for various travel grants to attend and present at conferences pertinent to this research and for an Academic Event Grant to organise a Symposium on The Future of Integrative Medicine. And the East-West Center of the United States for a Visiting Scholar grant by which to carry out archival research for this dissertation.

Finally, I am most grateful to the friends and family who supported me in various ways throughout this process: Ms. Penny Rogers, Dr. Elizabeth Sommers, Mr. Indrajit Roy, Ms. Nadiya Figueroa, Dr. Resi Hofer, Ms. Kaye Hung, Ms. Dominique Attala, Ms. Rachel Miller, and most especially my sister, Mrs. Sara Boynton, and my mother Mrs. Marcia Kadetz.

My most sincere gratitude to the people mentioned here as well as to the more than 1,023 informants who generously gave of their time to participate in this research and the Municipal Health Officers, Barangay Midwives, and translators who helped to arrange this research in each barangay and municipality. Thank you.

TABLE OF CONTENTS

Chapter 1 In the beginning ...there were no boundaries

1.1 Introduction	1
1.2 The Research Questions	3
1.3 Research Background	5
1.3.1 Why conduct research on healthcare integration?	6
1.3.2 Why conduct research on healthcare integration in the Philippines?	7
1.3.3 Why conduct research on healthcare integration in the Philippines at this time?	9
1.4 The Literature Review: locating this research in the literature	10
1.5 Theoretical Frameworks	15
1.5.1 Epistemological Frameworks	16
1.5.2 Primary Themes of Research and Analysis	18
1.5.2.1 Primary Themes of Research and Analysis I: Order	18
1.5.2.2 Primary Themes of Research and Analysis II: Identity	19
1.5.2.3 Primary Themes of Research and Analysis III: Alterity	21
1.5.2.4 Problematising Othering for the Purposes of This Analysis	23
1.5.3 Disorder, Pollution, and Risk: Othering Systems of Order	28
1.5.3.1 The Other has a Voice Even if the Self Isn't Listening	30
1.6 Theoretical Analysis: Navigating this Complex Framework	32
1.6.1 Applying Bourdieu's Social Structure to Douglas's Order	32
1.6.2 The Importance of Analysing Both Representation and Practice	34
1.6.3 Primary theoretical analysis: Social Constructionism and Discourse Analysis	36
1.6.3.1 Representations as Imagined Processes	36
1.6.3.2 Unpacking Representations Through Critical Analysis	36
1.6.4 Complex Adaptive Systems and Complex Systems Thinking	37
1.7 Chapter Summary	38
1.8 Conclusion	41

Chapter 2 The Research Methodology

2.1 Introduction	43
2.2 Sampling	43
2.2.1 Analysis of Multiple Levels Using Multi-sited analysis	43
2.2.2 Selection of Municipalities and Barangays	43
2.2.3 Informant Sample Selection	45
2.3 Data Collection	48
2.3.1 Barangay Members Interview Schedule	48
2.3.2 Local Healthcare Practitioner Interview Schedule	49
2.3.3 General Biomedical Practitioner Interview Schedule	50
2.3.4 Barangay Council Interview Schedule	50
2.3.5 Semi-Structured Individual Interviews	51
2.3.6 Pile Sorts	51
2.3.7 Participant Experience and Participant Observation	52
2.4 Data Analysis	53
2.4.1 SPSS	53
2.5 Research Ethics	54
2.5.1 Protecting Confidentiality	54
2.5.2 Informed Consent	54
2.5.3 Compensation	55

2.6 Research Bias	55
2.6.1 Informant Bias	55
2.6.2 Recall Bias	56
2.6.3 Sampling Bias	56
2.6.4 Interview Bias	57
2.6.5 Interviewer Bias	57
2.7 Reflexivity	58
2.7.1 Reflexivity Employed in This Research	58
2.8 Challenges in Conducting This Research	60
2.9 Conclusion	61

Chapter 3 The Construction of the Normative Representation of Healthcare Integration

3.1 Introduction	63
3.2 The Historical Construction of Healthcare Integration	63
3.2.1 Frederick T. Gates, Abraham Flexner, and The American Medical Association	64
3.2.1.1 Frederick T. Gates and The Rockefeller Foundation	64
3.2.1.2 American Plurality and The American Medical Association	67
3.2.1.3 Homoeopathy	68
3.2.1.4 AMA and American Medical Education Reform	69
3.2.1.5 The Flexner Report	69
3.2.2 The Rockefeller Foundation	72
3.2.2.1 The International Health Board & The League of Nations Health Organization	74
3.2.3 The Modernisation of China	75
3.2.3.1 The Undulating Adaptations of Chinese Medicine Over Four Centuries	77
3.2.3.2 Bridging Medical Modernity: The 19th Century Medical Missionaries in China	78
3.2.3.3 The Rockefeller Foundation in China	83
3.2.4 The Formation of TCM	87
3.2.4.1 The Movement to Eradicate Chinese Medicine	87
3.2.4.2 Compromises to Perpetuate Chinese Medicine	89
3.2.4.3 Chairman Mao and the Rockefeller Foundation	93
3.2.4.4. The Global Dissemination of a Maoist Model	96
3.2.5 Problematising the Adoption of a Model For Enforced Healthcare Integration	97
3.2.5.1 Was TCM the Only Model That Could Be Used For Integration?	100
3.2.6 WHO is the W.H.O.: a brief contextualisation of the World Health Organization	103
3.2.7 WHO's Adoption of Healthcare Integration	108
3.2.7.1 WHO and Which China?	108
3.2.7.2 The Influence of Sino-African Diplomacy	109
3.2.7.3 International Politics and The Adoption of a Model for Healthcare Integration	110
3.2.8 A brief analysis of the WHO integration discourse	113
3.2.8.1 Theme 1 Access: Healthcare Integration Will Improve Access to Healthcare	114
3.2.8.2 Theme 2 Safety, Efficacy, and Quality	116
3.2.8.3 Theme 3 Appropriate or Rational Use: Defining a Standard by Being Vague	118
3.2.8.4 Theme 4 WHO is Needed to Oversee the Appropriate Execution	118
3.2.8.5 Recommendations Tempered by Diplomacy	120
3.2.8.6 Contextualising the Priorities of the Traditional Medicine Unit at WHO	120
3.3 Conclusion	122

Chapter 4 Contextualising the Philippines and Philippine Healthcare

4.1 Introduction	125
4.1.1 A Demographic Contextualisation of the Philippines	125
4.2 The Construction of Healthcare through a Political and Economic History	126
4.2.1 Pre-Colonial "Indigenous" Inhabitants of the Philippine Islands	126
4.2.1.1 Pre-Colonial Social Structure	127
4.2.1.2 Pre-Colonial Healthcare: Religion as "Science"	129
4.2.2 Constructing the Philippines	131
4.2.2.1 The Centrality of Catholicism in a "Showcase of Faith"	132
4.2.2.2 Syncretism and Plurality	133
4.2.2.3 The Advent of Healthcare from Spain	135
4.2.2.4 The Codification of Elite Economic and Political Control	135
4.2.2.5 The Construction of Elite Fiefdoms	138
4.2.3 U.S. Colonialism and a "Showcase for Democracy"	141
4.2.3.1 The Irrefutable Benevolence of Modernity	142
4.2.3.2 The Rockefeller Foundation in the Philippines	144
4.2.4 The Post-Colonial Philippines: from enforced centralisation to decentralisation	145
4.2.4.1 The Post-Colonial Healthcare System: Building Healthcare Infrastructure	147
4.2.4.2 The Post-Colonial Healthcare System: Human Resources for the Local Level	148
4.2.4.3 Devolution, SAPs, & a Discourse of Empowerment	149
4.2.4.4 The World Bank and Health Sector Reform	152
4.2.4.5 Issues of Decentralisation in the Philippine Context	154
4.2.4.6 Decentralisation and the Magnification of Inequality	154
4.2.4.7 Healthcare Devolution in the Philippines	156
4.2.4.8 Summary	160
4.3 The Philippine Healthcare System	160
4.3.1 The Current Formal Healthcare System in the Philippines	161
4.3.1.1 The Structure of the Formal Philippine Healthcare System	161
4.3.1.2 The Barangay Health Station	164
4.3.1.3 Healthcare Access as an Outcome of Human Resources	165
4.3.1.4 Healthcare Access as an Outcome of the Cost of Pharmaceuticals	167
4.3.1.5 Healthcare Access as an Outcome of Healthcare Financing	171
4.3.1.6 Healthcare Access as an Outcome of Relational Othering	173
4.3.1.7 Other Issues Affecting Healthcare Access	173
4.3.1.8 Summary	174
4.3.2 The State of Health in the Philippines	174
4.3.3 The Current Informal Healthcare System in the Philippines	176
4.3.3.1 A Brief Overview of the Local Practices and Practitioners of the Philippines	178
4.3.3.2 The Local Practitioners and Practices Identified in the Barangays Studied	180
4.3.4 The Development of State Involvement in Non-Biomedical Practices	181
4.3.4.1 Local Healthcare Practices Have Local Meanings	181
4.3.4.2 The Arbitrary Administrative Divisions of Local and Imported Non-Biomedicine	183
4.3.4.3 The Political Threat of Non-biomedicine and Early Healthcare Integration	185
4.3.4.4 The Traditional Medicine Unit of The DOHP	190
4.3.4.5 The PMA	191
4.3.4.6 The Restrictions of TAMA	193
4.3.4.7 TAMA and the Formation of PITAHC	195
4.3.4.8 The Focal Point of Healthcare Integration in the Philippines	196
4.3.4.9 Summary	197
4.4 The Filipino Self	198

4.4.1 Locating the Filipino in a Sea of Plurality	198
4.4.1.1 Representations of the Fractured Colonial Self	199
4.4.1.2 A Geography of Modernity: The Temporal-Spatial Construction of Doxa	200
4.4.1.3 Shame and the Colonial Self: Othering the Self	202
4.4.2 How Do Filipinos [Emically] Represent Philippine Identity	204
4.5 Conclusion	206

CHAPTER 5 Understanding Healthcare Integration

5.1 Introduction	208
5.1.1 The Presentation of the Data	208
5.1.2 A Brief Overview of the Research Sites	209
5.1.2.1 Research Site 1: Bagabag	209
5.1.2.2 Research Site 2: Murcia	210
5.1.2.3 Research Site 3: Sadanga	211
5.1.2.4 Research Site 4: Bontoc	212
5.1.2 The Demographics of the Sample	212
5.2 The Perception and Representation of the Healthcare System	214
5.2.1 The Understanding of the Healthcare System	214
5.2.1.1 Barangay Member Results	214
5.2.1.2 Local Non-biomedical Healthcare Practitioner Results	215
5.2.1.3 Local and Municipal Biomedical Practitioner Results	216
5.2.2 The Current Practice and Use of Local Non-Biomedicine	217
5.2.2.1 Barangay Informant Reported Use of Local Non-Biomedicine and Biomedicine	217
5.2.3 Assessing the Assumptions of Beneficence of Normative Healthcare Integration	220
5.2.3.1 Assessing Perceived Changes in Access to Healthcare	220
5.2.3.2 Assessing the Normative Healthcare Integration Constructs of Quality & Safety	223
5.2.3.3 Assessing the Assumptions of Local Practitioner Standardisation	226
5.2.3.4 Assessing the Pile Sorts	231
5.2.3.5 Assessing the Perceived Appropriateness of Normative Healthcare Integration	234
5.2.4 Summary	236
5.3 Different types of Healthcare Integration are Perceived Differently	237
5.3.1 Comparing Normative and Heteronormative Examples of Integration	237
5.3.2 Comparing Healthcare Integration as a Centralised or Decentralised Process	240
5.4 Conclusion	241

Chapter 6 The Integration and Reintegration of Hilots in the Philippines

6.1 Introduction	244
6.2 The Historical Context of Hilot Reintegration	244
6.2.1 Fuzzy Data and Integration: Creative use of statistics to control TBA integration	244
6.2.1.1 The Rockefeller Foundation and the Early Training of “Old-type Midwives”	245
6.2.1.2 Data and the Dismissal of Sixty Years of TBA Trainings with WHO & UNICEF	247
6.2.2 Integrating hilots by prohibiting their practices	250
6.3 Assessing the Reintegration of Hilots through Barangay Members' Perceptions	255
6.3.1 Introduction	255
6.3.2 Results: Barangay Members' Perceptions of Appropriate Hilot Reintegration	256
6.3.3 Factors Identified Affecting the Appropriateness of Hilot Reintegration	257
6.3.3.1 Financial Access to In-Facility Birthing	258
6.3.3.2 The Perceived Restrictions of In-Facility Birthing	260
6.3.3.3 Capacity and Human Resources	263
6.3.4 Considering Potential Unintended Outcomes of the Reintegration of Hilots	264
6.4 Conclusion	265

Chapter 7 Integrating the Data to Analyse the Normative Representation

7.1 Introduction	267
7.2 Problematising Conceptual Elements of Normative Healthcare Integration	267
7.2.1 Conceptual Elements of Healthcare Integration I: The Healthcare System	267
7.2.2 Conceptual Elements of Healthcare Integration II: “traditional medicine”	270
7.2.2.1 Essentialising the Other's Order: The Other is "Traditional"	270
7.2.2.2 Traditional As A Representation Of Invented Traditions	272
7.2.2.3 Reifying Power: The Use of "Traditional" as Justification for Domination	273
7.2.2.4 Time and The Other	274
7.2.2.5 Purity and Boundedness	276
7.2.3 Conceptual Elements of Healthcare Integration III: Medical Pluralism	276
7.2.3.1 Examining the Normative Conception of Medical Pluralism	276
7.2.3.2 Medical Pluralism: The Representation of Boundaries	281
7.2.3.3 Rethinking Medical Pluralism: Unbinding That Which is Not Bound	282
7.2.4 Summary	283
7.3 An Analysis of The Normative Representation of Healthcare Integration	284
7.3.1 The Normative Models of Healthcare Integration	284
7.4 Conclusion	287

Chapter 8 Approaching the Border of Appropriate Healthcare Integration

8.1 Introduction	289
8.2 A Review of this Research Through the Findings to the Research Questions	289
8.2.1 The Primary Research Question: What is Healthcare Integration?	290
8.2.1.1 The Practice of Healthcare Integration 1	290
8.2.1.2 The Practice of Healthcare Integration 2	291
8.2.1.3 The Practice of Healthcare Integration 3	292
8.2.1.4 The Practice of Healthcare Integration 4	292
8.2.1.5 Integration and the Moral Imperative Toward (Western) Scientific Progress	293
8.2.1.6 Summary	294
8.2.2 Research Question # 2	294
8.2.3 Research Question # 3	297
8.2.4 Research Question # 4	299
8.2.5 Whose Healthcare Integration?	300
8.2.6 Summary	302
8.3 Meeting at The Border: How Might This Research Inform Development Studies	303
8.3.1 Etic Prescriptions and the Perpetuation of Intellectual Colonialism	303
8.3.2 The Post-Development Critique	304
8.3.3 Recommendations Identified from the Research: assets-based approaches	305
8.3.4 Recommendations Identified in this Research: complex systems thinking	307
8.3.5 How this Research Informs Global Health Governance	311
8.3.5.1 Governance Without “Experts”	314
8.3.5.2 Complexity, Assets-Based Approaches, and Rhizomes	315
8.3.5.3 Is "Healthcare" the Concern of Global Health Governance?	318
8.3.6 How this Research Informs Development Studies	321
8.3.7 Recommendations Identified in this Research	323
8.4 Conclusions	327
8.4.1 To Meet or Not Meet at the Border?	329

Bibliography	333

APPENDICES

Appendix 1 Map of the Philippines	358
Appendix 2 Methodology (Interview Schedules & Informed Consent)	360
Appendix 3 Excerpts from Ethnography	376
Appendix 4 Revising the Model for Healthcare Integration	388
Appendix 5 Publications & Presentations of Doctorate Research	399

List of Figures & Illustrations

Figure 1.1 Institutional Relationships of this Research from Global to Local Levels	6
Figure 1.2 A Summary of the use of Bourdieuan Structure and Douglas' Order.....	33
Figure 1.2 Summary of Theoretical Framework	38
Figure 3.1 Portrait of Po Ashing before surgery	80
Figure 3.2 Portrait of Po Ashing after surgery	80
Figure 3.3 Portrait of Le Sanying	81
Figure 3.4 Female Surgeon With the Bones of Past Patients	82
Figure 4.1 Pre-colonial to Post-colonial Hierarchical Social Structure in the Philippines ..	137
Figure 4.2 Poverty Incidence in the Philippines at the Municipal Level	155
Figure 4.3 Summary Timeline of Administrative Centralisation and Decentralisation	160
Figure 4.4 Organogram of the Department of Health of the Philippines	162
Figure 4.5 Schematic Outline of the Formal Public Philippine Healthcare System	164
Figure 4.6 Schematic Representation of General Layout of BHS Visited	165
Figure 4.7 Schematic Outline of Informal Philippine Healthcare system	177
Figure 5.1 The Municipality of Bagabag	209
Figure 5.2 The Municipality of Murcia	210
Figure 5.3 The Municipality of Sadanga	211
Figure 5.4 The Municipality of Bontoc	212
Figure 5.5 A Conceptual Map of Biomedical Informant Pile Sorts	231
Figure 5.6 A Conceptual Map of Barangay Informant Pile Sorts	233
Figure 6.1 Training Exam of “Old-Type” Midwives	246
Figure 6.2 Birthing Table in Mainit, Bontoc	261
Figure 6.3 Birthing Facility in Mainit, Bontoc	261
Figure 6.4 Staff of BHS in Bagabag Demonstrating Birthing Table	261
Figure 6.5 Normal Spontaneous Deliveries in Veterans Regional Hospital	263
Figure 7.1 The Stages of the Normative Model of Healthcare Integration	286

List of Tables

Table 2.1	Multiple Research Sites and Multiple Levels	47
Table 4.1	Five Leading Causes of Mortality in the Philippines	175
Table 4.2	Local Healthcare Practitioners in Philippines and identified in Field Sites	179
Table 5.1	Summary of Barangay Informant Demographics	213
Table 5.2	How Barangay Informants Perceive Their Healthcare System	214
Table 5.3	The Distribution of Local Healthcare Practitioners	215
Table 5.4	How Local Practitioners Perceive Their Healthcare System	216
Table 5.5	The Distribution of Local Biomedical Practitioners	216
Table 5.6	How Biomedical Informants Perceive Their Local Healthcare System	217
Table 5.7	How Barangay Informants Are Using Their Healthcare System.....	218
Table 5.8	Barangay Informants' Perception of the Relationship Between Healthcare	220
Table 5.9	Biomedical and Local Practitioner Referral as a Result of Integration	221
Table 5.10	Barangay Informant Perceptions of Safety and Quality of Healthcare System ..	223
Table 5.11	Perceptions of the Work of CHWs by Barangay Members of Murcia	226
Table 5.12	Standardisation of Local Non-Biomedical Practitioners	227
Table 5.13	Informants Perceived Appropriateness of Normative Healthcare Integration	234
Table 5.14	Barangay Council Perceived Appropriateness of Healthcare Integration	236
Table 6.1	Attended Births by Hilots and Biomedical Staff in the Philippines	251
Table 6.2	Results of Appropriateness of Hilot Reintegration	257
Table 6.3	Location of Delivery in Regions Throughout the Philippines	259

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AMA	American Medical Association
ASEAN	The Association of Southeast Asian Nations
BFAD	Bureau of Food and Drug of The Philippines (a division of the DOHP)
BHS	Barangay Health Station
BHW	Barangay Health Worker
CAM	Complementary and Alternative Medicine
CBHP	Community-Based Health Programs
CCP	Chinese Communist Party
CHW	Community Health Worker (a NGO designation distinct from BHW)
CMB	China Medical Board of the Rockefeller Foundation
CPHC	Comprehensive Primary Health Care
CPP	Communist Party of the Philippines
DOHP	Department of Health of the Philippines
GDP	Gross Domestic Product
IHB	International Health Board of the Rockefeller Foundation
IHME	Institute for Health Metrics and Evaluation at the University of Washington
IMF	The International Monetary Fund
INAM	Integrative Medicine for Alternative Health Care Systems; a local NGO
INGO	International Non-Governmental Organization
IRA	Internal Revenue Allotment
LBA	Local Birth Attendants (also known as Traditional Birth Attendants or TBAs)
LGC	The Local Government Code of 1991
LGU	Local Government Unit (The municipal administrative level of decentralisation)
LNHO	League of Nations Health Organization
MHO	Municipal Health Officer

NGO	Non-Governmental Organization
NPA	New People's Army
PHC	Primary Health Care (Usually referring to the movement for Comprehensive Primary Health Care that was codified under the Declaration of Alma Ata).
PhP	Philippine Pesos
PITAHC	Philippine Institute of Traditional and Alternative Health Care
PKP	Partido Komunista ng Pilipinas (First Communist Party of Philippines founded in 1930).
PMA	Philippine Medical Association
PRC	People's Republic of China
RHU	Rural Health Unit
RF	The Rockefeller Foundation
SPHC	Selective Primary Health Care
TAMA	The Traditional and Alternative Medicine Act of 1997
TBA	Traditional Birth Attendant (<i>Hilot</i> in Philippine context)
TCM	Traditional Chinese Medicine
TRIPS	Trade Related Aspects of Intellectual Property Rights (WTO Agreement)
TM/CAM	Traditional Medicine/Complementary and Alternative Medicine (a WHO designation)
TRM	The Traditional Medicine Unit of the WHO and Regional Offices
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	U.S. Dollar
WHO	The World Health Organization
WPRO	The Western Pacific Region Office of the World Health Organization
WTO	World Trade Organization

GLOSSARY

<i>Albularyo</i>	Local designation for local healthcare practitioners who treat with herbs and divination.
<i>Barangay</i>	Village. The basic administrative unit in the Philippines, a subdivision of a municipality pre-dating Spanish colonialism; historically related to tribal units in Philippine antiquity.
<i>Barangay Health Worker</i>	A barangay member who is part of the formal Philippine health care system. BHWs work in their barangay health unit assisting the barangay midwife.
<i>Commadrona</i>	Local designation for traditional birth attendant.
<i>Chinese Medicine</i>	The systematised healthcare practices of China that include acupuncture and Chinese herbalism. Chinese medicine is differentiated here from traditional Chinese medicine that was formally constructed in terms of biomedicine after the formation of the People's Republic of China.
<i>Hilot</i>	Used to refer to either traditional birth attendants or local local healthcare massage practitioners.
<i>Manghihilot</i>	Local designation for Bonesetter.
<i>Midwife</i>	The lowest level healthcare administrator to whom healthcare has devolved. Midwives administrate the barangay health unit. They receive two years of biomedical training in primary health care and maternal child healthcare; including labour and delivery. Unlike Western midwives, they are not advanced nurses and are hierarchically ranked below nurses who work in municipal health offices with physicians.
<i>Orasyon</i>	Prayer. Healing with prayer that can be accompanied by the practitioners sprinkling of “holy water” on patient or blowing on the patient. Can also describe a form of local treatment, whereby a prayer is written on paper (often in Latin) and the paper is the put in a cup with hot water. The patient then drinks the mixture, thereby embodying the prayer.
<i>Paltera</i>	Local designation for traditional birth attendant.
<i>Quack Doctor</i>	Local designation in certain barangays studied referring to local non-biomedical health care practitioners as a group. However, the term is not used pejoratively, as it is in the West.
<i>Supok (or men Supok)</i>	Local designation for local healthcare practitioners that primarily use prayer and divination for treatment.

<i>Tawas (or Tawal)</i>	A local form of diagnosis in which the diagnosis is made according to the manner in which a candle melts.
<i>Trad-med</i>	Terminology for all non-biomedical practices by the DOHP and PITAHC.
<i>Traditional Chinese Medicine</i>	The standardised codification of various schools of Chinese medicine in the 1950s under Mao Zedong's administration.
<i>Tui-na</i>	A Mandarin term meaning “push-pull”. Chinese orthopaedic massage.
<i>Ventosa (or Bintosa)</i>	Cupping. A local healthcare practice identified as “traditional medicine” in both Eastern and Western cultures. In the Philippine context it is used to “remove bad air from the body”. However, it is also currently taught and practised in the Philippines as an adjunctive practice of traditional Chinese medicine.

Chapter 1

In the beginning ...there were no boundaries

“Would you let your mother to go to one of them [a local birth attendant] if you had the opportunity to allow her to deliver in a hospital?! Frankly, it is an embarrassment that we are a middle-income country and they are the best we can do..What does that say about us?”

45 year-old male World Bank Maternal Child Health Project Director in the Philippines

“If I want real noodles, I'm not going to buy it in a box”

23 year-old female barangay informant from Sacasacan, Sadanga

1.1 Introduction

The processes of incorporating non-biomedical practices and practitioners into healthcare systems have been called integration. Healthcare integration has been represented in the literature as a means to improve access to healthcare since its formal adoption by the World Health Assembly of the World Health Organization in 1977. Although the literature has debated whether non-biomedical practices and practitioners should be integrated into healthcare systems, little research has sought to understand: what healthcare integration is and how it has been constructed; how it is being practised; if the manner in which integration is practised is appropriate to a given context; how healthcare integration is being perceived by various stakeholders; and how these different perceptions and understandings of healthcare integration may affect its practice.

The quotes that begin this Chapter are from two informants responding to a question regarding their perception of the appropriateness of healthcare integration. These two perspectives of the appropriate integration of local level healthcare into the formal healthcare system of the Philippines represent opposite ends of a continuum of Othering that is divided by a socially constructed boundary. The first quote, from a World Bank executive, justifies the eradication of local non-biomedical birth attendants with a discourse of biomedical modernity. In the informant's use of this discourse, the rejection of non-biomedicine is presented as a moral and nationalistic imperative, justified through a universalised construct of risk.

The second quote, from a rural informant, represents an opposing understanding in which local practices are perceived to lose their meaning¹ and value if they are being altered for, or by, integration. Because these local healthcare practices have been ordered outside the purview of a biomedical ordered system of understanding and meaning, this informant identified that it was essential for local healthcare practices to remain independent from biomedicine in order to maintain their integrity and potency.

For both of these informants, integration of their given ordered systems of understanding and meaning with the Other's is perceived as a threat to the potency, purity, and effectiveness of their healthcare practices. In both of these examples, the concept of the Self and its integrity is maintained by excluding what is being perceived as not-Self or the Other. Hence, the response of these two informants identify that there are myriad issues that can accompany the processes of integrating different healthcare practices and practitioners resulting from differences in being and understanding. In between these two opposing understandings exemplified here, are the various perceptions, representations, and practices of healthcare integration, filtered through multiple identities of Self and Other, that will be examined throughout this dissertation.

This dissertation will analyse the processes of healthcare integration in relation to the construction of the boundaries between ordered systems of understanding and meaning of Self and Other. Self and Other will be understood here to be relative designations to the given etic or emic context of analysis. Hence, this thesis will neither assume that the Self is an essentialised Western Self nor that the Other is the Orient; the subaltern; the poor; or any other designation signifying non-Western. Rather, this thesis is most interested in understanding multiple subjectivities from which any Other can also play the part of the Self. This, I maintain, is a means by which to understand the processes of healthcare integration beyond the singular representation produced by the biomedical Self.

¹ According to Leslie: "A central clinical fact of the way medical systems work is that they are social systems that give meaning and form to the experience of illness" (1980: 193).

Additionally this analysis will differentiate between the discursive representations² and observed practices of healthcare integration, in order to understand the processes of healthcare integration.

This Chapter will introduce the research questions examined in this dissertation, as well as provide a brief contextual background to explain why this research is being conducted at these field sites at this particular moment in time. A review of the literature concerning healthcare integration will follow in order to locate this research in the existing literature. This Chapter will conclude with an in-depth explanation of the theoretical framework, as well as a summary of the remaining Chapters.

1.2 The Research Questions

This research seeks to answer five primary questions. Firstly, this research seeks to define what healthcare integration is and how is it to be understood. Is healthcare integration to be understood by its discursive normative representation, as a single outcome that occurs at a state level of analysis, or is integration to be defined by how it is practised? And how then are representation and practice related and different? Furthermore, how did this representation of healthcare integration come to be normative? The entire methodology of this research has been designed to answer this primary research question, which will be analysed throughout the next seven Chapters.

In order to understand healthcare integration, it is necessary to unpack its discursive representations through an examination of: a) the model upon which it is based, namely the integration of traditional Chinese medicine (TCM); b) the primary institutions, in this research, adopting this model (i.e. The World Health Organization and the Department of Health of the Philippines); and c) a thorough critique of the applicability, accuracy, and appropriateness of this model for the field sites examined in this research. 3

² Throughout this dissertation, I will use the term “representation” in a similar manner to Saussure's use of the term “signified”; meaning a mental construct or concept (Holdcroft 1991: 63-4). However, representations will be further understood here to have been socially constructed and reified through discourse .

In tracing the construction of healthcare integration from the rise of the hegemony³ of biomedicine in the nineteenth century through to its implementation in local [non-Western] communities over a century later, I am attempting to assemble what Anderson calls: “a specific genealogy of metaphors” and practices by following “people, technologies, and ideas as they move from one site to another” (2002: 690). The exploration of these particular aspects of the primary research question will be analysed in Chapters 3, 4, and 7.

Secondly, this research will analyse how appropriate healthcare integration is being perceived and understood by its stakeholders and define what exactly constitutes the designation of *appropriate* healthcare integration for these stakeholders? This research will also examine how these perceptions of appropriate healthcare integration affect the practice of healthcare integration, particularly those perceptions identified at higher administrative levels? This question will also explore how stakeholders perceive their healthcare system and how this perception may affect the practice and representation of healthcare integration.

Thirdly, this research will examine if and how inter-subjectivity⁴ and Othering influence the way different ordered understandings of healthcare are integrated. Furthermore, how do these understandings affect the practice of healthcare integration and how, in turn, is the practice of healthcare integration affecting its stakeholders? Or as Kleinman and Kleinman (1991) ask; what is at stake in the politics between the Self and the Other?

³ Gramsci defines hegemony as the dominance and control “of a social group over the entire national society, exercised through the so-called private organizations, such as the Church, the unions, the schools” (1994: 67). “Elites control the 'ideological sectors' of society...and thereby engineer consent for their rule. By creating and disseminating a universe of discourse and the concepts to go with it, by defining the standards of what is true, beautiful, moral, fair and legitimate, they build a symbolic climate that prevents subordinate classes from thinking their way free” (Scott 1985: 39). However, the concept of hegemony can be challenged, as Bourdieu argues that the *doxa* of the dominant class can be altered by the underclass (1977: 168-9). In the context of biomedicine, hegemony refers to the ideological dominance achieved by biomedicine in which it was granted social dominion over all aspects of healthcare and the body.

⁴ Husserl considered inter-subjectivity a shared perspectivism between Self and Other, in which the Self attempts to understand the Other empathically (1960).

As there are no statistical methods by which to attribute healthcare outcomes to healthcare integration with any certitude, analyses of perceptions, subjectivity, and Othering facilitate an examination into what *might* be at stake with the implementation of the processes of healthcare integration. These questions will be examined throughout this dissertation.

Fourthly, healthcare integration is assumed to be beneficent in the literature, as well as in multilateral and state-level discourse. For example, both in the World Health Organization and Department of Health of the Philippines literature, healthcare integration is represented as inherently beneficent to populations; especially in terms of increasing access to healthcare and increasing the quality and safety of healthcare. But do the beneficiaries of healthcare integration perceive and experience this process to be beneficent? Do local level informants even want healthcare integration in their communities? These questions will be answered by the primary research interviews conducted at global, state, municipal, and local (community) levels. The historical and recent integration of local birth attendants in the Philippines will serve as a case example by which to analyse this question. The primary data analysis of this question is discussed in Chapters 5 and 6.

Lastly, this research is located in development studies in questioning how the examination of healthcare integration can inform development studies and the global governance and global policy-making discourses in general, as well as the appropriate knowledge/appropriate technology and community agency discourse in particular. These questions will be examined in the final Chapter of this dissertation.

1.3 Research Background

The following section will explain why this particular research was conducted at this time in the Philippines.

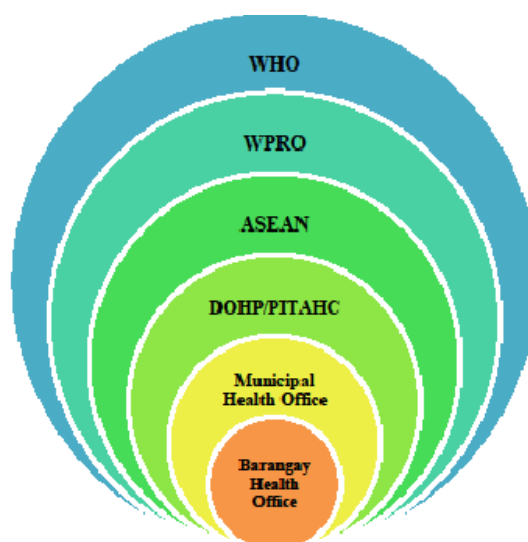


Figure 1.1 Institutional Relationships of this Research from Global to Local Levels

1.3.1 Why conduct research on healthcare integration?

Global healthcare policy-making has become a normative paradigm of healthcare, which by its very [global] structure necessitates a universalisation of the particular in local healthcare and an essentialisation of all healthcare users. The non-biomedical practices and practitioners of local healthcare⁵ have been estimated to serve as the primary source of healthcare for a majority⁶ of populations in low and middle income countries (Bodeker and Burford 2007).

The World Health Organization's (WHO) promotion of healthcare integration has remained an unchallenged policy since the Declaration of Alma Ata in 1978 (WHO 1978a; Lantum 2007; WHO 2008). Certain standardised non-biomedical healthcare practices were integrated into formal state healthcare systems, prior to 1978 in both low and middle income countries (e.g. Traditional Chinese Medicine in China and Āyurveda in India during the 1950s), as well as in high income countries (e.g. Kampo in Japan and Chiropractic in the United States).

6

⁵ A note on semantical conventions: Throughout this dissertation, I will attempt to use the designations that informants used. If, for example, specific practices or practitioners cannot be identified, then the terminology “local practices and practitioners” will be adopted. The designation of “traditional” will be avoided, except when quoting informants who used this term or as used in the literature. The reasoning for this is discussed in detail in Chapter 7.

⁶ Although several sources have quoted that 80% of developing countries use traditional medicine, they do not provide specific country data, hence this appears to be an estimation (See Bannerman *et al.* 1983).

However, the manner in which these practices were integrated into their healthcare systems were specific to their particular contexts.

Since the Declaration of Alma Ata, the integration of local healthcare practices and practitioners into state healthcare systems was understood as an important mechanism by which to address the (then) goal, of the World Health Assembly, of “health for all by the year 2000”. Mechanisms such as the use of local healthcare practitioners to increase capacity and redress human resource disparity for healthcare delivery were adopted into The Declaration of Alma Ata, based upon the purported success of the integration of traditional Chinese medicine and biomedicine and China's barefoot doctors programme in reducing rural healthcare disparities throughout China.

Hence, healthcare integration is not only important to understand as a process that can potentially affect healthcare systems and access to healthcare systems, but also as a process that can identify issues that are pertinent to development studies.⁷

1.3.2 Why conduct research on healthcare integration in the Philippines?

The Western Pacific Region Office of the World Health Organization (WPRO) has demonstrated a strong commitment to healthcare integration (WHO 2002a). The Philippines, a member state of WPRO, approved the legislation of a national adaptation of WHO's policy for healthcare integration; The Traditional and Alternative Medicine Act (TAMA) of 1997 (Republic of the Philippines 1997). The Philippine Institute for Traditional and Alternative Healthcare (PITAHC) is a government corporation affiliated with the Department of Health of the Philippines (DOHP). PITAHC was established through TAMA in 1997 to help “promote and integrate traditional medicine in the Philippines” (PITAHC 2009).

⁷ These include issues such as understanding change that is appropriate for a given local level, as well as the negotiation of differences in knowledge and technology between local, state, international, and global administrative levels in low and middle income countries.

The literature on healthcare integration has predominantly concerned the integration of well-established and government supported regional healthcare practices such as traditional Chinese medicine (TCM), Āyurveda, and Tibetan medicine. The local non-standardised healthcare practices of the Philippines offer a marked contrast to these well-established standardised systems. These local practices can thereby potentially problematise the normative healthcare integration discourse, which has been based on standardised international non-biomedical healthcare practices.

Furthermore, the Philippines offers an important historical context for this research, due to its long history of the integration of local birth attendants; generically known as *hilots*. The Philippines was one of the first countries in which UNICEF conducted trainings for non-biomedical birth attendants from 1952 (Vuori 1982). The rich history of the integration of *hilots* in the Philippines offers a valuable case example of healthcare integration over a period of six decades.

As a result of its varied geography, marked economic disparity, decentralised healthcare system, colonial history, and cultural diversity, the Philippines provides a unique and plural context from which to examine the impact and challenges of implementing a global healthcare policy at diverse local levels (Tan *et al.* 1988). Though the Philippines is represented as a unified country of individuals, this imagined community may be more accurately understood as an amalgamation of different and sometimes warring tribal groupings, in which allegiances, and identity, are more aligned with tribe and family than country (Jocano 1969; 1998; Anderson 1983).

As a result of devolution of the healthcare sector and the manner in which healthcare resources are now accessed, healthcare in the Philippines can only be accurately examined at the local level of a municipality or often on a barangay by barangay basis and thereby inherently challenges a policy that essentialises a population (Bautista 1996).

Thus, the Philippines provides a unique context for understanding the challenges of a global and state healthcare integration policy, by virtue of the marked diversity of Filipino communities' reactions to, interpretation of, and implementation of this policy into their local healthcare systems.⁸

1.3.3 Why conduct research on healthcare integration in the Philippines at this time?

Heretofore, the literature has assumed the beneficence of healthcare integration, in reducing healthcare disparity; improving population health; and in strengthening local healthcare systems, without assessing if local level populations even want their local practices and practitioners integrated into the state healthcare system. Specific unchallenged assumptions of the adoption of this policy include improvements in: physical and financial access to healthcare; the quality of local healthcare systems; use of local healthcare practices and practitioners; standardised training of practitioners; referrals between biomedical and local healthcare practitioners; and overall increased safety, efficacy, and quality of local healthcare practices. It would be central to an understanding of healthcare integration to assess if any of these assumed improvements are actually being perceived by local informants.

Devolution of healthcare in the Philippines has resulted in fragile local healthcare systems (CHD 1998; Bautista *et al.* 2002). Hence, the potential changes to these fragile healthcare systems that may be introduced by healthcare integration would be important to assess. Conducting this research more than ten years after the adoption of TAMA can facilitate an examination of any early changes to healthcare that local informants can identify.

⁸ Although I will adopt the word healthcare “system” throughout this dissertation, in agreement with Last (1981), local practices in the Philippines are not systematised, *per se*, hence, they are not part of a formal concept of “system”. However, I propose that although local practices may not fit into a Western construct of a “system”, it is irrelevant because it is emically understood as a system by barangay informants. Furthermore, I would argue that a healthcare “system” is created by each patient's plural use of the practices available to them. Therefore, I will apply the term local or informal healthcare systems thusly.

Furthermore, upon entering the field, the DOHP had just passed an Administrative Order stating that all women in the Philippines were to be considered at risk during pregnancy and that all deliveries were to be “facility based” and “managed by skilled birth attendants” (DOHP 2008: 2). Given the long history of the training and integration of *hilots* in the Philippines, the local reaction to this policy would be particularly important to examine to provide an understanding of the processes of healthcare integration.

Additionally, the current global marketing of non-biomedical practices and products has rapidly grown into a multi-billion dollar global market with numerous stakeholders (Price Waterhouse Coopers 2009). Integration, standardisation, and validation of many of these healthcare practices and products have now become a global health policy concern (WHO 1998; 2003b; 2005; 2007a; 2007b).

Finally, a renewed commitment to the values of Alma Ata appearing in WHO's Beijing Declaration (WHO 2008); the global debate on health reform; and the current pressure on countries to achieve the Millennium Development Goals⁹ by 2015, further substantiate the importance of conducting this research in the Philippines at this particular moment in time.

1.4 The Literature Review: locating this research in the literature

Prior to the Declaration of Alma Ata, information on non-biomedical practices and practitioners was primarily located in the anthropological, history of medicine, and colonial literatures, which documented, categorised, and interpreted these “native” practices.

⁹ Three of the eight Millennium Development Goals pertain to health and two pertain directly to Maternal Child Health. MDGs 4, 5 and 6 are respectively “to reduce child mortality; to improve maternal health; and to combat HIV/AIDS, Malaria and other diseases” (UNDP 2011).

However, scant literature could be identified discussing activities that could be distinguished as, or related to, healthcare integration beyond institutional archives that identify particular practices or practitioners, such as, the training of traditional birth attendants.¹⁰ Prior to the late 1970s, several authors documented the historical trajectory of state systematised popular practices, including that of Chinese medicine to traditional Chinese Medicine (Kwok 1965; Crozier 1968; Needham 1970; Sidel 1973; Crozier 1975) and the institutionalisation of modern Āyurveda (Filliozat 1964; Gould 1965; Brass 1972; Leslie 1968; 1973). However, the majority of literature located on healthcare integration dates from after the Declaration of Alma Ata.

Although a significant amount of post-Alma Ata literature examines the modernisation of local healthcare practices and practitioners, the majority of authors often reify the normative representation of healthcare integration, constructed by WHO, and neither critically examine nor challenge exactly what healthcare integration is or how it is constructed. Firstly, few authors have traced WHO's adoption of healthcare integration (exceptions include; Vuori 1982; Bannerman *et al.* 1983; Mahler 1983; Bodeker *et al.* 2005; Bodeker and Buford 2007); or have critiqued WHO's policy for healthcare integration and/or questioned its inherent value (Pillsbury 1982; Velimirovic 1982; 1984; MacCormack 1986; Oyebola 1986; Twumasi and Warren 1986; Hyma and Ramesh 1994; Lee 1997; Johnson 2001). Of this last grouping, only Johnson and Twumasi and Warren base their conclusions on actual research in the field.

The dissertations that were located on healthcare integration either trace the history of integration in a given area or healthcare system such as in China or Cuba (Ma 1995; Turner 1999; Cochetti 2008), or examine how integration is occurring as a state level process through modernisation (Bodeker 1989; Taylor 2000; Saxer 2011).

¹⁰ For example, the Archives of the Rockefeller Foundation, in which part of this research was conducted, provide extensive documentation on the training of traditional birth attendants in China dating to the 1930s.

Several dissertations have focussed on a particular practitioner category such as Traditional Birth Attendants, as was examined in Berry's 2005 ethnography of an indigenous village in Guatemala. However, outside of Bodeker's, the majority of these dissertations are descriptive and do not analyse or critique the integration process itself.

There has been a small amount of literature on healthcare integration specifically in the Philippines. This literature primarily describes how integration has been or will be practised (Bannerman *et al.* 1983; Kuan 1986; Tan *et al.* 1988; Tan 1996; Casanova-Dorotan 1996; Turner 1999; Lagaya 2001; Jocano 2004; Lagaya 2005; Mendoza 2009; Ordon 2009; PITAHC 2004; 2009). Of this grouping, only Mendoza presents a critique of integration. Kuan examined the attitudes of biomedical healthcare workers toward the use of herbs in a biomedical healthcare setting. And PITAHC (2004) assessed the means to validate herbal products. Plurality of healthcare was presented favourably in several studies that identified plurality as a means to increase healthcare access (Ponteras 1980; Tan 1987; Gracia *et al.* 1996; Tengson 2003; Miniano 2006). And the specific use of *hilots* was presented both favourably (Dizon and Miralo 1973; Marana 1983; Plan International 2001, Asian Development Bank 2007; Penwell 2009) and critically (USAID 2004; European Commission 2008).

The remainder of the literature on healthcare integration can be grouped into five broad themes. The first grouping contains papers that unquestioningly adopt the WHO model and argue for the need for integration through perceived assumptions of the inherent value of integration. These assumptions include cost-effectiveness, ability to improve access to healthcare, use of available resources, and preservation of disappearing cultures (Mahler 1977a; 1977b; Rappaport and Rappaport 1981; Neuman and Lauro 1982; Mahler 1983; Akerele 1987; Bodeker *et al.* 2005; Adams and Hawkins 2007; and almost all of the literature published by WHO, which is included in the bibliography).

The next grouping questions why healthcare integration has been slow to occur regardless of WHO or state efforts. This group includes papers that discuss stakeholder political and economic concerns of healthcare integration, as well as biomedical concerns of safety, efficacy, and quality (Green 1980; Pillsbury 1982; Last and Chavunduka 1986; Dauskardt 1990; Van Der Geest 2002; Bodeker and Buford 2007).

A third group of papers argues against the appropriateness of healthcare integration on the grounds that either it cannot be validated by biomedicine, and is therefore unethical and dangerous to promote, (Vlimirovic 1984; Rees and Weil 2001; McCarthy 2005; Ernst 2008) or that it should not and/or cannot be completely validated by biomedicine (Illich 1976; Witt *et al.* 2011). Yet, these papers do not examine the validity of the call for healthcare integration itself.

A fourth group proposes discrete ways to facilitate integration, especially in response to criticisms of scientific validation. This includes much of the recent literature on healthcare integration that has fully adopted WHO's concerns of validating non-biomedicine either through innovation in technological means such as imaging (Lei, Lin, Chang 2011); standardisation (Zaslowski and Lee 2011); or the use of an evidence-based framework (Flower, Scheid, Lewith 2011).

The last thematic grouping analyses healthcare integration as a practice. This includes: i) a consideration of who is being integrated and how integration is occurring (Van Der Geest 2002; Pillsbury 1982); ii) the legal aspects of healthcare integration (Bibeau 1982; Jeffrey 1982; Bishaw 1991; Offiong 1999); iii) how integration may alter healthcare practice; especially in terms of potency (Rappaport and Rappaport 1981; Pedersen and Coloma 1983; Hsu 2002; 2008); iv) healthcare integration that is a result of globalisation and the adoption of the global into the local level (Hsu and Høg 2002; Jennings 2005; Lo and Renton 2011; Kadetz and Perdomo 2012);

v) and integration as a function of commodification (Cunningham 1991; Dauskardt 1991; Adams 2008; Bodeker 2007; Cohen and Bodeker 2008; Hsu 2008b; 2009; Saxer 2010).

Much of the literature reviewed adopts a predominantly normative convention in discussing integration within WHO's representation of integration and thereby reifies, rather than critiques or problematises, this representation. This research attempts to break from this convention by questioning whether this representation of healthcare integration is corroborated in practice at local levels, and thereby, if this is an appropriate representation of integration? Secondly, there is an assumption adopted by many of these authors that integration is either inherently beneficent; universally appropriate and irrefutable; or benign enough to not render concern. Thereby integration can be reduced to a query of simply whether or not to integrate, rather than a more nuanced questioning of how and when integration should be practised.

Hence, the research of this dissertation is contributing to the existing literature, firstly by analysing the construction and representations of healthcare integration. Secondly, this research has attempted to transcend a simple systems reductionistic approach that renders the recipients of integration as a voiceless, subaltern “It”. This research demonstrates that all voices are necessary to be heard in order to understand healthcare integration more accurately. The many voiceless recipients of healthcare integration appear to have been rendered as such, more as an outcome of their absence in the literature, than due to any actual passivity on their part. For example, a significant proportion of the literature reviewed focusses on the policy or the policy makers, whilst ignoring the “policy recipients”. Furthermore, a majority of the literature reviewed is both reductionistic in its approach to non-biomedical practices and often essentialises the practices, the practitioners, and the patients.

As a result of these issues, the literature does not depict the patient who uses non-biomedicine as an agent, but rather as a circumstance of their social environment that is merely acted upon and forced to employ non-biomedicine out of poverty and/or lack of access.

Since only one side of the healthcare integration process is being examined in much of this literature, it would be easy to turn this dissertation into a polemic concerning what is being “done” to a given group. However, this research is also unique in assessing the complexity and context-dependence of the various possible processes of healthcare integration, that includes the agency employed by local stakeholders to maintain the integrity of their *field*.

Finally, in order to achieve a full analysis of healthcare integration, that will include all understandings and heteronormativities of stakeholders, this dissertation attempts to identify a different analytic means by which to represent and interpret healthcare and healthcare integration; through a framework of subjectivity, alterity, and ordering. Thereby, instead of participating in a theoretical debate supported by theory, I attempt to support theory by the findings of this research.

1.5 Theoretical Frameworks

It would be ideal to employ the work of one or at most two theorists or theories for a framework, but this research is attempting to stretch beyond a single theoretical and epistemological domain in order to understand healthcare integration from multiple perspectives. Thereby, theories that are reductive, universalised, or depend upon a simple systems framework will be insufficient in providing the multi-perspective understandings sought in this research. Hence, I will employ specific theoretical *themes* and particular theorists' adaptation of these themes that are best suited for the needs of answering the research questions and data collected.

If I were to adopt the normative [simple-systems] representation of healthcare integration, namely, as a singular essentialised outcome at the state level of analysis, then a single theoretical model or theoretician, such as, for example Foucault, might be appropriate. However, I would then only be able to analyse healthcare integration as practised by a single source, such as, for example, the World Health Organization or the Department of Health of the Philippines, whilst ignoring the other actors of healthcare integration and denying the possibility of exploring their own practices of healthcare integration. Such a singular and uni-directional focus effectively removes the possibility of considering that these actors might, in fact, possess agency that allows them to act with some degree of autonomy in terms of their plural use of their healthcare system. Because the normative representation of healthcare integration does not correlate with, or in any way explain, the data obtained from this research, I must identify a more accurate representation by which to examine these findings. Thereby, a more complex and nuanced representation of healthcare integration will require a more complex and nuanced theoretical framework on which to ground this data.

1.5.1 Epistemological Frameworks

Jack Goody states “the attempt to incorporate the most insightful elements (of anthropology) should not be limited to the propositional frames current in one's own field alone” (1982: 39). As the analysis of healthcare integration traverses several epistemological domains, it is necessary to approach this research both from and across several epistemologies. Firstly, this study is situated in the development studies framework. Specifically, this research relates to the appropriate technology/local knowledge discourse as well as the global/local and participatory/human capital discourses of development studies. Much of the research for this dissertation has been conducted in response to the challenges of the so-called post-development theorists (e.g. Sachs 1992 and Escobar 1995) who query “why do development?” or “might there be an alternative way to consider development?” (Nederveen Pieterse 1998).

This research attempts to engage with these post-development challenges as will be discussed in Chapter 8.

Secondly, this discourse is located in the domain of public health and specifically, international and global health policy. Healthcare integration is being examined in this research as a global and state policy implemented at local levels. This dissertation is located at what Roseberry calls; “the intersection of local interactions and relationships and the larger processes of the state and empire making” (1988: 163). Hence, public health perspectives particularly related to public health policy and community health will be employed in this analysis, in addition to discourse analysis and the anthropology of policy.¹¹

As this is a comparative study of stakeholder perceptions and constructions of appropriate healthcare integration, this research can also be addressed by the critical social anthropology framework, specifically, critical medical anthropology.¹² Furthermore, anthropological theory provides the means to understand healthcare integration in a far more holistic and reflexive manner than many other epistemologies, and can thereby facilitate the complexity that must be addressed in this domain. Thus, critical anthropology will serve as a primary framework by which to understand this research.

Finally, this dissertation will freely cross disciplinary boundaries as needed and employ interdisciplinary perspectives, such as social constructionism, that overlap the domains of anthropology and sociology. And lastly, my own life experiences and practices as a clinician of Chinese medicine and biomedicine can facilitate a crossing of disciplinary boundaries that, at least in theory, were meant to be bounded.

¹¹ See Shore and Wright 1997.

¹² Critical medical anthropology emphasises: “the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience, and healthcare” (Singer and Baer 1995: 5).

1.5.2 Primary Themes of Research and Analysis

I conducted this research both to understand what healthcare integration is beyond its normative representation and also to apply this research to certain social science theories. These theories include: identity; subjectivity; post-modernity; constructionalism; and foundationalism. A goal of this research was to attempt to understand many of these social theories beyond a normative construction based on Enlightenment reasoning. Though, for example, I resort in data analysis to Cartesian mathematical reductionism, I attempt throughout this dissertation to break through reductionism and with reflexivity reach beyond the normative analysis of healthcare integration. In order to achieve this I searched through several theorists to assemble a network of theories that would assist in this examination. This section will present the primary theoretical themes of this research with a brief explanation of how this theoretical network will be used.

1.5.2.1 Primary Themes of Research and Analysis I: Order

In order to understand healthcare integration, it is important to start with an understanding of what exactly is being integrated. These are not different healthcare *systems* that are being integrated, for in the Philippines few of the healthcare practices particular to a locale are at all systematised according to a normative [Western] understanding. Integration is normatively represented in the biomedical discourse as the integration of “traditional medicine” with biomedicine. However, this representation does not capture what was observed to be integrated in the Philippines, nor does it capture the dynamics of this process.

Mary Douglas' work (1966; 1973; 1992) has held a key to this research. From Douglas, it can be understood that what are being integrated are different systems of order that contain understanding and meaning which facilitate the means for navigation through life for any given group. These systems of order, which I heretofore refer to as ordered systems of understanding and meaning (or simply ordered systems) are foundational to social structure.

What is specific is the contents of these systems of order and the particular understanding and meaning which they provide.

Therefore, I approach this analysis with the understanding that in healthcare integration, as well as in any kind of transfer between two or more different groups, these ordered systems of understanding and meaning are precisely what are being integrated and transferred. A primary difference in this transfer, or in how ordered systems are being brought together, is a function of how the given Self differentiates Self from Other and the kind of boundaries that are created by virtue of this differentiation.

1.5.2.2 Primary Themes of Research and Analysis II: Identity and the Construction of Boundaries

Boundaries are socially constructed and therefore are perceived relatively. Even normative geographic boundaries are not universally perceived as boundaries. The anthropological work on ethnicity and identity is particularly germane to understanding the construction of subjective boundaries between Self¹³ and Other¹⁴. Etic¹⁵ boundaries may have little to do with emic understanding and identity. Formal etic classifications are often hierarchical and utilized to establish and support the superiority and supremacy of one group over another¹⁶ (Ashcroft *et al.* 1998). Etic hierarchies may also merely be a reflection of the normative paradigm employed, such as a modernist paradigm.

¹³ By the term “Self” I am referring (throughout this dissertation) to the concept of the social Self adopted in any given field; and the identity, or rather identities, that are adopted by an individual and fluidly utilised according to specific sociocultural needs.

¹⁴ The “Other” is also used here as a relative construction adopted according to contexts, needs, and the use of Self that one is currently adopting.

¹⁵ The concepts of emic and etic, derived from the linguistic terms phonemic and phonetic, have been cause for debate (Pike 1967). I use the terms here to distinguish the perspective and understanding of phenomena from within a given group (emic), from that which originates outside of that group and is often used to interpret or explain the group and their meanings (etic). This differentiation is central to a concept of context, which forms a foundation for this dissertation (See Headland *et al.* 1990).

¹⁶ Baumann states “The division of people to be governed into communities is a time honoured colonial strategy” (1996:29).

Emic boundaries may serve social functions that help to construct identity by differentiating Self from Other. However, these boundaries have often been represented too rigidly, as closed and static systems, to be able to account for either: actor autonomy and agency;¹⁷ outside influences acting upon a given group; or any change within the group. As Gerd Baumann notes: “Attributions of culture and community can clearly not be reduced to one factor alone” (1996: 5). Hence, a static representation of the Self or Other cannot account for the changes one must adopt in order to survive in any environment. Nor can a rigid approach account for the fact that people adopt several group identities, between which they freely move (*Ibid.*).

Boundaries are dependent on context and contingency. Identity changes as needs and context change.¹⁸ This fluidity of movement between multiple social identities can be understood as a mechanism of survival in a social landscape that requires such fluid navigation. Vigh describes this as a capacity to “navigate” the myriad needs, necessities, and obstacles of social worlds (2008). Hence, the identities of the [Bourdieuian] *fields* do not follow a particular progression or pattern. Identity is a plastic and dynamic (political-economic) strategy (Cohen 2004) “formed by internal organization and stimulated by external pressures...to defend” socio-cultural, as well as “economic and political interests” (Banks 1996: 35). Thereby, it would be erroneous to try to analyse or represent this fluidity with the rigid boundaries of a closed, linear, simple systems approach.

The representation of the boundaries between Self and Other as fluid, permeable, and context-dependent will be employed in interpreting this research. Neither boundaries, nor the Other, are constructed in a uniform manner.

20

¹⁷ For example, Barth (1969) posits that [ethnic] groups are by nature systems that are closed and bounded in order to maintain social organisation.

¹⁸ Baumann offers an illustrative case example: “The vast majority of all adult Southallians saw themselves as members of several communities, each with its own culture. The same person could speak and act as a member of the Muslim community in one context, in another take sides against the Muslims as a member of the Pakistani community, and in a third count himself part of the Punjabi community that excluded other Muslims, but included Hindus, Sikhs, and even Christians” (1996: 5).

The criteria for what distinguishes Self from Other is relative to a given construction of identity and a given context.

I am proposing here that healthcare integration can best be understood as an outcome of processes of Othering. Processes of Othering are not engaged in a universal manner. Therefore, if the process of Othering is not a singular process using one set of criteria, neither then are the processes of integration in which the ordered systems of understanding and meaning of Self and Other are being united.

1.5.2.3 Primary Themes of Research and Analysis III: Alterity and Othering

The title of this Chapter, “In the Beginning there were no boundaries”, also refers to the fact that without boundaries, there would have been no conception of the Other and thereby no activity of Othering. The paradisaal (pre-binary) state of wholeness depicted in the Old Testament's *Genesis* is a kind of pre-awareness state prior to the perceived difference between Self and not-Self. This state is similar to what has been conceptualised in theories of cognitive development, in which the infant does not perceive the mother as separate from Self (Piaget 1977). With awareness of the difference between Self and Other come boundaries, ordering, rules, laws, and taboos in order to preserve the *integrity* of the Self that is now perceived to be at risk from the Other (Douglas 1966; 1992). Binary oppositions though, are not inherent in all ordered systems outside of Western systems of order. Hence, in this dissertation, I maintain that preservation of the integrity of the Self and of the Self's ordered systems of understanding and meaning is foundational to understanding how two or more different systems of understanding and meaning can be brought together, as in healthcare integration. Although alterity and Othering are primary concepts employed for this dissertation, it needs to be clarified that these concepts are not merely employed as a means to *represent* healthcare integration, but rather the activity of Othering is precisely what is being employed in the processes of healthcare integration.

Alterity

Identity and subjectivity have been prominent ideas throughout philosophical and ontological inquiry. Philosophy, anthropology, critical and cultural theory have adopted the term “alterity” (OED 2011). The etymology of alterity can be found in ancient Greek (ἑτερότης) and classical Latin (*alter*). In post-classical Latin of the 4th century (*alteritas* and *alteritas*) meant “state of being different, otherness” as it did in 15th and 16th century Middle-French (*alterité*) (*Ibid.*). This meaning has not changed from the current use of the term. The Oxford English Dictionary defines alterity as a noun meaning:

“The fact or state of being other or different; diversity, difference, otherness; an instance of this” (OED 2011).

Emmanuel Levinas made alterity a central focus of his philosophy:

“Alterity appears as a non-reciprocal relationship...the Other is what I myself am not. The Other is this, not because of the Other's character, or physiognomy, or psychology, but because of the Other's very alterity. The Other is for example the weak, the poor, the widow and the orphan, whereas I am the rich or the powerful. It can be said that inter-subjective space is not symmetrical” (Levinas 1989: 48).

A problem with both this definition and how alterity is often employed discursively by many so-called post-colonial and post-modernist theorists, lay in the representation of the weak Other as acted upon by the dominant Self. Thereby the Other is being assessed only from the dominant Self's perspective, a perspective that often does not grant the possibility of agency to the Other. However, the agentless Other was not identified in this research. This dissertation, therefore, is most concerned with understanding multiple perspectives of healthcare integration, and not merely those of the dominant Self or even, as is found in post-modern critiques, the empathic dominant Self. Hence, alterity will be used to describe the perceived state of otherness that results from the processes of Othering, according to the perception and understandings of *any* group. Alterity is then the product of the act of Othering.

Othering

The Oxford English Dictionary defines Othering as a noun:

“The perception or representation of a person or group of people as fundamentally alien from another, frequently more powerful, group” (OED 2011).

Hence, Othering is defined here as an outcome. However, I am employing Othering as a process or action that leads to alterity, or the perceived Otherness of the Other (and of the Other's ordered systems). Thus, Othering will be used in this dissertation as a verb and will be discussed as a central process embedded in the processes of healthcare integration.

A common problem in anthropology is in ordering the subject according to one's ethnocentric referential standard. In interpreting subjectivity and inter-subjectivity, I will attempt to present the alterity displayed by the informants without resorting to Othering from my own self-referential perspective. I have attempted to avoid this by devising ways of ordering that are a direct result of the actual research, rather than an already conceptualised external construct.¹⁹

1.5.2.4 Problematising Othering for the Purposes of This Analysis

For the purposes of this dissertation, Othering will be specified according to what was observed in this research. The Othering observed in the field can be assembled within a taxonomy of what I am calling: representational Othering; relational Othering; situational Othering; hierarchical Othering; and inclusive/exclusive Othering.

Representational Othering

What I am calling Representational Othering, is described in the post-colonial literature of Said (1978); Spivak (1988); and Bhabha (1986) in which the Other is represented as an essentialised group holding particular (usually negative and stereotypical) traits, that help the Self rationalise and justify their treatment of the Other.

23

¹⁹ See, for example, Appendix 4 for a model derived from this research.

Thereby, the Other is Orientalised, the subaltern, the poor, deviants, or what Judith Butler would call “the etc.”²⁰ (1990). With representational Othering I ask: how does one group represent their designation of the Other? Thereby, representational Othering can be understood as a multi-directional process.

Relational Othering

Relational Othering asks what is the quality of the relationship of the Self to the Other. Martin Buber's work on the differentiation between “I-Thou” and “I-It” relationships is illustrative (2004). In I-Thou relationships, the Other is approached as a subject, a being. In I-It relationships the Other is an object; a category; a group without agency or significant variation that would thereby not require any understanding other than one which is essentialised; in other words, an “It”. Representational Othering usually represents the Other as an It. For example, “the subaltern” is an It category, as are most essentialised Other categories.²¹ Relational Othering, therefore, can facilitate or prohibit the perception of the Other as an entity in relation to the Self.

Relational Othering is of particular concern in the context of healthcare. For example, in biomedicine, all actors are interchangeable. Both practitioners and patients are “Its” from both the perspective of the hospital and the perspectives of one another. The patient's illness is treated, and not the patient, per se. Hence, the disease or pathology becomes the subject and is thereby granted Thou status by the physician and staff, whereas the patient is rendered an interchangeable body or object in the background of the expert's gaze, and thereby related to as an It.

²⁰ Butler concisely states the issue of representing the Other: “elaborate predicates of color, sexuality, ethnicity, class, and able-bodiedness invariably close with an embarrassed 'etc.' at the end of the list....these positions strive to encompass a situated subject but invariably fail to be complete” (1990: 143).

²¹ Weber traces this division to the rationality of the Reformation that he refers to as “instrumental rational action”. “Objective discharge of business primarily means a discharge of business according to calculable rules and without regard for person” (1978: 975).

Often in biomedicine, especially in hospital settings observed in the Philippines, an I-It relational Othering can be identified. However, I observed that the local non-biomedical practitioners (e.g. *hilots*, *albularyos*, and faith healers) and their patients would commonly relate to one another in an I-Thou manner, with the illness being rendered as an It.²²

In fact, many informants in the Philippines complained of the impersonality of physicians and nurses in biomedicine and the markedly different relationship they experience with their local practitioner. This relational Othering, for example, was cited as a primary reason many of the barangay member women informants reported that they would not agree to go to a hospital to deliver their baby. Both Levinas and Buber provide a framework by which to examine the quality of the relationship between Self and Other.

Situational Othering

Situational Othering problematises a reductive and simple systems understanding of Othering. In Situational Othering, the Self's identity in any given group changes depending on their dynamic situation and thereby so does their representation and relation to the Other. The work of several of the anthropological theorists on ethnicity is most helpful in understanding what I observed in the field. As mentioned, the work of Cohen and Baumann are especially helpful here. Their concept of a “circumstantial identity”, dynamically changing according to the given Self one has adopted to any given circumstance, is quite similar to what I witnessed in the field in terms of the plural use of healthcare dynamically changing according to situation, regardless of one's stated understanding.

An example of situational Othering can be identified in informants who did not perceive a contradiction in stating that they do not “believe” (*naniniwala*) in local healthcare practices, yet later in their interview described their use of many different local practices under specific conditions. As I was often taught by informants *depende* (or “it depends”) is never considered a contradiction in the Philippines.

25

²² The objectification of illness in the Philippines is quite literal, as certain local practitioners, such as psychic surgeons actually will withdraw the offending *object* from the subject-patient (Bryan 2007).

Hierarchical Othering

Hierarchical Othering acknowledges that the Other is not merely the opposite of the Self, but appears on a dynamic continuum of foreground (more like Self) to background (the opposite of Self); ever changing depending on context. An example of this is found in the acceptance of traditional Chinese medicine (TCM) in the West, as opposed to many other systematised and non-systematised non-biomedical practices. TCM is granted an etic distinction by the West, for being structurally taught and practised more like biomedicine than many other non-biomedical practices. Hence, though it is not the biomedical Self, it is more akin to the biomedical Self than many Others. This will be further discussed in Chapter 3 and in regards to the commodification of herbs in Chapter 4.

This problematisation of Othering again points to the work of some of the aforementioned post-colonial theorists and their rejection of simple opposing binary designations which, they assert, reify and maintain power.²³ Jacques Derrida is particularly informative in terms of the reality that binary opposites can create.²⁴

Hierarchical Othering helps to explain the varying degrees of Othering that was consistently observed at the local level in the Philippines. Filipino informants were observed to engage in hierarchical Othering in terms of tribal identity; geographic location; dialect spoken; religion; relationship to the land; and modernity. I was often reminded of this in the field, when informants asked where I had visited and then would share their distinct valuation of these other municipalities: “Why would you want to go there?” “Did you see witches flying on brooms?” “We are much friendlier here”.

²³ “The binary logic of imperialism is a development of that tendency of Western thought in general to see the world in terms of binary oppositions that establish a relation of dominance” (Ashcroft *et al.* 1998: 24).

²⁴ Derrida proposes that Western philosophy is built on binary opposites such as mind/body, and signifier/signified which he defines as “presuppositions and prejudices in Western culture” containing hierarchies “by which an order is imposed on reality and by which a subtle repression is exercised, as these hierarchies exclude, subordinate, and hide the various potential meanings” (Lamont 1987).

Furthermore, hierarchical Othering can help to explain the marked inequities in Philippine culture, identified especially between elite landowners and politicians versus the rest of the population. Both Taussig (1993) and Fabian's (2002) work are instructive here, as hierarchical Othering may coincide with a Western, and colonial, understanding of likeness (or mimesis) to the Western-Self according to the Other's place on a social evolutionary scale of development whose endpoint is the modern West. Thus, Others could be placed on a continuum of Othering depending upon how similar or dissimilar the Other is perceived to be by the Western or colonial Self. Bourdieu's concept of distinction is also applicable to hierarchical Othering (1989).

Inclusive/Exclusive Othering

Inclusive/Exclusive Othering asks, to what extent is the Other and their ordered systems of understanding included into, or excluded from, the Self and the Self's ordered systems? This quality of Othering is often ignored in the alterity literature and is essential for understanding the Othering found in this research. Much of the literature on alterity assumes that the Other is only the negative of the Self. However, this research problematises this analysis. What the Self values and perceives it is lacking consists of *at least* two possible Others, namely: 1) the Other that the Self is without and 2) the Other that the Self desires to be. Thereby, alterity can now be examined from any perspective and not merely the perspective of a dominant group. Inclusive and Exclusive Othering is particularly germane to how the Other's ordered systems of understanding and meaning are accepted or rejected.

The type or subject of Othering that is analysed in this research is that of ordering, in particular, the ordering of healthcare understanding and meaning. If illness is understood as an embodiment of both physical and social pollution that is due to a disruption of social order, then the function of healthcare practices is to reduce the risk of such pollution and to maintain order or regain the disrupted social order reflected in the body.

With this proposed typology of Othering, I am neither attempting to convey that these categories should be applied in other research, nor that these are the only means of analysing Othering, but merely that I found these groupings most useful to facilitate an understanding of the complex Othering identified specifically in this research.

1.5.3 Disorder, Pollution, and Risk: Othering Systems of Order

To review, the aspect of Othering that is central to this dissertation is what I am referring to as the Other's ordered systems of understanding and meaning. Douglas' work is particularly helpful in establishing the importance of maintaining the integrity of the social Self's ordered systems of understanding and meaning for any given group (1966). Although she has been criticised for equating disorder with pollution and danger, this precise relationship is central to understanding this research.

Douglas refers to the inherent drive of social groupings to make order out of chaos, as “a unity of experience” (1966: 3). The literature on healthcare integration reflects this idea of a unity of inter-subjectivity through terms such as “unification” (Mao Zedong); “harmonisation” (ASEAN); and, of course, “integration” (WHO). Thus, the creation of a coherence of order is identified as necessary and beneficent for healthcare. Anomaly threatens what is known, what is Self. “Ideas about contagion can certainly be traced to reaction to anomaly” (Douglas 1966: 6).

Thus, the unknown, which includes chaos, as well as the ultimate disorder of death,²⁵ threatens to destroy both social order and the order of the body. To make order out of chaos or anomaly is to make explicable; to make known. Ordering, according to Douglas, challenges the unknown. However, essentialising what is considered order and what is disorder is problematic for this research.

²⁵ Ernest Becker in “Denial of Death” also identifies a coherence in Western social behaviour to avoid death through the fetishised heroics of the drive to restore the order of the material world and thereby defy the chaos of nature (1973).

One's concept of order may be another's disorder. Hence, it is really the specific contextual understanding of order and disorder that need to be differentiated.

In many foundational Western ontologies, order is explicit with distinct boundaries of purity and pollution placed between binary opposites. Hence, maintenance of this boundary is understood as essential to avoid pollution and risk. Douglas traces this deterministic construct of order to Leviticus:

“Hybrids and other confusions are abominated. Holiness is exemplified by completeness. Holiness requires that individuals shall conform to the class to which they belong. And holiness requires that different classes of things shall not be confused. It therefore involves correct definition, discrimination and order. To be holy is to be whole, to be one; holiness is unity, integrity, perfection of the individual and of the kind” (Douglas 1966: 66-7).

This concept of systematisation and wholeness is possibly one explanation for the reason standardised ordered systems of non-biomedical healthcare such as Chinese medicine, Āyurveda, homoeopathy, and chiropractic, are recognised as medical “systems” by the biomedical understanding of order and wholeness, whilst non-standardised non-biomedical systems are not. However, biomedicine will be understood here as one among many ordered systems of understanding and meaning of healthcare, rather than *the* ordered system.

Any given Self negates that which is not ordered in a manner acceptable to their groups' particular acceptability of ordering. Thus, there is no single universally shared conception of order. Rather, an order of Self is shared by a given group, at any given time, and in a given context, which is in relation to the Self's perceived disorder of the Other.

For example, the local Filipino healthcare practices studied in this research are ordered both in terms of pre-colonial cosmology and informant's understanding of a “higher power”. However, such [Other] systems of order will not be recognised as *any* kind of order by biomedical institutions such as the WHO or the Department of Health of the Philippines.

Thereby, the biomedical Self will consider local Filipino healthcare practices disordered and will be ignored or defiled, in order to prevent pollution and compromise the purity, integrity and safety of biomedicine. Alternatively, from many barangay informants' perspectives, although an external order may be identified in biomedicine, there is no identifiable internal order linked to “God” or a higher power. Thereby, biomedicine is perceived to be *incomplete* in its ability to address all understandings of healthcare in the Philippines. Thus, local Filipino practices and biomedicine are understood by some barangay informants to address the two different realms of the sacred and the profane.

Hence, Douglas' theories are able to provide a map into how the need for ordered systems is linked to the reduction of risk and pollution to the individual and social Self. Douglas also provides an understanding for how maintenance or enhancement of relative order can be understood to increase the power and potency of that ordered system of understanding and enhance the social Self in general.

1.5.3.1 The Other has a Voice Even if the Self Isn't Listening

Although multiple ordered systems of understanding and meaning can be identified in the examples above, these are not to be depicted as socially equivalent. When Western systems of order are present, they tend to dominate all others. Brigitte Jordan identifies: even though “equally legitimate parallel knowledge systems exist” that people may “move easily between... [often] one kind of knowledge gains ascendancy and legitimacy” (1997: 56). She identifies this phenomenon as the domination of “authoritative knowledge” (*Ibid.*). A consequence of authoritative knowledge “is the devaluation, often dismissal, of all other kinds of knowing...as backward, ignorant, naive” (*Ibid.*). Thus, authoritative knowledge can be understood as a kind of *expert Othering*.

The power, then, of authoritative knowledge is not that it is “correct”, per se, but that it is valued, reified, and universalised as normative (Ibid.: 58).²⁶

Yet, the local informants in this research did not simply adopt biomedicine and abandon their local healthcare practices because of biomedicine's authority. The findings of this research problematise any simple representation of the Othering of ordered systems as a uni-directional process that is solely dictated by social power and control. The barangay informants I interviewed demonstrated agency and resistance concerning their healthcare. Their resistance was heterogenous and unorganised. Scott identified these “everyday forms of resistance”²⁷ (1985) as the embodiment of a multiplicity of forms of unorganised resistance or a *habitus* of resistance. Vigh also identifies unorganised resistance and agency in his example of the ability of disenfranchised groups to navigate “terrains of action and meaning” (2008: 5). Vigh notes that rather than resorting to apathy and passivity, crisis often results in “changing modes and means of action” and that in analysing practice “we see...people attuning their idea of movement and action to an opaque and fluctuating social environment”. Vigh portrays this observed flexibility as “motion within motion” (2008: 18).

The inability to conceive of healthcare integration as “motion within motion” and as being negotiated through everyday forms of resistance is, I maintain, a shortcoming of a reductionist framework and simple systems thinking.

²⁶ Authoritative knowledge then is very similar to Foucault's understanding of discourse as: “a system of statements within which the world can be known. It is the system by which dominant groups in society constitute the field of truth by imposing specific knowledges, disciplines and values upon dominated groups. As a social formation it works to constitute reality not only for the objects it appears to represent, but also for the subjects who form the community on which it depends” (Ashcroft *et al.* 1998: 42).

²⁷ Scott identifies “the ordinary weapons of relatively powerless groups: foot dragging, dissimulation, desertion, false compliance, pilfering, feigned ignorance, slander, arson, sabotage...forms of class struggle [that] have certain features in common. They require little or no coordination or planning; they make use of implicit understanding and informal networks; they often represent a form of individual self-help; they typically avoid any direct, symbolic confrontation with authority” (1985: xvi).

Thereby, I will be using Douglas' notion of maintaining order and purity as the means of avoiding risk and pollution throughout this dissertation, but I will reflexively attempt to problematise the inherent structural rigidity and simple systems thinking of her original theory with the fluid conceptualisation of identity that renders Othering and integration as dynamic navigational and negotiated responses to immediate social circumstances.

1.6 Theoretical Analysis: Navigating this Complex Research

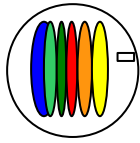
This section will briefly identify some methods by which to navigate this theoretical framework. Firstly, I will briefly demonstrate how Bourdieu's (1977) concepts of *field*, *doxa*, and *habitus* will be employed as the foundational concepts throughout this dissertation. Secondly, I will present a foundational theme of the differentiation between representation and practice. Thirdly, I will identify how social constructionism and discourse analysis will be used in my primary theoretical analysis. And lastly I will demonstrate how complexity thinking, as opposed to simple systems thinking, is integral to how this research will be approached and analysed.

1.6.1 Applying Bourdieu's Social Structure (1977) to Douglas's Order (1966)

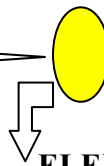
Orderings of understanding and meaning are formed within the boundaries of the acceptable parameters of possible discourse (or *doxa*) through which is facilitated a possible range of actions (or *habitus*) that will maintain the integrity of the given social Self (or *field*). Hence, if *field* is the given Self-identification of a group, *doxa* are the norms of the social field, setting the parameters of the possible discourse within that *field* that maintain the integrity of the *field*. And the *habitus* are the various embodied rules of how one should practice and act within a given *doxa* in order to maintain the *field*. An illustrated summary of how Bourdieu will be used in this analysis is illustrated in Figure 1.2.

Figure 1.2 A Summary of the use of Bourdieuan Structure and Douglas' Order in this Research

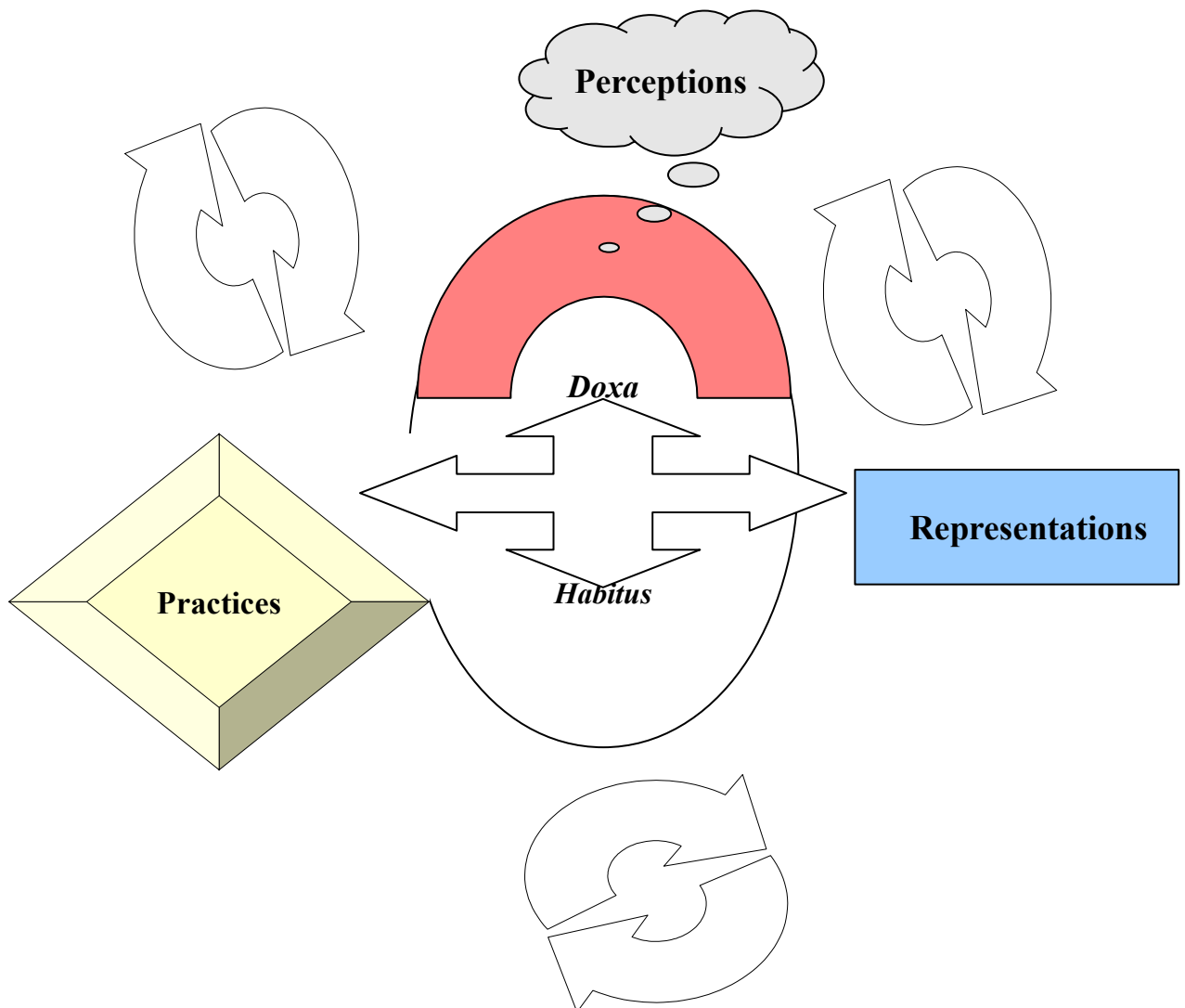
(a) *The Fields of The Social Self*



(b) *A Given Field Of The Social Self*



ELEMENTS OF A GIVEN FIELD



Therefore, for the analysis of this research I am proposing, following Baumann (1996), Banks (1996), and Cohen (2004), that the social Self is comprised of multiple [Bourdieuian] *fields* that are employed and freely navigated between, depending upon the varied needs of any given social context (Figure 1.2 (a)). However, if a single given *field* (Figure 1.2 (b)) of the social Self is examined, that *field* is organised according to what I am calling the ordered systems of understanding and meaning (of that *field*). Within these ordered systems are the possible discourses of the *field* (*doxa*) and the embodiment of these ordered systems of the *field* (*habitus*). Both *doxa* and *habitus* affect one another, as well as affect the perceptions, representations, and practices of that given *field*; which each also affect one another. These complex interactions can occur in any given *field* of the social Self and can therefore freely engage with one another across the given *fields* of the social Self depending upon the social context.

However, even this complex representation is problematic, as the *fields* are presented in Figure 1.2 (a) as separate bounded entities and in practice they are not bounded. A more appropriate visual metaphor is illustrated in the difference between a kaleidoscope made of solid or liquid parts. In a solid kaleidoscope the different coloured pieces will join to make new patterns, but there are a limited and definite range of patterns that can be rendered from these solid pieces. In a kaleidoscope made from different coloured oils there are no fixed range of patterns that can be identified, due to the infinite possibilities afforded by a fluid state. Hence, the solid state of *fields* depicted in this model are better understood as in a perpetual fluid state.

1.6.2 The Importance of Analysing both Representation & Practice and Their Articulations

Bourdieu maintains: “one has to avoid reducing practices to the idea one has of them” (2004: 39). There are, in essence, two studies presented in this research. The field research, which studies the practice of healthcare integration, and the study of the study, in which I deconstruct the reified representations found in this research.

Though I observed the perceptions of appropriate healthcare integration from various actors, I also went “backstage” to better understand what exactly is this practice called healthcare integration. Although representation and practice (as well as perceptions) affect one another to varying degrees (as illustrated in figure 1.2), in this research, I identified marked divisions between the representation of healthcare integration and the practice of healthcare integration.

Heidegger (1996) differentiates between the verb form of “being” and the noun; which I reinterpret here as the difference between arbitrary representation and lived experience or practice. How can representation approximate lived experience, if experience is abstracted to fit into preconceived categories of understanding? Merleau-Ponty (2002) builds on Heidegger's subjectivity, to reveal a process of continual becoming through the Self's experience of the world. Hence, both of these understandings problematise rigid objective representations of the world.

Scheid identifies that “the study of a medical practice should be analysed as a *practice*...rather than as a system of beliefs, knowledge, or technologies” (2001: 370). However, to understand healthcare integration more fully, it is essential to understand both how the ordered systems of understanding and meaning of Self and Other are being incorporated, as well as the effects of the representations of healthcare integration, and the interplay between the two.

Building on Hegel (1977), this research can also be understood to amplify the struggle between the representation of the universal and the practice of the particular. By problematising such dichotomies, this research will also examine the practice of the universal (for example, in my ethnography of participant experience of WHO. See Appendix 3) and the representation of the particular (in my ethnography of local perceptions of healthcare integration).

The interplay between representation and practice is a theme to which I will return throughout this dissertation.

1.6.3 Primary theoretical analysis: Social Constructionism and Discourse Analysis

1.6.3.1 Representations as Imagined Processes

Anderson (1983) identifies the construction of nations and nationalism as *imagined communities*, and Said (1978; 1993) deconstructs ethnocentrism and Orientalism as the product of *imagined geographies*, thus, the reification of the discursive representations of healthcare integration, can be understood as *imagined processes*. A goal of this research is to differentiate between that which is a constructed representation and that which is found in actual practice; and if and how one affects the other.

Bourdieu states: “The objects of knowledge are constructed...the principle of this construction is practical activity oriented towards practical functions” (1977: 96). This research will proceed from the understanding that knowledge is neither fixed nor inevitable, but rather constructed through social and cultural systems of meaning (Berger and Luckmann 1966; Searle 1995; Hacking 1999). No knowledge, including scientific knowledge, is divorced from the construction of its social context (Latour and Woolgar 1986). For the purposes of this dissertation and analysis, social constructionism provides the means to understanding how, and possibly why, certain paradigms, ideologies, and constructs associated with healthcare integration have come to be reified, normative, and universalised.

1.6.3.2 Unpacking Representations Through Critical Analysis

In order to facilitate a better understanding of healthcare integration, it is therefore necessary to unpack the construction of the discursive representations of how healthcare is perceived to be appropriately integrated. However, unpacking this reified construct need not include valuation.

A critical anthropological perspective of both the content of the policy, the process of policy development, the interpretation of the policy, and the implementation of the policy at the local level will provide another lens through which to analyse healthcare integration as a policy process.²⁸ Thus, the discourse of healthcare integration will be [in part] critically examined through WHO and DOHP documents.

1.6.4 Complex Adaptive Systems and Complex Systems Thinking: attempting to break out of the [Enlightenment] box

Healthcare integration challenges simple systems thinking, in which complex phenomena are interpreted via simple, closed, unidirectional, reductive, linear systems. Complex Systems thinking offers a more accurate alternative to simple systems models in addressing the integration of open-ordered systems of understanding. In complex systems models, both individual and contextual differences are able to be considered. Samir Rihanni has adapted complex systems thinking to both policy-making (2010) and development studies (2002). He calls for development projects to be considered as complex adaptive systems. Complex systems thinking facilitates an understanding of open dynamic systems whose independent and dependent variables can interact with one another in unpredictable ways forming new variables and outcomes via the process known as emergence.

Deleuze and Guattari's (1987) theoretical representation of complexity using the example of the rhizome's unpredictable, non-linear, non-Cartesian existence provides an apt metaphor, both for understanding the complex processes of healthcare integration and for the theoretical analyses that will be employed in this dissertation. The understanding of complex adaptive systems is central to this dissertation, which is attempting to analyse the full range of perceptions of healthcare integration and the processes of the practice of healthcare integration at multiple geo-administrative levels of analysis.

37

²⁸ According to Shore and Wright, one must “excavate the prescriptive tones and normative assumptions that underlie policies, [to] examine how policy discourses 'work' to control political agendas, and the complex ways in which policies construct their subjects as objects of power” (Shore and Wright 1997: xiii).

Hence, with this theoretical framework, both the representations and practices of healthcare integration can be analysed from multiple perspectives and better understood as dynamic, complex, independent, and interdependent processes simultaneously occurring at multiple levels of analysis. See Figure 1.3 for a summary of how this theoretical framework will be employed in this dissertation.

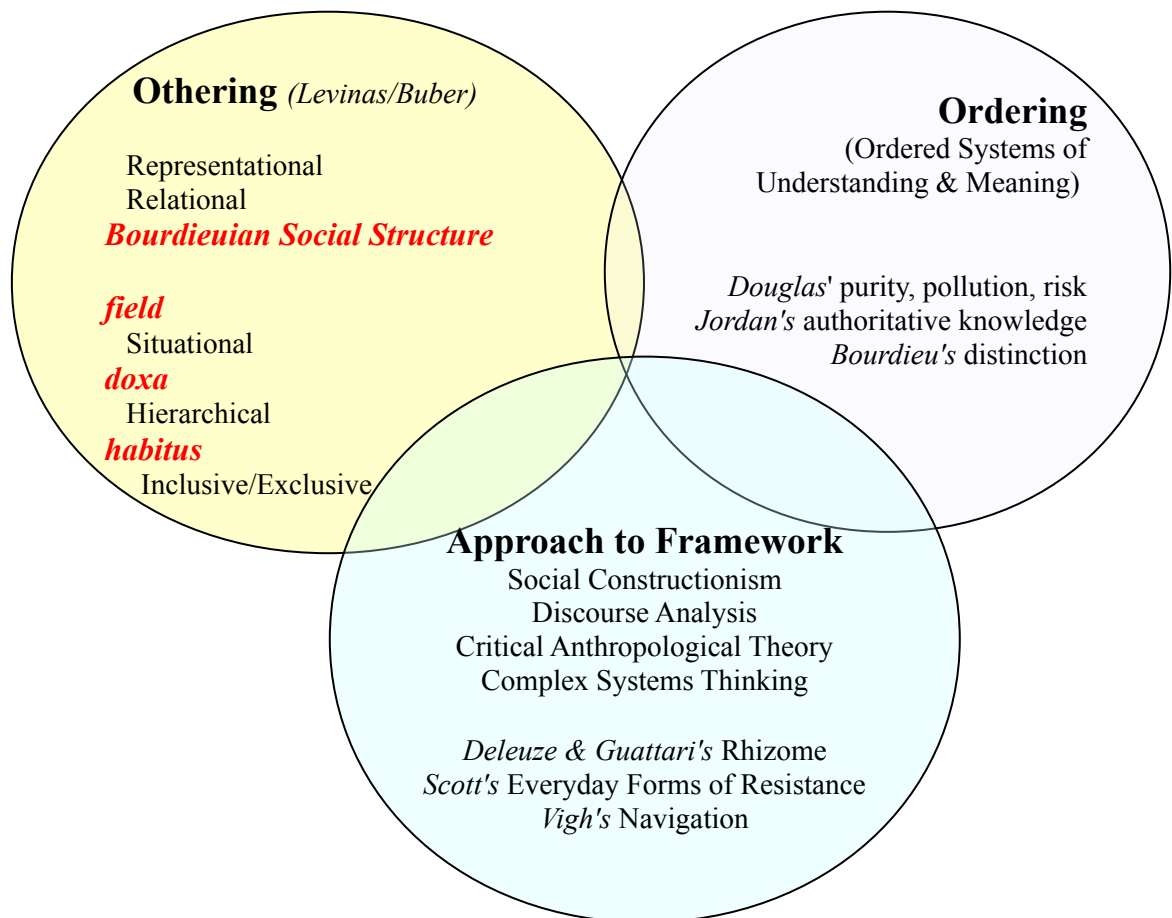


Figure 1.3 Summary of Theoretical Framework

1.7 Chapter Summary

Chapter 2 presents the research methodology and explains why this methodology is particularly suitable for addressing these research questions. The sampling methodology employed and a justification for choosing it for this research is presented. The chapter describes the data collection with an analysis of the interview schedules employed, and includes sections on data analysis, ethics, bias, and the importance of reflexivity to this research.

Chapter 3 answers the primary research question “what is healthcare integration” through an analysis of the normative representation of healthcare integration and how this representation was constructed. This Chapter examines how healthcare integration was constructed and represented through historical contextualisation based on archival research and literature review; discourse analysis of WHO Documents; and semi-structured interviews at multilateral organizations. This Chapter examines the development of the normative representation of healthcare integration from an historical analysis of the development of the hegemony of biomedicine. The representation of healthcare integration adopted by WHO is traced from its formation in China as a function of specific political and economic factors. These in turn were influenced by the international health épistème of the Rockefeller Foundation. This Chapter concludes with a critical analysis of the normative healthcare integration discourse of WHO.

Chapter 4 examines the healthcare context of the Philippines. The current state of healthcare in the Philippines is analysed via an examination of changing social structures and the historical development of the formal and informal healthcare systems from Spanish colonisation through to U.S. colonisation. The importance of the centralisation and decentralisation of healthcare is examined with reference to the current Philippine healthcare system. The structure of the current healthcare system of the Philippines is examined through political, economic, and socio-cultural factors.

Chapter 5 presents the results of interviews, pile sorts, and participant experience concerning healthcare integration. The results are discussed according to the type of integration employed in the communities investigated; informants' perceptions of integration; and the assumptions of beneficence of healthcare integration.

Chapter 6 examines the specific case example of the integration of *hilots* in the Philippines. This analysis explores the WHO and UNICEF's trajectory from the first trainings of Traditional Birth Attendants in the early 1950s to the cessation of these trainings with the recommendation of skilled birth attendants in the 1990s to the current “integration” of *hilots* in the Philippines through to the prohibition of their practices in delivering babies beginning in 2008. This Chapter presents the results of informants reported usage of *hilots*, and informant perceptions of the appropriateness of *hilot's* current “integration” in the contexts of their barangays. An analysis of WHO and DOHP data sets with data sets that demonstrate marked reduction in infant and maternal mortality during periods of TBA training is also reviewed.

Chapter 7 culls the information from the preceding Chapters in order to critically analyse WHO's representation of healthcare integration. This critical analysis is both in terms of WHO's model of healthcare integration, as well as the conceptual elements of this normative representation of healthcare integration. The concepts of “the healthcare system”, “traditional medicine”, and “medical pluralism” are all problematised by virtue of this research.

Chapter 8 weaves the broad of themes of this research together to answer the final research question of what this research reveals about healthcare integration and how these findings can be applied to inform healthcare integration, global health governance, and development studies in general. The research provides potential recommendations for further exploration of the issues identified in this dissertation. This Chapter concludes with an analysis of how best to work with multiple systems of understanding and meaning that may render development interventions more appropriate to a given context.

1.8 Conclusion

This Chapter has introduced the research of this dissertation and justifies the need for this research by identifying its contribution to the literature in this domain, whilst problematising the assumptions found within this discourse. The research questions have been reviewed, and their appropriateness to this research have been justified. This Chapter also briefly reviewed why the geographic, political, economic, sociocultural uniqueness of, and current healthcare integration issues in, the Philippines renders it an ideal context for studying healthcare integration and for answering these specific research questions. Lastly, this Chapter explained the reason for the theoretical framework chosen and how the multiple theories and theorists can facilitate an understanding of the complexity of the processes of healthcare integration.

CHAPTER 2

The Research Methodology

2.1 Introduction

This Chapter will review the research methodology chosen for this research and justify why this methodology is the most appropriate design to answer my research questions.

2.2 Sampling

2.2.1 Analysis of Multiple Levels Using Multi-Sited Analysis

Seeking data that will reveal how healthcare integration processes are understood and how they are occurring necessitates a research design that could afford comparisons between different local level and higher level examples of healthcare integration. Therefore, with the assistance of PITAHC, three different municipalities were chosen that were identified to display healthcare integration in three different ways and one municipality that did not identify any integration processes served as a comparison.

Given the complexity of the research it was important to choose rural sites whose healthcare systems offered manageable data collection and analysis. Access to different types of healthcare is generally more limited in rural than urban municipalities in the Philippines, yet rural municipalities may also offer more distinctive local healthcare practices than what may be found in urban areas (Bautista 2002). Furthermore, plurality of healthcare choice may be somewhat easier to analyse in rural areas of the Philippines, with relatively fewer practitioners per population, than in urban areas where informants might have a greater quantity and variety of healthcare choices.

2.2.2 Selection of Municipalities and Barangays

With the assistance of the staff of PITAHC, municipalities were generally chosen according to PITAHC's recommendations concerning the possibility of examining different examples of healthcare integration that might be able to be observed at both municipal and barangay levels.

However, this selection was potentially biased by the individual preferences and choices of the staff at PITAHC. For example, though I thought it would be best to study a municipality in Mindinao, PITAHC would not arrange any research in the Southern Philippines due to their perception that it would be too dangerous for a foreigner.²⁹ Hence, research sites were limited by PITAHC's choices of what they perceived would be most suitable for a foreign researcher that they could easily arrange.

Municipalities were also chosen in an attempt to be representative of the plural and diverse populations of the Philippines. Hence, the municipalities chosen were in different geographic and linguistic areas. The four municipalities were chosen according to the above criteria, as well as the restriction of which Municipal Health Officers would be available to help arrange for the hosting of this research.

A pattern emerged over the twenty-two month period during which research was conducted that proved to be the most helpful in organising this vast and complex research. PITAHC would endorse me to the municipal health officer (MHO) of a municipality in which I was to conduct the research. I would then send an abstract of the research to the municipal health officer with the interview schedules and a request for a minimum of four different types of focus groups in each barangay of the municipality visited. I quickly found it most productive to spend several weeks in each barangay with separately scheduled focus groups of five to ten informants in each group. Four to five barangays in each municipality were studied. I returned at least once to each municipality over the two year research period. Of course, in the field these plans would often change numerous times, and this initial process thereby served more as a guide.

²⁹ Safety of a given municipality was determined both by PITAHC and the Foreign and Commonwealth Office website: <http://www.fco.gov.uk/en/travel-and-living-abroad/travel-advice-by-country/asia-oceania/philippines>

Hence, the choice of barangays was limited to those with midwife administrators that would agree to participate in the research. Other limitations included: the perceived willingness of barangay members to be interviewed and physical access to barangays. Although I did conduct some interviews outside of this formal arrangement, the municipal health officers generally preferred that research be conducted in this formal manner, which may have resulted in a potential bias in sample selection.

The MHOs also arranged translators. Although I acquired a working knowledge of Tagalog, a different dialect was spoken in every municipality studied that was often incomprehensible to all but local speakers. Thus, in each municipality a translator was trained in the four interview schedules prior to the interviews. I trained all the translators in the same manner. The four municipalities of Bagabag, Bontoc, Murcia and Sadanga are described in detail in Chapter 5.

2.2.3 Informant Sample Selection

The informant sample can be divided into five major groupings. The lowest local administrative level of the barangay served as the main focus of the study. The barangay members, the barangay council, the barangay health workers, and the local healthcare practitioners served as the basis for four separate focus groups, each with their own structured interview. The last grouping consisted of primarily administrative stakeholders at several different administrative levels. These included: Local midwife administrators; municipal health officers; NGO representatives; state representatives; and multilateral administrators; interviewed individually with semi-structured interviews.

Informant inclusion criteria consisted of a minimum age of 23 years, with continual residence within the community during the period from 2005-2010. This time frame was chosen to establish if any changes could be identified with healthcare integration, (which was implemented from 2007 in both Bagabag and Murcia). Therefore, the minimum age of 23 was sought, to help ensure that the informant has been responsible for their own healthcare during this period; assuming that from at least 18 years of age, an informant would be more likely to initiate healthcare visits without a parent or guardian. Five years would also be considered an adequate time frame to expect for accurate informant recall and thereby, minimise potential recall bias.

The sampling of the entire study would be categorised as a non-probability sampling. Structured interviews were conducted in focus groups of convenience samples primarily gathered through snowball sampling via the barangay midwife administrators. Semi-structured interviews of stakeholders from barangay (midwives) to state and multi-lateral levels were gathered via purposive sampling. These informants were chosen because of their particular role as a stakeholder in healthcare integration.

In terms of sample size, there was no fixed numerical goal beyond attempting to interview as many available informants as possible. However, barangay informants were often restricted by time and other priorities and only a small proportion of barangay members were available for interviews.

Although local healthcare practitioners were central to the research, they were often unavailable and/or unwilling to be interviewed. Therefore, there is a smaller sampling of local practitioners in every barangay than originally intended. (See Table 2.1 for an overview.)

Table 2.1 Multiple Research Sites and Multiple Levels (with Stakeholder Examples)

Global/ Regional Level	INGO/NGO Level	State Level	Provincial Level	Municipal Level	Barangay Level
					Members Council Midwife BHWs Local Practitioners
WHO- Geneva	Philippine Medical Association	DOHP	<u>Mountain Province</u> Governor Provincial Health Officer	<u>Bontoc</u> Mayor Municipal Health Officer	Alab Oriente Bontoc Ili Guinaang Mainit Samoki
				<u>Sadanga</u> Municipal Health Officer	Anabel Poblacion Sacasacan Demang
WHO- WPRO	Philippine Acupuncture Association	PITAHC	<u>Neuva Vizcaya</u> Governor Chief of Regional Hospital	<u>Bagabag</u> Municipal Health Officer Municipal Nurse	Baretbet Careb Lantap Murong Paniki
World Bank	INAM	Bureau of Food and Drug	<u>Negros Occidental</u>	<u>Murcia</u> Mayor Municipal Health Officer	Blumentritt Caliban Damsite Minoyan Poblacion
Asian Development Bank	CHD	Senator Juan Flavier's Office			
UNICEF		Undersecretary of Health			
USAID		Minister of Culture			
		University of The Philippines Researcher			
		University of the Philippines School of Public Health Faculty			

2.3 Data Collection

I collected all data personally, with the assistance of a translator where needed. Informant answers were typically coded and recorded by hand. Occasionally, long semi-structured interviews were recorded by digital recording with informant permission. In the focus groups, informants would be asked a question and then answers were sought from each informant. Hence, the focus groups would be more accurately described as groupings of individual interviews, whereas individual interviews were slightly less structured and generally new questions would spontaneously be generated from informant answers.

All focus group informants were first asked demographic questions regarding age, income (annual gross salary), and educational level attained. This demographic information was sought to determine if there were statistically significant differences in informant responses according to their demographics. Informant names were neither asked nor recorded, rather all informants were assigned an individual interview number. The barangay hall is a central gathering place for an entire community. Focus groups were generally conducted in the barangay halls of the barangays studied.

2.3.1 Barangay Members Interview Schedule

Although Barangay midwives were asked by municipal health officers to recruit a representative sampling of barangay informants (in terms of age, gender, income, and education), females were more likely to participate than males. Hence, though the sampling reflects variety in terms of age, income, and education, females make up approximately 90 per cent of the barangay member sampling and thereby the sampling is less representative of barangays than intended (See Table 5.1).

The barangay member interview can be divided into five sections with demographic information as the first section. The second section seeks to answer how barangay members use their healthcare system. In the public health literature these questions would fall under the category of health seeking behaviour. The manner in which the barangay members construct their healthcare system can be determined by their particular plural use of healthcare and their perceptions of why they use their healthcare system in this manner.

The third section seeks to understand how barangay members perceive their healthcare system and what, in particular, they perceive are its advantages and disadvantages. The fourth section seeks to understand how barangay members perceive appropriate healthcare integration. The fifth and final section of the interview schedule attempts to determine how healthcare integration may change the informant's perceived access to, and quality of, healthcare. (See Table 2.2 in Appendix 2 for this interview schedule.)

2.3.2 Local Healthcare Practitioner Interview Schedule

The interview schedule for local non-biomedical healthcare practitioners is also divided into five sections that attempt to identify how local practitioners perceive their local healthcare system, their place in this system, and the perceived appropriateness of healthcare integration. The second section seeks to distinguish how local practitioners classify their role in their local healthcare system and how this contrasts with an etic perception of the healthcare system. The third section of this schedule questions if local practitioners perceive any changes in their practice or the healthcare system since integration has occurred. The final section of this schedule asks how local practitioners perceive appropriate healthcare integration. (See Appendix 2 Table 2.3 for summary of the Local Practitioner Interview Schedule).

2.3.3 General Biomedical Practitioner Interview Schedule

This interview schedule served as a general template for barangay health workers, barangay midwife administrators, and municipal nurses. The schedule was altered accordingly to each. This particular schedule in general attempts to analyse how appropriateness of healthcare integration was being constructed from biomedical practitioners, as well as how they perceive their healthcare system. The second section of the schedule identifies practitioner training and the informant's perceived role in the healthcare system. The third section attempts to distinguish if any changes were perceived to the healthcare system since integration had begun. The fourth section of the interview schedule analyses the biomedical practitioners perception of local healthcare practices and practitioners; including their referral to local practitioners. The last section of the schedule identifies practitioner perception of appropriate healthcare and how these perceptions compare to WHO's and those of local level informants. (See Appendix 2 Table 2.4 for summary of the Biomedical Practitioner Interview Schedules).

2.3.4 Barangay Council Interview Schedule

The Barangay Council Interview Schedule was designed to facilitate a better understanding of local healthcare administration in a devolved health sector and local administrative perceptions of appropriate healthcare integration. The second section of this schedule facilitates a contextual understanding of barangay healthcare administration and the barangay healthcare structure. The third section of this schedule assesses the barangay council's perceptions of appropriate healthcare integration and how this may differ from other informant groups. The data gathered from the barangay council interviews primarily were used in Chapter 4 contextualisation of the Philippine healthcare system. (See Table 2.5 in Appendix 2 for summary of the Barangay Council Interview Schedule).

2.3.5 Semi-Structured Individual Interviews with Administrators and Stakeholders from Barangay, Municipal, Provincial, State, NGO and Multi-lateral levels

The semi-structured interviews that were administered individually were designed for the particular role, context, and expertise of each stakeholder. Space does not permit for a display of each of these separate interview schedules, but these interviews shared a uniform purpose of understanding how stakeholders perceive healthcare integration and local healthcare systems, practices, and practitioners. Questions were also designed in order to determine to what extent stakeholders approached the integration of ordered systems of understanding and meaning from inclusive or exclusive Othering.

2.3.6 Pile Sorts

Pile sorts are an anthropological data collection method that provide a means to understand how concepts and domains are structured within a group (Bernard 2006). Salient terms (culled from interviews using NVivo) within the domain of Philippine healthcare practices and practitioners were written in local dialects on 27 index cards; each coded with a number. The informant was then told to arrange cards according to which cards they believe should be grouped together. There is no restriction in the number of groupings. The only rule is that there must be more than one group. Pile sorts are particularly suited for this research as they can assist in understanding how different stakeholders perceive the domain of healthcare in the Philippines and how they construct their healthcare system according to their ordered system of understanding and meaning. Chapter 5 will present the findings of the pile sorts analysis.

2.3.7 Participant Experience and Participant Observation

Elisabeth Hsu distinguishes between participant observation and what she identifies as *participant experience*:

“Participant experience meant that I should learn the skills I studied to such a degree that I could perform them myself. My conviction was that the acquisition of practical skills would give me more insights into the knowledge in which they were grounded than participant observation alone” (Hsu 2006: 149).

Part of this research was conducted in order to ascertain both how healthcare integration is understood by different stakeholders and how integration can be understood and most accurately represented. For example, healthcare integration can be an informal process that occurs without awareness of it being a separate or identifiable process (especially at an individual or community level). Querying about healthcare integration processes in interview may not be as reliable a method, to yield a better understanding of the integration processes currently practised, as participant experience of healthcare integration.

According to Bernard, *participant observation* provides a valuable level of meaning to observations (2006). Participant observation in barangays (in conjunction with barangay and municipal interviews) facilitated a fuller understanding of the healthcare integration processes that could be identified in the barangays and municipalities examined.

Participant experience was conducted with PITAHC and with the Traditional Medicine Unit of the Western Pacific Region Office of the World Health Organization (WPRO). From July 2009 through February 2011, I taught acupuncture classes to physicians and nurses through the Department of Health of the Philippines. I worked closely with the Director and staff of PITAHC and thereby developed an understanding of the priorities of PITAHC and how appropriate healthcare integration was constructed in a more phenomenological manner, than if I merely interviewed the staff of PITAHC. Similarly, consulting with the traditional medicine unit of WPRO from August of 2009 through September 2010 permitted a rich understanding of the traditional medicine unit's priorities, policy-making process, and staff perceptions of appropriate healthcare integration.

Each of the projects I completed for WPRO provided a different understanding of staff and organizational perceptions of healthcare integration, as well as an understanding of data collection at WPRO and the process of policy-making at WPRO. Excerpts from the ethnography of participant experience at WHO-WPRO is located in Appendix 3.

2.4 Data Analysis

It is essential to have an overall analytic framework by which to compare this vast data set collected through varied means. Phenomenological analysis provided an overall framework for data analysis. Specifically, Van Manen's method provided a three-tiered approach that combines holistic, selective, and detailed approaches in order to identify themes and determine essential meaning (1990).

2.4.1 SPSS

Structured interviews were coded into nominal data and analysed with IBM SPSS 19 using descriptive statistics. Cross tabulation and ANOVA were predominantly employed for data analysis. There are several reasons SPSS was considered best for this task. Firstly, SPSS can facilitate the identification of differences and correlations between barangay member's perceptions of appropriate integration, as well as an analysis of the sample in terms of demographic variables. Thus, SPSS permits both proportional and frequency analyses, as well as linear regression; disaggregating the sample according to age, gender, income, education, and barangay. Furthermore, SPSS provides a means to perform ANOVA analysis on the data and thereby compare within group responses (i.e. comparing the responses of barangay informants of the same municipality) with between group responses (or the comparison of responses of barangay informants from different municipalities). Semi-structured interviews were analysed with NVivo. Pile sorts have been analysed with Anthropic and Multidimensional Scaling Analysis. See Appendix 2, Table 2.6 for a summary of the data analysis methods used.

2.5 Research Ethics

As this research is studying the responses of human informants, ethics, bias, and reflexivity are especially important to consider and to be cognizant of in the research design. Guillemin and Gillam (2004) distinguish between procedural ethics and the actual ethics in the practice of research. Procedural ethics for this research has been secured and executed in following CUREC procedure and submitting documentation of research ethical standards to CUREC (The institutional review board of the University of Oxford).

2.5.1 Protecting Confidentiality

Protecting informant confidentiality was exercised through the choice of demographic information sought and the care taken to not utilise direct identifiers. In order to disaggregate data, gender, age, annual income, educational level, and residing barangays only were recorded. Neither names, pseudonyms, addresses, nor employment information was sought or recorded. Furthermore, in focus groups, informants were invited to either write down, or be interviewed privately about any information which they deemed sensitive.

Certain key actors, especially those who are representative of an agency, may have spoken on behalf of their positions. However, their positions or names are only used with their full consent. It should be further noted that intellectual property was protected by not filming or recording any local healthcare practices.

Epidemiological data consists of state and regional level data. Individual records were not examined. Hence, absolutely no identifiers of informants were used for the purposes of this research.

2.5.2 Informed Consent

An imperative aspect of any informed consent is the communication of the free will (or autonomy) of any informant to be able to choose to participate or not participate in the research.

Furthermore, informants may of their own volition stop participating in the research or choose which questions to answer or not answer at any time. The relevance of the explicit communication of informant free will is essential to ensure that research with human informants is conducted ethically. Due to illiteracy amongst informants, verbal informed consent was obtained from all informants. The informed consent form was read in its entirety in the local dialect (See Appendix 2 for the Informed Consent).

2.5.3 Compensation

Financial compensation for people's time was not feasible, as this research was conducted solely with personal funds. However, compensation took other forms. In discussions with PITAHC and with municipal health officers, I was informed that providing juices and snacks would be welcomed as compensation. But I was also informed that the various communities would appreciate a presentation. Hence, for each community a presentation on this research was offered, with a follow-up presentation the following year of the particular research findings. Furthermore, all informants were made aware of the particular reasons for this research and how their time was contributing to the knowledge that can be gained from this research.

2.6 Research Bias

This section will present the possible instances of bias encountered in this research.

2.6.1 Informant Bias

There are several potential issues with informant bias in these interviews. Firstly, integration, and healthcare in general, are political topics, especially in the Philippines where decentralisation of healthcare has been highly politicised (Bautista 1996; CHD 2003). Hence, many informants and key actors may feel very passionate about this topic and are likely to be, in some way, biased.

Bias can also be due to misunderstanding. Translators were trained to explain questions that informants may not understand in detail. Reflexively, questions were reworded through the course of the research in order to be better understood by local informants.

Bias is also possible in terms of the Hawthorne Effect. The Hawthorne Effect is demonstrated when an informant provides an answer that they assume the researcher/interviewer is seeking, as opposed to what may be their true answer to a question. In attempts to avoid the Hawthorne Effect, translators were trained to emphasise that there were no correct or incorrect answers to questions and instead we were only interested in informant opinions. Translators were also trained to respond in a neutral manner to informants and to not display agreement nor disagreement with informant answers.

2.6.2 Recall Bias

Recall bias is also a potential consideration in this methodology, as many questions referred to a period from the year before integration (which occurred in Bagabag and Murcia in 2007) to 2009 or 2010 (depending on when the informant was interviewed). In order to reduce recall bias, national events were mentioned that took place in a given year to help facilitate the informant's memory.

2.6.3 Sampling Bias

Convenience samples acquired through snowball sampling can yield a non-representative and biased sampling. Unfortunately, needing to follow a formal hierarchical protocol for conducting this research in the Philippines prohibited more randomised sampling. I attempted to control sampling bias by increasing sample size and conducting as many interviews as there were available informants. Both informant availability and sample size necessitated focus groups. However, focus groups also can engender a sampling bias.

In order to discourage informants from potentially conforming to a “group response”; informants were reminded throughout interviews that only their personal opinions were being sought. Furthermore, informants were encouraged to write down answers or be interviewed individually regarding any questions they may have perceived as sensitive. Many informants took advantage of this option for certain questions, suggesting that sampling bias was potentially being controlled.

2.6.4 Interview bias

The interview questions were carefully constructed so as not to bias informants to answer in a particular way. For example, Green in his study asked “If healers are engaged in practices detrimental to public health, don’t health and government officials have a public health responsibility to try to change these practices?” (Green 1988: 1127). While, I asked: “Do you have any concerns or see any reasons for concerns about local health practices and practitioners”?

2.6.5 Interviewer bias

One of the primary reasons I chose this research topic was because I sought to understand the processes of healthcare integration and did not possess an answer to my research questions prior to conducting the research. Hence, I was not conducting research in order to prove anything. In fact, I did not possess a strong opinion about healthcare integration. Nor did I fully understand healthcare integration. Therefore, as interviewer and research designer, I had many questions about these processes, without having preconceived biases. Employing reflexivity, as discussed in the next section, will help “unpack” personal biases that may be embedded in a research design or the execution, evaluation, or presentation of this research (Clifford and Marcus 1986).

2.7 Reflexivity

Reflexivity is a process that can provide the means for ethical and unbiased research (Guillemin and Gillam 2004). Mason identifies that reflexivity in research demands that the researcher be vigilantly aware of their role in the research process (1996). This process is one of reflecting on what one observes and then reflecting on the meaning and interpretation that one is applying to this observation, thereby, informing both what one observes as well as how one observes. Observation is thereby contextualised and subjectivity is exposed, rather than assumed to be non-existent. Consciousness of what one is doing, how one is doing it, and why they are doing it assists in upholding ethics in action. This mode of “conscious research” also facilitates a means by which a researcher can be aware of bias in research. By rendering interpretation as subjective and by not assuming that one's interpretation is objective fact, facilitates the generation of data possessing greater objectivity. In this manner, reflexivity can enhance the quality, validity and rigour of data. Furthermore, limitations of the research can be clarified.

2.7.1 *Reflexivity employed in this research*

Reflexivity was an imperative tool for this research. There is a perceivable “fit” of reflexivity and modified grounded theory, with research evolving through a feedback loop in which data informs theory, rather than the contrary. When I set out to do this research, I really did not know what I would find, nor did I have a strong feeling about integration, but more so sought to understand integration and what integration actually was doing. I originally embarked on this research to identify what outcomes, if any, resulted from integration. However, I realised through the research that though portrayed as an outcome in the literature, integration was, in fact, a series of processes of which outcomes were merely a part.

Furthermore, I realised that it would prove statistically impossible to disaggregate any epidemiological data in order to demonstrate that any changes that occurred during the period of integration, were, in fact a result of integration. Thereby, my research questions changed from public health questions seeking measurable outcomes to anthropological inquiry seeking to understand processes and how these processes were being perceived, constructed, and represented.

Reflexivity was influential in the research design. Structurally, the design of the research changed over the 22 month period of fieldwork in two important ways. Firstly, the municipality of Sadanga was not originally considered. I learned about Sadanga, after the research had begun, from informants in Bontoc. At the onset of the fieldwork, the municipality of Siquijor on the Island of Siquijor was to be a second control municipality along with Bontoc. However, research in Siquijor was poorly organised and the sample size was smaller than in other municipalities. Some informant responses from Siquijor are quoted, but the main research collected in Siquijor is not presented here.

A second reflexive alteration to research design concerned the case example of local birth attendants or *hilots*. After the research had begun, a DOHP Administrative Order was passed announcing that all women were to be considered at risk during pregnancy and must deliver in a facility with skilled birthing attendants. *Hilots* were to be integrated into the Maternal Child Health team only if they refuse to deliver on their own. I discovered this policy approximately a third of the way into the research. Coincidentally, I was seeking a singular local practice by which to examine integration. Examining all possible practices and practitioners, I found to be not only unwieldy, but yielded general data with which I was inherently placing all practices and practitioners in one category, albeit of local practices and practitioners. Thereby, I was repeating the same issue of essentialising these practices and practitioners that I was also critiquing and problematising. This data appears in Chapters 5 and 6.

Finally, reflexivity was imperative in facilitating the use of what the data was revealing, in order to question certain epistemological paradigms. For example, reflexivity concerning this research engendered questioning of the normative (specifically WHO's) constructions of healthcare integration, traditional medicine, safety, appropriateness, and even constructions of the healthcare system and global health. Also questioned as a result of reflexivity were anthropology's constructs of alterity, medical pluralism, and taxonomy; development studies constructs of appropriate technology/knowledge transfer, community participation, and needs-based approaches to development; and post-modern/post-colonial constructions of agency.

2.8 Challenges in Conducting This Research

There were several challenges encountered over the 22 month period of fieldwork. A common challenge in conducting this research was informant completion of the entire interview. Barangay member informants would often excuse themselves and not return or return after the focus group had ended. In these instances, either the portion of the interview that was answered was used or if missing parts of interviews rendered the data unusable, the entire interview would be discarded.

The field research was almost exclusively conducted using personal funds. Therefore, my budget was a significant consideration, and sometimes a restriction, in deciding where I could go and for how long I could stay.

Lastly, my physicality may have been a challenge. I conducted this research towards the end of a debilitating period of arthritic degeneration of my right hip. I required the assistance of a cane when I walked, yet still walked with a noticeable limp. I mention this under challenges because not only did it compromise my mobility, as a few barangays that required hiking up hills were inaccessible to me, but also, because of how it may have affected informant reaction.

I was told that I was viewed with some suspicion by some informants not only because I was a foreigner, but also because of my disability. I was told that it was disconcerting to many to see a “youngish” foreigner who needed to walk with a cane and it was believed that I must have committed some grave moral transgression to be so disabled. \Hence, to some extent my disability may have affected informant trust and possibly resulted in bias in some informants. This was another reason why a large sampling was sought.

2.9 Conclusion

This Chapter has presented an overview of the methodology employed for this research. Sampling methods, data collection, research ethics, and research bias were reviewed. The centrality of reflexivity in this research was also thoroughly reviewed. The entire methodology discussed in this Chapter is summarised in Table 2.6 in Appendix 2. The next Chapter will contextualise the normative representation of healthcare integration.³⁰

³⁰ A note on dissertation presentation: both quotes from the fieldwork, as well as longer quotes from the literature, will be indented throughout the dissertation. Quotes from the literature will be cited, whereas quotes from fieldnotes will be presented with an informant number and a brief demographic description.

CHAPTER 3

The Construction of the Normative Representation of Healthcare Integration

“The United States will undoubtedly play an increasingly important part in the scientific collaboration of the world” (Rockefeller Foundation 1917 Report: 47).

3.1 Introduction

This Chapter will answer the primary research question, “what is healthcare integration” via an analysis of the normative representation of healthcare integration and how this representation has been constructed. This analysis will utilise historical contextualisation based on archival research; literature review; discourse analysis of World Health Organization documents; semi-structured interviews; and participant experience at the Western Pacific Region Office of the World Health Organization (WHO).

3.2 The Historical Construction of Healthcare Integration

Integration is a broad category in the literature that generally describes the extent of a nation’s acceptance of non-biomedical practices and practitioners into the formal biomedical healthcare system. Hence, integration is normatively conceived as an outcome. However, Hyma and Ramesh identify that: “The WHO’s review of national experiences in the 1980s indicates that there is no single universally accepted concept of integration” (1994: 66). Thus, in order to understand the process of healthcare integration, it is necessary to examine the historical, political, and economic construction of this concept. This section will identify the myriad historical and socio-cultural factors that influenced the construction of the normative representation of healthcare integration.

3.2.1 Frederick T. Gates, Abraham Flexner, and The American Medical Association: The Standardisation of American Medical Education and the Eradication of Medical Sectarianism

*“Every man owes a debt to humanity, and in accordance with the manner in which he discharges that debt will he be judged”
(John D. Rockefeller 1907, quoted in Hewa 2002: 6).*

3.2.1.1 Frederick T. Gates and The Rockefeller Foundation

The work of The Rockefeller Foundation (RF) in the early twentieth century is not only central to the normative construction of international health, but also to the normative construction of healthcare integration. The standardisation of American medical education has commonly been attributed to the findings of a 1910 research project, in which American medical schools were categorically ranked according to a set of criteria. Hewa argues that the report of this research, the so-called Flexner Report, is merely the documented justification for the work that began in earnest ten years earlier by Frederick T. Gates of the RF (2002). Starr observes that the American Medical Association's (AMA) push for standardised medical education pre-dates both Gates and the Flexner Report (1982). This section will demonstrate that Flexner, Gates, and the AMA were equally influential in the reform of American medical education and the development of a hegemonic biomedicine and biomedical expert.

According to Hewa:

“Medical education reform in the United States was part of the broader social changes taking place in the late nineteenth and early twentieth centuries...With a rapidly expanding industrial economy, it became evident that the nation must have modern scientific education to provide a well-trained industrial labor force” (2002: 2).

Medical education reform became a central focus of the work of Frederick T. Gates (Hewa 2002). Although Gates generated the ideas for medical educational reform, he required a powerful means by which to disseminate these ideas; which he found in John D. Rockefeller Sr.

What has been referred to as “the doctrine of stewardship of wealth”³¹ is a late nineteenth century adaptation of Calvinism (Hewa and Hove 1997). As Max Weber observed, “the Calvinist creates his own salvation...or...the conviction of it” (1958: 115). Thereby, the pursuit of wealth, and the enhanced ability to engage in good works by virtue of this pursuit, became a post-Reformation moral imperative.³² In the doctrine of stewardship of wealth, the wealth of the few is justified in religious representations of “God’s elected” trustees. The accumulation of wealth was rendered both inevitable and beneficent via philanthropy. In this manner, Protestant ethics purportedly guided both the acquisition of wealth and its dissemination for the “greater good” of society.

The need for such a representation could be better understood when considering the more familiar representations of nineteenth century wealthy industrialists and financiers as “Robber Barons” (Hewa 2002: 6). This was especially a concern for John D. Rockefeller Sr.³³ Out of this discourse of civic duty and responsibility grew philanthropy and the representation of the benevolent capitalist.³⁴ The growing philanthropic foundations “were built on a combination of scientific principles and commercial practices, administered by paid executives with expertise in specific fields, law, medicine,³⁵ public administration, education, etc., they became businesses in their own right” (Hewa 2002: 8).

³¹ Calvin writes: “Let this, therefore, be our rule for generosity and beneficence: We are the stewards of everything God has conferred on us by which we are able to help our neighbor, and are required to render account of our stewardship” (1950, III: VII: 5: 695).

³² In “The Protestant Ethic and The Spirit of Capitalism”, Weber demonstrates how capitalism, progress, and professional specialisation became linked as moral imperatives by which to live; embedded in Protestantism and especially Calvinism (1958).

³³ Both Rockefeller and his Foundation were severely criticised from the turn of the century, but several events were considered particularly egregious in the public eye. The most damaging to the image of Rockefeller was the Ludlow Massacre of 1914, in which the private army of a mining company owned by Rockefeller shot and killed six striking workers and burned alive two women and eleven children (Brown 1979: 168).

³⁴ “Philanthropy as an act of human benevolence became thoroughly integrated with the structure and process of the industrial capitalist economic system. Benevolent conduct was no longer an informal act based on the emotions of individual givers, but a rational and calculable act coordinated within the modern organizational system” (Hewa 2002: 7).

³⁵ “From 1910-1935, Rockefeller philanthropies contributed 90-95% of all foundation monies going into American medicine. The Rockefeller-sponsored campaign against hookworm in the South and the medical discoveries at the Rockefeller Institute served to counter the negative image engendered by Rockefeller monopolistic practices and anti-worker violence” (Baer 1988: 189).

According to Brown: “The Rockefellers...set about making educational institutions, the agricultural economy, and the public health more supportive of the new industrial order” (1976: 899). The education of professional expertise, and the creation of elite technocrats in particular, became an imperative tool for the political economic dissemination of American capitalism and liberalism internationally and lay the foundation for American international dominance in trade³⁶ (*Ibid.*).

Rockefeller's early philanthropic work in the mid- to late nineteenth century centred around the Baptist Church and Baptist education (Brown 1979). The Baptist Church brought Frederick T. Gates to the attention of John D. Rockefeller (*Ibid.*). Gates was a Baptist minister who was also a fund-raiser for Baptist education (*Ibid.*). He was instrumental in persuading Rockefeller to build the University of Chicago (*Ibid.*). As a result of this venture, Rockefeller invited Gates to help him direct his growing philanthropy (Hewa 2002). Gates helped Rockefeller run his philanthropic activities as Rockefeller had operated his business ventures; namely, as a Fordist³⁷ managerial operation.

Gates was instrumental in convincing Rockefeller that medical education, in particular, needed to be systematised, standardised, and above all scientific (Hewa 2002). Gates proposed this goal could be established through an institute of medical research and through the establishment of the General Education Board (Hewa 2002). Gates was soon rewarding those medical schools that he personally deemed worthy of being supported (*Ibid.*). His hopes that these would flourish coincided with his wish for numerous other North American medical schools of the early twentieth century to vanish (*Ibid.*).³⁸ This may well have marked the onset of an exclusive Othering in American medical education. 66

³⁶ Arnone identifies this philanthropic dissemination of American standards and ideals as a form of neocolonialism; in which “political and economic power [is used] to exalt and spread the values and habits of a foreign culture at the expense of a native culture” (1982: 2).

³⁷ Fordism refers to “the use in industrial production of the methods pioneered by American industrialist Henry Ford, typified by large-scale mechanized mass production; a doctrine or theory advocating this” (Oxford English Dictionary 2011).

³⁸ “The Rockefeller Foundation gave \$1 million to the Johns Hopkins University between 1916 and 1922 to organize the first full-fledged school of public health in the U.S. Between 1921 and 1927 they gave \$3.5 million to Harvard University to organize a second school. In all, they contributed more than \$25 million for the development of public health schools in the U.S. and abroad” (Brown 1976: 901).

The medical school of Johns Hopkins University was the first to be funded by the Rockefeller Foundation through Gate's referral (Brown 1979). According to Gates and, later, Flexner, Johns Hopkins was to be the gold standard for all American medical education (*Ibid.*). However, Starr notes that the AMA first laid the groundwork for American medical education reform through its numerous battles to gain hegemony in American healthcare (1982).

3.2.1.2 American Plurality and The American Medical Association

In order to fully understand the pertinence of the work of Gates and Flexner to healthcare integration, it is necessary, first, to briefly review the historical context of American healthcare pluralism and the influence of the AMA in creating a monopoly of biomedicine. Starr identifies several historical periods of dominant medical practice in the plurality of U.S. healthcare (1982). Beginning with home or domestic medicine in the eighteenth century colonies to the rise of professionalism and medical sectarianism in the nineteenth century, Americans had a wide assortment of professional and lay practitioners from which to choose. These practitioners included: “Botanic practitioners, midwives...cancer doctors, bonesetters, inoculators, abortionists, sellers of nostrums...and native American Indian doctors” (*Ibid.*: 48). Many of these were eventually absorbed into the medical profession. But, from the onset there was a marked division between the medical physicians and all other practitioners.

“In 1763, physicians in Norwich, Connecticut, requested their colonial legislature 'to distinguish between the honest and ingenious physician and the quack or empirical pretender' by allowing doctors to found societies with licensing power” (Starr 1982: 44).

These early bids for exclusive Othering were initially rejected. Medical societies did eventually form and “sought to isolate 'quacks' by denying them all consultation with regular physicians; anyone conferring with them was supposed to be subject to penalties, such as expulsion” (Starr 1982: 45).

The ideology of American democracy fanned the flames between these warring practitioners for over 250 years. In one instance “Knives, pistols, chisels, bludgeons, etc. were freely displayed. The battle was finally settled when one side brought a cannon” (*Ibid.*: 94).

However, quite remarkably in this environment, bi-directional practice transfers did occur between professional and lay medicine. For example:

“some important remedies used by regular physicians, such as smallpox inoculation and quinine, were borrowed from folk cultures” (Starr 1982: 47).

Hence, inclusive Othering existed alongside exclusive Othering in an informal healthcare integration between individual practitioners during this period.

3.2.1.3 Homoeopathy: an early example of complete integration or complete eradication

One of the largest battles in U.S. medical history occurred between medical physicians and homoeopaths.³⁹ In 1846, the American Medical Association (AMA) was formed and though it “had not been formed primarily with homoeopathy in mind, it quickly turned to the challenge...the avoidance of contact with homoeopaths took on all the gravity of a pollution taboo”⁴⁰ (Starr 1982: 98).

Though the AMA had been gaining power through the late nineteenth century, their ability to do away with homoeopaths was prevented by the public's agency in the construction of their healthcare system (Starr 1982). However, some medical physicians were also against the removal of homoeopathy, for homoeopaths served as a lucrative source of referrals (*Ibid.*). Slowly homoeopaths were integrated into some aspects of the healthcare system, such as hospitals, in some of the larger Northeastern cities (*Ibid.*). 68

³⁹ Homoeopaths were popular for several decades after the Civil War; especially amongst the elites of Northeast cities (Starr 1982: 99). According to Brown, “from the mid-nineteenth century on, homeopathy in the United States appealed primarily to the upper classes. It was safer than the heroics of regular medicine, and it was a sign of affluence and taste since it was very fashionable among the European nobility and upper class, who were aped in many ways by wealthy Americans” (1979: 110).

⁴⁰ “The Surgeon General of the United States was denounced for having taken part in the treatment of the Secretary of State the night he was stabbed and President Lincoln was shot, because...[the Secretary's] personal physician was a homeopath” (Starr 1982: 98).

The result, however, from this integration was a fragmentation within the ranks of homoeopathy that eventually led to its dissolution and the complete co-optation into biomedicine by the turn of the century (*Ibid.*). This foreshadowing of future integrations to come is instructive. In this instance, hierarchical Othering and subsequent integration resulted in the homoeopaths' adherence to the biomedical Other's ordered system of understanding and meaning to the detriment to their own.⁴¹

3.2.1.4. The AMA and American Medical Education Reform

By the turn of the twentieth century, state licensing boards were controlled by members of the AMA who now: “made reform of medical schools a top priority...In 1904 the AMA established a Council on Medical Education...[with] a mandate to elevate and standardise the requirements for medical education” (Starr 1982: 117). In order to generate a full publishable situational analysis of American medical education, the AMA invited the Carnegie Foundation to conduct a report on the state of North American Medical Schools.

3.2.1.5 The Flexner Report

The outcome of early twentieth century medical education can be understood, at least in part, to have been a result of a rivalry between Rockefeller and Andrew Carnegie. Carnegie hired Abraham Flexner to conduct the AMA's requested comprehensive study of North American medical schools (Hewa 2002). Formally titled *Medical Education in the United States and Canada: A Report To The Carnegie Foundation For The Advancement Of Teaching*, the report set a standard for North American medical education that resulted in the subsequent closure of over half (84) of North American medical schools from 1919 to 1928 (Chapman 1974).

⁴¹ “The incentive to differentiate oneself was now counterbalanced by an incentive to conform and accommodate” (Starr 1982: 102).

Of the 76 schools remaining, all offered the same curriculum, set the same academic standards, and followed the same entry requirements (*Ibid.*: 106). They thereby constituted a coherent ordered biomedical Self.

Flexner also determined where schools should be placed and how many physicians should be graduated yearly according to the size of the local population (Flexner 1910). Such changes would inevitably render medicine as a more viable business venture for new physicians seeking profit for their expertise.⁴²

Flexner concludes:

“Reorganization along rational lines involves the strengthening of democratic principle, because it tends to provide the conditions upon which well-being and effectual liberty depend” (Flexner 1910: 155).

Thus, Flexner creates an ideology that equates standardisation, regulation, and professional exclusivity with a proportional increase in the American quest for freedom and liberty. Thereby, the standardisation of healthcare practices is represented as inherently beneficent, by contributing to the ideals of democracy; ideals which, by their very nature, are meant to be ethically irrefutable.

The most pertinent section of his report for this dissertation is the short Chapter entitled: “The Medical Sects” (Flexner 1910). Flexner concedes:

“Prior to the placing of medicine on a scientific basis, sectarianism was, of course, inevitable” (*Ibid.*:156). Flexner asks if “sectarian medicine”, which he defines as allopathy, homoeopathy, and osteopathy, is “logically defensible” and “justifiable...in this era of scientific medicine”. He extrapolates that “modern medicine uses knowledge with no preconceptions”. Whereas, “men possessed of vague preconceived ideas are strongly disposed to force facts to fit, defend, or explain them”, interfering with “the free search for truth”. He concludes that “modern medicine denies outright the relevancy or value of allopathy or homoeopathy” (*Ibid.*).

⁴² The president of the American Medical Association reported at the annual meeting in 1903: “the profession was becoming overcrowded and that, to correct this 'the ease and facility with which a medical degree may be secured in this country must be diminished'” (Chapman 1974: 110). Hence, the business of medicine was concerned with the reduction of competition and thereby the reduction of supply in order to increase the value of demand.

Herein lies a seed of both the justification for the future hegemony of biomedicine, as well as the exclusive Othering and invalidation of all other healthcare practices, practices that Flexner considers inherently morally unethical by virtue of their obstruction of truth.⁴³ What is so powerful in Flexner's statement is the representation of the modernisation and scientisation of healthcare as a moral imperative. What is also relevant here is the sole ascendancy of the biomedical physician as the representation of the true “healer” to the detriment of all other practitioners. Biomedical knowledge is thereby rendered the only authoritative healthcare knowledge by virtue of being scientific.⁴⁴ Thus, the boundary between the physician/scientist and all others is clearly drawn, the Other now being all who veer from this group's self-proclaimed excellence. Here, then is an uncompromising rejection of any plurality of healthcare or the validity of any other healthcare practice.⁴⁵

Yet, Flexner does not thoroughly dismiss all other practices, for he identifies some value in the medical education of homoeopaths, whom he identifies as misled.

“Science, once embraced, will conquer the whole. Homoeopathy has two options: withdraw into the isolation in which any peculiar tenet can maintain itself [or] to put that tenet into the melting pot” (Flexner 1910: 161).

Thus, homoeopathy can only survive by being conquered by science.⁴⁶ His prognosis was profoundly prescient, for homoeopathy was to be co-opted by biomedicine before being entirely extinguished (Starr 1982).

⁴³ Douglas states: “These are pollution powers which inhere in the structure of ideas itself and which punish a symbolic breaking of that which should be joined or joining of that which should be separate. It follows from this that pollution is a type of danger which is not likely to occur except where the lines of structure, cosmic or social, are clearly defined” (1966: 140).

⁴⁴ According to Strong, “a dominant social group legitimates its power by grounding it in a set of authoritative understandings. These understandings are taken for granted, and they permeate and structure lived experience” (1999: 5).

⁴⁵ “A polluting person is always in the wrong” (Douglas 1966: 140).

⁴⁶ Quite ironically, John D. Rockefeller Sr. favoured the use of homoeopathy his entire life. “I am a homeopathist”, he scolded his staff. ‘I desire that homeopathists should have fair, courteous, and liberal treatment extended to them from all medical institutions to which we contribute...Homeopathic teaching should...be provided for the same as Allopathic’” (Quoted in Brown 1979: 110).

But Flexner was also prescient in his representation of healthcare integration as a “conquering of the whole”. Thus, in this representation, only by submitting one's ordered systems to the dominant biomedical Other can the non-biomedical Self survive. It is a form of integration that will be identified throughout this dissertation. However, it is only one kind of integration among many.

A seed of biomedical Othering took root aggressively in North America before being disseminated internationally. It is an exclusive Othering upon which whose exclusivity the existence of the expert Self is contingent. And with this contingency in place, the physician expert was poised to become the dominant, if not sole, “expert” of international and global health, whose paternalism was thereby justified and irrefutable.

3.2.2 The Rockefeller Foundation and the establishment of an International Health “épisteme”⁴⁷

The centrality of the dissemination of science worldwide to the RF is indicated in the Rockefeller Foundation Report of 1917 in which the RF describes itself as:

“a world-wide organization in the interests of scientific knowledge applied to human welfare...turning science from the destruction of the race to the healing of the nations” (1917: 49).

Through their work in international vertical public health projects; the funding of medical and public health schools;⁴⁸ assistance in the formation of public health systems in various countries; and the training and employment of public health administrators; the RF played a central role in the construction of international health.

⁴⁷ The Oxford English Dictionary defines *épisteme* from Greek (*ἐπιστήμη*) meaning “scientific knowledge, a system of understanding” (OED 2011). I am specifically using the term as Foucault has defined; “the strategic apparatus which permits of separating out from among all the statements which are possible, those that will be acceptable within...a field of scientificity...which makes possible the separation, not of the true from the false, but of what may from what may not be characterised as scientific” (Foucault 1980: 197).

⁴⁸ The Rockefeller Foundation not only funded and affected the curricula of medical schools worldwide, but also schools of public health. These include schools of public health in London, Toronto, Warsaw, Prague, and notably, the University of the Philippines (Solomon 2000).

At the turn of the twentieth century, the first RF project for hookworm eradication in the Southern U.S. served as a precursor for many of the international projects that followed. From its original intention “to integrate the 'backward' South into the industrial economy controlled by Northern capitalists”, the Foundation identified hookworm infestation as the source of decreased productivity of workers,⁴⁹ which in turn affected profit⁵⁰ (Brown 1976: 898). Hence, the primary purpose underlying the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease was to increase profitability through increasing worker productivity (*Ibid.*). Thereby, an ideology was established wherein the value of the health of a population became understood in terms of worker capacity and measured in terms of “quantitative increases in productivity” (*Ibid.*). Once investing in healthcare was understood as a profitable enterprise, medicine and capitalism were married.

The success of the domestic hookworm programme led to the formation of the RF's International Health Commission in 1913; later to be renamed the International Health Board (IHB) (Rockefeller Foundation 1917). Anderson notes:

“The new International Health Commission ...needed a means of entry into the colonial tropics...The hookworm campaign might prove a tool permitting ingress to a colony, or a new state, and a means of enabling the Rockefeller Foundation to build, or rebuild, a health program” (2002: 702).

Beyond the promise of increased productivity of labour, international health provided a safe, irrefutable, and inherently beneficent means by which to disseminate an American ideology across the globe. Nye labels this subtle form of international diplomacy “soft power” (1990).⁵¹

⁴⁹ Hookworm infection can result in a debilitating form of chronic anaemia and increased vulnerability to other communicable diseases, which could severely compromise a person's energy and ability to work (Rockefeller Foundation 1917: 24).

⁵⁰ It was calculated that 25% more labourers were needed to achieve the same output in countries with heavy hookworm infestation as those without infestation (Brown 1976: 898).

⁵¹ According to Nye, with soft power, one is able to “get other countries to want what it wants...through attraction rather than coercion” (1990: 166).

According to Brown, the RF established international health projects, to infiltrate the Other's beliefs.⁵²

“The Rockefeller Foundation public health programs in foreign countries were intended to help the U.S. develop and control the markets and resources of those nations”⁵³ (Brown 1976: 897).

3.2.2.1 The International Health Board and The League of Nations Health Organization: Building an Elite Network of Expertise

The IHB identified its mission as taking on health issues that extended beyond political and geographic borders (RF 1917). They identified that an “international transfer of expertise” was essential to improve national healthcare systems (Weindling 1997: 269). This was evident in the IHB's work. For example, The RF funded forty percent of the budget of the League of Nations Health Organization (LNHO) (Loughlin and Berridge 2002). Their emphasis at LNHO was on “the development of a pool of international experts in public health” (Weindling 1997: 273).

“The RF's funds were specifically targeted to broaden the involvement of medical officers and medical researchers in the work of LNHO, particularly through study visits and its network of specialist committees”⁵⁴ (*Ibid.*: 275).

The RF used the LNHO as the means to improve health through the institutional resources of a scientific and medical “expert elite” (Weindling 1997: 269). In this manner, the LNHO provided a paradigm for international health with a RF ideology embedded within, that could be sustained and disseminated through the RF's continued training of public health experts.

⁵² In regard to the RF's work in Southeast Asia, Liew states, “Regarded with suspicion and hostility in most territories, the Board found it expedient to play down its American origins by highlighting itself as a representative and promoter of a culturally odourless brand of modern medical science” (2006: 9).

⁵³ Brown identified four steps through which the Rockefeller Foundation intended to achieve these goals. First, through the “U.S. control of the resources and the markets...political control...was considered important to maintaining their openness to profitable investment. Second increased development...was seen as necessary to the successful exploitation of their resources, markets, and investment opportunities by capitalist countries. Third...diseases were believed to be obstacles” to undeveloped country development. Lastly RF “strategists believed the biomedical sciences and their application through public health programs would increase the health and working capacity of these people and help induce them to accept western industrial culture and U.S. economic and political domination” (Brown 1976: 897).

⁵⁴ “By 1927, the foundation supported 435 individuals on League of Nations' exchanges and 75 individual scholarships. This matured into a more elitist scheme for meetings of directors of the new schools of hygiene to which the foundation had so substantially contributed” (Weindling 1997: 275).

Philanthropies such as Carnegie, Ford, and Rockefeller Foundations identified that the dissemination of a particularly American political economic ideology into low or middle-income countries could be accomplished most directly through education.⁵⁵ The RF's international training of an elite cadre of experts provided a demonstrable means to achieve both biomedical hegemony and U.S. capital, and later neoliberal market domination.

By the early 1920s, the IHB “was presenting itself as the watchtower of public health for the world at large” (Solomon 2000: 409) working to “fit its 'Made-in-America' programs to foreign realities”⁵⁶ (*Ibid.*: 411). At the turn of the century, China was believed to offer “a vast potential market for American goods, American culture, and American democracy” (Ma 1995: 57). The IHB was destined to direct its gaze to China.

3.2.3 The Modernisation of China:

political defeat engendering inclusive alterity and the reordering of a Chinese doxa

The normative model of healthcare integration is based on Mao Zedong's integration of traditional Chinese medicine and biomedicine. In order to understand the construction of this model it is necessary first to understand the reception of Western modernity in China. Modernity asserts that the world can be known and controlled through reductive ordered systems of reasoning. Harvey summarises:

“The development of rational forms of social organization and rational modes of thought promised liberation from the irrationalities of myth, religion, superstition, release from the arbitrary use of power as well as from the dark side of our own human natures” (1990: 12).

Such a liberation project is problematised by Horkheimer and Adorno precisely because a justified domination of nature could, they believe, eventually result in the justified domination of nature in the Other and, thereby reach its apotheosis in the domination of nature in the Self (2002: 11).

75

⁵⁵ In *The Shock Doctrine*, Naomi Klein discusses how the education of young economists from low income countries, predominantly in Latin America, on scholarships to the University of Chicago, led to the formation of elite technocrats who were able to champion a radical form of neoliberal economics under such repressive dictatorships as Pinochet's in Chile (2007).

⁵⁶ By 1917, the IHB “was at work in 37 areas, which included 25 foreign states and countries” (RF 1917: 36).

Modernity in China resulted from collusion with the West about China's need to adopt Western knowledge and technology in order to survive (Ma 1995). However, this was not a uniform process.⁵⁷ Nor was this process agreed upon by all segments of the Chinese population. Nor even by the same segments of the population at different times.

In the mid-nineteenth century, China was engaged in a revivalist philosophical movement toward ancient Han teachings that it had entered since the sixteenth century (Unschuld 1992: 144). China appeared disinterested in Western modernization until a series of crises occurred beginning in 1840 with the Opium War; followed by the thirteen year Taiping rebellion in 1851; the loss of Vietnam to the French in 1885; the Anglo French Invasion of 1857; and the loss of Korea to Japan in 1895 (Schoppa 2000; Barnes 2005).⁵⁸

Although Western mathematics, physics, and astronomy merged with its respective Chinese counterparts in 1644 (Needham 1969; 1970), modernity would not become a force for debate in China until the late 19th century (Andrews 1996). The elites of the intelligentsia believed that the adoption of Western science was a prerequisite for economic productivity (Elman 2003).⁵⁹ The heart of the *Westernisation Movement* (yangwu yundong 洋務運動), from 1860s to 1890s, concerned the adoption of Western knowledge and technology (Ma 1995: 25). By virtue of loss of perceived power after numerous defeats in battle, the collective Self in China was perceived as inferior to the Other (of both the West and Japan) and the Other's modern systems of ordering.

⁵⁷ Cohen extensively critiques this unidirectional representation of Western modernity as a patently ethnocentric construction in historical writings concerning China (1984).

⁵⁸ In the first Opium War (1839-1842) England fought China in hopes of restoring its trade balance with China by attempting to guarantee access to Chinese markets for opium from India. From 1842 and the Treaty of Nanjing to 1858 and the Treaty of Tianjin, several treaties opened China to international trade via foreign nationals in China gaining substantial rights (Schoppa 2000: 16).

⁵⁹ According to Elman, Wang Rejun, in 1897, “stressed the importance of science in the creation of a strong China, and rationalized this mastery by affirming the ancient foundations of Chinese learning...based on forced parallels with the specialized fields of Western science” (2003: 5).

3.2.3.1 The Undulating Adaptations of Chinese Medicine Over Four Centuries

Chinese medicine cannot accurately be represented as a static and stagnant system prior to the reception of Western modernity. Unschuld (1985: 5) identifies “seven major conceptual systems” that influenced Chinese medicine over a period of approximately 3,500 years from both internal sources or adopted from foreign cultures. Throughout its history, a paradigm of cause and effect maintained a durable core of Chinese medicine (*Ibid.*).

Unschuld maintains the changes that occurred in Chinese medicine did so primarily as a result of changes in sociopolitical ideology (*Ibid.*). And Andrews identifies that the modernisation of Chinese medicine is an outcome of the pressures to modernise, in general, resulting both from massive losses in war and capitalism (1996).

“For a century after 1840, the actions of Western nations and Japan were endeavouring to force China to submit to the disciplines of international free trade”, which after the defeat of China “in the Sino-Japanese War of 1894-5, encouraged the Chinese political executive, in self-defence, to emulate Western political structures” (Andrews 1996: 2).

Thus, the adoption of modernity in China might possibly be understood as a kind of shield with which China protected itself. “Chinese physicians mobilised Western knowledge as a resource...to defend themselves and the values they aimed to uphold” (Andrews 1996: 2). In this manner, China provides an illustration that an adoption of a practice of inclusive Othering, with the incorporation of Western understandings into Chinese ordered systems of understanding and meaning, was used to strengthen and sustain China's *doxa*.⁶⁰

Marked agency was displayed in China in terms of the choice of how Western concepts and practices would be incorporated, understood, and justified. The meaning applied to these incorporations would be the [Chinese] Self's. Integrity of the *doxa* would thereby be preserved.

⁶⁰ This depiction of modernity, as not inherently corrupting, is also discussed in Giddens' *The Consequences of Modernity* (1990).

This distinction is reflected in the late nineteenth century sentiment that “Chinese classics were the essence, and the Western study was only a tool” (zhongxue wen ti, xixue wei yong 中學文體西學為用) (Ma 1995: 32).

China's particular adoption of Western modernity is exemplified by its adoption of biomedicine. Biomedicine was appropriated in a manner which was explicable to China and did not destroy the integrity of Chinese *doxa*, nor compromise the purity and order of Chinese systems of understanding and meaning. Similarly, Andrews maintains that even though Chinese medicine was invariably modernised, it remained a distinctly Chinese system of understanding (1996). Furthermore, biomedicine was adopted according to a culture-specific reformulation,⁶¹ which contradicts the conceptualisation of a universalised adoption of biomedicine (*Ibid.*; Berg and Mol 1998). Several authors (including Hsu and Høg 2002; Rizer 2004; and Jennings 2005) have referred to this phenomenon, in which the global is adapted to facilitate local needs, understandings, and meanings, as glocalisation.⁶²

3.2.3.2 Bridging Medical Modernity: The 19th Century Medical Missionaries in China

*“The object with an army, is not merely to kill...the enemy, but to conquer them...
So with the church, her object is not only to convert as many individuals as possible,
but also to subdue the nation as a whole to Christ”*
An American Protestant Missionary College President (quoted in Ma 1995: 29).

According to Ma, “The primary purpose of Christian missionaries in China was to convert the Chinese to Christianity, not to develop modern education for them” (1995: 21). However, missionary schools were quite instrumental in incorporating modernity into curriculum (*Ibid.*: 27). From 1875-1899 the number of foreign missionary schools increased from 800-3,000 (*Ibid.*: 28). By the end of the nineteenth century, “thirty-nine missionary hospitals out of sixty had medical students” (*Ibid.*: 23).

78

⁶¹ Andrews notes that from the 16th century, the Chinese practised variolation (the deliberate introduction of infected smallpox material from a small pox sufferer into young children) in the south of China. Though the Jennerian Vaccine was not introduced in China in 1805 it still needed to be justified or sinicised according to Chinese understanding (1996).

⁶² Jennings defines glocalisation as “the synthesis of the local and the global to create something that both reflects its constituent parts and functions as something distinctive” (2005: 467).

Medical missions to China laid the groundwork of the public healthcare system in China with the first biomedical clinics and hospitals and the first medical and nursing schools. Regardless, of the professed science involved, American missionary doctors in late nineteenth century China purportedly “viewed diseases as penalties for violations of the laws of nature” (*Ibid.*)

Furthermore, the missionaries generally freely disparaged Chinese medicine:

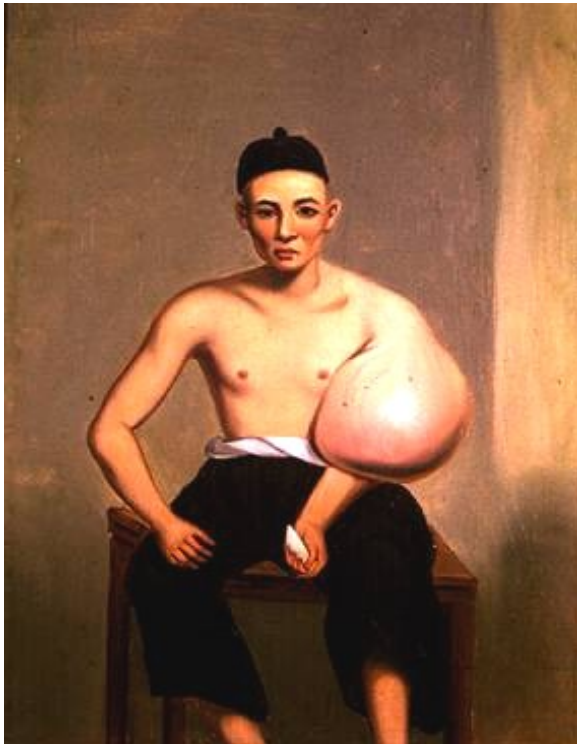
“In their attempt to educate the Chinese on health and hygiene, these missionary doctors were unhesitant in proclaiming the superiority of their medical knowledge over traditional Chinese medicine...denouncing traditional Chinese physicians as 'thoroughly unorganized, unprogressive and unfit’” (Yip 1982: 1199).

A Western ideology that linked order with cleanliness and spiritual purity was, in effect, being transferred through biomedicine, though rejected by most Chinese at the time (Yip 1982). In fact, the overall reception to the medical missionaries was hostile by non-Christian Chinese who resented the missionaries' emphasis on a link between health and Christianity (Ma 1995). The Chinese may have also been critical of the lack of the modernity they “expected”, which was not readily found in this confusion of science and religion; a juxtaposition that concurrently resulted in the Chinese rejection of their own medicine.

Throughout this period of modernisation, understandings of Self and Other were challenged. Changes in the Chinese perception of Self, as a result of the adoption of Western modernity, can be identified in a set of portraits documenting the work of one missionary surgeon. In 1834, Reverend Dr. Peter Parker arrived in China and performed surgeries on gross deformities. A Chinese artist trained in a Western style of portraiture documented Parker's patients.

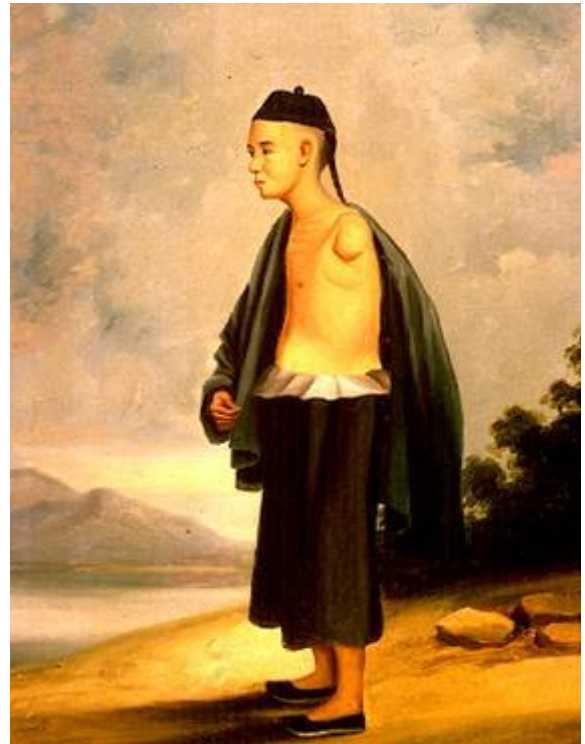
In comparing the setting of the first two portraits, the pre-surgical patient is painted in an enclosed space, as if trapped, in Figure 3.1. However, post-surgically (Figure 3.2), the amputation of a limb appears to have not only freed the patient, but paradoxically returned the patient to a state of wholeness and oneness with nature. In fact, the amputation is represented as preserving nature and providing hope. The order of nature appears to reflect the regained state of harmony of the patient in Figure 3.2.

Figure 3.1 Po Ashing before surgery (ca.1836)



Credit: Courtesy of The Gordon Museum

Figure 3.2 Po Ashing after surgery (ca. 1837)



Credit: Courtesy of The Gordon Museum

Figure 3.1 represents the “grotesque body” of the Enlightenment. Shabot summarises:

“The grotesque body defies clear definitions and borders...and occupies the middle ground between life and death...subject and object...one and many...the grotesque body is inherently ambiguous” (2007: 59).

Shabot understands the grotesque body as a more general threat to modernist reasoning.

“The grotesque world is a fragmentary, complex reality plagued by the multiple relationships to self and other, where clear hierarchical relations, derived from well-defined binary oppositions are not viable...grotesque ontology embraces change, fluidity and disorder...the grotesque in sum deals with difference in the sense of concreteness, specificity particularity and irreducibility to general principles (Shabot 2007: 60-2).

Such disorder is a threat to the Western Self's ordered systems, and yet the Western resolution of this disorder (Figure 3.2) is a representation that is completely offensive to the Chinese Self's sensibility of wholeness and the Confucian dictate of the necessity to preserve the integrity of the body (Andrews 1996).⁶³ Hence, these portraits appear to provide an illustration of the [Chinese] Self's adoption of the [Western] Other's construction of order and integrity, even though this construction may be completely contradictory to the understanding of order of the Self. This adoption of the [Western] Other's ordered system is depicted in figure 3.2 as restoring order and harmony within an implicitly Chinese understanding of order. Thereby, this pairing could be understood as a visual representation of the inclusive Othering of a Western *doxa* by the Chinese Self.

Figure 3.3 Le Sanying (ca. 1838)



Credit: Courtesy of The Gordon Museum

In another portrait, subtitled: “a victim of malpractice”, the tumorous growths on the woman's head and ear were blamed on the incorrect surgical procedure of the “native physician” (Figure 3.3). Hence, a distinction is being made to hierarchically Other the skilled Western surgeons (who can restore order) from the mimetic Chinese surgeons (who do not yet, purportedly, have the ability to restore order).

81

⁶³ “One of the doctrines of Confucianism is that the body is a sacred gift from one's parents and is not to be mutilated in any way” (Andrews 1996: 22).

What can be understood to be represented here is the Othering of the Self. Or the making of Self into the Other through adoption of the Other's standards. Hence, even if understanding and meaning is transmitted, the Other may never fully master the Self's ordered system, precisely because they remain the Other.

However, biomedicine practised by a Western physician was also depicted as not fully accepted by the Chinese Self. What appears a complex perception of modernity is illustrated in Figure 3.4. A Western female surgeon removes a breast tumour. Although the text praises her skills; the value of such praise is mocked by the skulls and bones of former patients sitting on the upper left top shelf of her cabinet.

Figure 3.4 Female Surgeon With the Bones of Past Patients



Credit: Courtesy of Spotted Stone Pictorial (ca.1884)

China's reception of Western modernity, specifically biomedicine, was also problematised by the reaction of elites. The elites of China originally rejected biomedicine and Christianity. Yip describes most Chinese as “resentful” of medical missionaries, “because of the emphasis placed by the missionaries on the link between health and Christianity” (1982: 1200). In fact, some were so outraged by some surgical practices,⁶⁴ perceived as mutilating the body in a defiance of Confucianism; that anti-Christian riots were documented (Andrews 1996: 11). The elite in rebellion at this time were to return to their traditional practitioners, whilst the poor sought the biomedicine being offered to them by the missionaries without a fee (*Ibid.*). Thereby, the lowly status of biomedicine was further reinforced in the eyes of the elite. The status of biomedicine was not fully accepted by the Chinese populace until the state began to embrace biomedicine in the Republican period (*Ibid.*).

3.2.3.3 The Rockefeller Foundation in China

“In China, as throughout the world, the Rockefeller philanthropists soon concluded that medicine and public health by themselves were far more effective than either missionaries or armies in pursuing the same ends” (Brown 1979: 124).

“We [white men] are firmly persuaded that our civilization and our way of life are immeasurably better than any other, so that when we come across a nation like the Chinese, we are convinced that the kindest thing we can do to them is to make them like ourselves” (Russell 1922: 208).

Although a distinct shift in the Imperial Court's attitude toward modernity and biomedicine can be identified from the time of the *Self-Strengthening Movement* (from 1860 to 1895), it was not until after the Revolution of 1911 that the government embraced biomedicine (Andrews 1996).

“A new medical elite” was established “working in cities...and catering to the wealthy” who through association “with the politicians and bureaucrats of the emergent Chinese state...were able to acquire some of the status and authority of the state” (Andrews 1996: 15). 83

⁶⁴ This is not to say that surgery was not performed in China. However, removal of tumors and amputation of limbs was not considered acceptable practice (Andrews 1996: 28).

It was in this particular environment that the RF began expanding into China. The RF established the China Medical Board (CMB) in 1914 to oversee its work in China. The function of the CMB was “assistance in the development of a comprehensive and adequate system of medicine in China” (Rockefeller Foundation 1917: 223). The CMB specifically supported Chinese medical schools and hospitals. Chinese students were also sponsored by the RF for medical studies in the U.S.⁶⁵ (Elman 2003: 17).

The RF simultaneously sponsored the professionalisation of American medicine in China by building a leading medical centre for research and teaching in Beijing (Elman 2003: 21). As its first medical project in Asia, and its most expensive medical project until that time, the RF chose the formerly mission-run Union Medical College of Peking⁶⁶ (Brown Bullock 1980; Ma 1995: 1). It reopened as Peking Union Medical College (PUMC) in 1921 (*Ibid.*). The RF modelled PUMC on their most successful educational venture; the Johns Hopkins Medical School (*Ibid.*). Ma singles out the “total commitment to the scientific method...high academic standard and elite social status of its students and faculty” as distinguishing features of PUMC (1995: 146).

The PUMC charged twice the tuition of other medical colleges and actively sought to recruit the elite (Brown Bullock 1980). Most importantly, the RF succeeded in training the leadership in medicine and public health in China. The majority of the 315 physicians granted degrees from PUMC whilst under RF control “became leading administrators of China's modern medical education and public health” (Ma 1995: 152).

The relevance of the RF in China to this dissertation is in their effect on healthcare integration in China. There were two primary ways in which the RF influenced healthcare integration through its work in China.

84

⁶⁵ “During the year 1917, Foundation funds to the amount of \$45,487.24 enabled 57 individuals to come to the United States for training. The group included: 1 Brazilian doctor, 3 Chinese pharmacists, 3 Chinese nurses, 7 Chinese students, 13 Chinese physicians, and 31 medical missionaries from China” (Rockefeller Foundation 1917: 47).

⁶⁶ PUMC was chosen primarily for its location near the heart of China's governance (Ma 1995: 1).

The first was through PUMC students who became the leaders and administrators of medicine and public health in China and whom Mao utilised to oversee the transformation of Chinese medicine into Traditional Chinese Medicine. The second influence was through rural health programmes (Yip 1982).

Interestingly, it was in China that the RF distinctly diversified its medical interventions to concern social factors, even though social medicine was not typically favoured by the IHB (Solomon 2002).⁶⁷ This difference in approaches of the China programmes may have been due to the influence of the RF's Dr. John B. Grant. Grant, who established a Department of Public Health and Preventive Medicine in 1924, was interested in both curative and preventative measures, as well as community health, quite unlike many of his RF colleagues⁶⁸ (*Ibid.*).

Prior to the 1920s, the foreign medical missionaries “were the only practitioners of Western medicine to extend their reach significantly into” rural areas (Andrews 1996: 15). Through Grant's influence, the RF can be understood to have established the groundwork for Mao's barefoot doctors programme nearly forty years later⁶⁹ (Yip 1982). Harvard and PUMC graduate C.C. Ch'en headed the health department of the *Mass Education Movement* in Tingshien in 1929 (*Ibid.*). As part of this programme:

“Village Health Workers and paramedics received short-term training in first aid and hygiene. These health workers were crucial in providing health information and simple curative and preventive services to their fellow villagers” (*Ibid.*: 1203).

⁶⁷ The influence of the RF in international medical education and public health can also be understood by what was not supported or eschewed by the Foundation. For example, Solomon notes that the director of the Foundation's IHB was “openly antagonistic” to social medicine and the Soviet approach to public health (200: 416). Much of the China Medical Board's work under John Grant were antithetical to these normative RF sentiments.

⁶⁸ Grant sought “an organized core of a regionalized system of community health care” that would also be an integral part of PUMC training (Yip 1982: 1200).

⁶⁹ Grant had envisioned “health for all” through his China rural programme that predated Alma Ata by more than half a century. Grant was committed to charging no more than the equivalent of US\$1 per person per year. This amount was believed to be the maximum that could be affordable to a Chinese peasant at that time (Rohde 2001: 39).

This creation of a network of community health systems, with the expectation for community biomedical healthcare, “formed an important part of the medical legacy that the Communists inherited” (Yip 1982: 1203). In 1931, plans were made for rural health stations that would provide healthcare at the lowest level possible, using minimally trained village health aides (*Ibid.*). This was supported by Andrija Štampar from the LNHO, who drew on his experience in rural Croatia (*Ibid.*).

By 1934, with the help of Grant, Ch'en developed a functioning health district that consisted of a district health centre encompassing administrative offices, a fifty-bed hospital, a laboratory, and classrooms for training, plus seven sub-district health stations that served more than seventy-five villages (Yip 1982). Grant's plan was to have the Rockefeller PUMC serve as the “organizational core of a regionalized system of community health care” supported by doctors trained at PUMC (*Ibid.*: 1201).

The RF's China Rural Health Programme was initiated in 1935, but ended abruptly in 1937 due to the Japanese invasion of China (Yip 1982). However, Yip argues that the failure to recognise the importance of Chinese medicine led to the limited acceptability and effectiveness of many of these programmes. “Instead of seeking to integrate traditional medicine with Western, scientific methods of medicine, they [RF] tended to reinforce the gulf that already existed between the two systems” (*Ibid.*: 1203). Yet, considering the RF's prioritisation of the hegemonic rise of biomedicine, it would be an unusual expectation for the RF to suddenly consider healthcare integration and inclusive Othering as viable options.

Ma maintains that as careful as the RF were to be covert in their influence on domestic American policy making, is as aggressive as they were in their influence on foreign policy; demonstrating “a strong interest in influencing [the] Chinese government's education policy” (1995: 99). From training to practice, the health system of China would follow a Rockefeller épisteme.

Another result of Grant's work was that many of the public health officials were “American-trained experts” from PUMC who became important in the shaping of future public health policies of the Republican period (Yip 1982: 1201). Thus, a Rockefeller agenda began to permeate throughout China.

The Ministry of Health was inaugurated in 1928 and represented the first steps toward a health bureaucracy under the Nationalist regime (Yip 1982). Under Chiang Kai-shek and the Nationalist government, health became equated with national strengthening.⁷⁰ Although China adopted a predominantly American model of medicine and public health, Yip argues that ultimately “the 'technique' approaches of the RF which were adopted by the majority of health officials of the Nationalist government were inappropriate in...China” (1982: 1197). The RF's approaches: “tended to ignore the cultural and socio-economic realities of China where the overwhelming majority of the population lived in the countryside and were dependent on traditional practitioners” (Yip 1982: 1197). Regardless of these criticisms, the RF's influence was already established.

3.2.4 The Formation of TCM:

From the Republican Period to Mao's Exclusive Unification Solution to China's Alterities

3.2.4.1 The Movement to Eradicate Chinese Medicine

One primary concern that can arise with the adoption of the [Western] Other's ordered systems is what to do with those ordered systems of understanding and meaning of the Self that do not comply with the newly adopted ordered systems of the Other. Should the non-compliant systems of the Self be unified with the other? Should the Self's order dominate and only adopt those elements of the Other's order that comply with the Self's? Or should the Self's order be completely sacrificed to comply with the Other's order?

⁷⁰ The *National Strengthening Movement* demonstrates interesting parallels with the Rockefeller ideology of the use of healthcare for a more productive work force.

Though the last possibility appears particularly extreme, all of these possibilities were chosen by those considering what to do with Chinese medicine after the adoption of biomedicine in China.

Not only did foreign missionaries attack Chinese medicine, but the RF also disparaged Chinese medicine. According to Ma, the RF needed to attack Chinese medicine in order to justify PUMC and their presence in China. Their justification was through their attempt to demonstrate the superiority of biomedicine and “Western civilization in general” (Ma 1995: 206). Roger Greene of the RF made a speech to the students of PUMC in 1916 stating:

“they [practitioners of Chinese medicine] receive no systematic training, and any quack may announce himself as a practitioner. Taking the most favorable view possible, they cannot be said to know more than our doctors of a hundred years ago” (Ma 1995: 209).

Unsurprisingly, many of the students and faculty of PUMC subsequently became the most vocal critics of Chinese medicine (Ma 1995). Ma posits: “There was no question that the RF sought to influence Chinese opinions on both Western and Chinese medicine” (*Ibid.*: 212). It is noteworthy that the RF battled for the absolute hegemony of biomedicine in China as it had in the U.S.

The difference between the influence of the missionary campaigns against Chinese medicine and the RF's campaigns is in the power and influence that PUMC graduates held in the Ministry of Health and in the government. The Republican government, having embraced modernity, set out to eradicate Chinese medicine completely (Ma 1995). In 1929, the bill entitled “*Abolishing the Old Medicine In Order To Clear the Obstacle for Health and Medicine*” was accepted by the Department of Health (*Ibid.*). Ma locates the turn against Chinese medicine in the politics of the Guomindang government; the increased number of foreign schools, whose country support the Guomindang sought and dared not offend; and Chiang Kai-shek's conversion to Christianity (1995: 218).

Hence, Chinese medicine was Othered by the government according to their interpretation of RF-disseminated biomedicine. Chinese medicine was criticised precisely for not being scientific. Thus, science was now adopted as the Self by many Chinese in positions of power at this time. All else, including that which was heretofore Chinese, was to be Othered.

3.2.4.2 Compromises to Perpetuate Chinese Medicine

“If Chinese medicine refused to learn the strong points of Western medicine, it would be like sleeping on burning wood” (Ma 1995: 220).

Adherence to Chinese medicine was believed by some intellectuals to “lead the country down a dark, autocratic and theocratic road” (Ma 1995: 205). However, not everyone was in agreement.

“The domination of the health organizations by Western-trained physicians with their generally unsympathetic attitude toward traditional doctors and their attempts to regulate or even abolish traditional medicine led to a prolonged and often bitter feud between the two groups” (Yip 1982: 1201).

Furthermore, there was a small contingent of scholar-practitioners of Chinese medicine known as the *School of Merging* [Chinese and Western Medicine] (huitong pai 匯通排), who since the late nineteenth century to the end of the Republican era sought to preserve Chinese medicine by modernising it with biomedicine (Scheid 2001: 370). They promoted Chinese medicine as “essential to Chinese culture” (Andrews 1996: 15). This group was part of a larger national movement, “which opposed the wholesale adoption of Western culture” (*Ibid.*). However, they believed it detrimental to ignore biomedicine, and instead sought to justify Chinese medicine via biomedicine (Ma 1995).

“Their efforts ranged across a wide spectrum from assimilation of certain Western ideas to Chinese medicine to the use of biomedical knowledge to instigate total reform of Chinese Medicine” (Scheid 2001: 370-1).

They attempted to standardise the teaching and practice of Chinese medicine through government licensing of schools and practitioners (Scheid 2001).

Yet, they also hierarchically Othered many Chinese “popular medical practices, as ignorant superstition unworthy of scholarly consideration” (Andrews 1996: 16).

The School of Merging called for the reform of Chinese medicine and biomedicine; known as *huitong* (會同) or synthesis. Ma observes that several of these “reformers” opened their own schools (1995). “The first of these, Liji Medical School, opened in 1885 and...offered elementary Western medical education courses such as anatomy, psychology, and public health” (*Ibid.*: 221). The school also offered a teaching hospital and a medical journal (*Ibid.*). Although several of these modernised Chinese medicine schools opened during this period, none were documented to have survived the 1911 Revolution (*Ibid.*).

Nevertheless, these early attempts at the integration of Chinese medicine with biomedicine introduced the possibility of the modernisation of Chinese medicine, and subsequently its potential future for healthcare integration, into the consciousness of several influential reformers, reformers who were later to be subsumed into Mao's integration “from above” (Scheid 2001). Their work was also a direct contradiction to what the RF tried to instil at PUMC, namely that one system negated the other and there was no room for both. Yet, it could be understood that, in their attempt to eradicate Chinese medicine, PUMC graduates and the RF actually stimulated healthcare integration as a compromise.

Prior to 1928, there were few fully organised public health programmes in China (Yip 1982). The structure of the healthcare system through which Mao and the Chinese Communist Party (CCP) operated was instituted by American missionaries; the Soviet model of biomedicine; and the work the RF developed and implemented in the 1920s through the LNHO and the CMB (Loughlin and Berridge 2002). In general, China's healthcare system was predominantly an American model of public health and healthcare.

Despite the efforts of missionaries, the RF, and independent projects to improve rural healthcare, biomedical healthcare primarily catered to elites and was dominated by physicians and public health experts trained at Harvard, Johns Hopkins, or London (Yip 1982). This two-tiered system resulted in increased rural inequity of healthcare that provided an immediate issue for the new CCP government to address (*Ibid.*).⁷¹

During the formation of the CCP, Mao Zedong wrote his key text, “*On New Democracy*” (新民主主義論), published in 1940, in which he emphasised:

“We want not only to change a politically oppressed and economically exploited China...but also to change a China which has been ignorant and backward under the rule of the old culture into a China that will be enlightened and progressive” (quoted in Taylor 2001: 344).

Four years later, Mao stressed:

“This type of new democratic culture is scientific. It is opposed to all feudal and superstitious ideas; it stands for seeking truth for facts, it stands for objective truth and for unity between theory and practice” (*Ibid.*: 345).

This distinctive blend, of science, nationalism, democracy, and moral imperatives is oddly reminiscent of Flexner's 1910 Report. In fact, Mao singled out Chinese medicine as a “hindering factor”⁷² toward the “new democratic culture,” which required “remoulding” to become part of the revolutionary movement (Taylor 2001: 345). Later in the speech Mao begins to lay the foundation for integration.

91

⁷¹ According to Sidel, there were between 21,000 and 40,000 biomedical physicians practicing in China in 1949 (1973:20).

⁷² There are numerous conflicting reports about what Mao thought or said about Chinese medicine depending on when he said it and to whom. However, an interesting personal account is retold by his physician, identifying that the conflict may have been in Mao himself. “Mao attributed China's large population to the efficacy of Chinese medicine. 'For thousands of years' he told me, 'our people had depended on Chinese medicine. Why were there still people who dismissed Chinese medicine? What I believe is that Chinese and Western medicine should be integrated. Well-trained doctors of Western medicine should learn Chinese medicine, Senior doctors of Chinese medicine should study anatomy, physiology, bacteriology...and so on. They should learn how to use modern science to explain the principles of Chinese medicine...then a new medical science, based on the integration of Chinese and Western medicine can emerge. That would be a great contribution to the world....even though I believe we should promote Chinese medicine, *I personally do not believe in it*. I don't take Chinese medicine. Do you think that is strange?’” (Zhisui 1994: 83-84). Throughout his biography of Mao, his physician retells several accounts in which Mao personally refuses Chinese medicine whilst rhetorically promoting it and politically enforcing integration.

“If we only rely on the new medicine [biomedicine], we will not be able to solve our problems. Of course the new medicine is superior to the old medicine, but if they [the doctors of the new medicine] are not concerned about the sufferings of the people, do not train doctors to serve the people, and do not unite with the thousand old doctors...of the old school...in order to help them improve, then they will actually be helping the practitioners of witchcraft by callously observing the death of a large number of men...Our task is to *unite* with the old style doctors who can be used, and to help educate and remould them. In order to remould them we must first unite [with them]. Only if we act appropriately will they welcome our help [emphasis added]” (quoted in Taylor 2001: 346).

Mao's criteria for the development of a “New Democracy” was that practices, including healthcare practices, must be new (*xin* 新), scientific (*keuxue* 科學⁷³), and unified (*tuanjie* 團結) (Taylor 2001: 344). This speech is central to this research for several reasons. Firstly, Mao would not again address healthcare access and the need for “remoulding” until the mid-1950s (*Ibid.*). Secondly, Mao observes that the adoption of modernity, whilst potentially meeting the needs of the future, is not meeting the political and economic needs of the present. Thereby, modernity can be tempered by using the newly modernised resources of the past to meet the needs of the present and the future. Hence, this particular integration that Mao is proposing is specific to the political and economic needs of China at a given moment in time.

This speech is also illustrative of the rationale for a particular kind of Othering. The old style doctors (舊醫生) are to be modernised and *united* with the doctors of the new medicine (新醫), in order to redress healthcare access, access that cannot be addressed through dependence on biomedical physicians, as they predominantly practice for the urban elite. Yet, Mao specifies “exclusion and disdain for others to take the attitude of sectarianism is wrong” (对别人采取排斥和鄙弃态度的宗派主义也是错误的) (Taylor 2001: 360).

⁷³ Note, according to Taylor, “Mao's use of the term 'science' referred to the Marxist sense of the word, which implies the search for 'true knowledge' and as such is not restricted to any particular nation or discipline” (2001: 359).

Hence, Mao is neither suggesting a fully exclusive nor inclusive Othering, but rather an Othering between both extremes. To act appropriately, social order is to be maintained by acting “in unity” (團結). And the integrity of the ordered understandings of the CCP is maintained through an adherence to dialectical materialism.⁷⁴ Thereby, Chinese medicine is being altered by biomedicine in order to yield a new unified medicine.

What is particularly noteworthy here is that Mao is not only proposing to integrate two healthcare systems, but also to integrate several epistemologies from Chinese traditional philosophy to the Western philosophies of Marx, Engels, and Lenin. Thus, the event of the integration of Chinese medicine must be understood both in its socio-cultural context, as well as its ontological context within the CCP's newly ordered system of understanding and meaning. Hence, Mao's integration of “old style doctors” not only offers political economic solutions to issues of rural healthcare access and disparity, but was also harmonious with the newly adopted CCP philosophy of dialectical materialism, and thereby able to maintain the newly ordered *doxa* of the CCP.

3.2.4.3 Chairman Mao and the Rockefeller Foundation:⁷⁵

From Unity to Integration to the Global Model for Healthcare Integration

Speaking of Integration

Mao did not speak of integration at first. During the 1940s, Mao continued to stress the political slogan that “Chinese and Western medicine *should join together*” (*zhongxiyi tuanjie* 中西醫團結) (Taylor 2001: 361).

⁷⁴ Farquhar explains that a rationale of nationalism and a justification through Marxist dialectical materialism were equally employed in developing traditional Chinese medicine from Chinese medicine. “The strategy...has been to simultaneously insist that medicine, with its 'spontaneous materialism and naive dialectics', is entirely consistent with Marxism-Leninism and to emphasise that medicine is a 'great treasurehouse' of the precious accumulated experiences of China's laboring masses. The rhetorical force in socialist China of centering these two features of Chinese medical action is (ideally, at least) to make the field ideologically unassailable” (1994: 171).

⁷⁵ It is interesting to reiterate, that the two men who may have had the strongest influence on the model of healthcare integration both practised the opposite of what they represented; as Mao refused to use Chinese medicine and Rockefeller refused to give up homoeopathy.

From the mid-1950s, however, Mao specifically called for integration of biomedicine and Chinese medicine under the slogan “Chinese and Western medicine *should be integrated*” (*zhongxiyi jiehe* 中西醫結合) (Taylor 2001: 361).⁷⁶

Integration of Chinese medicine and biomedicine was only meant to be a first step toward Mao's final goal of unification (Taylor 2005). With unification, Mao sought to achieve a new unified form that was neither Chinese medicine nor biomedicine, but a hybrid meant to be greater than the sum of its parts (*Ibid.*).⁷⁷ However, Mao was only able to achieve the first step of unification, or integration (*Ibid.*). The process of what Mao called integration was meant to raise Chinese medicine to a “higher” scientific level comparable to biomedicine before they could be unified (*Ibid.*).

Integration was actually the standardisation of different schools of Chinese medicine along a biomedical framework. Basically, Mao employed biomedical physicians, primarily from the Ministry of Health and PUMC, to comb through the practices of Chinese medicine and remove any superstitious or spiritual elements, keeping those elements that were more “biomedical-like” and capable of being standardised (*Ibid.*).⁷⁸ In this manner, what was to become the normative representation of healthcare integration could be understood as a process of both deculturation and biomedical acculturation. What was developed by these physicians is what is now generically referred to (in English) as TCM or traditional Chinese medicine. Eventually, TCM was incorporated into hospitals and clinics and employed for any given patient in conjunction with biomedicine.

94

⁷⁶ Lo suggests “Mao's response has to be read within the particular political context of the breakdown of Sino-Soviet relations. Mao reverted to a kind of practical nationalism surviving on the resources China had. Hence, his statement that 'Chinese medicine is a great treasurehouse' infers Chinese cultural genius of the past can be mined for contemporary scientific treasures” (Lo in interview 2011). Lo's interpretation echoes Unschuld's thesis that the circuitous historical trajectory of Chinese medicine was, at least in large part, a result of “socio-political” necessity.

⁷⁷ It is interesting to note, that though WHO acknowledges their adoption of Mao's model of integration, any mention of his intended goal of unification toward a new hybrid medical system, cannot be identified in the WHO literature reviewed.

⁷⁸ According to Zhu Lian, an early proponent of integration in the CCP; “Reform does not mean that Chinese medicine should drop all its original theories...instead we need to choose those areas of ancient medicine which are appropriate, drop those areas which are not appropriate, use scientific methods, sort out the experience...so as to improve its scientific theory” (quoted in Taylor 2001: 360).

The confusion often surrounding the normative representation of healthcare integration is that the practice of using TCM in hospitals or clinics in conjunction with biomedicine is what is being identified as integration. However, what is being integrated in this instance is itself an already integrated system that was standardised by biomedical physicians. TCM is different from the varied practices of its precursor; Chinese Medicine. And even Chinese Medicine is arguably a more standardised system than most local practices worldwide. Hence, few practices will be as standardised or even capable of being as standardised as TCM.

TCM and the Rockefeller Foundation

According to Johnson, it is difficult to separate Chinese government health policy from the policies of the RF and its CMB, which funded healthcare programmes in China from 1913 to 1949 (2008). As a result, “there was little dispute in China that the Ministry of Health, established after the foundation of the People’s Republic of China in 1949, was to function entirely on the basis of biomedicine” (Taylor 2005: 6). Lucas maintains that the various political upheavals from the 1949 revolution to the Cultural Revolution did not alter the basic policies of national medicine first diffused to China in the late 1920s (1982: 1).

According to Lampton (1977), public support of Mao's proposal for Chinese medicine may have been a result of the understanding that biomedicine, as was currently practised, was unable to offer universal healthcare to the population. However, the practice of TCM itself would not reduce health disparity, especially rural health disparity, without training more practitioners. Therefore, in the mid-1960s, Mao began a campaign to train community health workers, or “barefoot doctors” as they were called, in a combination of biomedicine, public health prevention, and TCM to serve as a first line of healthcare in the rural areas of China⁷⁹

(Lucas 1982).

95

⁷⁹ Barefoot doctors were farmers, who were elected by their peers to train in a commune hospital for 3 months to two years. Specifically, they were trained in preventative medicine, “anatomy, physiology, bacteriology, pathology, environmental sanitation, and epidemiology. Some would also learn birth delivery and care of pregnant mothers, and all would study acupuncture and production and use of traditional Chinese herbs, as well as usage of 40-50 Western drugs” (Ha°klev 2005: 6).

Thereby, the barefoot doctor became the first fully integrated practitioner. The precursor of the barefoot doctors programme, as discussed, was the RF-sponsored China Rural Health Programme under John Grant.

Hence, when Mao chose biomedical physicians, many of whom were trained at PUMC, to lead the integration of the various local systems of Chinese medicine into the formation of traditional Chinese medicine, it is questionable whether he was acting completely autonomously, or, was Mao functioning within the boundaries of a healthcare paradigm already established by the CMB; the IHB; the LNHO; Frederick T. Gates; John B. Grant; the Flexner report; and the standardization of U.S. medical school education, all ultimately propagating the ideologies of the Rockefeller Foundation.

3.2.4.4 The Global Dissemination of a Maoist Model

After China joined the WHO in 1973, their purported success with both the barefoot doctors programme and the integration of TCM into the formal healthcare system was adopted by the WHO as the model to address health disparity in many developing countries (Siddiqi 1995). At the urging of Russian WHO delegates, and possibly influenced by the Chinese nationals in positions of power at the WHO at the time, China's model of healthcare integration became an integral component of the Declaration of Alma Ata (*Ibid.*). Thereby, the erratic and sometimes violent political process that resulted in the invention of TCM and the formation of the plural Chinese healthcare system has remained the primary model for healthcare integration as advocated by the WHO.

As discussed, what the WHO represents as the model for healthcare integration, is not the integration of Chinese medicine and biomedicine into the state healthcare system, but rather the integration of the already integrated TCM.

The relevance of the WHO using TCM as a model for healthcare integration with biomedicine, whilst not acknowledging that TCM is already an integrated system, is that it:

- a) falsely projects the idea that any non-biomedical practice can be successfully integrated into a national healthcare system, whilst disregarding the fact that few practices may be as systematized and standardized (in terms of biomedicine) as is TCM;
- b) may thereby be facilitating the integration of only those non-biomedical practices that have been systematized, standardized, and legitimated by biomedicine; and
- c) makes it appear as if integration can be achieved by any nation at any point in time, regardless of political and socioeconomic contexts, as comprehensively as the PRC appeared to do.

3.2.5 *Problematizing the Adoption of a Model For Enforced Healthcare Integration*

Basing all healthcare integration on the integration of TCM and biomedicine in Maoist China poses important challenges when applied to other countries or even to China today (Liu *et al.* 1999). Firstly, it is imperative to acknowledge that healthcare functions within a given political economy. The formation of TCM and the barefoot doctors program were conceived and implemented within an egalitarian–authoritarian economic and social system, which may not be transferable into liberal–democratic or other economic and social systems (Walt 1994).

Secondly, although Mao believed that the integration of Chinese medicine could provide an opportunity to redress rural health inequities with the practitioner resources readily available, he had to overcome marked opposition from biomedical physicians, Chinese medicine practitioners,⁸⁰ the Ministry of Health,⁸¹ and the early CCP who originally sought to extinguish Chinese medicine⁸² (Lucas 1982).

97

⁸⁰ Although Mao was attempting to engage in an inclusive Othering of these systems, much of the opposition he encountered was from those who wanted to maintain exclusive Othering of these systems. For example, many Chinese medicine practitioners were called “purists” for their rigidity in attempting to ensure the integrity of their ordered system and they, like the Ministry of Health, emphasised the importance of maintaining boundaries to guarantee this integrity (Taylor 2005).

⁸¹ Despite CCP directives, the Ministry of Health, comprised predominantly of graduates from Peking Union Medical College, continued to oppose integration of Chinese and biomedicine throughout the 1950s (Lampton 1974; 1977; Farquhar 1994). Mao attacked the Ministry for only being concerned with the urban elite, as well as for their sole focus on curative rather than preventative medicine; over-dependence on the Soviet healthcare model; and refusal to integrate TCM and biomedicine (Sidel 1973; Lampton 1974).

⁸² Though according to Farquhar, the CCP has usually been credited with continual support for Chinese

Therefore, the rationale for the modernisation of Chinese medicine could be understood more accurately as a compromise to redress healthcare disparity within specific political circumstances.

Since healthcare integration in China could not be achieved by complete consensus, coercion and force were employed (Rosenthal 1981). This was accomplished on several fronts: 1) Mao took advantage of the nationalistic fervour that erupted in China since the Treaty of Versailles (1919) and the May Fourth Uprising, which “catalyzed the political awakening of a society which had long seemed inert and dormant”⁸³ (Meisner 1999: 17).

2) Mao’s rhetoric of Chinese medicine, as a “national treasure” to serve alongside biomedicine was more the product of a nationalist movement, that included a revival in many of the arts of China, than of any consideration for Chinese medicine’s therapeutic value (Taylor 2005).

3) Physicians were forced to engage in TCM studies. Those who resisted integration were labelled bourgeois, criticized, and/or exiled to distant areas (*Ibid.*).

4) At the onset of the Cultural Revolution, the Ministry of Health was blamed for ignoring rural health⁸⁴ and the CCP took over complete administration of healthcare in order to facilitate integration; insisting that practitioners of Chinese medicine be placed in biomedical hospitals and clinics (Rosenthal 1981; Ha°klev 2005).

5) During the Cultural Revolution, the same social pressures that had previously been directed toward biomedical physicians were now directed with even greater ferocity towards those Chinese medicine practitioners who sought to maintain autonomy and ideological separation from biomedicine. Classic medical texts were burned.

98

medicine in order to maintain “a coherent historiography of the party” and its influence on medical history (1994: 13).

⁸³ The May Fourth uprising in 1919, in reaction to the subsequent transfer of land in Shandong that was formerly ceded to Germany and to Japan without Chinese intervention or return to Chinese sovereignty. The May Fourth uprising also validated that a socialist revolution was possible in China (Mesiner 1999).

⁸⁴ Speaking on the eve of the Cultural Revolution, Mao condemned the Ministry of Health: “The Ministry of Health serves only 15% of the urban population. It should be renamed the Urban Health Ministry, or the Lords’ Health Ministry...in medical and health work, put the stress on the rural areas!” (Sidel, 1973, 28).

Chinese medicine schools were closed. And classic Chinese medicine practitioners became the object of ridicule or physical attack and their practices and pharmacies destroyed (Scheid 2002).

Thirdly, although presented as a complete process, integration was merely intended as an early stage of Mao's original goal of complete unification of TCM and biomedicine in order to form a unique new medical system. According to Taylor, Mao believed that Chinese medicine, the reputation of which had been in decline since the early 19th century, had to be "raised" to a certain scientific level before it could be unified with biomedicine (2005). However, owing to the extensive opposition from both the CCP and practitioners, among other factors, integration and the formation of TCM became part of Mao's unfinished project (*Ibid.*).

Finally, Mao's attempt at integration cannot be considered full healthcare integration in two primary aspects. Firstly, actual practice may be the most significant indicator of full integration. As Croizier notes: "In the decade from 1955 to 1965 it was clear that, although integration of Chinese and Western medicine was the official policy, in practice, the administration of medical policy still gave [Chinese medicine] a secondary position" (1975: 30). Hence, the CCP's representation of a fully integrated healthcare system is brought in question. Furthermore, the extent to which non-biomedical practices are integrated in the minds of the public may reveal the most about the actual extent of integration. In modern China, TCM has been employed primarily according to perceived best interventions for particular ailments (Scheid 2002).

However, most importantly for the purposes of this dissertation, not only were many local practitioners not integrated, but several types were actually prohibited. For example, Ha°klev notes that though herbalists may have been eligible to become barefoot doctors, shamans and diviners were ineligible (2005: 6).

Immediately, such conditionalities concerning who may or may not be integrated into the healthcare system problematises the representation of Mao's model of integration as a true or complete integration of a country's practices and practitioners into a healthcare system.⁸⁵ As mentioned, this is more of a model of biomedical acculturation, than a model of syncretism or even parallellism; as evidenced in the integration of Āyurveda into India's healthcare system. And yet, despite these challenges to China's representation of healthcare integration, WHO chose to perpetuate this representation.⁸⁶

3.2.5.1 Was TCM the Only Model That Could Have Been Adopted For Integration?

TCM was one of many models of healthcare integration from which the WHO could have chosen. One particularly noteworthy overlooked integration model was that of Āyurveda. The integration of Āyurveda dates from the eighteenth century, when Indian physicians began to adopt "English medicine" into their practice (Leslie 1992: 178). In the early nineteenth century, an East India Company-sponsored programme taught European anatomy and medicine with instruction in Āyurveda and Yunani tibbia (*Ibid.*).

From the 1920s and 30s, a generation of practitioners had been trained who sought a national medical system dominated by Āyurveda (Leslie, 1992). By the mid-twentieth century, Āyurvedic practitioners were divided between those who “wanted to elevate the status of Āyurveda by assimilating modern diagnostic technology, medicine, and surgery” and those who envisioned an Āyurveda that was pure and unhampered by biomedicine (Leslie 1992: 180). Āyurveda's current coexistence with biomedicine in India was predicated on the political power and agency employed by Āyurvedic practitioners in the twentieth century.⁸⁷

100

⁸⁵ Rosenthal suggests that Mao's attempt at integration would be more accurately classified as a selective form of integration, as was demonstrated in the selective development of TCM, for institutional arrangements left the biomedical physicians “utilizing combined treatment extensively, but on their own terms” (1981: 610).

⁸⁶ A representative from WHO in writing about healthcare integration in China states: “The integrated system has proved economical, effective, easy to apply and acceptable to the community” (Vuori 1982: 135).

⁸⁷ The political power of Āyurvedic practitioners in India was also linked to the anti-colonial nationalist movement and the waning power of British colonialism in the early twentieth century (Bala 2007).

Yet, the integration of Āyurveda is conspicuously missing from the WHO integration discourse, which is fully dominated by the model of TCM and biomedicine. For example, although numerous practice and teaching guidelines, textbooks, and standardised nomenclature guides for acupuncture (alone) have been published by the WHO, there has been one publication committed to training in Āyurveda as of this writing (WHO 2010a). And though 7 of the 19 (or 37%) WHO Collaborating Centres for research in traditional medicine are located in China, none are located in India or conduct research on Āyurveda or other Indian healthcare systems and practices (WHO 2010b).

Where TCM has become a global commodity that offers education and licensure nearly worldwide, Āyurveda has no formal licensure beyond South Asia and part of Southeast Asia. It is primarily led by the private sector. And there is no formal lobby in any government of Āyurveda within the WHO. Hence, it could be questioned if WHO did not adopt Āyurveda, because Āyurveda itself was somehow not as adoptable or adaptable as TCM, as witnessed by TCM's global popularity. However, this popularity could also be a result of WHO's concerted efforts to popularise TCM, which it did not extend to Āyurveda. It could also be argued that Āyurveda was never really completely integrated with biomedicine but the two remained separate but equal state-recognised systems (Bodeker 2001). However, the same critique has been made of TCM, as discussed in the preceding section.

Finally, it could be said that Āyurveda was not considered as a viable model by WHO because the integration of Āyurveda was, in general, a more complex process than that of TCM. For example, plurality remained central to the modernisation of Āyurveda, which became integrated with elements from biomedicine, homoeopathic medicine, Yunani Tibia, and Tantric ritual. Therefore, biomedicine was neither central to the modernisation of Āyurveda, nor was it controlling this process.

But the integration of Āyurveda can also be identified as a complex process precisely because it was a democratic rather than enforced process. Within India, the debate of this policy was predominantly led by practitioners who were granted the agency to lobby for what they wanted (Leslie 1992).

What is important to consider in these two different examples of healthcare integration is the means by which non-biomedicine was being integrated. The governmental reduction of control and power granted to biomedical physicians and Chinese medicine practitioners that rendered them politically impotent offers a stark contrast to the political agency of Āyurvedic practitioners in India at approximately the same historical moment (Leslie 1992). Whether such political and social capital is necessary for local healthcare practitioners to achieve this “separate but equal” status with biomedicine is not clear, but may possibly be one element that affects the type of integration some non-biomedical practitioners seek and achieve. It is important, then, to consider whether WHO's choice of this particular model for healthcare integration has inherently engendered an inequity of power between key actors and stakeholders by virtue of its historical implementation, or if Mao's model for healthcare integration compromises the agency of local level populations.⁸⁸

Summary

In this section, I have attempted to identify reasons why the universal application of China's representation of healthcare integration is problematic. In brief, the success of the transfer of this representation may be specific to a given context. The policy and processes of healthcare integration are not shaped solely by a biomedical agenda, but are very much a product of specific political, economic, philosophical, and cultural forces that may not be replicable from one context to another.

⁸⁸ Lantum identifies “where Mao Tsetung in the 1949 Great Liberation policy had imposed the valorization, development and integration of Chinese traditional medicine into the health care system affords us an opportunity to appreciate benevolent dictatorship as a possible source of health development policy” (2007: 9).

3.2.6 *WHO is the W.H.O.: a brief contextualisation of the World Health Organization*

According to Siddiqi, the U.N. agencies “have been repeatedly accused of 'politicisation'; a process that is said to lead to ineffectiveness” (1995: 2). However, he maintains that such politicisation “has been evident from the birth of the WHO,⁸⁹ and indeed from the inception of international health cooperation since the 1850s” (*Ibid.*). My participant experience at WPRO supports Siddiqi's position; however, I would propose that such politicisation will be embedded in any multilateral cooperation, and any health organisation, because health is political. For the purposes of this thesis, the history of WHO will be analysed on a continuum between two approaches to healthcare. Social medicine, supported a preventative and horizontal approach to healthcare, whilst a biomedical approach supported curative measures executed through vertical disease-focused programmes.

The WHO was formed as a technical agency of the United Nations in 1948, with the first World Health Assembly in Geneva⁹⁰ (Lee 2009). It subsumed, among other international health institutions, the LNHO. Even though prominent advocates of social medicine, such as Rene Sand and Andrija Štampar, both of LNHO, were involved in the early planning of WHO, WHO continued many of the vertical programmes of the LNHO. Success of these vertical programmes (e.g., global smallpox eradication) were balanced by failures (e.g., global malarial eradication) (Siddiqi 1995). However, vertical disease-focused programming was the predominant practice of the WHO, regardless of the more social medicine elements of its charter. Part of this focus was due to the subsequent dominance of a U.S. agenda,⁹¹ following the departure of the Soviet Union, China, and other communist countries shortly after the WHO began operations in 1949.

⁸⁹ Siddiqi identifies that controversies as varied and seemingly disparate from health as apartheid, Zionism, and nuclear disarmament have found their way into the World Health Assembly (1995).

⁹⁰ Brown *et al.*, define the WHO as “an intergovernmental agency that exercises international functions with the goal of improving global health” (2006: 62).

⁹¹ According to Brown *et al.*, the U.S. “and its allies believed that global malaria eradication would usher in economic growth and create overseas markets for U.S. technology and manufactured goods...and help win 'hearts and minds' in the battle against communism” (2006: 65).

The agenda which ensued sought “modernization with limited social reform” (Brown *et al.* 2006: 65). Hence, the policy decisions inside WHO were, at least in part, a reflection of the agendas of larger international political economic alliances.

Therefore, it was somewhat extraordinary that in the 1970s, WHO became concerned with universal primary healthcare and preventative medicine through horizontal programming. Several factors are believed to have supported the adoption of what was to be known as Comprehensive Primary Health Care (CPHC). These factors include: a) a renewed appreciation in the 1960s for the need to strengthen healthcare infrastructure after assessing the failure of certain vertical programmes, such as malaria eradication; b) the readmission of China as a member state of the World Health Assembly in 1973; c) the support of several African nations for China's healthcare approach; d) the influence of the Soviet Union and their support for a primary healthcare model;⁹² and e) the world economic recession of the 1970s (Lee 2009; Huang 2010).

Furthermore, in the 1970s the biomedical healthcare model “was failing to meet the basic needs of populations in poor countries” and became an increasingly untenable model (Lee 2009: 73). Finally, the marked gains of community-based models (especially in Latin America and Bangladesh) and demonstrations of improved health outcomes despite resource-poor conditions (such as in Cuba and Kerala), along with the purported success of the barefoot doctors programme, promulgated this consensus for a paradigm shift in the approach to healthcare in low-income countries (*Ibid.*).⁹³

⁹² It must be reiterated that the Soviet model of healthcare, with its focus on universal, social, and preventative medicine, not only predated and heavily influenced the CCP model of healthcare, but also influenced the WHO model of primary healthcare and “health for all”.

⁹³ This paradigm shift was also supported by the simultaneous publications of several academics and development practitioners. Bryant summarises the general consensus: “The most serious health needs cannot be met by teams with spray guns and vaccinating syringes” (1969: x).

Central to this debate was Halfdan Mahler, the third Director-General of WHO from 1973-1988. Though Mahler was reported to be at first tentative about the Soviet approach to primary healthcare,⁹⁴ he strongly interjected a social justice ideology into WHO and especially into the “health for all” paradigm⁹⁵ (Lee 2009). Mahler, along with Henry Labouisse, Director of UNICEF, hosted the Conference on Primary Healthcare in 1978 in which the “health for all” paradigm was officially adopted (*Ibid.*). This shift from a vertical (disease-specific) approach to a horizontal (more integrated) approach, which facilitated the adoption of a normative understanding of health as a human right, was endorsed by all 134 World Health Assembly member states attending the conference (Brown *et al.* 2006).

However the struggle between the two approaches to healthcare reached an impasse in 1979 in the aftermath of the Declaration of Alma Ata. The proposed preventative horizontal approach was criticised as being too expensive, too broad, and too horizontal in implementation to be seriously considered for addressing universal healthcare at a Rockefeller Foundation-sponsored conference (Magnussen *et al.* 2004). Kenneth Warren (Director of Health Sciences at the Rockefeller Foundation), along with Julia Walsh, (faculty at NYU), presented a paper that while praising the goals of the Alma Ata Conference as “above reproach” and “the best available means of conquering global disease” (Walsh and Warren 1979: 970), argues “yet its very scope makes it unattainable because of the cost and numbers of trained personnel required” (*Ibid.*: 967). Instead, “a rationally conceived, best-data-based, selective attack on the most severe public-health problems” was proposed (*Ibid.*). In other words, the normative vertical curative approach, which addresses particular diseases, was presented as “the most effective means of improving the health of the greatest number of people” (*Ibid.*: 970).

⁹⁴ According to Brown *et al.*, “Mahler was initially reluctant because he disagreed with the Soviet Union's highly centralized and medicalized approach to the provision of health services” (2006: 67).

⁹⁵ Mahler's ideology is clearly stated in a 1976 address to the World Health Assembly. “Social revolutions have taken place because social structures were crumbling. There are signs that the scientific and technical structures of public health are also crumbling” (Lee 2009: 74).

This newly labelled approach of “Selective Primary Health Care” (SPHC), was touted as the best possible option for low-income countries “until comprehensive primary healthcare can be made available to all” (Walsh and Warren 1979: 970). This approach was supported by then World Bank president, Robert McNamara, and donor agencies including USAID, the Ford Foundation, and the Rockefeller Foundation (Brown *et al.* 2006). In other words, this decision was heavily orientated toward U.S. policy and political economic considerations. The new Director of UNICEF, James Grant,⁹⁶ adopted SPHC as the paradigm through which UNICEF would immediately operate⁹⁷ (*Ibid.*). Thereafter, a boundary was placed between WHO's paradigm of CPHC and the SPHC paradigm of UNICEF, and a debate in international health circles was born, which has continued for the past three decades.

SPHC was criticised for being the same as the former biomedical model of WHO with a new title. “Health for all” and CPHC was simply seen as “too political” by the United States, a major funder of WHO and UNICEF. Some criticised UNICEF's adoption of SPHC as bowing to U.S. pressures, which was argued to have led to an increase in child mortality and communicable diseases (Werner 2001).

With the shift in emphasis by UNICEF, WHO was alone in contending with the World Bank's neoliberal encroachment on healthcare (Armada *et al.* 2001). In 1979, the World Bank created the Population, Health, and Nutrition Department; “funding both stand-alone health programs and health components of other projects” (World Bank 1980; Brown *et al.* 2006: 67). The World Bank's involvement in health reached a zenith in the early 1990s, when World Bank loans for health were nearly triple WHO's entire annual working budget

(*Ibid.*).⁹⁸

106

⁹⁶ It is noteworthy that James Grant's father was John D. Grant, who, as discussed, was responsible for the primary healthcare programmes in China. In fact, it was the elder Grant whose emphasis on “health promotion, hygiene, home gardens for improved nutrition, and immunization” introduced a focus of social medicine to the RF, that would now be categorised as CPHC (Rohde 2001: 39).

⁹⁷ SPHC at UNICEF was “operationalized under the acronym 'GOBI' (Growth monitoring to fight malnutrition in children, Oral rehydration to fight diarrheal diseases, Breastfeeding...and Immunizations)” (Brown *et al.* 2006: 67).

⁹⁸ The World Bank's support for social service programmes such as health “grew from 5% of its portfolio in 1980 to 22% in 2003” (Ruger 2005: 61).

The World Bank is identified as “one of the world's largest external funders of health” (World Bank 2011), “committing more than US\$1 billion annually in new lending to improve health, nutrition, and population in developing countries” in 2005 (Ruger 2005: 61). The turning point of the World Bank's involvement in healthcare came with the *World Development Report 1993, Investing in Health* (World Bank 1993). This document was criticised as a thinly veiled “neoliberal agenda” that was antithetical to the basic values of public health⁹⁹ (Armada *et al.* 2001; Werner 2001).

Whilst under the leadership of Director-General Nakajima, the WHO attempted to return to an agenda of health for all (Brown *et al.* 2006). However, myriad circumstances, including the budgetary restraints of a static budget, led to an ideological shift toward economism and a fixation on efficiency, whilst “developing closer links with the World Bank, the World Trade Organization, and the private sector”¹⁰⁰ (Lee 2009: 128). This economism was especially emphasised in the late 1990s under Director-General Gro Brundtland (*Ibid.*).

This brief contextualisation of the WHO attempts to demonstrate that firstly, the WHO is not an autonomous organization, but quite beholden to the agendas of powerful member states (particularly in terms of their donating power), other U.N. agencies, the private sector, and the ideological influences of the various Directors-General. Secondly, the WHO is a political organisation, that must be self-conscious of this role to remain a viable global leader. Thirdly, WHO healthcare policy and projects are not only influenced by politics, but often more so by economics.

⁹⁹ The neoliberal approach to development, which the World Bank adopted in the 1990s, emphasises “macroeconomic stability, privatization, trade liberalization, and public sector contraction” (Ruger 2005: 60). Specifically, the World Bank requested its lenders use available resources more efficiently and integrate public and private financing of healthcare (Brown *et al.* 2006: 67).

¹⁰⁰ Extrabudgetary funding of WHO from multilateral agencies and the private sector increased to such an extent, that by the early 1990s it comprised 54% of WHO's total budget and surpassed the regular budget by US\$21 million (Brown *et al.* 2006: 68).

And lastly, at its core, WHO operates according to a biomedical approach and understanding of health and healthcare that has adopted a more social approach to international health at various times throughout its history.¹⁰¹ However, as part of WHO's inherent scientism and globalised role is a standardised approach that essentialises and universalises any recommendations.

3.2.7 *WHO's Adoption of Healthcare Integration*

A brief review of WHO's history, in terms of its on-going debates, assists in contextualising WHO's adoption of healthcare integration. Central to this narrative is WHO's historical relationship with China.

3.2.7.1 WHO and Which China?

An interesting example of the politicisation of WHO can be found in the narrative of the battle for the representation of which China would gain UN member state status between the two Chinas. In light of China's absence from the WHO for nearly the first three decades of its work, it is interesting to consider that the idea for a single international organisation for health was the conception of a Chinese national.¹⁰²

China was a member of WHO from its inception in 1948. In 1949, with the formation of the People's Republic of China (PRC), China separated from the former Republican party of the Guomintang, who became the Republic of China (i.e. Taiwan). The UN agencies not knowing which China to recognise as “The China”, eventually, with the support of the United States and other prominent Western nations, recognised the Republic of China as “China”. It was not until 1971, after the return of full membership to Soviet¹⁰³ and other socialist states, as well as many developing countries, that the decision of 1950 was reversed.

¹⁰¹ It is important to note that these two approaches, though represented as oppositional and therefore exclusive, are not inherently incompatible (Brown *et al.* 2006).

¹⁰² Siddiqi identifies Dr. T.V. Soong, the Chinese delegate at the UN conference on International Organization in 1945, as “the first person to suggest the founding of a single international health organization” (1995: 110).

¹⁰³ The Soviet Union returned to the UN and WHO as a member state in 1956 (Brown *et al.* 2006).

Despite U.S. opposition, the PRC became recognised as the UN member state of China and the Republic of China was expelled “from the place they unlawfully occupied at the UN and in all organizations related to it” (Siddiqi 1995: 112).

3.2.7.2 The Influence of Sino-African Diplomacy

The path of WHO's adoption of healthcare integration is similar to the circuitous path of primary healthcare at WHO. Firstly, the “developing countries” which were so influential to China's reintroduction into the U.N. system and the World Health Assembly in 1973, were several African nations with whom China had developed extensive diplomatic relations (Siddiqi 1995). The connection between China and African countries can be understood in terms of aid and diplomacy, especially health diplomacy.¹⁰⁴ Although health diplomacy is but one element of China's engagement with Africa, it plays a prominent role (Youde 2010).

The interventions and technology transferred from China to Africa have differed from the transfers of the West. China brought TCM and the barefoot doctors programme to Africa, which appear to have been particularly appropriate for the local contexts in Africa.¹⁰⁵ Chinese herbal remedies were welcomed in most African communities, wherein many local informal health economies are dominated by herbal use (Hsu 2002; 2008b). Professional human resources, which were most needed by local level beneficiaries, have always been a central component of Sino-African health diplomacy, since the first health diplomacy projects of the 1960s.¹⁰⁶

Sino-African relations in the 1950s and 1960s singularly promoted Maoism as the most appropriate model for development and anti-colonialism (Youde 2010).

China specifically supported the African Liberation Movements of the 1960s (Li 2007). 109

¹⁰⁴ In general, health diplomacy has been defined as any activity between countries directed toward healthcare, with the underlying intention of improving political, economic, and/or cultural ties between donor and recipient countries, that ultimately may fulfill foreign policy goals of the donor country (Thompson 2005; Adams, Novotny, Leslie 2008; Felbaum and Michaud 2010; Fidler 2010).

¹⁰⁵ “The phenomenon of barefoot doctors in China provided one of the main inspirations for the Alma Ata conference” (Roemer, 1993, 40).

¹⁰⁶ “Since the first medical team arrived in Algeria in 1964, more than 15,000 Chinese medical personnel have served in 47 different African states and treated at least 180 million patients” (Youde 2010: 151).

Countries such as Uganda, Tanzania, and Zambia (formerly Northern Rhodesia) had recently won their independence and, after breaking ties with European countries, gravitated towards socialist and communist states (*Ibid.*). Unlike the Soviet Union, the Chinese government presented itself to African constituencies as a patron who rejected the imperial mandates of Western powers and understood the unique struggles of “peasant movements”¹⁰⁷ (Youde 2010). In return for China's support, twenty-six African nations supported China in regaining member state status in the United Nations in 1971¹⁰⁸ (Huang 2010).

3.2.7.3 International Politics and The Adoption of a Model for Healthcare Integration

China's re-entry into WHO, along with the support of a number of African countries and the Soviet Union, facilitated the adoption of the healthcare integration of TCM and biomedicine to be used as the model for healthcare integration by WHO.¹⁰⁹ To understand WHO's early representation of healthcare integration, an analysis of Halfdan Mahler's contribution to the WHO publication, *Traditional Medicine and Healthcare Coverage*, is illustrative. Mahler, in reference to attaining the goal of : “Health for All by the Year 2000”, stated that “to succeed in attaining this goal, all useful methods will have to be employed and all possible resources mobilized. Among these methods are various kinds of indigenous practices; and among those resources are various types of traditional practitioners and birth attendants”¹¹⁰ (Mahler 1983: 7).

¹⁰⁷ China successfully characterised its relationship with Africa as a strategic partnership of two sister nations, rather than a paternalistic relationship between a superior donor country and its inferior recipient. Thereby, African governments were to be treated as equal partners and allies in development with one developing country helping another (Chan 2008).

¹⁰⁸ A WHO delegate from Guinea stated that Chinese “health squads ...were rooted in people...taking as their starting point the real needs of people”. The delegate at the close of his speech “offered sincere thanks to Chinese for assistance rendered” (Lee 1997: 36).

¹⁰⁹ Several informants have also attributed the adoption and perpetuation of this model specifically to Chinese funding and the presence of Chinese nationals in particular positions at WHO, but this could not be verified.

¹¹⁰ It is noteworthy that Mahler distinguishes between “traditional practitioners and birth attendants”. This distinction is not explained in the WHO literature reviewed, yet appears consistently in WHO discourse and is repeated in the DOHP's literature. This distinction will be explored further in Chapter 6.

This statement clarifies several points of Mahler's and WHO's perspectives on integration. Firstly, and most importantly, healthcare integration is proposed as the means to achieve universal access to healthcare. Secondly, what and who should be integrated is defined as those practices that are deemed to be “useful” and all resources (including practitioners) that are deemed to be “possible”. Neither “useful” nor “possible” are further defined, leaving marked flexibility in determining what is useful and what or who are to be considered possible resources. It is noteworthy that this distinction inherently normalises the need for the construction of a hierarchy amongst practices and practitioners according to which are deemed useful and possible. But then, we must ask, “useful and possible” according to whom and whose standards?

Mahler goes on to describe that as outlined in the Declaration of Alma Ata “traditional practitioners” are to be used “as needed” and “who are suitably trained socially and technically to work as a health team and to respond to the expressed needs of the community” (Mahler 1983: 7). Again, the construction of integration can be analysed. This undifferentiated group of “traditional practitioners” are to be used “as needed”. This begets the question, who is determining this “need”? The community? The Department of Health? They have to be “suitably trained” through “social and technical training in order to be able to work as part of a health team”. But again what is “suitable” training and according to whose standards of suitability? And do local practitioners not already “respond to the expressed needs of the community”? According to the barangay informants interviewed in the Philippines, if a local practitioner was not meeting their needs, informants would no longer go to them for treatment.

There are, however, two larger assumptions in this statement that are not supported by my findings. Firstly, is the assumption that local practitioners desire to be trained or formally integrated. And secondly, is the assumption that neither local practitioners nor local barangay members already consider local practitioners to be part of the healthcare team. As will be discussed in Chapter 5, the majority of local practitioner informants do not seek formal integration or training. Those that sought training did so to incorporate any training into their own practice as they saw fit, rather than the opposite. Secondly, all local practitioners interviewed, as well as a majority of barangay informants, already perceive local practitioners to be part of the healthcare team and their healthcare system.

Mahler's representation of integration and local healthcare grants neither local practitioners, nor patients, the agency to determine these matters and to distinguish the understanding of their healthcare system for themselves. Furthermore, such a representation could not be corroborated by the findings of my fieldwork. But more so, local representations and understandings of healthcare are disregarded in this representation. Hence, if local practitioners are already perceived to be part of the healthcare team without being required to have further training, as was identified in the barangays studied in the Philippines, then it is questionable exactly for whom is this training and validation of local practitioners?

Mahler justifies the need for integration “on the grounds that the healers know the sociocultural background of the people and...are highly respected and experienced in their work” (Mahler 1983: 7). He also identifies “economic considerations”; “distance”; “strength of traditional beliefs”; and “shortage of health professionals, particularly in rural areas” as justifications for the need for integration (*Ibid.*).

He concludes: “it is hoped that this information will be of use to governments when they consider the most appropriate methods for inclusion in their health strategies” (Mahler 1983: 8).

Since the WHO operates at the global, regional, and state levels, predominantly with ministries of health, it would appear that the WHO discourse of healthcare integration is directed to these same levels, primarily to the ministries of health. But what is also noteworthy here is that the use of “appropriate methods” is to some extent to be determined by each state. Yet, in this research I examine if the state level is, in fact, the “appropriate” level by which to conduct healthcare integration. An important assumption here is that what is decided and/or implemented at the state level will automatically be implemented at local levels. However, in my field research, I found implementation to be context dependent, especially in a setting with a devolved healthcare system.

This brief analysis of Mahler's statement provides an introduction to a more comprehensive analysis of the WHO discourse of healthcare integration, in general.

3.2.8 A Brief Analysis of the WHO Healthcare integration discourse

This section will briefly examine the healthcare integration discourse of WHO. Prior to its introduction in the Declaration of Alma Ata in 1978, there was little literature or international discourse referring to healthcare integration. The non-biomedical work of WHO/UNICEF commenced with trainings for Traditional Birth Attendants, which interestingly began first in the Philippines with *hilots* in the 1950s (Pillsbury 1982). Although these trainings were sometimes noted in the literature prior to 1978,¹¹¹ they were identified as trainings rather than as formal integration. After 1978, and especially into the 1980s, there was an exponential leap in publications on healthcare integration. In all WHO documents after 1977, whenever traditional medicine is mentioned, integration is almost always the recommended goal.

¹¹¹ See, for example, WHO. 1975. “The Traditional Birth Attendant in Maternal and Child Health and Family Planning” and Djukanovic and Mach. 1975 “Alternative Approaches to Meeting Basic Health Needs in Developing Countries. A joint UNICEF/WHO study”.

What Mahler wrote in 1983 could serve as the template for all WHO documents which followed concerning healthcare integration.¹¹² Regardless of the documents or who wrote them, there are several words which without fail appear in almost every WHO document related to healthcare integration. The 2002 WHO Traditional Medicine Strategy states:

“Member states want assistance from WHO in formulating national policy and regulatory frameworks about traditional medicine; in ensuring the *safety*, *efficacy* and *quality* of the practices; in guaranteeing the *access* to such treatments and in assuring their *rational use*” (WHO 2002b: 14).

In fact, WHO defines:

“its role in TM/CAM by developing a strategy to address issues of policy, safety, efficacy, quality, access and rational use of traditional, complementary and alternative medicine” (*Ibid.*: 1).

Therefore, for the purposes of this thesis, these italicised terms that appear in the first mention of healthcare integration in the WHO literature in 1975 will be analysed here as four broad themes of healthcare integration in the WHO discourse.

3.2.8.1 Theme 1 Access: Healthcare Integration Will Improve Access to Healthcare

Healthcare integration was introduced into the WHO discourse as a means to address the particular goal of “Health for All by the Year 2000”. As Mao identified in the PRC, universal healthcare could only be considered if all resources were utilised, especially in the rural areas of low-income countries. However, as I previously examined, what Mao was able to achieve was only possible in the particular circumstances in which healthcare integration was enforced, especially during the Cultural Revolution (Taylor 1995). Therefore, although integration is irrefutably believed to achieve greater healthcare access, access has not been evaluated in the literature reviewed and thereby remains an unchallenged assumption. 114

¹¹² Although all WHO publications and documents referring to healthcare integration were analysed for this section, the primary documents that will be discussed include: the *Report of the WHO Meeting on the Promotion and Development of Traditional Medicine* (WHO 1977); *The WHO Traditional Medicine Strategy 2002-2005* (WHO 2002b); and *The Regional Strategy for Traditional Medicine in the Western Pacific 2002-2010* (WPRO 2002a). These documents were chosen for this discussion because of their discursive representativeness of the WHO healthcare integration literature.

The relationship between non-biomedicine and access in the WHO literature makes several assumptions. Firstly, there is an assumption that a) non-biomedical practices and practitioners are more accessible than biomedicine, especially in rural areas; and b) because of their greater accessibility, non-biomedical practices and practitioners will be able to redress the general access to healthcare if integrated into the healthcare system.

“Access to TM [traditional medicine] is to be increased to help improve health status” (WHO 2002b: 25).

However, I did not find part (a) of this statement to always be valid in the barangays studied. Rather, I found that there were far more barangay midwives and barangay health workers than local non-biomedical practitioners (See Tables 5.3 and 5.5). Part (b) of this statement will be examined in Chapters 5 and 6. In brief, healthcare integration was found to have context-specific effects on healthcare access and was not found in this research to increase access to healthcare, in general.

Secondly, it is assumed in the WHO discourse that non-biomedicine is used primarily because of its physical and financial accessibility.

“In developing countries, broad use of TM is often attributable to its accessibility and affordability” (WHO 2002b: 2).

However, as I will discuss in Chapter 5, informants in the Philippines were fairly equally divided amongst the reasons they used local healthcare practices and practitioners, which was not always reducible to access.

Lastly, the discourse assumes that intervention and oversight from outside of a community are necessary to ensure access to local non-biomedical practices and practitioners.

“Increase the availability and affordability of TM/CAM, as appropriate” (WHO 2002b: 5).

The assumption here is that external control is needed either to ensure greater access to local healthcare or because people who don't use local healthcare will suddenly use it because it is more readily available.

However, in general, informants identified that when they did not use local healthcare, it was because they did not “believe in it”; not because it was not accessible.

Hence, this first theme, that appears in all WHO healthcare integration literature examined, justifies the need for healthcare integration. The next themes concern the manner in which healthcare integration should be executed.

3.2.8.2 Theme 2 Safety, Efficacy, and Quality: Universalising Expectations & Fears and Justifying Evaluation and Validation

In the 1977, *Meeting on the Promotion and Development of Traditional Medicine*, it was decided that:

“effective integration, like that of the Chinese experience, entails a synthesis of the merits of both the traditional and so called 'western'...through the application of modern scientific knowledge and techniques” (WHO 1977: 16).

This statement is illustrative for several reasons. But primarily, this statement reifies healthcare integration as a scientific process that cannot occur outside the confines of scientific validation. This validation is primarily achieved through the establishment of safety, efficacy, and quality; all of which are, again, determined according to biomedicine. However, the findings of this research, discussed in Chapters 5 and 6, challenges this conceptualisation of healthcare integration.

Vuori states: “WHO does believe in the potential of traditional medicine, but wants to subject it to rigorous scientific evaluation” (1982: 131). WHO identifies the development of norms, standards, and guidelines as the means by which to achieve safety, efficacy, and quality of non-biomedicine (WHO 2002c). They also establish the need for a hierarchical Othering by suggesting that those practices deemed to be safest or most effective are the practices to be promoted (*Ibid.*). However, it is noted that “both a lack of research” and “a lack of adequate or accepted research methodology for evaluating traditional medicine” are challenging the establishment of safety, quality, and efficacy of non-biomedicine (WHO 2002b: 21).

Within this discourse, it is interesting that research methodology is presented as it is here, for this caveat acknowledges that non-biomedicine may not be able to be evaluated or validated by biomedicine and biomedical standards.

In the 2002 *WHO Strategy for Traditional Medicine*, the term “safety” appears 74 times; “quality” appears 72 times; and “efficacy” appears 66 times. The reason for these similarities in frequency within the document is that they almost always appear together. In the WHO discourse, safety, quality, and efficacy are understood to be outcomes of evidence-based research, guidelines, and regulations. The 2002 WHO-WPRO Strategy states:

“Safety is the primary concern in medical treatments — to patients and practitioners alike. Formal standards of safety for medication and non-medication treatment modalities are to be established by Ministries or Departments of Health or other governmental agencies” (WPRO 2002b: 20).

It goes on to state that the effectiveness of a local practice is best determined by researchers and the Department of Health (*Ibid.*: 22).

There are three primary assumptions in this statement. First is the paternalistic assumption that safety is a primary concern of patients regarding local healthcare practices. As I will discuss at length in Chapter 5, a markedly low percentage of informants (18% or fewer) had any concerns regarding their local healthcare practices. The second assumption, that stems from the first, is an ethnocentric one; that the biomedical construction of safety, efficacy, and quality is universally shared. Again, this was not found in informant interviews in the barangays and will be discussed in Chapters 5 and 6. Lastly is another paternalistic assumption that also directly brings the Western ethical and bioethical concepts of agency and autonomy into question. The statement assumes that a treatment identified as good; that will work; and is safe cannot be determined by a patient, but rather can only be decided for the patient by an outside expert. Again, this poses marked issues when the patient's conception of safety, efficacy, and quality do not conform to WHO's normative conception.

3.2.8.3 Theme 3 Appropriate or Rational Use: Defining a Standard by Being Vague

In the 2002 WHO Strategy, the word “appropriate” appeared 32 times (23 times in the 2002 WHO-WPRO Strategy) and the word “rational” appeared 24 times. Although “appropriate” and “rational” are used interchangeably and in varying contexts in the WHO documents examined, they most frequently refer to how integration should be accomplished.

The 1977 Thirtieth World Health Assembly:

“urges interested governments to give adequate importance to...utilization of their traditional systems of medicine with 'appropriate regulations' as suited to their national health systems” (WHO 1977).

In the Declaration of Alma Ata:

“Traditional workers and traditional birth attendants” are to be included in the healthcare system “as needed” and “where appropriate” (WHO 1978a).

The 2002 WHO Traditional Medicine Strategy tells member states to:

“Integrate TM/CAM with national health care systems, 'as appropriate' ” (WHO 2002b: 43).

Although rarely defined in the WHO literature, “appropriate” is defined in the 2002 WHO strategy.

“ 'Appropriate' is taken to refer to TM/CAM health care that does not cost more and which is no less safe and efficacious than recommended allopathic care for the disease or health problem” (WHO 2002b: 43).

Hence, according to this definition, appropriateness and rational use are to be employed in the same manner for non-biomedicine as for biomedicine. Thus, this recommendation assumes that all ordered systems of healthcare understanding are by nature interchangeable.

3.2.8.4 Theme 4 WHO is Needed to Oversee the Appropriate Execution of the Previous Three Themes

“Member states' requests insistently reach WHO every day...seeking assistance...about traditional medicine” (WHO 2002b: 14).

Embedded throughout this discourse is an assumption of necessary and justifiable paternalism.¹¹³ In other words; it is assumed that community healthcare integration can only be executed by the government and that WHO's assistance is essential for the technical support needed for healthcare integration.

Firstly, WHO posits that it [WHO] is needed for the sake of the perpetuation of “traditional medicine”:

“Traditional medicine...has tended to stagnate through not exploiting the rapid discoveries of science and technology for its own development” (WHO 1978b: 9).

However, this is assuming, as did the AMA and the RF, that any non-biomedical practice is working from the same or similar paradigm or ordered system to that of biomedicine. Thereby, comparison and competition between biomedicine and any non-biomedical practice can be warranted, and simple adoption and replacement of certain elements from biomedicine can be easily transferred.

Secondly, WHO is documented to be needed by the member states to guide the healthcare integration process. WHO defines its core role in healthcare integration as:

“articulating policy and advocacy positions; working in partnership; producing guidelines and practical tools; developing norms and standards; advocating rational use; stimulating strategic and operational research; developing human resources; and managing information” (WHO 2002b: 5).

Many of these goals are executed through the WHO Collaborating Centres; of which there are nineteen worldwide (2010b). However, the findings of this research, question if WHO involvement is actually appropriate for all healthcare integration contexts. This is an assumption that will be discussed in Chapter 8.

¹¹³ Beauchamp and Childress define paternalism as “the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden” (2009: 208). Though the authors claim the definition is “normatively neutral”, “an act of beneficence” is a distinctly western conception of “normative” in the liberal tradition; which may not translate accordingly to all contexts (*Ibid.*).

3.2.8.5 Recommendations Tempered by Diplomacy

Pillsbury's analysis of the early WHO discourse is instructive in its approach. Pillsbury questions why there has been poor implementation of healthcare integration in WHO member states, which she attributes to the semantics of the policy itself (1982). In her preliminary analysis of the 1977 WHO resolution and the 1978 Declaration of Alma Ata, the wording of these documents are depicted as purposely vague, cautious, qualified, and generally uncommitted, and thereby fully open to interpretation (*Ibid.*).

For example, terms such as “where appropriate”; “as needed”; “suitably trained”; “deserve further study”; “well worth the possibilities of”; appear with great frequency throughout these documents and many of the WHO documents examined. Ultimately such terms facilitate a wide gap of interpretation for implementation by state and local stakeholders. Hence, many of these documents may be more illustrative of the caution of the designers of these policies, than of the actual intentions of the policy. Pillsbury attributes these issues to the fact that these documents were drafted by consensus (1982).

However, beyond the politics of the process, a primary issue here is one of distinguishing how best to order the Other's system of understanding and meaning to make it suitable for inclusion into the biomedical order. This prioritisation shifted with specific changes at WHO.

3.2.8.6 Contextualising the Priorities of the Traditional Medicine Unit at WHO

Although WHO has been depicted in this thesis as an indivisible organisation, it must be clarified that WHO is an organisation of numerous units of variable priority and that traditional medicine has “most definitely been their [WHO's] lowest priority”, according to an informant who was a former WHO consultant of many years. After Alma Ata and the waning of the focus on CPHC, the discourse on traditional medicine became the priority solely of the Traditional Medicine (TRM) unit at WHO headquarters in Geneva and in its sister regional office TRM Units.

According to a WHO informant, WHO's general attitude toward the traditional medicine unit was at best one of disinterest. The informant explained that in the organisation's restructuring and streamlining after the departure of Halfden Mahler, Director-General Nakajima could not find justification for funding the TRM unit and had decided to close the unit unless the TRM unit could locate external funding. Prior to becoming Director-General, Nakajima was a physician-researcher who became “Chief of the WHO Drug Policies and Management Unit where he played a key role in the development of the concept of essential drugs” (Lee 2009: 83). The then TRM Unit head was Dr. Xiaorhui Zhang, a Chinese national. According to the WHO informant, Zhang convinced the CCP to fund the TRM Unit in order to keep it within WHO headquarters, as purportedly there was a bid at the time to move the TRM unit to Delhi, India. The CCP agreed to fund the unit, which may partly explain WHO's marked emphasis on TCM research and publications. However, in Nakajima's restructuring the TRM unit was now under the management of the Essential Medicines Division of WHO.

In a chronological analysis of WHO publications, there is a clear division in the priorities and content of the guidelines published by the TRM Unit before and after this reorganisation under Essential Medicines. The WHO's traditional medicine discourse can be identified to have shifted from issues of access and primary healthcare to distinctly more pharmacological and commodified priorities of Good Agricultural and Collection Practices (2003b); Herbal Regulations (2005); Good Manufacturing Practices (2007a); and Quality for Herbal Medicines regarding contaminants and residues (2007b). Furthermore, the specific terms “safety”, “efficacy”, and “quality” appeared with a far greater frequency in WHO publications after the restructuring under Essential Medicines. The frequent use of such terms would comply with the *doxa* of an essential medicines *field*.

Thus, with a renewed emphasis on herbal medicines, commodification, and manufacturing, the original ordered system of the TRM Unit has been replaced by the ordered system of the Essential Medicines unit of WHO.

This prioritisation was also identified in the participant experience I conducted at WPRO in both the choice of experts for the future strategy meeting, which included herbal manufacturing executives, as well as in the priorities of these experts, which tended to focus on international trade issues such as labelling of raw herbs, reduction of heavy metal content, and the domestic and non-domestic production of herbal products. Hence, the priorities of the TRM unit of WHO can be understood to be, at least partly, an outcome of political and economic delegation, justified through a biomedical discourse.

3.3 Conclusion

An informant, who worked over several years with the Traditional Medicine Unit (TRM) at WHO headquarters in Geneva, recounted an incident that occurred at a conference with the then Director of the TRM. The members of the conference made several recommendations for respecting the spiritual aspects of traditional medicine. The Director was reported to be shocked;

“Spiritual? Spiritual? What is this spiritual? Traditional medicine is a science.”

This supposed position of a long-term director at WHO may summarise some issues inherent in the WHO priorities for integration. These Priorities include: the discursive themes of safety, efficacy, and appropriateness and the biomedical paradigm by which to assess (and hierarchically Other) non-biomedical practices. These repetitive discursive themes have become reified assumptions that are not corroborated by the findings of this research.

The paradigm employed, as well as these discursive themes, can be traced back to the Flexner Report, the work of Frederick T. Gates and the RF, and the work of the AMA in establishing the global hegemony of biomedicine's ordered system of understanding and meaning. Thereby, the biomedical physician (the primary agent of this order), is guaranteed the status of sole expert in all aspects of domestic and international health; including how to manage non-biomedical practices and practitioners. The control, and often eradication, of non-biomedicine was identified to be historically linked to securing the dominance and hegemony of biomedicine; both domestically in the U.S. and internationally.

This Chapter has attempted to answer the research question: “what is healthcare integration”, by examining how healthcare integration was constructed and how this construction has informed the normative representation of healthcare integration. According to the research of this Chapter, the WHO representation of healthcare integration is understood as the incorporation of non-biomedical practices and practitioners into a formal state healthcare system according to the biomedical standards of safety, efficacy, and quality.

The on-going construction of healthcare integration, and non-biomedicine in general, through the evidence-base and policy making process, was examined and problematised through a year-long participant experience in the Traditional Medicine Unit of the Western Pacific Region Office of the World Health Organization (WPRO). I document pertinent excerpts from this ethnography in Appendix 3.

The applicability of WHO's representations to the practice of healthcare integration at local levels in the Philippines will be examined in the Chapters that follow.

Chapter 4

**“Medicine has some advantages over machine guns”
Contextualising the Philippines and Philippine Healthcare**

“Dispensaries and physicians have of late been peacefully penetrating areas of the Philippine Islands and demonstrating the fact that, for purposes of placating primitive and suspicious peoples, medicine has some advantages over machine guns”
(Rockefeller Foundation Report 1917: 42).

4.1 Introduction

In order to understand healthcare integration in the Philippines, it is necessary to briefly contextualise the political, economic, and colonial history of the Philippines; the socio-cultural context of the Philippines; and the construction of the Philippine healthcare system. This Chapter will commence with a brief overview of the history of the people and healthcare of the Philippines, from pre-colonial through Spanish and American colonial occupations. In general, the history of the Philippines will be analysed both in terms of the elite and underclass that were created as a result of the control of colonial land, and the movement between centralised and decentralised governance and administration.

The next section of this Chapter will identify how these historical patterns shaped the current Philippine healthcare system. To understand how local informants use their local healthcare, the local healthcare practices and practitioners identified in this research will be presented. Epidemiological data from the national level will then be presented to summarise the state of health in the Philippines.

Overall, the purpose of this Chapter is to provide an understanding of the context of the particular kinds of healthcare integration presented in this research.

4.1.1 A Demographic Contextualisation of the Philippines

The Republic of the Philippines is an archipelago of 7,107 islands in the Western Pacific (see Appendix 1). 91 million residents encompass 24 official ethnic groups and speak one of ten official languages (National Statistics Office 2008). The national language is Filipino, which is based on Tagalog. The official languages are Filipino and English (*Ibid.*). 160 ethnolinguistic groups have been identified (Marcello 2008).

Of the more than 70 ethnic groups in the Philippines, the Tagalog make up the largest group, comprising approximately one-quarter of the Philippine population (*Ibid.*). Ninety percent of Filipinos are Roman Catholic, five percent are Muslims, and the remainder are Buddhists, Bahai, Hindu, Sikhs, and Animists (National Statistics Office 2008). With a GDP (PPP) per capita of US\$3,539, the Philippines is ranked 122 out of the 179 countries in terms of GDP per capita¹¹⁴ (UNDP 2009). On the Human Development Index, the Philippines is ranked 105 out of 182 countries (UNDP 2009).

4.2 The Construction of Healthcare through a Political and Economic History of the Philippines

4.2.1 Pre-Colonial “Indigenous” Inhabitants of the Philippine Islands

Archaeological and linguistic analysis have assisted in identifying the pre-colonial inhabitants of the islands. The cultural alliance with the Malay-Polynesians of Indochina¹¹⁵ can be located in both language and socio-cultural characteristics (Jocano 1975a). Vegetation also identifies both Indo-Malay and Formosan (Taiwanese) influence (Nelson 1968: 9-10).

The earliest surviving written records discussing the Philippines are historical accounts from China concerning trade (Scott 1984). Trade was instrumental in fostering contact between the archipelago and other countries. India purportedly made contact circa 800 BCE (Jocano 1975a). Artifacts, such as porcelain ware, have identified trade with China from at least the tenth century¹¹⁶ (*Ibid.*). Arab traders and missionaries are believed to have been on the Islands from the ninth to fifteenth centuries influencing the spread of Islam, particularly in the Southern regions of the archipelago, which thereafter remained impenetrable to colonisation (Nelson 1968).

¹¹⁴ In 2010, GDP was reported to grow 7.3% in the Philippines. Bilateral trade reached US\$27.7 billion in 2010, a 35 % increase from the previous year. The U.S. is the largest trading partner of the Philippines followed by Japan and China (Guangjun and Lan 2011).

¹¹⁵ The link to Indochina is also identified in both Chinese and Sanskrit words identified in Tagalog (Joaquin 1992).

¹¹⁶ Trade of sugar-cane with China is identified as early as the twelfth century (Quirino 1978).

4.2.1.1 Pre-Colonial Social Structure

A brief analysis of the pre-colonial social structure provides an understanding of the Filipino acceptance of post-colonial decentralisation and insight into the ordered systems of understanding and meaning of the Filipino Self.

Pre-colonial political boundaries were both tribal and familial, and organised in social units known as barangays. Barangays were socially, politically, and economically independent social units linked by kinship (Jocano 1975a). Currently, barangays are the [most] local geo-administrative designation. However in the original use of the term, barangays were not understood as places, but rather designated different, often mobile, tribal groups of hunter-gatherers (*Ibid.*).

Barangays were organised hierarchically according to wealth and political influence (Jocano 1975a). They were commonly composed of approximately 30-100 families under a single male ruler known as a *datu* (Garcia 2004). The *datu* acted as the political leader and protector of the barangay; interacted with visitors/outsidere; and made decisions for the barangay (Jocano 1975a). Though the *datu's* position was inherited, he needed to demonstrate his leadership through his adeptness “in all aspects of life” by possessing “wisdom, great physical strength, and wealth among other virtues” (*Ibid.*: 175). In return, the *datu* was granted political, economic, and religious power by his barangay members (*Ibid.*). Barangays were often named after the *datu* (*Ibid.*).

The position of the *datu* was followed by the *maharlika* or freemen (Jocano 1975a: 176). The *maharlika* assisted the *datu* in his endeavours, without needing to pay taxes or tributes to the *datu* (*Ibid.*). Comprising the majority of the barangay were the *timaqua* or common class, who were protected by their *datu* for service to him. Lastly were the *alipin* or dependent class (*Ibid.*).

The *alipin* were servants that were relegated to their class due to: a crime they committed; an inability to pay a debt; disobedience to the *datu*; or because they were the offspring of a parent who fell into this class (*Ibid.*). *Alipin* were divided into the *saguiguilir* (who lived in the homes of the families they served and were considered part of the family) and the *namamahay* (who lived in their own homes, but worked for a family) (*Ibid.*). Although this hierarchical structure was organised at the level of the tribal barangay, it can be understood to have facilitated the adoption of the Spanish colonial administrative hierarchy for the archipelago and the post-colonial administrative structure of governance. See Figure 4.1.

Boundaries and Othering were identifiable between barangays in both dialect and culture. Neighbouring barangays were noted as often being on good terms and intermarried for the protection of mutual interests (Jocano 1975a). However, exclusive Othering and hostility were also identified between warring barangays¹¹⁷ (*Ibid.*). Such differences were obvious in the field. I required four different translators for five different municipalities; three of which were located on the island of Luzon. I was told that the difference in dialect rendered sharp boundaries for even basic communication. Although Tagalog is the official and national language, not everyone, and especially few in rural areas, spoke Tagalog. One's dialect appeared to have preference over Tagalog, which can also imply that one's local identity was given precedence over a national identity. The only two municipalities studied that did not require a different translator were the neighbouring municipalities of Bontoc and Sadanga. However, even between these two municipalities, I observed that barangay members would define a sharp boundary between Self and Other, in which the Other's otherness was a source of criticism.

¹¹⁷ A binary valuation system akin to good and evil, punished those in the afterlife by sending them to a hostile barangay for eternity (Jocano 1975a).

Early laws also identify the sharp tribal boundaries of barangays. “No one belonging to another barangay will cultivate the land unless after purchase or inheritance”¹¹⁸ (Jocano 1975a: 173). In general, certain social structures and ordered systems of understanding and meaning united the pre-colonial inhabitants of this archipelago.

4.2.1.2 Pre-Colonial healthcare: religion as “science”

The cosmology of the archipelago established several deities who could be followed for their protection from illness (Raedt 1969; Jocano 1975a). For example, “*Mangangaway* was responsible for disease on earth. Anyone who crossed her path or incurred her wrath was severely punished with bad luck or prolonged illness” (*Ibid.*: 219).

Early disease prevention and curing occurred during religious ceremonies officiated by diviners known as *catalohan* (Jocano 1975b). *Catalohan* also commonly oversaw ceremonies insuring the safety of mother and child during birth (*Ibid.*). These diviners were respected, but feared, by their barangays (*Ibid.*).

“The mediums were [believed] to have acquired their powers from the different deities who inhabited the different parts of the spirit-world...only those whom the ancestral spirits called upon to perform these tasks were given the power to communicate and heal the sick”¹¹⁹ (Jocano 1975b: 227).

Jocano identifies ritual ceremonies accompanying healing known as *paniwata* (1975a: 227).

¹¹⁸ However, in general, there was no concept of individual private property before Spanish colonisation (Jocano 1975b). Land was owned communally by the barangay (Steinberg 2002).

¹¹⁹ This quote by Jocono is particularly germane to this research, in which all local healthcare practitioners interviewed reported that they were called upon by “God”, in a dream or vision, to heal. In this dream or vision; “God” taught them exactly how to heal. Hence, though the dream or vision was not always the same, the method of transmission of “healing” knowledge was culturally consistent regardless of geographic location or practitioner type.

“For the sick, a lodge would be built into which the patient was transferred. Seven days after transfer a curing ritual was performed. A pig was slaughtered, its blood smeared, and its entrails 'read' by the medium who could then diagnose the nature, stage and cause of illness” (Jocano 1975a: 228). In another ceremony “the medium danced and went into a trance and communicated with the spirits. If she announced that spirits were pleased with the ceremony, a pig would be slaughtered and part of it used to anoint”

the patient and the rest of the barangay. “Then the pig was divided and eaten. After the diagnosis was made, another ritual was performed and the medium would communicate with the spirits on how to heal the patient. If the patient was determined not to recover, the medium prayed, stating the patient's accomplishments and how brave the patient is. After this, there was a feast, regardless of the diagnosis” (*Ibid.*: 228).

Informants in Sadanga reported that when someone was injured or ill in their barangay, barangay members would gather and pray. Prayer would then be followed by a ceremony in which a pig was sacrificed, followed by a feast. Although I was not permitted to observe the ceremony, I did observe many a tied pig being carried on a pole up a hill during my research in Sadanga. However, according to informants, the reading of entrails is commonly practised in the Philippines. For example, I observed a *supok* (faith healer) who “read” the organs of a chicken in making his diagnosis.

Furthermore, various inanimate objects were observed to be used for diagnostic purposes *across* practitioner categories. I observed a form of diagnosis in which meaning was derived according to the particular way a candle melted. This is known in the sites I visited as *tawas* or *tawal*. I also observed another method of diagnosis in which a *supok* held a long stick behind his back and stood completely still until gradually the stick led his body to twist in a particular direction. Diagnosis depended on the direction in which the stick twisted his body.

These examples provoke skepticism toward assumptions that Spanish (and/or American) colonialism simply replaced or eradicated pre-colonial ordered systems of understanding and meaning.

For I observed what might be described as pre-colonial rituals alongside catholic rituals, as identified in section 4.2.2.2 “Syncretism and Plurality”. During my field work, numerous examples were observed of a Self that was not completely Othered by colonialism. For example, rice terracing, the predominant form of agriculture in the highlands of the Philippines, was identified to have been practised well-before the arrival of the Spanish.

Furthermore, Philippine ordering does not always appear to differentiate or evaluate ordered systems in terms of temporality or modernity.¹²⁰ Still, these reflections of social structure were to be altered with the arrival of Spanish colonists and their need to structure their new colony according to the ordered systems of understanding and meaning of the Spanish Self.

4.2.2 *Constructing the Philippines: Spanish colonialism and the Incorporation of 7,107 Islands*

In 1542, the words “Islas Filipinas” were first used by Ruy Lopez de Villobos, to refer to two islands of the archipelago; Samar and Leyto (Nelson 1968: 31; Jocano 1975a: 2). Later this referred to the entire archipelago in honour of the son of King Don Carlos I of Spain; Felipe (Jocano 1975a). When Philip of Spain was made king, the Islands named after him were made a Spanish colony primarily for trade with China; via the Manila Galleon (Nickels 2002).

Thus, the Spanish interest in the Philippines was originally for its use as an entrepôt for the transpacific galleon trade between China and Spain via Mexico,¹²¹ as well as to establish its own market in the spice trade, at the time dominated by Portugal (Puzel 1992; Tan 1999).

131

¹²⁰ However, the adoption of modernity is context specific. Hierarchical Othering was commonly observed in the field. For although no one in Sadanga would think anything odd about slaughtering a pig in a ritual ceremony, thirty minutes down the hill, in neighbouring Bontoc, people mocked the fact that in Sadanga “they *still* sacrifice pigs”.

¹²¹ “The Spanish Crown’s principal interest in the islands was in establishing Manila as a naval base in the Pacific” (Puzel 1992: 44).

Although Ferdinand Magellan of Spain led the first expedition to the Philippines in 1521 (Putzel 1992), it was not until 1565 that Miguel Lopez de Legazpi conquered the Island of Cebu. In 1571, de Legazpi officially “proclaimed Manila the capital of the Philippines and became the first governor of the archipelago” (Nelson 1968: 30). Therein began 350 years of Spanish rule immediately followed by half a century of U.S. colonial rule.

Catholic missionaries, intervening through *datus*, became the most potent force in Spain's colonisation of the islands. For although the Spanish understood centralisation of the autonomous barangays as essential for administrative control, without the pre-existing social stratification of the barangays, outside control might have been rendered more difficult. The pre-colonial hierarchy of the barangay offered a well-established socially accepted mechanism for political and economic control via elites.¹²² This elite control was observed to have continued into the present (Puzel 1992).

4.2.2.1 The Centrality of Catholicism in a "Showcase of Faith"

“Philippine nationalism, the Philippine identity, the Filipino's value system, and the economic and social fabric of the society are all linked directly to the Roman Catholic experience” (Steinberg 2000: 83).

One of Spain's intentions for the Philippines was to be a “showcase of faith” (Steinberg 2000: 80). The spread of Christianity throughout the newly colonised islands was an important priority for the Spanish. In a letter dated 1564, an Augustinian Missionary priest explained his mission.

“You are expected to accomplish your mission by preaching and the practice of the Christian Virtues...teach them also their duty to obey their natural rulers...and to reject all superstitions” (Lopez and Felix 1965: 255-6).

¹²² Claims on surplus produce in the Barangays were socially granted to the *datu* and *maharlika*. The *alipin* essentially performed an early socially codified form of sharecropping (Puzel 1992: 44).

Political and economic colonial control are thereby justified, and facilitated, through religious conversion. Religion, in this period “stamped every institution and aspect of Philippine society”¹²³ (Steinberg 2000: 93).

Education and religion were taught and controlled by the friars (Steinberg 2000). “The local cleric was the teacher of truth” (*Ibid.*: 80). Whereas, the Chinese had rejected their modernity mixed with the religion of missionaries, the Jesuits, who brought Western science and education to the Philippines, were represented favourably. Jose Rizal in 1880 wrote “The Jesuits...represent progress; the Philippines owes to them their nascent education” (quoted in Anderson 2006: 18).

4.2.2.2 Syncretism and Plurality

Polytheistic pre-Spanish religions were pervasive in the archipelago (Jocano 1975a). Although it appears that there may have been as many religions as there were tribes, a unifying cosmology joined the various tribes (*Ibid.*). Ancestral worship and divination were practised by mediums (Nelson 1968). The understanding of an afterlife is identified from excavations finding valuable artefacts buried with the dead throughout the islands (Jocano 1975a).

With colonisation and nationalisation, the archipelago became divided in terms of religious belief. Mindano, uncolonised by Spain due to its pre-colonial, predominantly Muslim, population, and many of the highlands followed an indigenous religion (Tan 1999). Yet, it is inaccurate to represent the ordered systems of religious understanding and meaning in the Philippines as bounded. Tan Alora and Lumitao identify that Roman Catholicism “was integrated into Filipino culture without complete abandonment of native religiosity, which was primarily animistic” (2001: 6).

133

¹²³ Politics and religion have been historically difficult to extricate from one another in the Philippines, as political movements have been intricately linked with religious movements, particularly in the nineteenth and twentieth centuries. Steinberg notes “The Jesuits openly supported land reform and unionization, worked for squatters rights and became advocates of social change” (2000: 94). In my field research, I noted that *INAM*, and other local healthcare NGOs, approached health politically whilst maintaining strong religious affiliations.

Steinberg identifies that “folk Catholicism and traditional eclecticism were never successfully vanquished...both the initial alien faith and the domestic environment fused so that many traditions and customs have a global exterior and a local interior (Steinberg 2000: 87). Hence, for example, the “miracle” in Catholicism is the reflection of the “magic” of the local spirit-medium (*Ibid.*).

Stewart and Shaw describe this fluid synthesis of religions as syncretism (1994). Syncretism suggests a blending of systems of order without complete co-optation or replacement of one ordered system for another. It is an illustration of inclusive Othering. Thus, syncretism is messy. Syncretism breaks boundaries. And syncretism threatens purity that is based on exclusive Othering.

Peel suggests, “variation depends primarily upon how those involved *interpret* what they are doing, rather than upon the mechanical assignation of cultural traits” (1968: 140). The act of interpretation suggests that even in a colonial context, the colonised are not mere empty vessels which the colonisers fill. Filipinos determined what they would interpret and how. Therefore, interpretation and syncretism can be included in a local ordered system of understanding and meaning without disrupting the integrity of their existing *doxa*. What is noteworthy in the process is the involvement of agency, even within a context of colonisation. Thereby, syncretism can be identified as a form of resistance, a means by which to protect and preserve the Self's ordered system of understanding and meaning. Syncretism then can be a reaction to an imposition of the dominant Other's order onto the Self, requiring forms of navigation around these imposed orders. The syncretism of religion in the Philippines illustrates a parallel process to the plural use of healthcare and the integration that was observed to occur on an individual basis.

4.2.2.3 The Advent of Healthcare From Spain

The first hospital in the Spanish colony of the Philippines started as a medical dispensary in 1577, by the Order of Friars Unilova for Manila's indigent and poor Spaniards (Ford and Cruz 1957; Anderson 2006). It operated as San Juan de Dios Hospital at its original site until 1945 (Ford and Cruz 1957). The San Lazaro hospital was founded the following year for the poor (Anderson 2006: 18). Several religious orders followed suit and constructed hospitals for the poor and private physicians for the elite (*Ibid.*). A two-tier class system of healthcare that mirrored the social order was already entrenched in the Philippines by the sixteenth century.

The physician of Spain's Charles the IV arrived in the Philippines in 1805 and introduced the smallpox vaccination, establishing the first official public health institution in the Philippines; the Central Board of Vaccination in 1806 (Ford and Cruz 1957). The University of Santo Thomas was the first university in the Philippines to offer courses in medicine and pharmacy in 1871 (Anderson 2006). In 1876, the colonists appointed provincial health officers known as *medicos titulares* that were employed in almost all provinces of the Philippines by the beginning of the twentieth century (Ford and Cruz 1957). The first department of public health, the Board of Health and Charity, was established in 1883 (Anderson 2006). Hence, the rudiments of a national healthcare care system were developed during the Spanish colonial period. This healthcare system was a reflection of the ordered systems of understanding and meaning of the Spanish colonial Self.

4.2.2.4 The Spanish Colonial Social Order: the codification of elite economic and political control

Unlike in many of its other colonies, Spain had limited interest in developing the agricultural potential of the Philippines, due to their overriding interest in the galleon trade (Puzel 1992). In the early colonial period, land grants divided parcels from 42 hectares to 1,700 hectares amongst 120 individuals; the majority of whom were Catholic friars (*Ibid.*).

Spanish friars exerted both civic and religious authority¹²⁴ (Tan 1999). “At the Synod of Manila in the 1580s, the several orders of friars agreed to divide the Philippines into spheres of influence and to proselytize in the vernacular”¹²⁵ (Steinberg 2000: 80). Control was thereby reinforced via the Spanish that was only spoken by elites which resulted in elites being more akin to the Spanish Self (Anderson 1988).

A new colonial administrative structure replaced the pre-colonial hierarchy of the *barangay* throughout the colonised Philippines.¹²⁶ At the top of this hierarchy were the Spaniards born in Spain, the *peninsulares* (Puzel 1992: 45). Beneath them were the Spaniards born in the Philippines, the *insulares* (*Ibid.*). And the former *barangay datus* were integrated into this hierarchy as local officials, the *cabeza de barangay* (*Ibid.*). The *cabeza de barangay* now organised labour and collected tax for the compensation of a portion of the collection¹²⁷ (*Ibid.*). Collectively this group were known as the *principalia*, the prominent ones (*Ibid.*). And their titles were hereditary. Thereby, an important convention of power distributed within families was established.

Spanish colonialism also brought a Western understanding of geo-administrative divisions, distinguished by geographic area and population size. The *barangay* became the *barrio*. Several *barrios* formed a *pueblo* (or municipality). Larger *pueblos* were designated *cabildos* (or cities). And the administrative unit of multiple municipalities and cities in a given region were *provincias* (provinces).

136

¹²⁴ In a letter to an Augustian priest, dated 1864, they are instructed: “In the Philippines...your first duty will be to get information about the ports, towns, products, people, trade, etc., as well as about the people with whom they trade, the quality of their spices, the prices...you must try to trade with them for spices, drugs, gold and other products which may be of special value...You will settle where conditions are most favorable, always with the understanding that you will then hold that land permanently” (Lopez and Felix 1965: 262-3).

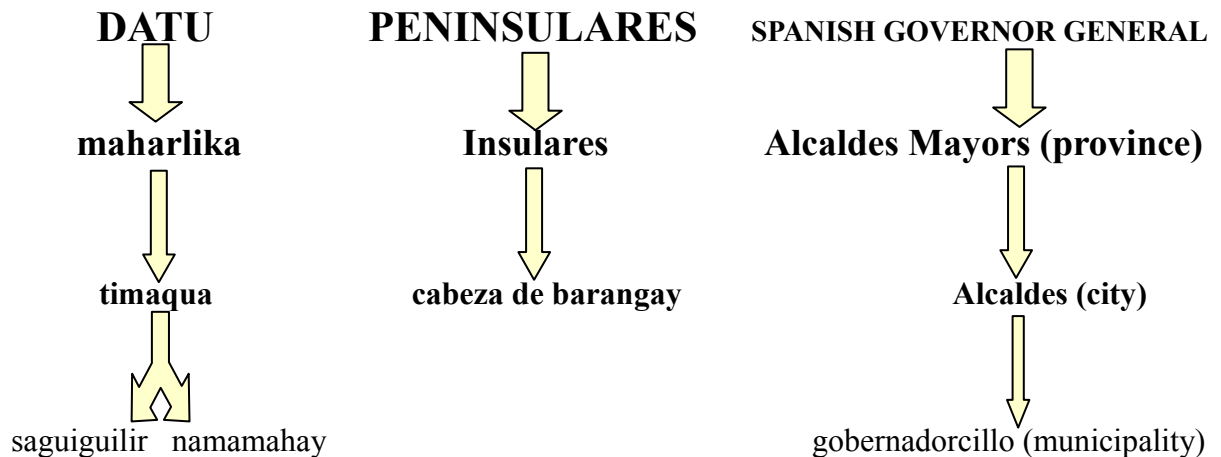
¹²⁵ “The Friars became the translators of government decisions made in Spain or Manila. The friars consistently held the power on the Philippines, even over the archbishop of Manila” (Steinberg 2000: 81).

¹²⁶ This is qualified here as the “colonised Philippines” after Anderson (1983: 266-7). For although the Spanish represented these designations as the social structure of the Philippines, the Spanish colonists did not uniformly control the archipelago, nor all of its inhabitants. Thereby the non-colonised were not subjected to this etic social structure. Hence, this structure remained an etic representation for those beyond the purview of Spanish colonisation.

¹²⁷ A hierarchical racial Othering was thereby employed in distinguishing Self and Other according to Spanish, creole, mestizo (mixed), or indio (indigenous) birth.

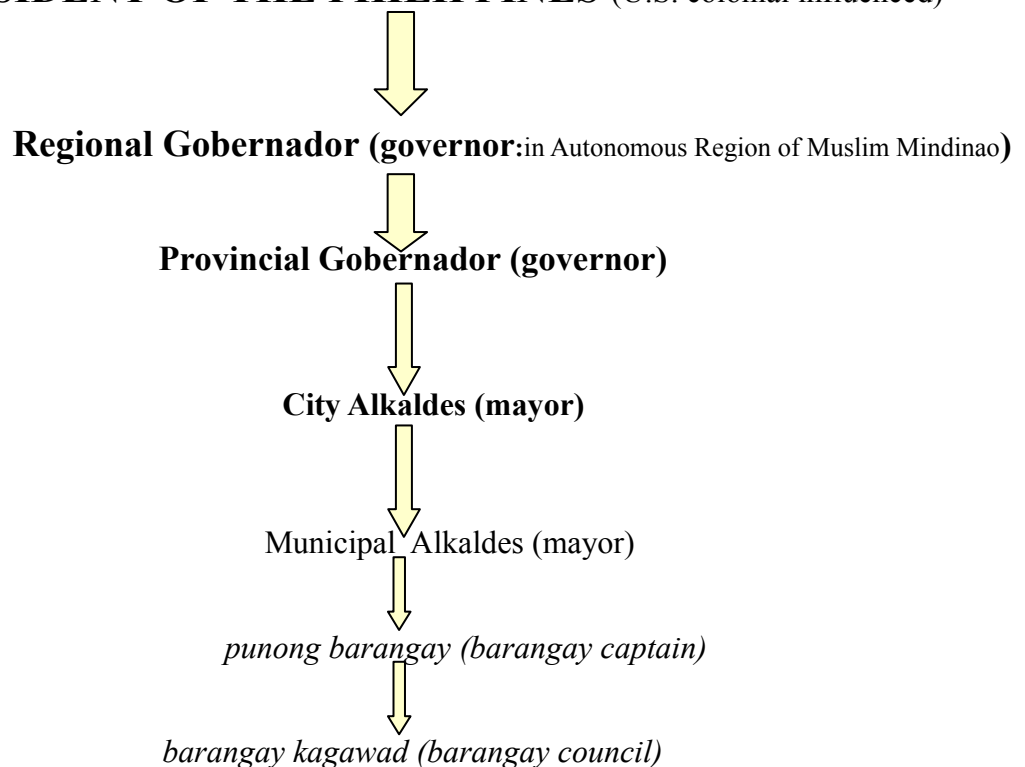
The pueblos were administered by a *gobernadorcillo*. Cabildos by *alcaldes*. And provincias by *alcaldes* mayors; who were assigned by the Spanish Governor General (Garcia 2004). Many of these administrative designations have remained in use to the present.¹²⁸

Figure 4.1 Pre-colonial to Post-colonial Hierarchical Social Structure in the Philippines



1. Pre-colonial social structure 2. Spanish colonial hierarchy by birth (the *Principalia*) 3. Spanish administrative divisions

PRESIDENT OF THE PHILIPPINES (U.S. colonial influenced)



4. Post-colonial administrative divisions

¹²⁸ The current administrative units (with the title of their head administrator) include: the barangay (run by a barangay *kagawad* or council, usually of seven elected members, whose captain is known as the *punong barangay*); the municipality (run by a municipal mayor); the city (run by a city mayor); the province (run by a provincial governor); and the region (large groupings of provinces; of which there are 17 designated regions in the Philippines) (Local Government Code of 1991).

The final post-colonial administrative division illustrated above (4.) depicts a syncretic and integrative outcome of pre-colonial social structure (with the addition of the barangay captain) and both Spanish and American colonial social structure (with the additions of the President and the barangay council). Hence, the integration of the final social structure represented above is a result of the collaboration of Spanish, American, and Filipino ordered systems of understanding and meaning. Thus, the alterations of social structure in the Philippines cannot be understood as closed, simple-systems processes occurring in a unidirectional manner. These complex processes combined in a manner reflecting the context of the agency, of the various groups involved, to protect the integrity of their ordered systems of, in this case, social structure. Hence, syncretism and integration can be understood to occur throughout the social realm and are not restricted to, for example, particular socio-cultural sectors, such as religion and healthcare, or particular contexts of time or space.

4.2.2.5 The Construction of Elite Fiefdoms

A form of a semi-feudal sharecropping system, *kasamahan*, was established in the eighteenth century, in which the large agricultural *haciendas* were farmed by tenants who rented the land for payment to landowners in grain, resulting in widespread peasant penury (Steinberg 2000: 85). By the late eighteenth century, indigenous land became increasingly encroached upon by the *principalia* who by the nineteenth century had become powerful landowning families. These families have controlled the economics and politics of the Philippines to the present (Puzel 1992). The domination of land ownership by the *principalia* was joined at the end of the nineteenth century by a group of educated mestizos; the *Ilustrados*. These former estate managers and intermediaries, who operated the hacienda system on behalf of the friars, were now buying the tracts of land they had managed (Steinberg 2000).

Post-colonisation provided a social structure that supported and further reinforced the power that elite families gained during colonisation. The late twentieth century process of decentralisation resulted in even greater local control by elite families. In participant observation throughout the Philippines, the power of some elite families I encountered was salient.

For example, I was invited to a party given by the chief of a hospital. The Chief's siblings were lawyers and politicians who held substantial control in local municipal politics including the municipal mayor. The family had owned substantial land in the area for several generations. It was made clear to me that the sources of power in this municipality were all gathered at this family party.

In another example, I interviewed the governor of a province who invited me to see the new provincial hospital she built with a significant portion of public funds. She spoke excitedly about the beautiful design of the hospital and how it was more modern than many of the hospitals in Manila. After the interview, I was told that the hospital was, in fact, a private hospital which the majority of local residents could not afford. I was also told that the Governor's family owned a successful contracting firm that had been hired by the LGU to construct this hospital, as well as all other major provincial building projects.

In another interview, a 38 year old female informant in Siquijor confided that she was displeased with the way healthcare was run in her municipality. She explained that the same family had controlled local politics for years. I asked her why she didn't vote for someone else in the elections. She looked incredulous and whispered; "If I vote for someone else, I won't have a job. They [the family in power] know who doesn't vote for them".

Throughout my fieldwork, I was acutely aware of the power of local elites. Control of local governance and multiple sectors is particularly relevant to the potential issues of local healthcare in a decentralised structure. These issues include the allocation of funds for, and the equity of access to, healthcare.

Elites and their networks are an appropriate level of analysis by which to understand local and global power and control. Navarro (2007) argues that [Wallerstein's] world systems theory is inaccurate in its highly aggregated levels of power between states and regions. He suggests it is more accurate to consider elites who cross national boundaries and, I would add, administrative levels. Thus, in the case of the Philippines in the twenty-first century, Navarro's framework may be more useful, than Wallerstein's (1974; 1983). But perhaps, in the Philippine context, a link can be identified between Wallerstein and Navarro. Early colonisation can be understood through world systems theory; whereby the centre (Europe) controlled the periphery. However, within the periphery, colonisation established more local centres, maintained by local elites.

Therefore, it would be erroneous to think of current elite control as solely domestic. For example, in conducting this research I noted in an informal built environment assessment, that no matter where I travelled in the Philippines, the same corporations had a monopoly over local business. One or two domestic and/or multinational corporations would dominate in each retail sector. Hence, control in the Philippines may be best understood as the domain of both domestic and multinational elites and their corporations.

The power of elite families was reinforced during American colonisation by “U.S.-Governors-General, supported by powerful politicians and lobbies” in the U.S., who appeared to be “more concerned with consolidating a close relationship with the emerging landed oligarchy than with improving the plight of the peasantry” (Puzel 1992: 43). According to Anderson, under colonialism, the U.S. relied on a “collaborative compromise” with local elites in order to secure control of the islands (2002: 693).

4.2.3 U.S. Colonialism: a “Showcase for Democracy”

*“According to President McKinley, the lord told him it was America's duty
'to educate the Filipinos, and uplift and civilize and Christianize them' ”*
(Senator William Fulbright quoted in Nelson 1968: 49).

If elite control of the Philippines was encouraged by the social order of the Spanish, elite fiefdoms were solidified through American colonialism and the rhetoric of American democracy. Eager to expand an American empire, U.S. President McKinley was encouraged to take advantage of what was believed to be Spain's waning colonial powers at the end of the nineteenth century (Nelson 1968). After blowing up the Port of Havana and declaring Cuba independent in February 1898, McKinley set out to establish an American base in Southeast Asia by attacking a Spanish fleet in Manila Bay and capturing Manila (*Ibid.*). Three months later the Spanish surrendered, ceding the Philippines to the U.S. for US\$ 20 million (*Ibid.*).

The American colonial period commenced with the three-year Philippine-American war ending with Filipino surrender in 1902 (Abinales and Amorso 2005). McKinley's goal to make the Philippines a showcase for democracy, through [an enforced] “democratic” rule, was facilitated by a group of young Americans, the so-called “Thomasites”, who came to the Philippines “by the hundreds to teach English, science, and secular education to the Filipinos” (Steinberg 2000: 94). American colonialism set about to immediately instil American state building institutions.

The political, legal, economic, educational, and American policy of separation of church and state were instituted in short order following an American model (Nelson 1968). English was taught in secular education. And an American mercantilism was devised to favour American goods (*Ibid.*). Although many of these institutions appeared unassailable, even to nationalistic Filipinos, the nationalism which spread from the waning of Spanish colonialism resulted in varied reactions to the American colonials (Ileto 1988).

At one extreme were the Spanish-speaking elite who “quickly adapted themselves to the new administration and became outwardly pro-American”¹²⁹ (Nelson 1968: 53). At the other extreme were political resistance movements, such as the founding of the Communist Party of the Philippines (PKP) in 1930; the formation of a liberation discourse by various groups seeking independence; and the Muslims of the Sulu Archipelago who resisted the Americans, as they had resisted the Spanish (*Ibid.*; Tan 1999). In between these extremes stood the majority of provincial and rural Filipinos who were not extremely interested in modernisation, mistrusted the Americans, and, for the most part, continued in their socio-cultural lifestyles (*Ibid.*). Hence, like the Spanish, the American influence over the archipelago, though more far reaching and in a shorter period of time, remained incomplete. Thereby, U.S. colonisation further contributed to the plurality of social worlds throughout the Philippines.

4.2.3.1 The Irrefutable Benevolence of Modernity and The Multiple Understandings of the Institutionalisation of American Healthcare: *science as religion*

“The Problem is, that we inherited a healthcare system from the United States that doesn't even work for the Americans! So, how is it supposed to work for us?”
An executive-level informant from the DOHP

That the American healthcare system served as the model for Philippine healthcare, has been criticised by many informants interviewed; especially in the upper echelons of the DOHP. However, the general consensus in the literature is that American colonial healthcare was understood to be inherently beneficent through its reduction of mortality.

“Even nationalist writers in the Philippines find it impossible to interrogate the established notion that among the blessings of American colonial rule was a sanitary regime which saved countless Filipino lives” (Ileto 1988: 125).

Philippine historians and academics “order the past in terms of the triumph of reason and science over superstition and backwardness” (Ileto 1988: 126). 142

¹²⁹ As the elite benefited during Spanish colonialism, so too would they during American colonialism; during which they were to lead American enforced democratic institutions. Elite-dominated democracy continues to the present in the Philippines (Quimpo 2008).

Even supposedly nationalistic Filipino writers critical of American colonialism adopt a perspective of the beneficence of the colonial Other in discussing medical modernity: “The competent American doctors and public health officers...were up against a formidable wall of ignorance and superstition” (Agoncillo and Guerrero 1977: 425). The ill and diseased Filipino becomes the backdrop for a story of “American heroism” and the “saga of progress” (*Ibid.*). Thereby, colonialism itself is rationalised by the justified necessity of biomedical paternalism. Hence, colonial healthcare is commonly depicted in a neutral light, for science is normatively perceived to be divorced from ideology or political economic agendas.¹³⁰

Ileto, however, argues that there was little differentiation between the 1902 “war against cholera and the pacification of Filipinos” (1988: 127). To combat Asiatic cholera, infected houses were burned; residents were strictly quarantined in detention camps; medicine needed to be administered with “the use of force”; and bodies of the deceased were burned (*Ibid.*: 134). However, each of these measures threatened the integrity of the ordered systems of their intended beneficiaries. Thus, Filipinos resisted these measures and disease was thereby exponentially spread. Houses that were destroyed would not usually be replaced and residents had no means of replacing their homes and therefore, they rebelled against attempts to burn their homes (*Ibid.*). Quarantine resulted in resistance through escaping quarantine and hiding in outlying areas, thereby rapidly spreading cholera even further than if quarantine had not been instituted (*Ibid.*). Desecration of the dead via cremation was completely forbidden in Filipino ordered systems of understandings and meanings. Therefore, rather than allow them to be burned, Filipino families hid the bodies of their dead under homes and in swamps, which thereby served as potent vectors for cholera.

Hence, the American attempts to control cholera provide an illustrative example of the issues resulting from attempting to impose one's ordered systems of understanding and meaning on the Other.

¹³⁰ “Since the health campaign is represented in purely medico-sanitary terms, and resistance to it conflated with superstition and backwardness, the issue of colonial domination simply fades away” (Ileto 1988: 126).

For even though the U.S. colonists perceived their paternalism as not only justifiable, but moreso to be beneficent, their means of controlling cholera was in direct contradiction and, in the case of cremation, violation of the ordered systems of the Filipino “beneficiary” who resisted in order to protect the integrity of their ordered systems. Thus from the biomedical Other's imposed order ensued chaos.¹³¹

The promotion of health and sanitation was identified as one of the most aggressive programmes of the American colonial regime (Cortes 1990). In 1902, the provincial board of health was organized in Manila (*Ibid.*). The municipal boards of health were later organised in municipalities (*Ibid.*). Health and sanitation were taught in schools (*Ibid.*). And there was an emphasis on vertical programmes, such as aggressive vaccination campaigns against smallpox (*Ibid.*).

4.2.3.2 The Rockefeller Foundation in the Philippines: the perpetuation of biomedical hegemony through vertical programmes

Possibly because of American presence already in the Philippines, the Rockefeller Foundation (RF) completed more projects in the Philippines than elsewhere in Southeast Asia (Liew 2006). Under the direction of Dr. Victor Heiser, the IHB's activities in the Philippines from 1916 to the early 1930s, concentrated on medical and nursing education, malaria control and, of course, the RF's signature programme of hookworm eradication¹³² (Anderson 2002: 703). The RF's work in the Philippines also included funding the University of the Philippines-Manila, School of Public Health and the operation of a medical ship in Mindinao, performing outpatient services and emergency operations.

¹³¹ This theme will be revisited throughout this dissertation. The key words here are “imposed order”. Similar to the logic that “reason” or democracy can somehow be imposed on another; imposed order was not identified as a feasible construct in this research.

¹³² The RF's campaign of what Anderson refers to as “hygienic evangelism” (2002: 701).

Beginning in 1928, the RF conducted rural health work in the Philippines that predated their rural health programmes in China (Anderson 2002). These programmes focussed extensively on sanitation and hygiene via increasing the availability of clean water; sanitary excreta disposal system; education, and propaganda; as well as on “anti-larval methods for malaria control; dispensaries, and immunization programs” (*Ibid.*: 705).

However, Anderson observes another side to many of Heiser's sanitation projects, noting their particularly fetishistic and racist qualities in their obsession with toileting and memesis and in their attempts to control the “promiscuous defecator”¹³³ (Anderson 1995; 2002).

Hence, the work of the RF was myriad and impossible to judge in a essentialised manner. Just as there are myriad issues with the post-colonial critique, so too are there issues with the post-colonial critique of biomedicine. Liew identifies a “problematic assumption of 'Western' medicine as a monolithic entity cast upon passive and hapless colonial subjects” (2006: 20). Again, identifying any group as an essentialised “It” will render inaccurate and biased research and understanding.

4.2.4 The Post-Colonial Philippines: from enforced centralisation to enforced decentralisation

Decentralisation of state administration to lower levels of governance has occurred simultaneously in numerous countries, often, but not solely, as a result of political economic changes (Mills *et al.* 1990: 11). For example, throughout the 1950s decentralisation often accompanied decolonisation (*Ibid.*). Both Spanish and American colonisation resulted in a highly centralised Philippines; with the majority of public services available only in Manila. Centralisation in Manila was a colonial mechanism of administrative control that proved unpopular amongst Filipinos, especially with increasing nationalism in the post-colonial period.¹³⁴

¹³³ “Microbiology became civic destiny, organised into a typology that positioned immature native germ-carriers (and distributors) against responsible, clean, yet especially vulnerable whites” (Anderson 2006: 3).

¹³⁴ “Centralized direction had become inexpedient and ineffective” (Valencia 1963: 4).

Although the post-colonial period began after the Japanese occupation and American colonialism ended¹³⁵ on July 4, 1946, decentralisation of government administration began a decade before. With the 1935 constitution, a gradual transfer of power occurred from the central government to local administrative units (Garcia 2004). Recovering from the Japanese occupation¹³⁶ (1941-1946) and economically dependent on the U.S., Filipinos rebuilt their country within the confines of the predominantly U.S. institutions already in place. The post-colonial period saw an escalation in state corruption, whilst certain sectors were slowly decentralised.¹³⁷

As early as the 1950s, sectors such as health began to be decentralised from Manila to greater provincial and municipal control. Because the majority of the population has historically lived outside of Manila and major cities, centralisation in Manila was no longer justifiable without colonialism. From the 1950s to the 1980s, local infrastructure was built.¹³⁸ However, full decentralisation, or devolution¹³⁹ in the Philippine context, was not enacted until after the adoption of the Local Government Code of 1991 (LGC) (Brillantes 1993; Padilla 1993).¹⁴⁰

146

¹³⁵ Technically though, the Americans were still very much in control of Philippine “monetary and exchange policy” and were granted the right to maintain military bases in the Philippines for 99 years (Abinales and Amorso 2005: 171).

¹³⁶ In the battle that ensued between the U.S. and Japan “eighty percent of Manila was destroyed” (Abinales and Amorso 2005: 163).

¹³⁷ Decentralisation can be defined as “the transfer of authority, or the dispersal of power, in public planning, management and decision-making from the national level to subnational levels,” as well as from the public to the private sector (Mills *et.al.* 1990: 11). In administrative decentralisation, authority, responsibility, and accountability for the planning, financing, and management of public services are transferred from the state to more local administrative or sometimes non-governmental levels.

¹³⁸ In 1959, the Division of Local Government was formed to enact the formal transfer of administrative functions to local governments. Local government autonomy was then enacted through several laws that granted more administrative powers to local levels (Garcia 2004: 32). In the 1970s, during the Marcos administration, greater authority was granted to the local level in efforts to return to a pre-colonial form of Filipino governance (Garcia 2004). The first local government code was established towards the end of Marcos' administration in 1983 and resulted in the designation of Local Government Units (LGUs) (*Ibid.*).

¹³⁹ Administrative decentralisation can be classified in order of increasing transfer of authority to local levels from deconcentration, and delegation to devolution. In devolution the majority, if not all responsibility for decision making, finance, and management is transferred to local, quasi-autonomous administrative units (Mills, Vaughan, Smith. 1990: 11).

¹⁴⁰ The goal of decentralisation in the LGC of 1991 was to “delegate powers, functions and responsibilities to the local authorities such as the LGUs in light of better service delivery, allowing them to more or less govern themselves”. The five sectors that would be devolved from the central government to the local government units include: agriculture, social services, maintenance of public works, environmental protection, and health (Garcia 2004: 22).

4.2.4.1 The Post-Colonial Healthcare System of the Philippines and Decentralisation: building healthcare infrastructure at the local level

The post-colonial healthcare system of the Philippines was partly inherited from the Spanish, further developed by the Americans, and mostly local and non-biomedical in the rural barangays. The formal biomedical healthcare system was highly centralised in Manila and urban centres. One of the first tasks of post-colonial administrations was to build biomedical healthcare infrastructure in the provinces and rural areas. Thus, began healthcare decentralisation.

The basic philosophy of the early post-colonial reorganization of the Department of Health of the Philippines (DOHP) was that reorganization would “ensure” that public health services would serve the largest number of people (Valencia 1963). From the Magasaysay administration (1953-7) municipalities built Rural Health Units (RHUs) that emphasised education and preventative care (Gonzalez 1996: 176). RHUs were first operated by a midwife and a sanitary inspector, before they were later joined by a physician and a nurse (Cortes 1990: 174). It was the responsibility of the RHU staff to go out to the barangays and provide further medical service¹⁴¹ (*Ibid.*). The DOHP was reorganized in 1958 as the result of a government survey and reorganization commission, which identified the necessity for the DOHP to expand its services and provide better geographic coverage in order to take care of the needs of an exploding population (Valencia 1963; Tayo 1965).

During the Marcos administration, structural decentralisation was employed, resulting in several initiatives at the local level including: Medicare insurance; hospital-based care for employed rural families; the community-based health program; and the barangay health station (BHS) providing primary care at the barangay level (Gonzalez 1996: 176). However, resource efficiency and impact effectiveness were not addressed in structural decentralisation (*Ibid.*). Structural decentralisation led to process decentralisation.

147

¹⁴¹ In observing the Municipal Health Officer of Murcia, I noted that he was in the field nearly double the amount of time he was present in the RHU.

4.2.4.2 The Post-Colonial Healthcare System of the Philippines and Decentralisation: Human Resources for the Local Level

In 1979, the healthcare delivery system was restructured with a primary healthcare approach.¹⁴² 9,000 trained midwives¹⁴³ were deployed to barangay health stations to act as primary care providers and BHS administrators (Roxas 1988: 55). However, it was believed that less than 70% of the total population in the Philippines was covered with a BHS. In 1981, Barangay Health Workers (BHWs), volunteer community health workers trained by the Philippine Department of Health, were introduced in pilot communities (Bautista 1996).

Barangay Health Workers (BHWs) were considered the essential human resource component for health service delivery at the local level¹⁴⁴ (Bautista 1996). BHWs became assistants to the midwife administrators of Barangay Health Stations. Under the midwife's direction, they became primary providers for the treatment of: simple symptoms; monitoring of chronic diseases; immunisation; family planning; and basic health education for their community (*Ibid.*). Without the establishment of the local health service delivery providers, decentralisation to the barangay level would not have been possible.

Concurrently, at the grassroots level, community-based health programmes (CBHP) emerged from NGOs and the Catholic Church at a time of mounting criticism against Marcos (Rifkin 1985: 121). The community health approaches of the 1970s, focusing on the political aspects of development policies, engendered projects in the mid-1970s to train Community Health Workers (CHWs). “The objective was to motivate poor, rural communities to begin to take responsibility for their own health and welfare” (Rifkin 1985: 122).

¹⁴² “Under a legal mandate, the Ministry was instructed to develop plans and implement programs which focus on health development at the community level, especially in depressed areas in cooperation and coordination with other government ministries; NGOs engaged in social, political and economic endeavors; and community members” (Roxas 1988: 56).

¹⁴³ In the Philippines, midwives receive two years of post-baccalaureate training consisting of midwifery and primary care. However, they are not considered nurses, who typically receive four years of nursing training and are employed in the RHUs.

¹⁴⁴ “Barangay Health Workers were initially conceived as functional partners in meeting the critical health needs of the community” (Bautista 1996:12). The BHW programme was influenced by the Declaration of Alma Ata, which itself was derived from the barefoot doctors programme.

Approaches to community participation were part of the “people's participation” discourse of community development; influenced by the liberation theology of the Church in the Philippines (CHD 1998). The work of the NGO *INAM* that was followed for the field research in Murcia was a CBHP NGO. Thereby, studying *INAM* provides the opportunity to “examine some of the potentials and problems in translating the rhetoric of 'People's participation' into reality” (Rifkin 1985: 121).

Hence, although formal and full healthcare devolution is attributed to the LGC, local-level healthcare infrastructure, necessary for decentralisation, was instituted almost from the onset of the post-colonial period attempting to improve access to local healthcare delivery.

4.2.4.3 Devolution, SAPs, and a Discourse of Empowerment: representing decentralisation as a return to the Self

The pre-devolution literature of the Philippines markedly differs from the post-devolution literature. Whereas, the post-devolution literature is highly critical of the outcomes of devolution, the pre-devolution literature understood decentralisation as an irrefutable imperative to bring social justice and equity to the Philippines. The political left, in particular, championed decentralisation as a people's movement (Abinales and Amorso 2005).

The popularity of decentralisation, in part, can be understood by the unpopularity of the Marcos presidency, especially after his enforcement of martial law. Marcos' administration (1965-1986) represented, for many, both the worst excesses of corruption after years of political corruption and, possibly even more egregiously, Filipino authoritarianism (*Ibid.*). Marcos was “ousted” in a mass uprising,¹⁴⁵ after he falsified and ignored the results of an election, which his opponent, Corazon Aquino, had won (*Ibid.*).

¹⁴⁵ In the so-called “Edsa Revolution”, a coalition of over one million Aquino supporters along with the Catholic Church “formed a line of defense against marines flown in to defend the presidency” (Abinales and Amorso 2005: 224-5).

The election of Corazon Aquino in February 1986 signified to the people a shift from “authoritarian to democratic constitutional government”¹⁴⁶ (Abinales and Amorso 2005: 225). This shift in governance is reflected in the first sentence of Aquino's first speech after being sworn in as president: “Sovereignty resides in the people and all government authority emanates from them” (*Ibid.*: 226).

After formally announcing the “People's Power” movement,¹⁴⁷ Aquino utilised this popular sentiment to win the public's approval on decentralisation.¹⁴⁸ Aquino justified decentralisation as a means to avoid the corruption of the centralised government of her predecessor; by bringing governance to the level of the people. After martial law, the populace was eager for what was publicised as a means for total local control of public services and thus a control of state corruption and interference. Furthermore, on a cultural level, decentralisation could be understood as a return to the true Filipino Self of the barangay tribal order, which was never fully eradicated by four centuries of colonialism.

However, these arguments for decentralisation are extremely flawed in the political economic context of the Philippines, wherein local corruption can be far more threatening than centralised corruption and control by local elites can more directly impinge on one's life (Bello 2009). Furthermore, decentralisation without decentralising appropriate material and knowledge-based resources can prove extremely problematic to well-intentioned, but ill-prepared, local contexts (Bautista *et al.* 2002).

150

¹⁴⁶ In 1987, Aquino drafted a new constitution which “restored the pre-martial law constitutional system” (Abinales and Amorso 2005: 234).

¹⁴⁷ Abinales and Amorso argue that the “People's Power” discourse was problematic. “As a fairly spontaneous mobilization, people power was *not* a sustainable political action, even as a form of revolutionary change...The limits of people power would soon become evident as the constituent elements of the Edsa Revolution returned to politics” (2005: 231).

¹⁴⁸ Aquino was in many ways symbolised as a modern day saviour and benevolent mother; commonly known as “Tita (Auntie) Cory” (Abinales and Amorso 2005: 230). This may have been partly due to the “martyrdom” of her husband, Senator Benigno Aquino Jr, assassinated in August 1983 under order from Marcos (*Ibid.*). Azurin, argues that Aquino remained an “allegorical figurehead in people's consciousness” regardless that in reality “her hold on power had become precarious because of...her series of turnabouts as regard her populist campaign promises” (1995: 1). Her representation as a populist leader also ignores the reality that Aquino was in actuality a member of the landed elite from the powerful Cojuangco-Aquino political clan (Anderson 1998).

This last consideration was particularly noted in the rapid decentralisation enacted by Aquino's administration following the ratification of the LGC (Brillantes 1993; Padilla 1993).

Furthermore, the truth of the necessity of decentralisation has often been overlooked. Aquino inherited an economy in severe recession with international debt “estimated at US\$27.2 billion in 1986” (Abinales and Amorso 2005: 233). Under pressure from the World Bank, The International Monetary Fund (IMF), and the United States, Aquino agreed to funnel the majority of Philippine GDP into World Bank/IMF Debt repayment. However, not only did Aquino fully honour all debt obligations the Philippines incurred under Marcos, but also completely complied with IMF conditionalities (*Ibid.*). These conditionalities, known as “structural adjustment”,¹⁴⁹ required that countries receiving World Bank/IMF loans at the time must agree to “a series of reform targets to liberalise the economy”;¹⁵⁰ meaning that the economic agenda would now be set by technocrats¹⁵¹ (*Ibid.*: 233).

Modern administrative decentralisation since the 1980s has most often been a result of economic neoliberalisation embedded in the conditionalities of government loans from the World Bank and IMF. These two highly centralised multilateral UN organisations made the structural adjustment of governments, which included sectoral decentralisation and privatisation of government-owned and administered public services, primary contingencies to receive government loans.¹⁵²

151

¹⁴⁹ Todaro and Smith define structural adjustment loans as fostering “structural adjustment in LDCs [less developed countries] by supporting measures to remove excessive governmental controls, getting factor and product *prices* to reflect *scarcity* values, and promoting market competition” (2006: 828). Arguably, the thrust of structural adjustment is to liberalise a country's market.

¹⁵⁰ Liberalisation plays a prominent role in the earlier “stabilization programs” of the IMF. Two of the central contingencies of the stabilization programs concerned the abolition or liberalization of foreign exchange and the control of government deficit through curbs on spending (Payer 1974: 33). In the Philippine context “indiscriminate liberalization of trade...destroyed many local industries, destabilized agriculture, and thrown [sic] hundreds of thousands out of work” (Bello 2009: 23).

¹⁵¹ Bello identifies three phases in which structural adjustment was enacted in the Philippines. Phase 1 1980-1983 emphasised trade liberalisation. Phase 2 1983-1992 emphasised debt repayment. Phase 3 1992-2000 emphasised rapid deregulation, privatisation, and trade and investment liberalisation (2009: 12).

¹⁵² MacDonald summarises the conditionalities of Structural Adjustment as primarily concerning the demand for reduction of governmental social spending in order to repay loans; reduction or elimination of restrictions for foreign ownership; and a reduction of import tariffs and agricultural shift from subsistence farming to export agriculture (2008).

The Philippines has been such a frequent recipient of World Bank/IMF loans since the Marcos administration, fifteen in total, that they have been informally labelled “the guinea pig of Structural Adjustment” (Broad 1988: xix). Every Filipino president from Marcos to Arroyo actively embraced a neoliberal agenda for the country with marked privatisation and deregulation (Bello 2009).

4.2.4.4 The World Bank and Health Sector Reform

The structural adjustment programmes of the World Bank and IMF frequently necessitated healthcare reforms which compromised central governments' abilities to deliver public services. The World Bank was also a major voice of health sector reform with the 1987, *Financing healthcare: an Agenda for Reform*, in which it actively promoted a reduced role of state intervention and increased use of “the market” to fund and deliver healthcare (World Bank 1987). Thereby, healthcare finance policy became part of the conditional framework of structural adjustment.

“Thus by the end of the 1980s, governments throughout the world were reducing their responsibilities in the public sector, moving away from providing services directly, while retaining regulatory and financial control” (Walt 1994: 12).

In terms of healthcare, since 1993 the World Bank was directing governments to change their health programs by: a) reducing public expenditure for tertiary facilities, specialist's training, and health interventions; b) promoting private financing of essential clinical services, user fee services, and individually privately-managed health insurance; and c) encouraging private suppliers to compete in delivering clinical and public health services” (Miniano 2006).

Privatisation of healthcare can render it to be less physically and financially accessible, as well as less appropriate for patient needs. The Philippines is considered “among the most privatised health sectors in Southeast Asia” (Ibon 2008: 41).

One outcome of the privatisation of healthcare in the Philippines is the emphasis on curative, rather than preventative healthcare and non-communicable chronic morbidity, rather than communicable morbidity. Thereby, privatised healthcare can be understood to be directed towards the needs of the upper quintiles of wealth, whilst rendering healthcare more inaccessible to the lower quintiles.

However, healthcare decentralisation need not be tied to neoliberalisation, privatisation, and reduced public expenditure. Although decentralisation is invariably a top-down process, towards greater potential political and fiscal autonomy at the local level, it can be executed in numerous ways and to varied extents in any given context (Atkinson 2002; Buse *et al.* 2005). Nor should centralisation and decentralisation be considered mere binary opposites, but rather as “movements between two poles. Both central and local elements are required in any health system; the issue is what balance should be struck ...and what means are at its disposal to alter the existing balance” (Mills *et al.* 1990: 11).

Therefore, decentralisation is not inherently deleterious to healthcare.¹⁵³ The process of decentralisation is an inherently neutral process. However, context can determine what unintended or intended consequences healthcare decentralisation may yield beyond local administration of healthcare. Atkinson and Haran identify that outcomes of decentralisation are an “artefact of the informal management, and the wider political culture in which a local health system is embedded” (2004: 822). Hence, it is necessary to consider how decentralisation is executed; over what period of time; with what policies and other processes of health reform accompanying this process; and the particular political, economic, and socio-cultural contexts in which decentralisation is being instituted.

¹⁵³ Brazil provides an illustrative example, in that within one country healthcare decentralisation has yielded both favourable and deleterious outcomes (Atkinson and Haran 2004).

4.2.4.5 Issues of Decentralisation in the Philippine Context

In the Philippines, a discourse of beneficent decentralisation was intertwined with the rhetoric of community participation and empowerment (Tapales 1993). However, Gill Walt notes that decentralisation to the local level may merely mean that power is now in the hands of local landowners and the local power elite (1994). This is particularly a concern in the decentralised Philippine context, where, as discussed, landowners generally comprise the elite and control all political, administrative, and healthcare decisions at even the lowest of administrative levels. Hence, decentralisation in the Philippine context is often decentralisation to the local elites.

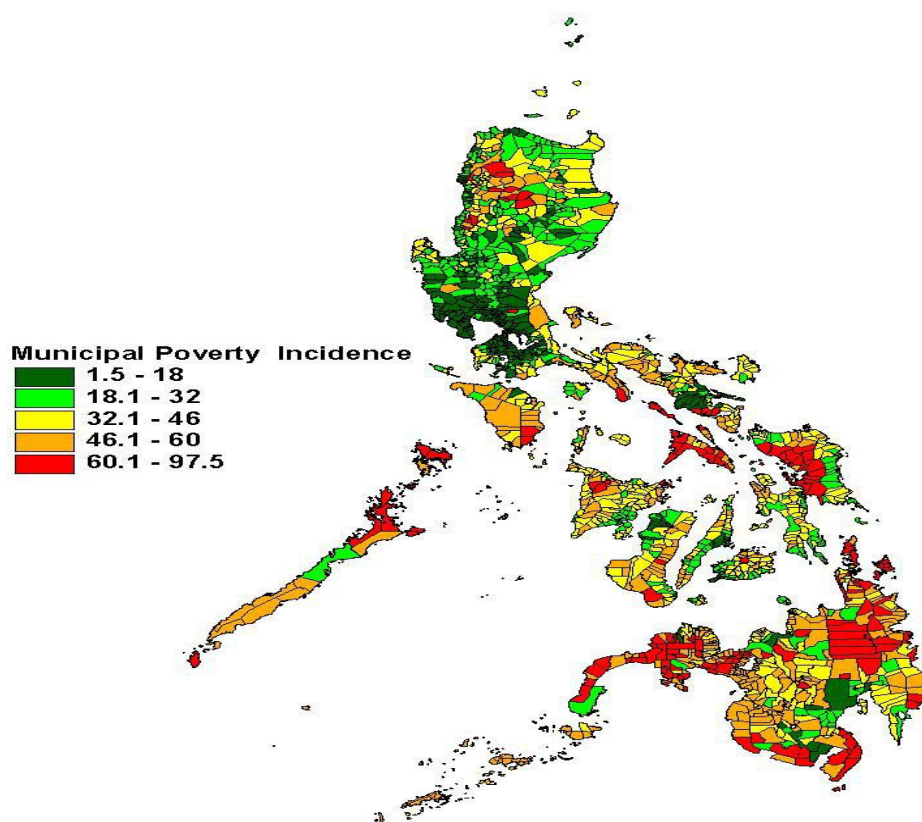
Furthermore, both the decentralisation and community participation discourse assume that all local levels are equal and equitable in their possession of the knowledge and material resources by which to administer the public services that have been decentralised to their level. However, this would necessitate a population that was already fairly equal.

4.2.4.6 Decentralisation and the Magnification of Inequality

The Gini coefficient is a measure of the unequal distribution of income in a population (Todaro and Smith 2006). With an average Gini coefficient of 0.458, and as high as 0.536 in some provinces, the Philippines is ranked amongst the 35 most unequal countries, in terms of unequal income distribution, out of a total of 136 countries. It is the fourth most unequal nation in Southeast Asia after Thailand, Singapore, and Malaysia (CIA 2011). Healthcare inequality is partly an outcome of both income inequality and the unequal distribution of the Internal Revenue Allotment (or IRA). Figure 4.2 illustrates the wide variation in poverty even between neighbouring municipalities.

The IRA is the national allocation of revenue to local governments.¹⁵⁴ IRA funds were originally distributed according to population size (70%) and land area (30%); with 25% of the IRA allocated to provinces; 25% to cities; 40% to municipalities; and 10% to barangays (Florano 1996). Although a 1985 study found the IRA formula inequitable,¹⁵⁵ the formula was only slightly modified in the 1991 LGC. In the LGC, geographic allocation demonstrated a reduction of the IRA to provinces and cities from 25% to 23%; a reduction from 40% to 34% in municipalities; and an increase from 10% to 20% for barangays (*Ibid.*). However, the more marked changes were identified in the redistribution of the IRA with the allotment for population reduced from 70% to 25%; equal sharing weight increased from 10% to 25%; and land factor increased from 20% to 50% (*Ibid.*).

Figure 4.2 Poverty Incidence in the Philippines at the Municipal Level (2009)



Source: NSCB 2009.

¹⁵⁴ The IRA went into effect in 1973 with Presidential Decree 144.

¹⁵⁵ This study assessed the distribution of the total tax burden in 1985 finding that individuals with an annual income less than PhP6,000 a year used 11.72 per cent of their income to pay taxes. Whilst Filipinos earning between PhP6,000 and PhP30,000 a year paid an average of 10.30 per cent of their annual income for taxes (Yoingco *et al.* 1994: 176).

Although this change in the IRA sought to strengthen a Local Government Unit's capacity to handle functions that have been devolved, separate studies found the revised formula did not correlate with need or income disparity, and was still found to be inequitable¹⁵⁶ (Yoingco *et al.* 1994).

According to Florano, the choice of the criteria of land area and population size guarantees that the IRA will remain inequitable regardless of any alterations to the formula (1996). He suggests that an equitable IRA could only be achieved with a new set of criteria including: poverty incidence (receiving 50% of IRA distribution); followed equally by LGU income classification (25%) and population density (25%) (*Ibid.*).

I am emphasising this contextualisation of decentralisation, because it has had such a marked effect on the Philippine healthcare system, as well as on healthcare integration. The next section will examine healthcare devolution specifically from the period following the Local Government Code of 1991.

4.2.4.7 Healthcare Devolution in the Philippines Since the Enactment of the Local Government Code of 1991

Although healthcare devolution was passed into law with the LGC of 1991, it was not effectively employed until the Ramos administration. Devolution was fully employed under the 1993 Administrative Order 11 stating that primary healthcare as a policy would permeate the healthcare devolution process that puts “health in the hands of the people...in order to enable people's active participation and involvement for better health and self-reliance” (Bautista 1996: 33). Bautista proposes that when the community manage their own healthcare:

“there is a greater manifestation of independence since decision-making resides in the people and activities undertaken are self-initiated...there is more self-reliance on the part of the community to determine and generate the resources they need” (*Ibid.*: 4).

156

¹⁵⁶ “Correlation tests confirmed that the IRA formula is inequitable”; richer provinces (heavily populated and occupying larger land areas) received the majority of the IRA, even though they had little need for the IRA since their local revenues were already adequate for their expenditures, whilst provinces in need received smaller shares (Florano 1996: iv).

There are manifold assumptions in both of these statements. Firstly, it is assumed that a community not only has the financial and educational resources that would grant them the ability to be responsible for their community's healthcare, but that they even want to be responsible for their own healthcare; though this is what they are *being told* they want. This assumption was problematised by interviews with barangay council members, who commonly reported that they neither had the capabilities (financial and knowledge resources) nor the desire to be responsible for the health of their barangays. Thus, we return to the question if this is truly a valid argument for decentralisation or, as Walt queries, a ploy for governments to reduce spending and unburden state healthcare responsibilities onto the public (1994). Discursive concepts such as “self-empowerment” and “community participation” are brought into question when the resources are not available at the community level to render any empowerment and/or participation as feasible (Cleaver 1999; DeFilippis 2001).

Furthermore, studies reveal less than favourable outcomes for the healthcare devolution of the Philippines. In terms of local level access to healthcare, only 16,219 of the 42,000 barangays have a barangay health station (BHS) or a little more than one-third of all barangays (Ibon 2008). Yet, there was an increase of approximately 50% from 10,151 BHS in 1990 to 15,204 in 2000 with a slight increase of 230 BHS from 2000 to 2005. However, from 1990 to 2005 there was a 1% decrease in RHUs from 2,266 to 2,295 (*Ibid.*). In another study, 35% of informants reported that devolution resulted in a scarcity of resources (Garcia 2004). In my own research, the perceptions of the barangay councils were generally negative in terms of having adequate material and financial resources by which to execute local healthcare. However, the reactions from barangay members were far more nuanced.¹⁵⁷

¹⁵⁷ See Chapter 5.

In their study for the DOHP, Ramiro *et al.* identified that as a result of devolution:

“drugs in health centers became less available; local budget for health had become less adequate in meeting community needs; health workers reported loss of morale; and respondents believed that devolution had not brought about improved access, greater efficiency and quality of services” (1999).

The study attributes the poor outcomes of devolution to a multitude of factors. Firstly, there are financial factors, which include insufficient, and seemingly arbitrary, budgets allocated for health; static improvements in cost-efficiency, with two-thirds or more of total local healthcare budgets going toward salaries of healthcare personnel;¹⁵⁸ and the availability of funds that are contingent on “the annual priorities of the mayor or the local government and the policies involved in the appropriation of funds” (Ramiro *et al.* 1999: 4).

Secondly, a lack of material and knowledge base preparation for devolution was identified (Ramiro *et al.* 1999). LGUs reported to be unprepared for all aspects of devolution, thereby thwarting a smooth transition (*Ibid.*). Inadequate health resources were a particular issue and RHU personnel reported their training to be “inadequate” (*Ibid.*: 4).

Thirdly, there was a general disregard for the healthcare team. Though the DOH officials were reported to be in favour of devolution, health workers were reported to be opposed to devolution from the start (Ramiro *et al.* 1999: 4). Healthcare workers also cited grievances concerning: workers not being proportional to population size; the localisation of their salaries; being supervised and monitored by the LGU; and health and health resources becoming a local political issue¹⁵⁹ (*Ibid.*). Lastly, there was a relatively low priority of healthcare for most LGUs and mayors (*Ibid.*). In fact, the only benefit of healthcare devolution that Ramiro *et al.* can identify is “simpler and faster decision-making”¹⁶⁰ (*Ibid.*).

¹⁵⁸ In the barangays I studied, almost the entire barangay healthcare budget was allocated toward salaries, with little left over for medication or the upkeep of the BHS.

¹⁵⁹ In the barangays visited, the local politicisation of healthcare was central to the healthcare available in any given municipality. As Ramiro *et al.* identify: “Health plans still emanated from and were mainly determined by the MHO and/or the DOH representative...with final decisions contingent on the preferences and priorities of the mayor along with the availability of funds” (Ramiro *et al.* 1999: 4).

¹⁶⁰ However, informants also reported that “red-tape” and delays have intensified with devolution.

Petralba summarises what many informants have agreed is the dismal failure of healthcare devolution in the Philippines.

“Devolution has served more as a catalyst, aggravating the state of public health services and of public health workers in their deterioration, than as an instrument that propelled the emancipation of the marginalised and economically powerless people...devolution has reinforced the supremacy of metropolises and inferiority of the satellites, and has doubtless paved the way for greater privatisation and commercialization of the supposed public health system. The LGC of 1991 has been a dismal failure” (Petralba 2004: 99)

As a result of the initial unpopularity of healthcare devolution, a bill was brought to President Ramos in 1995 that would have returned the functions and services devolved to the LGUs back to the DOH. Ramos vetoed the bill (Florano 1996). However, my own research identified that the outcomes of devolution are relative to a given municipality, especially in terms of: its IRA; the amount of funds allocated to healthcare by the LGU; and the effective utilisation of those funds.

But the valuation of healthcare devolution is also contingent on perceptions. Some barangay members preferred devolution. Perceptions of devolution were to some extent contingent on what people have now versus what they had before. For example, in barangays that now have a major new item, such as an ambulance, devolution has been welcomed; regardless if the presence of the item was an actual outcome of devolution. For those who reported that they received free medicine before devolution that was no longer available after, devolution was unwelcome. However, in general, barangay council informants did not perceive that they were given the proper resources to appropriately care for their barangays. The general consensus was that healthcare devolution was not working for their barangays.

As my findings with healthcare integration will illustrate, representation, practice, and perception of healthcare decentralisation may be more contingent on context than on any universalised understanding or statistic.

4.2.4.8 Summary

This section has identified an overall historical pattern of social order in the Philippines from decentralisation, in the pre-colonial barangay, to the highly centralised enforced construction of Spanish and American colonial administration. Centralisation continued into the early post-colonial period with the exception of infrastructure development at the local level. Post-colonial healthcare decentralisation began with the development of healthcare infrastructure and human resources at local levels before complete healthcare devolution. Healthcare equity was found to be inherently compromised by the inequitable distribution of the Internal Revenue Allotment and the personal and political priorities of local administrators. The relationship between these processes of social order and healthcare are summarised in Figure 4.3.

Figure 4.3 Summary Timeline of Administrative Centralisation and Decentralisation with Healthcare

Type of Healthcare

<u>Formal:</u> Healthcare	<i>centralised</i> Spanish Biomedicine Hospitals/Medical Colleges		<i>centralised</i> U.S. Hospitals/Clinics Public Health System	<i>decentralised</i> DOHP Public Private Healthcare
	<i>decentralised</i> Local Non-biomedical Healthcare Practices		<i>decentralised</i> Local Non-biomedical Healthcare Practices	<i>decentralised & centralised</i> Local Non-biomedical Healthcare Practices
<u>Period</u>	<i>pre-colonial decentralisation</i> - mid 16th century	<i>Spanish colonisation centralisation</i> mid 16th century-1898	<i>U.S. colonisation centralisation</i> 1898-1946	<i>Post-colonial/WB-IMF decentralisation</i> 1946 -

4.3 The Philippine Healthcare System

This section will examine the structure of the formal and informal healthcare systems identified in this research. An overview of factors that have been identified to affect access to healthcare in the Philippines will also be analysed. Finally, this section will present an overview of both local and imported non-biomedical practices in the informal and formal healthcare systems identified in the field sites studied.

4.3.1 *The Current Formal Healthcare System in the Philippines*

“The state shall protect and promote the right to health of the people”
(1987 Philippine Constitution, article 2, section 15)

This section will briefly present the formal healthcare system identified in the Philippines at the time of this research. This section will first outline the structure of the formal Philippine healthcare system. Next, issues of access will be discussed. Healthcare access was identified in the previous section to be affected by devolution. However, healthcare access is also being affected by human resources; the control of pharmaceutical cost; the national healthcare insurance; interpersonal factors; and the physical state of facilities. All of these factors will be examined in this section. Finally, this section will briefly present an overview of the current state of health in the Philippines.

4.3.1.1 The Structure of the Formal Philippine Healthcare System

The Philippines has a two-tiered healthcare system. Public and private healthcare systems are completely separate and considered not at all equal (Bautista *et al.* 2002; Estrada-Claudio 2006).

Barangay informants have described the private healthcare system as “belonging to a different country” and the public hospitals as “where you go to die”. (69 year-old female in Poblacion, Sadanga #713 and 50 year-old female in Caliban, Murcia #224)

Private healthcare, as well as the majority of local non-biomedical practices and practitioners, are considered part of the informal healthcare system and public healthcare is considered the formal healthcare system.

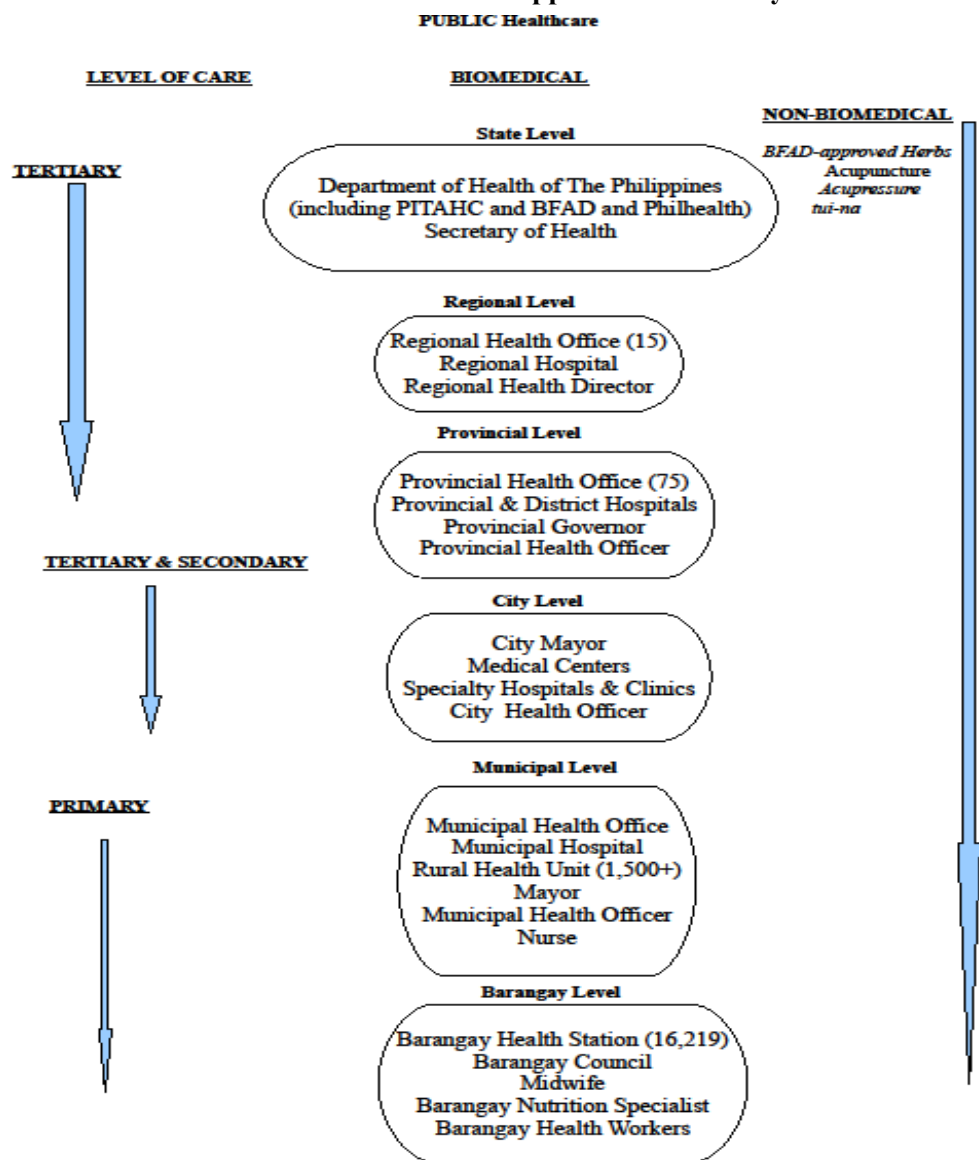
The formal healthcare system will be defined in this dissertation as the healthcare services, practices, and practitioners that are administered and regulated through the state healthcare apparatus of the Department of Health of the Philippines (DOHP). The formal Philippine healthcare system is comprised of both biomedical and select non-biomedical practices (Figure 4.5).

Large metropolitan areas are categorised as cities. Cities are under the governance of a city Mayor. Some city health officers oversee city hospitals, as well as secondary clinics. Health center physicians also are employed by some city health centers. At the local level there is more of a focus on public health and primary care than at higher levels. The municipal level is under the management of a Mayor and a LGU; which includes the Municipal Health Officer (MHO). Municipal healthcare consists of a Municipal Health Office or a Rural Health Unit and can also have Municipal Hospitals offering primary care. The MHO is a physician who serves both administrative and practice functions for the municipality and for all the barangays of a given municipality. The MHO is commonly assisted by a nurse.

Although the barangay level is run by a barangay council, the council is under the control of the Municipal Mayor and the LGU. All funds to a barangay are allocated through the LGU at the municipal level. However, specific allocations of barangay funds received can be influenced by the barangay council. The Barangay Health Station is under the administration of a midwife who is also the primary biomedical practitioner in the barangay. The midwife oversees the Barangay Health Workers and occasionally any trained *hilots* that collaborate with the midwife.¹⁶¹ Although the day to day management of community healthcare has become the responsibility of the BHS, administrative healthcare policy is primarily dictated from the DOHP at the state level down to the municipal level, and healthcare funds and resources are primarily allocated for the barangays at the municipal level by the mayor of each municipality. Figure 4.5 summarises the current formal Philippine healthcare system.

¹⁶¹ In practice, I observed this can change on a case by case basis usually depending if the midwife feels she needs the help of the *hilot* and/or if the midwife is comfortable working with local *hilots* and vice versa.

Figure 4.5 A Schematic Outline of the Formal Philippine Healthcare System

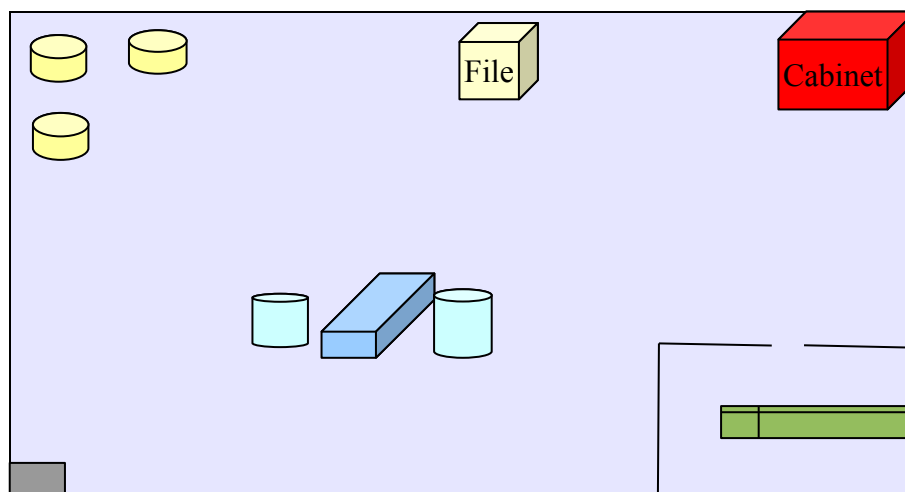


4.3.1.2 The Barangay Health Station

A majority of the field research for this dissertation was conducted at the level of the barangay health station (BHS). The BHS I visited were located either at the entry or center of the barangay and were usually linked to the Barangay Center where the barangay council kept their offices. Almost all the BHS visited were less than 10 square meters and had a waiting room with a few chairs, a desk for the midwife, a file cabinet, and sometimes a medicine cabinet. Usually one small examining room (enclosed by a door or a curtain) that could only fit a small bed was just beyond the waiting area. There were generally public health posters lining the walls and often there were no toilet or restroom facilities.

Barangay Health Stations visited were typically only stocked with the most basic antibiotics and/or with paracetamol and aspirin. One midwife informed me that she would often need to pay for whatever drugs were kept in the BHS and hope the municipal mayor would eventually reimburse her. Although one of the duties of BHWs was to monitor barangay members' vital signs, few had a working sphygmomanometer or stethoscope by which to monitor blood pressure; even though heart disease and vascular pathologies were the number one and two most prevalent pathologies in the Philippines (See Table 4.1).

Figure 4.6 Schematic Representation of General Layout of Barangay Health Stations Visited



4.3.1.3 Formal Healthcare Access as an Outcome of Human Resources

Healthcare access in the Philippines is an outcome of several factors both dependent upon, and independent of, decentralisation. Decentralisation directly impacted access to healthcare human resources by necessitating dual roles for almost all formal healthcare staff at municipal and barangay levels. In fact, private physicians and local non-biomedical practitioners are the only local health workers who are not administrators; as even the Barangay Health Workers reported to handle some of the administrative duties of the midwife. Thereby physicians, nurses, and midwives were both clinicians and administrators.

Both practitioner and barangay member informants identified that access to healthcare was thereby reduced by the availability of staff at any given time due to their administrative responsibilities. Thus, although the number of healthcare administrators were increased, the number of full-time clinicians were, in effect, reduced.

In several of the barangays studied, access was also limited by the hours the BHS was open. There were several instances observed in which a midwife serving more than one BHS was only available every other day, in any given BHS. This reduction of human resource availability is in addition to an already chronic shortage of human resources, especially in rural areas.

A 52 year-old female nurse informant from Manila noted: “We think that there is not a shortage of nurses in the Philippines, because we [nurses] can't always find work, but we do need nurses. Hospitals just always work with a shortage of staff to save money”.
#887

Furthermore, physicians and nurses generally were identified to prefer the amenities available in urban areas, where the pay scale is higher. In 1993, when Senator Juan Flavio Velasco was the Secretary of Health, he instituted a programme in which medical, and later nursing, students were required to complete a two-year internship in a rural under-served barangay in order to be granted their degrees (Pamatian 2004). Although the programme only survived until Flavio left the DOH to become a senator, many informants reported the success of this programme in which 337 doctors were deployed to the barangays of 271 poor municipalities (*Ibid.*).

The other chronic issue resulting in reduced human healthcare resources in the Philippines is the well-documented migration of medical professionals to the West. The Philippines is the largest exporter of nurses in the world (Ibon 2008). It has been estimated that approximately “65% of the University of the Philippines college of medicine alumni work in North America and 4,000 physicians are studying nursing in order to go abroad as nurses” (Miniano 2006: 19).

Of the total number of registered Filipino nurses who are employed, 84.8% are employed in fifty countries outside of the Philippines (Lorenzo et al. 2007; Ibon 2008). From 2000-2007, the top three destinations for Filipino nurses were Saudi Arabia (44,923); the UK (14,194); and Ireland (3,692) (Ibon: 2008: 105). Overseas health workers contribute to as much as 10% of the Philippines' GDP¹⁶² (Library of Congress 2006).

Informants often mentioned that the reason many became physicians and nurses was to be able to migrate out of the Philippines for higher salaries. Part of the lack of interest in remaining in the Philippines is not only due to lower wages, but also because of working conditions. For example, an informant who is a nurse reported "on average, a nurse attends to 40-60 patients per shift". Whereas, in a U.S. hospital, a nurse would typically be responsible for no more than four to eight low-care patients (or two critical care patients) at any given time (*Ibid.*: 20). These factors combined have resulted in a shortage of healthcare professionals working in the Philippines.

4.3.1.4 Healthcare Access as an Outcome of the Cost of Pharmaceuticals

The majority of Filipinos have little financial access to affordable essential medicines¹⁶³ (Ibon 2008). According to the Family Income and Expenditure Survey, of the total family expenditure on healthcare, nearly half (46.4%) was allocated for drugs and medicines in 2000. The Philippine pharmaceutical industry is predominantly controlled by foreign corporations. Before World War II, there were twenty mostly Filipino-owned pharmaceutical companies (Ibon 2001). However, after World War II foreign investment, particularly U.S., was encouraged in order to reconstruct the war-devastated economy (*Ibid.*). This resulted in the eclipse of the local drug industry by the large and rapid growth of foreign pharmaceutical firms (*Ibid.*). 72% of domestic drug market is in the hands of foreign investors and 5% by Filipinos or multinational corporations that are jointly owned by Filipinos and foreign investors (Miniano 2006: 25).

167

¹⁶² Approximately nine million Filipinos have worked overseas in 192 countries making the Philippines "the most overseas remittance-dependent country of any significant size in the world" (Ibon 2008: 13).

¹⁶³ "Less than thirty percent of the population has regular access to essential drugs" (Ibon 2008: 111).

Due to the absence of a national drug industry, a very profitable market was created for imported medical commodities. Retail transnational corporations control over 90% of the pharmaceutical retail [drugstore] sector (Miniano 2006). Although retail drugstores are the most physically accessible to the average Filipino, their pharmaceuticals are financially inaccessible¹⁶⁴ with a minimum of 7% to 15% mark-ups on the costs of their products (*Ibid.*). After Japan, the highest costs for pharmaceuticals in Asia are found in the Philippines (Lao 1999). Philippine drugs are typically 250% more expensive than in countries, such as India, Sri Lanka, and Pakistan, and up to 1600% more than in some ASEAN countries (*Ibid.*). Thus for example, *Bactrim* (sold by Roche), which sells for PhP0.69 in India and PhP1.03 in Pakistan, sells for PhP15.55 in the Philippines (Ibon 2008: 112).

The difference can be understood by the distinction in how patents are granted. India provides a case comparison. Patents are granted in the Philippines according to the drug brand, whereas in India the patent is awarded according to the process of how the drug was produced (Miniano 2006: 30). This, then, provides opportunities for local manufacturers in India to produce the same or similar drug as the original, as long as the process in which the alternative version of the drug produced is *not identical* to the one employed by the patented product (*Ibid.*). Whereas, when patents are awarded according to brand name, as in the Philippines, transnational corporations are encouraged to create a monopoly for their products with rigid price controls¹⁶⁵ (Miniano 2006).

¹⁶⁴ Government hospitals contract the lowest bidder pharmaceutical company, thereby some pharmaceuticals sold in public hospitals can cost as much as 75% less than those sold in drugstores or private hospitals (Miniano 2006: 27). However, though government hospitals provide more financial accessibility to pharmaceuticals, they are either physically inaccessible to the majority of Filipinos or perceived by Filipinos as a last resort and thereby avoided.

¹⁶⁵ In general, patents allow transnational corporations the ability “to obtain exclusive rights to market their product at prices they dictate, leading to a standstill in the domestic manufacturing of pharmaceutical products in poor countries” (Ibon 2008: 124).

Furthermore, local drug manufacturers in the Philippines “depend heavily on the high cost of imported raw materials, thereby prices are a result of the exchange rate of the peso (domestic inflation); the inflation from the country of origin (international inflation); and the raw materials which transnational corporations sell to local firms at a higher cost than the cost in the world market” (Miniano 2006: 30).

Other reasons for this cost difference include the dependence on transnational corporations due to the underdevelopment of the local Philippine pharmaceutical industry. The Ibon Foundation identifies that drugs are more expensive in the Philippines than in other countries in the region because the local pharmaceutical industry is so dependent on the transnational corporations “for basic chemicals and technology to manufacture pharmaceutical products” (Ibon 2008: 112).

Access is also affected by the centralisation of the pharmaceutical market in Manila (42%) or in other areas of the island of Luzon (31%) (Ibon 2008: 116). Hence, though healthcare is decentralised in the Philippines, the products necessary for the practice of biomedicine is highly centralised in Manila or its immediate surroundings.

In order to try to attempt to resolve the issue of pharmaceutical access, Aquino signed the *Generics Act* (RA 6675) into law in 1988. The *Generics Act* sought to ensure the production of drugs according to their generic name (Varela 1997). However, the law was not successful due, in part, to the low consumption of generic drugs and the low procurement of generics by the government (*Ibid.*). These poor outcomes were directly due to the opposition of generic drug use by the transnational pharmaceutical corporations and the opposition of the Philippine Medical Association (PMA), both of which are powerful Philippine government lobbies (Miniano 2006: 33).

Physician opposition¹⁶⁶ to mandatory generic prescribing may have been the most damaging to the promotion of the use of generics, as Filipino patients often take medication as directed by their physicians (Tan Alora and Lumitao 2001). Such actions by physicians undermined the entire reason for the *Generics Act*, which sought to provide enough information to Filipinos about generics so they could make their own informed choices (Ibon 2001).

The local manufacture and production of essential generic drugs was also thwarted by the international control of the World Trade Organization's policy known as Trade-Related Aspects of Intellectual Property Rights or TRIPS. TRIPS grants patent holders “the right to prevent the unauthorized manufacture, use, commercialization or importation of patented materials and products obtained from the patented process” (Ibon 2008: 124). In brief, the *Generics Act* and other recent laws¹⁶⁷ have resulted in short-term solutions that have not sustainably remedied access to pharmaceuticals. As a result, some informants reported to be less inclined to see a biomedical practitioner, because even if it is free to go to the RHU, the medication prescribed is usually cost-prohibitive.

One outcome of the cost of pharmaceuticals is an inability to afford a full recommended dosage and duration of pharmacotherapy. For example, in the field. I observed that physicians or midwives would provide a one to two day dosage of an antibiotic, expecting the patient to purchase the remainder of the drug for the full course of treatment; which informants generally reported they could not afford to purchase. The potential hazard of such a pattern is the creation of multi-drug resistant diseases. Multiple drug resistance has already been identified as a serious problem in the Philippines, especially in relation to the antibiotic *ciprofloxacin*, which is being used in the field sites examined for such common problems as urinary tract infections (Nys *et al.* 2004; Song *et al.* 2004).

170

¹⁶⁶ Physicians “questioned the scientific basis for the assertion that drugs with the same generic active ingredients and the same doses are the same” (Ibon 2001: 33).

¹⁶⁷ Neither the “*Universally Accessible Cheaper and Quality Medicines Act of 2008*”, nor the “*Botika ng Bayan*” government project of 2004, which sought to reduce the cost of essential medicines by half, succeed in increasing pharmaceutical access (Ibon 2008: 125-7).

4.3.1.5 Healthcare Access as an Outcome of Healthcare Financing

The total expenditure on health as a percentage of the GDP in the Philippines has been reduced from 3.4% in 1990 to 3.3% in 2006 (Ibon 2008: 52). However, this has fluctuated annually with a recent high of 3.78% in 2009 and a low of 2.96% in 2002 (WHO 2011). The WHO ranks the Philippines 171 out of 191 countries in 2009 in terms of the total governmental expenditures on health as a percentage of the GDP (*Ibid.*).

As discussed, an outcome of the adoption of structural adjustment programmes is the reduction of government spending on public services, such as healthcare. Of the total sources of funding for health, the government share was reduced from 36.2% in 2001 to 28.7% in 2005, or a 7.5% reduction in government spending over five years (Ibon 2008: 790). If this is disaggregated between national and local government spending on healthcare, the reduction is from 17.2% (2001) to 15.8% (2005) at the national level and from 19.1% (2001) to 12.9% (2005) at the local level (*Ibid.*). The greater (6.2%) reduction at the local level is particularly problematic for a devolved healthcare system that innately requires greater resource allocation at the local level because of devolution.¹⁶⁸

The greatest increase in spending, as a source of funds for healthcare in this five year period, was identified in out-of-pocket spending, with an increase from 43.8% (2001) to 48.4% (2005) (Ibon 2008: 790). This was followed by the increase in the share of the public health insurance funding of *Philhealth*, with an increase in the share of healthcare funding from 7.7% (2001) to 10.7% (2005) (*Ibid.*). Thus, privatisation of healthcare has resulted in a decrease in government healthcare spending, particularly at the local level, with an increase in the single largest source of healthcare funding, out-of-pocket spending, followed by an increase in public health insurance spending.

¹⁶⁸ It is also problematic because as identified in interviews with barangay council members, the funds allocated for healthcare in the barangays interviewed is barely sufficient to cover the wages of the midwife and BHWs, with little, or sometimes nothing, remaining to purchase pharmaceuticals.

According to the Ibon Foundation: “Filipinos pay for large amounts of their health services out of their own pockets, often going into debt and even mortgaging property in cases of severe illness in the family” (2008: 78).

However, the increase in *Philhealth* spending is misleading if what *Philhealth* actually covers and how this affects the perception of access is not identified. Several informants who are government officials were asked how *Philhealth* was going to be able to cover the new DOHP administrative order requiring all women to give birth in a facility (discussed in Chapter 6). Repeatedly, various informants said: “the money is just sitting waiting to be used. We have plenty of money”. Because, so many informants repeated the exact same words, I considered this to be true. But then, if the funds for *Philhealth* are available, why aren't they being used?

Although *Philhealth* has been represented in the literature (ILO 2006) and in interviews with *Philhealth* representatives as successfully replacing the gaps left by government healthcare financing reductions, the practice is more complex than the representation. The Ibon Foundation notes that although *Philhealth* funding increased from PhP8.6 million (2001) to PhP13.4 billion (2005) “The average value paid *per claim* actually fell from PhP5,244 to PhP4,665” within the same period (2008: 81). What this means is that more of the population has been covered for less.

According to informants this is understood as a deterrent for healthcare access. *Philhealth* covers both government and other employees, as well as the indigent. Informants at all sites mentioned that although *Philhealth* might cover a hospital stay, for example, it would not cover all procedures needed or medications. These were somehow to be covered by the patient, many of whom reported that their families did not even have the funds for the transportation to the hospital.¹⁶⁹

172

¹⁶⁹ Transportation to health facilities was a predominant concern amongst barangay informants, in almost all barangays that are not near the town centre or *poblacion*. CHD identifies that physical access was a primary reason for the formation of the various CBHP programmes throughout the Philippines: “Even if there were services, the fact was (and is) that they [barangay members] cannot afford medical fees or even transportation costs” (CHD 1998: 13).

Hence, barangay informants were more concerned with what *Philhealth* did not cover and, thereby, what they would somehow be held responsible to cover, than with what was covered. Even a representative from *Philhealth* was critical:

“If there is no transportation to go there [a healthcare facility] why should they go there!”

Also, depending on the facility, a deposit covering what would be covered by *Philhealth* was often demanded upon arrival, before the patient would be admitted or treated. Informants feared that if they did not have these funds they would be turned away. All of these were perceived by informants as deterrents to utilising *Philhealth*.

4.3.1.6 Healthcare Access as an Outcome of Relational Othering

Although not normatively considered in terms of access, informant's perception of treatment by the healthcare workers of the formal healthcare system, especially physicians and nurses in hospitals, was identified to affect access. In every barangay studied, barangay members would mention that they often would not consider going to a particular hospital or RHU by virtue of their phenomenological experience of physicians and nurses, who, as mentioned, often Othered patients in an “I-It” manner.

4.3.1.7 Other Issues Affecting Healthcare Access

According to a 2007 study, less than 40% of barangays have a BHS. Although barangays are grouped administratively within a municipality, in terms of physical distance barangays can be several kilometres apart from one another and separated by rugged terrain. Hence, the actual number of facilities in a given geographical area will affect access.

Barangay informants also reported to not use their BHS due to its physical condition, with disarray reported as a deterrent. Additionally access to care was identified as compromised due to physical access. In many of the barangays visited, difficult terrain coupled with weather conditions that block roads and cause landslides were reported to commonly compromise physical access to healthcare.

4.3.1.8 Summary

In summary, access to the formal healthcare system was found to be affected by a multitude of issues, many of which may not be normatively considered to affect access, but which barangay informants identified as relevant to their access.

Formal healthcare access is particularly germane to this research, firstly, because the primary justification for healthcare integration has been to address access and secondly, because informants revealed that access was often an important consideration in choosing which practitioner to go to under given circumstances. This was particularly true of the use of *hilots*. Women in every barangay studied reported that *hilots* were always accessible and available to them, which was identified as a primary consideration for childbirth.

4.3.2 The State of Health in the Philippines

Malnutrition is inherently linked to a vulnerability to infection and disease (Schaible and Kaufmann 2007). Although the prevalence of malnutrition in the Philippines has been steadily reducing, more than a quarter of children from infancy to age ten have been identified as underweight or stunted (Ibon 2008: 23). In 2003, 27.6% of children age 0-5 and 26.7% of children age 6-10 were identified as underweight (*Ibid.*). Stunting (or under height for age) has been used as an indicator to identify chronic malnutrition. 30.4% of children age 0-5 and 36.5% of children age 6-10 were identified to be stunted (*Ibid.*).

From 1998-2007, morbidity is dominated by communicable diseases. Upper and lower respiratory tract infections and diarrhoeal diseases remained the top three causes of diseases in this period (Ibon 2008: 28). Influenza, Dengue, Malaria, Chickenpox, and measles have, in various order, also been prevalent (*Ibid.*). Hypertension and cardiovascular pathologies are the only non-communicable diseases identified in the top ten leading causes of morbidity in this period (*Ibid.*).

The leading causes of mortality have changed from 1980-2004. Until the early 1990s, the leading causes of mortality in the Philippines were dominated by communicable diseases (Ibon 2008: 30). After 1995, chronic non-communicable diseases dominated the leading causes of mortality (*Ibid.*). Heart and vascular diseases have remained within the top four causes of mortality throughout this period, followed by malignant neoplasm (*Ibid.*). Pneumonia and tuberculosis have remained the leading communicable diseases leading to mortality within this period (*Ibid.*). In 2004, 59% of mortality was attributed to non-communicable diseases; 24% to communicable diseases; 11% to accidents; and 6% unknown (*Ibid.*). Although the order of ranking of aetiologies have changed, the top-ten causes of mortality in the Philippines have remained fairly constant from 1980-2004 (*Ibid.*). As Table 4.1 illustrates, there has been an identifiable trend toward decreasing mortality from communicable diseases and increasing mortality from chronic non-communicable diseases.

Table 4.1 Five Leading Causes of Mortality in the Philippines (1980-2004)

Rank	1980	1985	1990	1995	2000	2004
1	Pneumonia	Pneumonia	Heart Diseases	Heart Diseases	Heart Diseases	Heart Diseases
2	Heart Diseases	Heart Diseases	Pneumonia	Vascular Pathologies	Vascular Pathologies	Vascular Pathologies
3	Tuberculosis	Tuberculosis	Vascular Pathologies	Pneumonia	Malignant Neoplasm	Malignant Neoplasm
4	Vascular Pathologies	Vascular Pathologies	Tuberculosis	Malignant Neoplasm	Pneumonia	Accidents
5	Malignant Neoplasm	Malignant Neoplasm	Malignant Neoplasm	Tuberculosis	Accidents	Pneumonia

Source: Ibon 2008.

BMI's Burden of Disease Database reveals that a total of 7,655,379 disability-adjusted life years (DALYs) were lost to non-communicable disease in the Philippines during 2008 (IBON 2008). It is predicted this figure will increase 9.1% by 2030, as a result of more cases of cardiovascular conditions (the leading cause of death in the Philippines), followed by cerebrovascular diseases and malignant neoplasms (National Statistics Office 2008).

The number of DALYs lost to communicable diseases, such as pneumonia, tuberculosis, and diarrhoeal diseases (the current leading causes of morbidity and mortality in the Philippines), is predicted to decline by 70% in the same period due to vaccination campaigns and improved access to pharmaceuticals¹⁷⁰ (*Ibid.*).

However, Tan cautions that epidemiological statistics in the Philippines are usually not representative of the entire population due to under-reporting and a bias toward urban areas and particular islands, such as Luzon¹⁷¹ (1999). Also, from this research, I noted a tendency for epidemiological data to be aggregated at higher and sometimes arbitrary levels of analysis. This was especially true of the data concerning maternal and infant mortality discussed in Chapter 6. Thus, in the Philippines, analysing epidemiological data at arbitrary levels of analysis may obscure the data of some groups.

This section has presented a brief overview of the state of population health in the Philippines. The next section will review the informal healthcare system with a focus on non-biomedical healthcare practices and practitioners.

4.3.3 The Current Informal Healthcare System in the Philippines

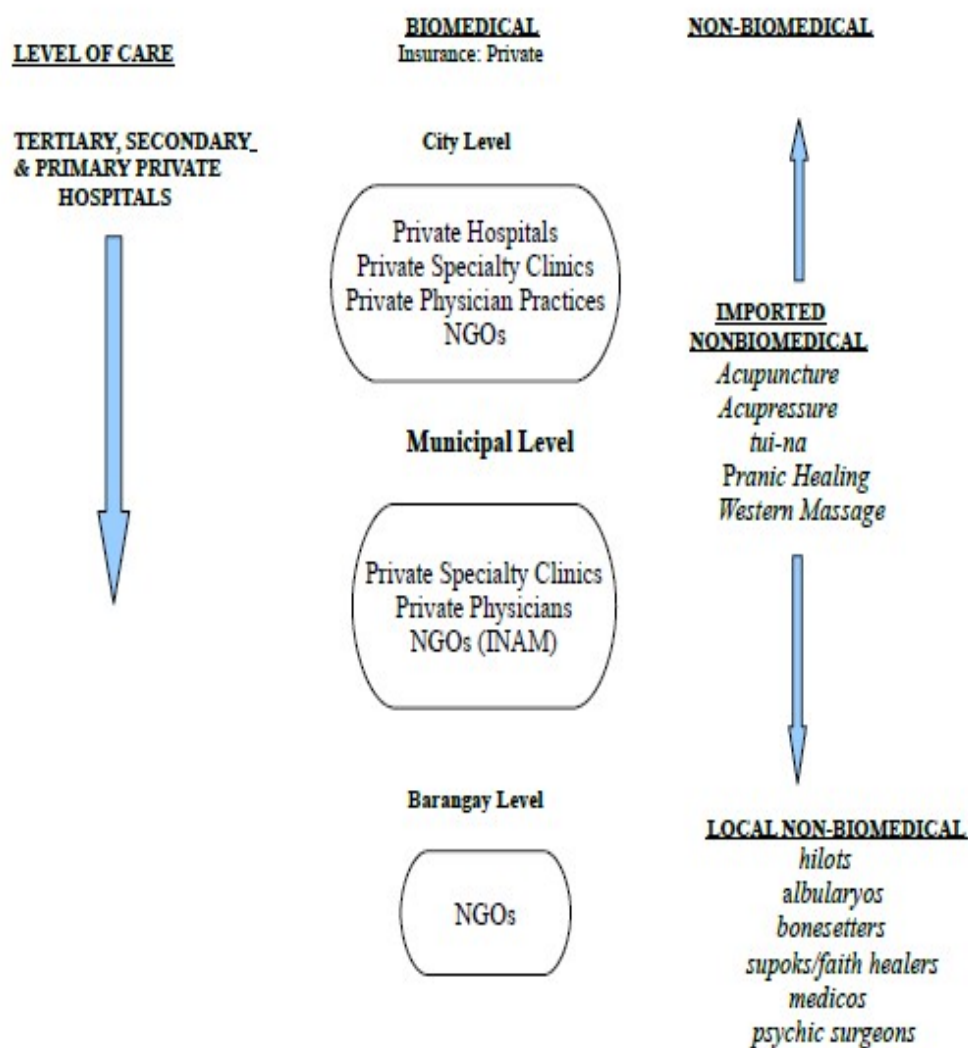
The informal healthcare system is comprised of both biomedical and non-biomedical practices and practitioners (Figure 4.6). In terms of biomedicine, “there are 1,742 hospitals in the Philippines, only 37% of which are government hospitals and the remaining privately owned” (Miniano 2006: 23). However, private healthcare is beyond the affordability of most Filipinos (Ibon 2008). In contrast to the formal healthcare system, the private sector is “largely unregulated” (Tan 1999: 33) and this research identifies that local non-biomedical healthcare practices and practitioners are unregulated as well.¹⁷²

¹⁷⁰ However, as noted previously, access to pharmaceuticals have not improved in the Philippines. Hence a 70% reduction in the burden of communicable diseases is questionable and may be more attributable to sampling.

¹⁷¹ For example, Tan notes that in the province of Tawi-tawi “only 1 % of deaths were registered” (1999: 32).

¹⁷² Even the DOHP Administrative Order dictating all women should deliver in-facility under skilled birth care does not, currently, regulate *hilots*. This will be discussed in detail in Chapter 6.

Figure 4.7 A Schematic Outline of the Informal Philippine Healthcare System



The remainder of this section will examine the structure of local non-biomedical healthcare practices and practitioners; and issues that arise in attempting to categorise them according to their practitioner designation.

4.3.3.1 A Brief Overview of the Local Non-Biomedical Practices and Practitioners of the Philippines

“Traditional medicine is so much a part of Philippine culture. In many areas of the country, traditional medical practitioners continue to be the main providers of healthcare”
(Tan *et al.* 1988: 73).

The general categories of local practices and practitioners in the Philippines that have been identified in the literature include the *albularyo* (or *herbolarios*); referring to a local practitioner whose principal treatment employs herbs. However, other practitioner categories also use herbs, and *albularyos* will use prayer and other diagnostic and treatment modalities. The last official estimate for the number of *albularyos* in the Philippines is 100,000 (Bannerman *et al.* 1983).

Although the *hilot* usually refers to the local birth attendant, the designation has also been used for the *manghihilot*. *Manghihilots* (also referred to as *agilot* and bonesetters) use some form of physical manipulation to treat dislocations, fractures, and other orthopaedic injuries. *Hilot* also refers to the *hilot-massahe*, who uses massage or touch, but can also use *bintosa*, a form of cupping. However, the term *hilot* (also *paltera*, *magpapaanak* or *commadrone*) most commonly refers to local (traditional) birth attendants. *Hilots* treat prenatal, delivery, and postnatal care using massage, herbs, prayer, and any combination thereof. They also assist pregnant women in numerous capacities throughout the pre- and post-natal periods. Bannerman *et al.* estimate 40,000 *hilots* throughout the Philippines, but from my data -in which there were normally one or two *hilots* per barangay (and there are approximately 42,000 barangays)- this may be an under estimate. *Hilots* shall be discussed at length in Chapter 6.

Medicos is a designation reserved for local practitioners that incorporate biomedicines into their practice. *Supoks* is a local designation for faith healers and diviners. *Supoks* commonly use prayer in conjunction with the laying on of hands, massage, oils, and herbal use. A *magluluop* is a kind of diviner who burns incense for diagnostic purposes.

The *manggagaway* is thought to be a sorcerer, magician or witch. Hence, they are understood to have the power to both heal and harm. However, it is important to recognise that any of these practices can be performed by any of these practitioners regardless of their given practitioner designation. For example, although *albularyos* are the designated practitioners for using herbs, practising with herbal remedies does not solely fall under the purview of *albularyos* and any of the above named practitioners can treat with herbs.

Practitioners can also be specialized to only treat one issue. For example, there were practitioners identified in the barangays studied who only treat dog bites or who remove fish bones.¹⁷³ Furthermore, it should be noted that these general designations, and the practices that fall under them, change from province to province and even community to community (Tan 1987; Jocano 2004). Hence, it is difficult to distinguish what identifies one practitioner category from another, not only by virtue of an overlap of practice categories, but also because many of these practices are self-taught (or taught via “spiritual guidance” received in dreams and visions) and thereby quite distinctively and individually practised (*Ibid.*).

Table 4.2 Local Healthcare Practitioners in Philippines identified in Field Sites

Practitioner Designation	Identified in Philippines	Identified in Field Sites
Albularyo	Yes	Yes
Hilot	Yes	Yes
Supok/Faith Healer	Yes	Yes
Hilot-Massahe	Yes	Yes
Bonesetter	Yes	Yes
Magluluop	Yes	No
Manggagaway (Witch)	Yes	No
Medico	Yes	No
Specialists (e.g. Dog Bites; Fishbones)	Yes	Yes

¹⁷³ For more in-depth discussions see Jocano 2004; Turner 1999; and Tan 1987.

4.3.3.2 The Non-Biomedical Local Practices and Practitioners Identified in the Barangays Studied

With few exceptions, of the 19 barangays in which I conducted research, the majority had an average of 2-4 local non-biomedical practitioners.¹⁷⁴ Most had at least one *hilot*, one bonesetter, one to two *supoks*/faith healers, and some had an *albularyo*. Barangay informants did not identify *medicos* in their barangay.¹⁷⁵ Though psychic surgery has been sensationalised in the Philippines, there were no psychic surgeons in the barangays studied.

Two practitioners I studied used prayer (*orasyon*) in two very different ways. In treatment with *orasyon*, I observed that prayer can be used by itself or in conjunction with something applied to the body, laying on of hands, or blowing the words of the prayer onto the patient's body. However, the prayer does not always need to be spoken. In the first instance, I observed a *supok* in Siquijor who wrote her prayer on a piece of paper in Latin. She then put the piece of paper with the prayer in a cup and poured hot water over it. After several minutes the ink dispersed in the water and the patient was told to drink the mixture. In ingesting the prayer, the patient was incorporating the potency of the prayer into their body. This example appears to demonstrate that by ingesting, and thereby incorporating into one's body, a potent representation of one's ordered system of understanding and meaning, the disorder inside the patient can be resolved.

In the second example, I was a patient. A *supok* I interviewed in Ponblacion, Murcia noted I walked with a cane and suggested after the interview that she could treat me. I agreed. She started by reading my pulse. I was informed by my translator that she was actually famous throughout the Philippines for her pulse diagnosis. Although pulse diagnosis is a common diagnostic skill of Chinese medicine, I noted that she did not perform her pulse diagnosis in the manner of Chinese medicine.

180

¹⁷⁴ Although in the sites I visited I usually identified more biomedical practitioners than local non-biomedical practitioners, this may not be true of all areas of the Philippines or at all times. For example, in the province of Pangasinan in 1957, 692 local practitioners were identified, compared to 277 physicians (Stauffer 1966: 11).

¹⁷⁵ See Table 5.3.

After taking my pulse she then began to pray over my bad hip. She paused and told me to close my eyes and concentrate on the pain. I did. She continued to pray as she splashed a warm liquid across my leg. In less than five minutes, it was over. The liquid was identified as “holy water”. She said something to my translator as we left. I asked the translator what she had said. “Oh” she smiled, “She said it probably won't do anything for you, because you are a non-believer”. Although she was correct, her treatment did do nothing for me, I was astonished that she knew I was a “non-believer” without having said anything.

These two examples identify the difficulty of distinguishing practitioner categories. Although both practitioners were self-designated as *supoks* and both used *orasyon* as part of their treatments, they did so in markedly different ways and sometimes, as in the case of pulse taking, in singular ways that were not identified again in this research.

4.3.4 *The Development of State Involvement in Non-Biomedical Practices and Practitioners*

4.3.4.1 Local Healthcare Practices Have Local Meanings: why imported non-biomedical practices cannot be substituted for local non-biomedical practices

I maintain throughout this thesis a functionalist understanding of local healthcare practices, as specific and integral to a particular socio-cultural context, in order to fulfil the specific ordered systems of understanding and meaning of a given context, and thereby maintain the integrity of the *doxa* of a given *field*. A primary misunderstanding identified in the traditional medicine discourse, explored further in Chapter 7, is the essentialised etic representation of all non-biomedical practices as one and the same and, thereby, interchangeable. Furthermore, non-biomedicines are often represented as having the same value to patients and that either a) local communities will not differentiate between local and imported non-biomedical practices and/or b) imported non-biomedical practices will be understood to be of a higher quality, by virtue of being standardised and validated by WHO or biomedical institutions in the West, and will therefore be more valued by local communities than their own local practices.

Such perceptions, in which the biomedical Self assumes the non-biomedical Other will share their reasoning of appropriateness in healthcare, were voiced by informants from the WHO, PITAHC, Municipal Health Officers, and local NGO stakeholders. Such perceptions ignore the myriad socio-cultural functions that local non-biomedical practices and practitioners serve, functions that cannot simply be replaced or substituted with an etic non-biomedical practice or system.

According to this research, imported non-biomedical practices do not belong to the local Self's ordered system of understanding and meaning. In fact, biomedicine may be considered more likely to be understood as a field of the local Self than imported non-biomedical practices, such as acupuncture or homoeopathy, which were identified as completely alien to local barangay informants. This is clearly illustrated in the results of the pile sorts presented in Chapter 5. Furthermore, fewer barangay informants reported to seek out or "believe in" acupuncture compared to biomedicine. All informants were familiar with biomedicine and to various degrees perceived biomedicine as a *doxa* within their *field*, whereas, acupuncture could not even be considered to be part of local informant's ordered system of understanding and meaning of healthcare.

This example illustrates that although etic, non-biomedical practices can be essentialised as "traditional", emically, an imported practice with no socio-cultural meaning cannot merely be substituted for a local practice. Nor can local practices that are used for different purposes be substituted for one another. Hence, the boundaries of understanding and meaning between imported and local non-biomedicine are quite clear and important to barangay informants and yet often ignored by biomedical stakeholders (i.e. informants from WHO, the DOHP, PITAHC, and some MHOs). This is further reflected in the arbitrary administrative divisions of local and imported non-biomedicine both at the state and global levels.

4.3.4.2 The Arbitrary Administrative Divisions of Local and Imported Non-Biomedicine

The etic, biomedical ordering of all non-biomedicine as one undifferentiated grouping is reflected in the arbitrary designation of state administration of local and imported non-biomedical practices and practitioners. The designation of administration is partly a result of historical administration; partly according to the function of different divisions of the DOHP; and partly a result of the government corporation status of PITAHC.

From 1952, *hilot* trainings were organised between UNICEF/WHO and the Maternal Child Health division of the DOHP (discussed in detail in Chapter 6). The Western practices of massage therapy and reflexology are regulated under *Presidential Decree 856 of The Sanitation Code of the Philippines by the Department of Health* (1997) and require registration with the DOHP. PITAHC has no affiliation with *hilots* and is only affiliated with massage via the presence of one PITAHC officer on the *Committee of Examiners for Massage Therapists* (Presidential Decree 856 1997: Section 4.2c). Informants who had worked on TAMA (the Traditional and Alternative Medicine Act of 1997) reported an awareness that attempting to restructure these historical administrative linkages between the DOHP and certain non-biomedical practices were not even considered for PITAHC due to the concern that attempting to restructure the DOHP could jeopardise the passage of TAMA.

In terms of the functions of DOHP divisions, the only local non-biomedical practice to be fully integrated into the Philippine healthcare system are ten herbs regulated by the Bureau of Food and Drug of the DOHP (BFAD), four of which are produced at manufacturing plants by PITAHC (DOHP 2004b; PITAHC 2009). As PITAHC has no regulatory abilities, the functions for drug regulations and enforcement fall under the jurisdiction of BFAD. BFAD established specific criteria for establishing the evidence of “claimed application”, meaning that the evidence of safety and efficacy needs to be demonstrated by herbal products (DOHP 2004a; 2004b).

However, if BFAD requirements cannot be met via empirical evidence and/or randomised controlled trials, then the herb would need to be registered and regulated as a food supplement (*Ibid.*). Herbal medicines sold with any type of therapeutic claim have undergone randomised controlled trials, whereas those that are classified as food supplements are labelled without any therapeutic claim (*ibid.*).

Hence, herbs have been regulated as prescription medicines and non-prescription medicines, as well as household remedies. The type of regulation for herbs classified as “herbal medicines” is the same regulation as that for pharmaceuticals and is listed in the Philippine National Drug Formulary (DOHP 2004a). Out of the more than 2,000 herbs identified in the Philippines, only four have undergone rigorous scientific research permitting their enlistment in the Philippine Drug Formulary (*Ibid.*). These herbs are: *Blumea balsamifera* (local: Sambong); *Vitex negundo* (local: Lagundi); *Mentha x cordifolia* (local: Yerba Buena) and *Ehertia microphylla* (local: Tsaang Gubat) (*Ibid.*).

The corporate status of PITAHC is exemplified in PITAHC's projects and the kind of practices that are emphasised, which have predominantly focussed on imported non-biomedical practices and practitioners. To date, PITAHC has trained Barangay Health Workers in Tui-na¹⁷⁶ and preparation of herbal remedies; trained and licensed acupuncturists; compiled a classification list of *albularyos*; and maintained four herbal processing plants (Ordoná 2009). PITACH's future plans include accreditation of the practices of acupuncture, chiropractic, homoeopathy, and Āyurveda, as well as establishing “collaboration with the State Administration of Traditional Chinese Medicine (China) and the Korean Institute of Oriental Medicine (Korea) concerning training, research, development” and integration (Ordoná 2009: 6). PITAHC has also defined the scope of practice for acupuncture, acupressure, and tui-na.

¹⁷⁶ A standardised Chinese medicine form of bodywork.

Pranic healing¹⁷⁷ provides an example of syncretisation. This recent practice was derived from both Indian and Chinese healthcare practices, such as yoga, meditation, and TCM, by a Filipino who then organised trainings, supported through PITAHC, of over 12,500 physicians, nurses, and lay practitioners from 1992-2001 (PITAHC 2009).

Of all practices, PITAHC has devoted the most energy to the integration of acupuncture into the Philippine healthcare system. According to Lagaya, approximately 250 physicians have received training in acupuncture through one to two week courses sponsored by PITAHC¹⁷⁸ (2005). PITAHC has been working with *Philhealth* for coverage of acupuncture, but issues of standardised acupuncture training in the Philippines have challenged this process.

However, the work of PITAHC must also be understood in an historical context, in which the practice and teaching of some non-biomedical practices were understood as radical, political acts that threatened the state.

4.3.4.3 The Political Threat of Non-biomedicine and Early Healthcare Integration: The Radicalisation of Local Healthcare Organisation

As I have illustrated throughout this Chapter, healthcare is political in the Philippines context. When organised at the grass-roots level, healthcare has been represented as a threat by several government administrations. Although such logic appears contradictory to decentralisation, the radicalisation of grassroots healthcare has been represented as a concern from Marcos' government through to events recorded during this research.

The groupings of grassroots programmes known as Community-based Health Programs (CBHP) were born from the poverty and political repression of the late 1960s.

¹⁷⁷ Similarly, the imported European practice of Anthroposophic healing, has been popularised by physicians and nurses, but has remained independent of PITAHC and the DOHP.

¹⁷⁸ Anecdotally, this figure would appear to be a gross underestimate, as I personally trained over 150 physicians, nurses and lay practitioners in acupuncture for PITAHC.

These programmes were started in reaction to poor healthcare access: “At its inception, the health program was a reaction to existing approaches to healthcare, which did not reach the people most needing them - the poor especially in rural areas” (CHD 1998: 11). Informants have discussed both “community building” and “nation building” as a primary desired outcome of CBHP groups.¹⁷⁹

CBHP groups trace their origin to the Rural Missionaries of the Philippines (ca. 1969) organised by the Association of the Major Religious Superiors of Women in the Philippines (CMD 1998: 12). Although the BHW programme appears patterned after the barefoot doctors programme, informants from the various Community Health Worker (CHW) programmes of the CBHP groups identified the barefoot doctors programme as the template for CBHP. A CHD manual identifies CHWs as volunteer members of communities that “are chosen by the community” and “trained in basic health skills such as prevention and treatment of common diseases, first aid, use of herbal medicine...acupuncture and acupressure...and dental hygiene and tooth extraction” (CHD 1998: 8-9; 31). This CBHP curriculum was standardised in 1984 (*Ibid.*: 44). Hence, CBHP attempted to build a healthcare system, from a plural healthcare model that was already integrated from the bottom-up. *INAM*, whose bottom-up integration was studied in Murcia, is a CBHP.

Acupuncture was also an early addition to the CBHP programmes, that further linked them to China and the barefoot doctors programme. According to informants, during the Marcos administration China and the Philippines engaged in a cultural exchange. As part of this exchange, China offered both formal and informal short training courses in acupuncture in the Philippines, primarily for physicians. The DOHP was often involved in arranging this cultural exchange. Acupuncture was quickly identified as an important cost-effective intervention for CBHPs.

¹⁷⁹ According to CHD the goals of the CBHPs include “community building through organizing, increasing participation of the people in decision-making and developing self-reliance” (CHD 1998: 14).

Although Marcos initiated many rural health pilot programmes, most were centrally controlled through the DOHP.¹⁸⁰ CBHP organisation was soon viewed by the Marcos administration as “conscientizing activities...considered crimes by the government” and linked to revolutionary communist groups (CHD 1998: 15). CHWs “were arrested and killed because of being targeted as 'subversives'” (*Ibid.*: 30). To fully understand this government reaction requires a brief history of organised political resistance in the Philippines.

The *Partido Komunista ng Pilipinas* (PKP) founded in 1930 is the “oldest leftist party in the Philippines” (Quimpo 2006: 56). In 1968, a group of “young communists” broke away from the PKP and started the *Communist Party of the Philippines* (CPP) (*Ibid.*: 58). The CPP denounced “U.S. imperialism, feudalism, and bureaucrat capitalism” calling for “the revolutionary overthrow of the reactionary Philippine state” (*Ibid.*). Several months later, in 1969, the CPP acquired a “guerilla army” known as the New People's Army or NPA (*Ibid.*).

The NPA became aligned with a larger “revolutionary united front” in which several, but according to informants, not all, CPHP groups were aligned (Quimpo 2006: 56). It was during the period of martial law, beginning in 1972, that any members of groups believed to have any affiliation with the CPP or NPA were routinely “arrested, tortured, detained or killed” (*Ibid.*). Several informants including university professors and physicians described years of torture and imprisonment for a suspected, though unproven, link with the NPA.¹⁸¹ “Thousands disappeared without any trace, while many others were summarily executed” (CHD 1998: 42). Several informants stated that neither one's political affiliation, nor the fact that equitable healthcare was the goal sought was relevant to the government. The mere fact that community level organising was involved, in and of itself, constituted a threat to the government.

187

¹⁸⁰ A pilot programme for the development of community herbal gardens was not a centrally-controlled project, per se, but was implemented by few communities and to varying degrees (Bautista 1996).

¹⁸¹ However, Marcos' reaction was considered inadequate and not harsh enough to justify continued support from the U.S. According to Anderson “The rapid growth of the CPP-NPA so alarmed the United States that it finally turned against Marcos” (1998: 277).

The NPA became a significant national movement especially through forging bonds with the rural poor (Jones 1989). A 62 year-old female physician in Manila states:

“It seemed that communism was the way that Filipinos could be free of colonialism...and the NPA was fighting for a revolution to change the system”. #982

Healthcare was a primary concern of the NPA and many young medical students became affiliated with both the NPA and/or CBHP groups in this capacity.

According to informants, it was specifically the Philippine armed forces who began to affiliate acupuncture with the NPA, as well as CBHP groups.¹⁸² Jones notes the NPA had their own “medics” who were “trained to perform acupuncture and acupressure treatments and were skilled in the use of herbal medicines” (*Ibid.*: 233). One male NPA informant reported:

“We learned [acupuncture] from books...from Chinese books and some trainings from community doctors. Basic training was three days”. #780

However, other informants identified that the CPP was able to send some members to China to study acupuncture.

Another NPA informant stated: “We use acupuncture because it is cheap and does not require much [sic] materials”. #431

One physician informant stated: “They [the NPA] accept acupuncture and you are put on a pedestal if you are an alternative doctor”. #820

Interviews with current and former NPA-identified informants revealed that the NPA would utilise acupuncture as a means to recruit NPA members in rural barangays. Informants explained that recruitment was initiated through free acupuncture treatments and later through acupuncture trainings. Thereby, the CBHPs, and especially the practice of acupuncture became intensely politicised from the early 1970s.

¹⁸² One NPA informant stated: “The assumption is that if acupuncture is being introduced by communists, then those who use [acupuncture] are supporters of communism. The armed forces branded those who use acupuncture as communists and rebels”.

The mere presence of an acupuncture needle was considered sufficient evidence to identify one as having NPA affiliation. One female family medicine physician in Manila reports:

“When we were travelling in Mindanao, we would travel with [acupuncture] needles inside of pens, because we were afraid that the army was there ...at a checkpoint and you would be checked for needles. If they found them you would be tortured -at best- or more likely killed”. #963

Providers were not the only group harassed. Patients were also harassed for seeking treatment from CBHP groups. One nurse informant who worked with several CBHP groups identified:

“The military were always watching us, and our patients were afraid to come in and be treated because of them...so they often would have no treatment”. #481

Harassment of CBHPs did not cease after Marcos, but actually intensified with Aquino's administration, resulting in the cessation of CBHP groups in 267 barangays and disruption in an additional 305 barangays (CHD 1978: 53).

However, this affiliation of acupuncture with political radicalism and the harassment of independent healthcare workers was identified at the time of this research. While in the field, I interviewed several informants about a group of 43 healthcare workers undergoing training in disaster management and acupuncture. This group, the so-called “Morong 43”, were arrested by the military and detained for ten months on charges of illegal possession of firearms and explosives and acupuncture needles. According to an informant working with the Morong 43:

“They were illegally detained and tortured, whilst the military attempted to force them to admit they were part of the NPA. The group filed a civil case for damages against Arroyo [the former president] and high ranking military officials.” #1008

This history renders an understanding of PITAHC's embrace of acupuncture even more perplexing. However, through participant observation with PITAHC, I found that acupuncture was strictly being taught to physicians for a profit.

The use of acupuncture as a cost-effective means to redress health inequity was never discussed by PITAHC. Hence, it was actually the CBHP groups that integrated both imported and local non-biomedical healthcare with biomedicine informally, long before formal integration was proposed through TAMA.

4.3.4.4 The Traditional Medicine Unit of The DOHP

Although no informant who worked with the DOHP on formal healthcare integration identified a relationship between the processes of healthcare devolution and healthcare integration, it is interesting to note that whilst formal healthcare devolution was enacted in 1993, during the Ramos administration, a policy for formal healthcare integration was being assembled. Under the direction of then Secretary of Health, Dr. Juan Flavier, the DOHP assembled ten policies for primary healthcare. One of these policies specifically called for healthcare integration as the “development and promotion of Philippine medicine” (Bautista 1996: 35). The policy proposed that medicine and allied health professions incorporate the education of “traditional medicine”, accompanied by scientific research for purposes of validation (*Ibid.*). Thus, primary healthcare was recommended to include the formal integration of non-biomedical practices and practitioners as was originally proposed in the Declaration of Alma Ata.

Flavier created a Traditional Medicine Unit in the DOHP specifically for the purpose of integrating local and imported non-biomedical healthcare practices into the national healthcare system (Lagaya 2001). According to Flavier's Undersecretary of Health:

“both of us had a passion for trad med living with poorest and dealing with the poorest and he [Flavier] came in and said let's start a trad med unit and strengthen ties with China and we wanted 100 herbs, but we agreed to start with the magic number of ten”.

In 1995, UNDP, in consultation with WHO-WPRO, awarded a grant to the DOHP in order to “test the theories of a government-initiated program to introduce a non-formal, but popular healthcare system with the existing form, Western medicine oriented system [sic]” (Lagaya 2001: 314). According to informants, the sole purpose of this research was to generate data to support a political bill presented by Flavier, who became a senator in 1995. One 43 year-old Female physician in Manila who conducted the research stated:

“We were seeking a pilot project to integrate and document [local] beliefs and [healthcare] practices especially about herbs. So we invited both BHWs and various [local] healers to exchange ideas about how they diagnose and treat illness, such as coughs and colds, so we were not dominating with Western paradigms. Our goal was to strengthen the grass-roots healthcare delivery system through the utilisation of traditional medicine. We used the project to lobby for this in the senate”.

As a result of the pilot research findings, WHO-WPRO, in conjunction with Flavier's technical assistants and lawyers, assisted in drafting the *Traditional and Alternative Medicine Act (Republic Act 8423 or TAMA)*. Informants who had worked with Flavier identified that the Senator generated the idea for TAMA based on the Declaration of Alma Ata.¹⁸³ However, several were opposed to the bill. The most vocal opponents to the bill were the lobby of the Philippine Medical Association (PMA).

4.3.4.5 The PMA

The Philippine Islands Medical Society was founded in 1903 as a member association of the American Medical society, which was heavily influenced by the U.S. from its beginnings; with Americans taking the positions of the first president and all five counsellors (Stauffer 1966). However by the 1920s, all positions were held by Philippine citizens and it was renamed the Philippine Medical Society Association in the late 1930s (*Ibid.*). Being a component society within the American Medical Association, it continued to receive direction from the AMA.

¹⁸³ Informants identified that the Declaration of Alma Ata and the support of WHO was used specifically to legitimise TAMA for passage into law.

In fact, “the PMAs first constitution was patterned after the comparable units in the United States; oligarchic control was established along AMA lines; and the American Medical code of ethics was applied without modification for Filipino physicians” (*Ibid.*: 21). Hence, the PMA was very much a product of American colonialism along with the hegemonic biomedical agenda of the AMA.

Historically, the PMA has had issues with factionalism (Stauffer 1966: 16).

“Many disputes within the PMA arise from clashes in interest between the government physicians who pioneered work in the rural areas and the private practitioners who more recently have been moving into non-urban practice” (Stauffer 1966: 10).

However, like the AMA before them, the PMA was organised around a mission to protect biomedicine, especially against the non-biomedical Other.

“The PMA must defend the modern physicians, public and private, against the 'quacks' as it designates the traditional practitioners” (Stauffer 1966: 13). Stauffer identified: “Those who rejected trained physicians did so out of a continuing belief in spirits as causes of diseases and therefore assumed that a traditional practitioner could handle diseases caused by evil spirits better than one out of medical school” (*Ibid.*: 12).

As a result many BHUs stood unused, not meeting the needs of barangays. Although Stauffer wrote this in 1966, many informants in this research expressed similar sentiments:

“I go to the doctor for influenza, but he can't get rid of a curse. If the influenza stays, it might be a curse. Then I go to the faith healer ...anyone else would be a waste of time”. (43 year old woman in Siquijor). #12

Several informants involved with the development and lobbying of TAMA identified the PMA as the primary source of obstruction to passage of the bill. A former Secretary of Health identified “it took PMA up to 2005 to no longer object to acupuncture *alone* [emphasis added]”.

In interviews with PMA leadership, I was told that “although PMA supports PITAHC on an official level, as recommended by the boundaries of the WHO standards and PMA's code of ethics, we do not subscribe to 'quack medicine' where there is no scientific basis. But we do recognize herbal medicine and we have in our drug formulary. It is the scientific fact that is important and using the WHO standards plus the tenets of our code of ethics is no harm. Safety is the primary concern of our code of ethics. Take for example [the herb] *legundi*, we are concerned with adverse drug reactions. The reason it may not be a concern to other doctors is because they haven't experienced any adverse drug reactions...so the PMA is supporting traditional medicine as long as it is in line with the WHO and the PMA code of ethics. We refer to PITAHC, but PITAHC is not usually referring more than herbs and acupuncture”. #940

The PMA informant's statement is important for several reasons. Firstly, this offers a clear illustration of exclusive Othering immediately reminiscent of Flexner's words in 1910. Either the Other's ordered system adheres to the rules of the biomedical Self's order or it is dismissed as “quack medicine” Secondly, is the illustration of the influence of the WHO and their policy, especially in regards to safety; though, it can be argued that both WHO and the PMA share a biomedical paradigm. And lastly, traditional medicine is only being recognised as herbs and acupuncture, purportedly because this is all that PITAHC is “referring”. And yet, in interviews with PITAHC, the PMA was often blamed for an opposition to everything but acupuncture and herbs. Hence, is the PMA making PITAHC accountable for the PMA's own restrictions?

4.3.4.6 The Restrictions of TAMA

All informants interviewed that had worked on TAMA with Flavier shared the “bottom-line” desire to just see the bill passed by the Philippine House of Representatives. Hence, decisions on how to present the bill, in terms of wording and content were chosen according to what would render the bill least subject to opposition, especially from the PMA.

One anonymous DOHP informant stated:

“They [the PMA] were professionally threatened -meaning that Western medicine was all they knew- and partly economically threatened, because some doctors receive retainer fees from pharma [multinational pharmaceutical corporations]”. #988

And one fifty-five year-old female physician in Manila who helped to design TAMA stated:

“We believed traditional medicine could and should be recognized, but we only attempted to integrate what was considered safe and thereby implementable. Our original law included standards and regulations and we were advised (by policy experts) that TAMA should just be for promotion and [possibly] only later for enforcement. We had to keep the law simple and silent about many things. So we removed the regulatory component and it became a general promotions bill about creating a government-owned corporation. A government corporation was decided as the easiest way to get the bill passed; then we would not have to compete for logistical requirements and seek money from the government...We tried to make TAMA unchallengeable. And so, we had to be conscious of what PMA would and would not accept. We knew from the beginning the PMA would be against what we were suggesting. *They* were our wall. We needed to go by what they deemed safe. So, we focussed on acupuncture and herbs because they were easiest to get the PMA to agree to, rather than *albuaryos* or faith healers”. #961

This description of the formation of TAMA was corroborated by several other informants. The very political restrictions that directed the policy-making process of TAMA is a reflection of the political process described in Chapter 3 of the construction of what may be understood as the “mother policy” of TAMA; The Declaration of Alma Ata. In both of these policy-making processes, that are central to the healthcare integration examined in this thesis, the normative representation of the rational policy-making process is severely challenged by the omnipresent “politicking” involved.

Firstly, similar to Halfdan Mahler's championing of The Declaration of Alma Ata, Flavier's championing of TAMA is an example of how health policy can be a function of the particular agendas of their policy makers.

Furthermore, although TAMA was designed to improve access to healthcare, in the policy-making process, the emphasis shifted more toward altering TAMA in any manner necessary in order to see it enacted into law. Thus, TAMA became less concerned with initial motivational factors (such as healthcare access) and more concerned with appeasing powerful special interests groups (such as the PMA) by relinquishing the regulatory capabilities of PITAHC; and thereby appeasing the government by insisting that PITAHC can be self-sufficient, and appeasing almost all stakeholders involved by only discussing the integration¹⁸⁴ of herbs and acupuncture. These “compromises” were also identified in the vague language of the Declaration of Alma Ata. Thereby the policy-making process of TAMA was, first and foremost, a political process that defined the boundaries of formal state healthcare integration in the Philippines according to a particular biomedical Othering.

4.3.4.7 TAMA and the Formation of PITAHC

TAMA was approved in 1997, and with this approval the official division of the DOHP, the Philippine Institute for Traditional and Alternative Care (PITAHC), was created (PITAHC 2009). PITAHC promotes the use of “traditional health modalities” with the objectives of addressing:

“the growing lack of medical manpower in remote areas that are not served by our doctors and delivering basic health services through traditional and alternative healthcare; and provide [sic] training to Barangay Health Workers on traditional and alternative healthcare to enable them to treat common illnesses in their communities” (Ordon 2009: 2).

However similar this mission statement for PITAHC is to Alma Ata, it appears to be an emphasis on paper only. In fact, in my participant experience with PITAHC, access to healthcare through “traditional and alternative” practices was never discussed.

¹⁸⁴ An informant affiliated with TAMA's passage defines integration as “having the many traditional systems and modalities available in the facility from the BHS to the hospital with all practitioners working together as a team”. As will be identified in Chapter 5, Sadanga is a municipality that was studied whose integration is most similar to this definition.

One PITAHC stakeholder blames the compromises of the diluted version of TAMA that was finally passed, referring to it as a “law without teeth”, meaning that without regulatory abilities, PITAHC was rendered impotent. However, informants outside of PITAHC single out PITAHC's “uninspired” leadership for the lack of realisation of the goals of TAMA. One criticism of PITAHC repeated by several informants concerned projects that would be abandoned and not extended from one administration to the next. However, in participant experience with PITAHC, the primary issue I identified appeared to be embedded in their construction as a government corporation.

4.3.4.8 The Focal Point of Healthcare Integration in the Philippines: Access or Profit

In participant experience with PITAHC, I became quickly aware of the constant pressure on PITAHC staff to make PITAHC's work profitable. The threat of PITAHC's imminent closure was discussed on at least two occasions over the eighteen months I conducted observation at PITAHC. One of the former Secretaries of Health of the DOHP and one of the Founders of PITAHC stated in interview:

“They are not on the radar if they are not profitable. They have to be [financially] viable because they are a government corporation,¹⁸⁵ so that has taken over the priority as the reason for their existence. To make PITAHC profitable they have had to focus on things like Western massage, because then they can work with The Spa Association of the Philippines and focus on the Medical Tourism and Wellness industry.¹⁸⁶ The problem is you have public health physicians running a government corporation. PITAHC is burdened by people not meant to do business.”

PITAHC informants identified that imported non-biomedical practices such as acupuncture¹⁸⁷ were more profitable through classes and licensure.

196

¹⁸⁵ The same informant explained that originally PITAHC was meant to be funded by “cigarette and alcohol tax and a duty free shop”. However, “the Asian economic crisis in 1998” thwarted these income generating possibilities.

¹⁸⁶ It is likely more than coincidence that the surge in interest in non-biomedical practices, both in the Philippines and globally, coincided with the “wellness movement”, whose public demand resulted in the development of a wellness industry in which “traditional” was equated with natural, and wellness was equated with both.

¹⁸⁷ The business of acupuncture is not restricted to PITAHC. Several universities, Such as University of the East and University of the Philippines-Manila offer courses to medical students. One informant on staff at the University of the Philippines noted: “They want us to teach acupuncture because it earns [money] for them...period”.

The cost of a week-long acupuncture course was often at least half as much as the monthly salary of a general physician. I also witnessed PITAHC focus on the licensure of visiting Korean acupuncturists, whilst ignoring the licensure of Filipinos, because they could charge a higher amount for a Korean license to practice acupuncture in the Philippines. However, given PITAHC has no regulatory capabilities, it is questionable if licenses issued by PITAHC would be considered legally binding.

The only local non-biomedical practice to be emphasised by PITAHC since its formation in 1997, are the ten local herbs approved for use by BFAD. Three of which -*legundi*, *tsaang-gubat*, and *sambong*- PITAHC manufactures in processing plants they inherited (PITAHC 2009). The herbs are manufactured as drugs in the form of tea and tablets, which I found to be ubiquitous in the research sites studied (Callope 2008).

PITAHC is not without critics. Miniano blames the “tragic state” of Filipino traditional medicine on PITAHC's “indolence” and “foreign drug companies that collaborated with the ruling political elite” (2006: 15). She cites instances in which “drug companies hire lobbyists to lobby against the entry of newly marketed herbal products” (*Ibid.*). The “bio-piracy of indigenous plants”¹⁸⁸ is also identified as a result of the poor intellectual property protection of TRIPS.

4.3.4.9 Summary

This section has reviewed the development of state involvement in non-biomedical practices and practitioners in the Philippines from the politicisation of non-biomedical practices to their promotion into law through TAMA. The limitations of TAMA, primarily imposed by the PMA, restricted what the government corporation of PITAHC could do and which practices could be promoted. Commodification of non-biomedical practices has played a significant role in deciding which practices were to be integrated.

197

¹⁸⁸ To date, the herbs *ilang-iulang*, *banaba*, *sambong*, and *nata de coco* have been identified to be patented by foreigners (Miniano 2006: 16). Yet, oddly, when I interviewed lawyers in the government division of intellectual property rights, the lawyers could cite no past cases of intellectual property right infringements in the Philippines.

4.4 The Filipino Self

A contextualisation of the Philippines would not be complete without attempting to understand the Filipino Self. To better understand why the healthcare system is used the way it is used, it will be helpful to offer a brief contextualisation in this section of some factors affecting the Filipino Self.

4.4.1 *Locating the Filipino in a Sea of Plurality*

As inappropriate as it may be to attempt to define identity by virtue of citizenship, it is possibly even more problematic in a country in which the people of an archipelago of 7,107 islands appear to be more joined by a colonial administrative designation than by any discernible national identity. Therefore, whilst trying to locate a Filipino Self, it is doubtful that such a coherent identity exists. Yet, both the literature reviewed and several informant interviews attempt to represent such coherence.

Interestingly, little of the political literature reviewed discusses the primary importance of centralisation and decentralisation to the Philippine people and to Philippine identity. Philippine social structure in rural areas had not significantly changed from the pre-colonial barangay structure. Family and barangays remained the focal point of one's identity.

For example, one 32 year-old male informant in Demang, Sadanga had recently relocated to his wife's barangay in a different province. In his description, of this change, he explained that he had not merely relocated, but with his new barangay relationships he had “taken on a new life” and a new identity. #700

Norgaard describes the notion of individual as community whereby: “Nothing exists in and of itself...you are embedded in a family that extends out to the community and everything you do affects and is affected by everything each of the other members do” (1994: 132). Hence, in the majority of the Philippines “you are where you live and with whom you live”. In other words, identity of *field* is formed through the local *doxa* defining the Self.

Thereby, to have political and economic control of one's local level can be understood as not only breaking with colonialism and the Other's ordered systems, but also returning to a social structure that represented the ordered systems of understanding and meaning within emic *doxas*.

4.4.1.1 Representations of the Fractured Colonial Self

Despite observing the maintenance of the integrity of local *doxa* in this research, the post-colonial critique in the Philippines often focuses on a fractured Filipino identity resulting from the colonial Othering of the Self. Azurin argues that colonialism resulted in a “compartmentalised being” in which modernization has “separated the person from their belief” through the “subtle brainwashing of Filipino intellectuals by their colonial mentors” (1995: 4-5).

This sentiment was echoed by many of the academics and DOHP informants interviewed. A repeated theme identified was the anger directed toward the issues Filipinos now faced as a result of the legacy of colonialism. Yet, I observed that although the living legacy of colonialism was being perpetuated by the numerous family elites dominating all aspects of life in the Philippines, the anger was mostly directed toward the institutional legacy of colonialism. Informants identified the institutions of education and healthcare as particularly pernicious to the Filipino Self.

However, the influence of both Spanish and American colonialism was never uniform across the archipelago and was more concentrated in particular areas. In my research in the barangays, I did not encounter this post-colonial fracture of which Azurin wrote, though it was oft-repeated by academics I interviewed.

4.4.1.2 A Geography of Modernity: The Temporal-Spatial Construction of a Colonial Doxa

A deficiency found in simple systems analyses and reductionistic representations of modernity is that change can only be understood to occur in a hegemonic “all-or-nothing” manner within any population. However, colonisation was not a uniform process between all of the islands of the Philippine archipelago, nor within all of the areas of any given island, nor even uniformly throughout any town.

The movement of modernity in the Philippines may be partly understood as an outcome of where colonists perceived they could safely travel. For example, the Spaniards tended to remain in the more accessible lowland areas and refrained from travel to the highlands, especially in Northern Luzon and Mindanao (Nelson 1968). This may be partly due to the tribes of the Northern Luzon highlands being associated with headhunting and were thereby feared (Raedt 1969; Rosaldo 1980). However, the Americans did infiltrate many areas where the Spanish feared to go. The division is reflected in the Catholicism of the lowlands that shifts to Protestantism in the highlands.

However, identifying the geography of colonial influence is even more nuanced within individual towns. The Spanish colonists remained near Manila and town centres (known as *poblacions*). The further a barangay was located from the *Poblacion*, the less likely it was to be under Spanish rule or even indirectly influenced by colonisation. Those barangays far from the *poblacion* and difficult to navigate were very often relatively free from Spanish influences. Thereby a gradual weakening of Spanish influence can be detected the further one travels from the town centre.

I had noted in Sunday church services near a *poblacion* that hymns and songs were sung. However, in churches further from the town centre congregants would sing chants that appeared improvised and would continue for hours. One service I attended at 10am continued until 7pm.

The Minister of Culture of the Philippines identified in interview, that music can be used as a marker for the geography of modernity via the adoption of a Western understanding of temporality. The further one travels from the *poblacion*, the less the music can be distinguished as a song. What is significant here is that the songs and hymns sung nearer the town centre had a beginning, a middle, and an end, whereas in the improvised chants identified further from the centre of town there were no such linear boundaries, and chanting simply continued until congregants were tired. Thereby, chanting can be understood to occur outside of a Western conception of time, and identifies that whatever influence colonialism or the modern world exerts on this barangay; they are eclipsed by emic ordered systems of understanding and meaning.

This same phenomenon can be observed in the sequence, or lack thereof, in serving a meal. The further one is from a *poblacion*, the less likely will there be any order in the serving or eating of a meal. Thereby, there are no first, second, or third courses but only the placement of whatever is going to be served at the table and eaten in any order that a person chooses. Life, thereby, appears to be lived in a permanent present.

These observations seem to be identifying the difference between the adoption of a *doxa*, compared to the adoption of a *habitus* through mimesis. Music and eating are the products of a *habitus* of a given *doxa*. Thus, it wasn't just that Filipinos influenced by the Spanish and American colonists mimicked their customs, but rather adopted the colonists way of thinking about linearity and time. Hence, those Filipinos most influenced by the colonists were also more likely to demonstrate aspects of ordered systems of understanding and meaning, such as time, that was more akin to the Western Other's. Thereby, the notion of a uniform Filipino cosmology or identity is challenged and problematised.

4.4.1.3 Shame and the Colonial Self: Othering the Self

“Most of us are expatriates right here in our own land. America is our heartland whether we go to there or not” (de Quiros 1990).

Regardless of the location of a barangay, I often noted in interviews, especially in focus groups, that some barangay informants would lower their voice, blush, giggle, avert their eyes, and otherwise display signs of embarrassment when asked or answering questions about their use of local non-biomedical practitioners and practices. Reflexively, I was concerned that this may have been a reaction to me, the questions, or the way the questions were being asked. However, each time this occurred I would query the translator afterward and was told the reaction had to do with “their shame”.

One female informant assessed: “It is colonial shame...we believe we are not good enough unless we are more like them”. #322

I was reminded of the whitening soap that can be purchased from the furthest outpost and the ubiquitous roadside billboards I observed throughout the Philippines that displayed advertisements with young Filipinos whose features appeared markedly European. One twenty-eight year old female informant from Paniki, Bagabag explained:

“They look like they are from Spain. That is what is considered beautiful”. #15

It would be inaccurate to interpret this in an essentialised manner, and assume that all Filipinos exhibited so-called “colonial shame” and sought to emulate and become the Colonial Other. However, a prevalence of hierarchical Othering was observed in the sites studied. Hence, adopting the colonial Other and their ordered systems of understanding and meaning in place of the ordered systems of the Self may offer insight into the depictions of shame it appears I witnessed.

However, I did witness an entire municipality react in what appeared to possibly be embarrassment and shame. Several weeks prior to my visiting Bontoc, there was, what was described to me by the MHO, an “epidemic of students in the local high school who were possessed”. Purportedly 47 teenagers all simultaneously believed themselves to be possessed by an evil spirit and the entire municipality corroborated these fears. I was told that psychiatrists and psychologists came from as far as Manila; a fifteen hour bus ride away. However, local exorcists were also employed by families. According to the MHO, the psychiatrists and psychologists worked alongside the exorcists without sharing a word. What was noteworthy was after the event. By the time I arrived, I attempted to speak with teachers from the local high school and parents of some of the students. Although people agreed to be interviewed, I was never able to interview anyone. No one ever showed up. Apparently, my translator relayed, the Governor and Mayor placed a “gag order” on Bontoc residents from speaking with either media or outsiders. It may be more than coincidence that Bontoc was heavily influenced by American colonialism and American Medical missionaries.

Interestingly, an informant who helped to develop TAMA stated that shame and Filipino identity were some of the main concerns for many of the team that helped to draft TAMA, especially in terms of the promotion of local healthcare practices and practitioners.

“Even the idea of integration was to reduce shame. If we are ashamed of our own medicine than possibly by legitimising it, will have an impact on its development and everyone's development. We wanted to help raise the self-esteem of Filipinos. We wanted to demonstrate that what is Filipino is *real*, and what is real is of value. And that we do not need to depend on the U.S. for that. We believed that this would ultimately help us build the nation...by using culture for sustainable development in all aspects. Shame is an obstacle to self-development that has been placed on us from the outside and taken into the Filipino identity. If you feel shame you are not driven to performance.”

This statement is noteworthy for several reasons. Firstly, as was discussed, this statement corroborates that the making of a policy for the promotion and integration of local healthcare in the Philippines was not solely motivated by concerns of access or controlling the informal healthcare economy as is represented in WHO documents. Secondly, shame, or what I am interpreting here as “Self-Othering”, is identified in practice to be detrimental to not only identity, but to sustainable development and “nation building”. Thereby, the promotion of culture, in this example through local healthcare practices, can enhance sustainable development. Thus, eradicating or ignoring culture may compromise sustainable development and nation building.

4.4.2 *How Do Filipinos [Emically] Represent Philippine Identity*

The Filipino Self is far more than a reaction to the colonial Other. An emic representation of identity might always be more accurate than any etic attempt at understanding, interpretation, and representation. Very often, something can be lost in the translation of etic interpretation. Philippine identity was explained to me by several informants using a popular metaphor.

Informants understood their identity in contrast to the Western representation of the individual. The Western individual, it was explained to me, is like a hard-boiled egg. Every person is protected by a shell, an armour, and has an obligation to protect oneself. Thereby, the obligation is toward preserving the Self. However, the Philippine identity was compared to several uncooked eggs, which when cracked, their whites blend into one another (as a shared being) but still maintain a focal yolk (or centre of being). Thereby, part of the Filipino self-identity *is* the Other, and thereby there is an obligation toward preserving the Other. For by preserving the Other, one is also preserving a part of the Self.

This was also explained to me by the barangay council in Sadanga.
“When someone is hurt in the field, we will all come and help.
Your barangay is there to help you, so you are never alone”.

It was also explained that barangay members would not consider to move away from their barangay, nor on the outskirts of the barangay, because they would lose this connection with their barangay that is understood as essential.

Interestingly, this is not understood as altruism or charity in the Philippines. In fact, it could be argued that the Western conception of altruism is based on a perspective of Self-preservation. Whereas, in the Philippines self-preservation is Other-preservation or more accurately there is not a Western type of Othering because the Other of the barangay *is* the Self. Such an understanding is in direct contradiction to the Western enlightenment “individual”. The individual is not understood to be in isolation or apart from others in the Philippines, but rather a part of others. Hence, the Philippine concept of *Kapwa* (i.e. the other) illustrates an understanding of “the Unity of self and others” and thereby a shared identity in a construction of “I” (Mulder 1997: 19).

This was explained in another way. I previously identified that Filipino's do, in fact, engage in Othering, according to one's tribe, religion, beliefs, and family. I was told by an informant that this kind of Othering was superficial and not entrenched in Filipino identity, but more akin to a kind of gossip that is not deeply entrenched and does not affect behaviour. One thirty-year old male in Blumentritt, Murcia stated:

“In moments of crisis, Filipinos will be as one.” Thereby, during one of the annual “natural” disasters due to typhoons, flooding, and landslides Othering will wash away, as opposed to, what informants observed “with Hurricane Katrina in the United States, where the residents were made as refugees in their own country [sic]”. #237

However, I would question if the Othering practised among Filipinos was not more entrenched than superficial as identified in tribal identity as a marked boundary extending to *habitus*. One fifty-year old Female informant in Murong, Bagabag describes:

“Even when peeling potatoes, Ilocanos will peel the potato one way and Visaynas peel the opposite way”. #335

But far more serious consequences of Othering were observed. For example, I observed in Sadanga, that in an emergency, barangay members would often avoid going to the neighbouring municipality of Bontoc where there was a hospital, and instead travel 30 kilometres further specifically to avoid Bontoc, with whom Sadanga has had long-standing tribal disputes. Hence, both hierarchical and exclusive Othering can be identified in the Philippines.

This section has provided a brief overview of the emic and observed representations of the Filipino Self.

4.5 Conclusion

This Chapter has prepared an analysis of healthcare integration in the Philippine context, firstly through an examination of the political-economic and socio-cultural history of the Philippines and the pre-colonial inhabitants of the archipelago.

The development of the Philippine healthcare system was explored through the movement of social organisation and administration from decentralisation to centralisation and back. Decentralisation, in particular, has affected access to healthcare and the need for local non-biomedical healthcare practitioners. Other factors affecting access to healthcare include: decreased access to affordable medication, decreased human resources in rural areas as a result of professional migration, and poor municipal budgets due to both the Internal Revenue Allotment and the low prioritisation of healthcare in municipal budgets.

The structure of the formal and informal healthcare systems of the Philippines was examined. The development of healthcare integration into the national healthcare system was traced from the early informal integration by politicised organisations, such as Community-Based Health Programs and the New People's Army, through the Passage of TAMA and the development of the DOHP's PITAHC.

CHAPTER 5

Analysing Healthcare Integration in the Barangays of Four Municipalities in the Philippines

5.1 Introduction

This Chapter will present and analyse the results of interviews, participant observation, ethnography, and pile sorts with barangay members, barangay council members, local non-biomedical practitioners, and local biomedical practitioners in the barangays of the municipalities of Bagabag, Bontoc, Murcia, and Sadanga.

Firstly, I present data on how informants represent and use their healthcare system. Next I analyse informant perceptions of how integration has, or has not, affected: physical and financial access to healthcare; referrals between biomedical and non-biomedical practitioners; and if informants perceived normative healthcare integration as appropriate for their barangay. Lastly informant perceptions of safety, efficacy, and quality will be presented and analysed. A comparative discussion of the types of integration found in each municipality concludes this Chapter.

5.1.1 *The Presentation of the Data*

In order to understand the variation between municipalities and between the barangays within each municipality, an ANOVA statistical test was conducted. In ANOVA analysis between the four municipalities, significant variation was demonstrated between each municipality with p values of 0.05 at a 95% Confidence Interval. Therefore the null hypothesis stating there is no variation between municipalities could be rejected. However, in conducting an ANOVA to identify significant variation between the nineteen barangays within the four municipalities, p values greater than .05 at a 95% Confidence Interval (of the magnitude of .410 or higher) were derived with each variable assessed. Therefore, the null hypothesis could not be rejected and it is statistically verified that in these data sets there is no statistically significant variation between barangays within a given municipality. Thus, there is no statistical justification for presenting the data in terms of nineteen separate barangays.

Therefore, although the data was collected and analysed at the barangay level, for the purposes of Chapter 5, much of the data will be discussed at municipal levels.

The issue with a municipal level presentation of the data, is that it may not afford an analysis of the informal integration processes occurring at the barangay level. The agency that was identified in barangay midwives and health unit workers, local practitioners, and barangay officials and members would also be ignored in a singular presentation at the municipal level. Therefore, though statistical analysis will be discussed primarily at the municipal level, ethnography and selections from interviews at the barangay level will also be presented.

5.1.2 A Brief Overview of the Research Sites

5.1.2.1 Research Site 1: Bagabag



Figure 5.1: The Municipality of Bagabag

Bagabag, is a municipality of 32,787 residents in 19 barangays in the Province of Neuva Vizcaya in Northeastern Luzon (National Statistics Office 2008). Bagabag has been implementing the policy of integration (top-down through the Municipal Health Office) since 2007. Data was collected in the barangays of *Baretbet*, *Careb*, *Lantap*, *Murong*, and *Paniki*.

Formal Healthcare Integration Identified

The Municipal Health Officer employs both acupuncture and Chinese orthopaedic massage (*Tui-na*) in the Municipal Health Office. Both the Municipal Health officer and the Municipal Health Nurse practice acupuncture.

The MHO also prescribes the herbs manufactured by PITAHC. The Public Health Nurse reported that she had conducted trainings for *hilots* at least once a year, until funding from the DOHP ceased in 2008.

5.1.2.2 Research Site 2: Murcia



Figure 5.2: The Municipality of Murcia

Murcia (in the province of Negros Occidental on the Southwest Island of Negros) has a population of 71,289 in 23 barangays (National Statistics Office 2008). Murcia is located in an area of numerous sugar cane haciendas on which many of the informants work. Data was collected in the barangays of *Blumentritt*, *Caliban*, *Damsite*, *Minoyan*, and *Poblacion*.

Formal Healthcare Integration Identified

The Municipal Health Office conducted trainings for *hilots* in the past but has not conducted any trainings since 2008, due to lack of funding from the DOHP for trainings. No other formal healthcare integration was identified from the MHO or the barangay health stations. Informally, local lay volunteer community health workers (CHWs), were trained by the NGO *INAM* in acupressure and *Tui-na*; the use of local herbs; and biomedical hygienic education. After completion of their training, the CHWs work in their own barangays visiting barangay members.

5.1.1.3 Research Site 3: Sadanga



Figure 5.3: The Municipality of Sadanga

Sadanga, is a municipality in Mountain Province (in the highlands of Northern Luzon) with a population of 9,076 in 8 barangays (National Statistics Office 2008). Sadanga was the most physically inaccessible municipality studied, due to its rugged, mountainous terrain and frequent dangerous landslides. Sadanga was relatively unaffected by both Spanish and American colonialism, due to its inaccessibility and historical reputation for headhunting (Raedt 1969). As noted in the ethnography in Chapter 4, sacrifice rituals are regularly practised in Sadanga. Data was collected in the barangays of *Anabel*, *Poblacion*, *Sacasacan* and *Demang*.

Formal Healthcare Integration Identified

In Sadanga, the Municipal Health Officer invites the local bonesetters and *arbularyos* to treat people in the Municipal Health Office and in barangay health offices as needed. The Municipal Health Officer commonly refers patients to other local practitioners including faith healers. BHWs in several of the barangay health stations use wild local herbs. According to informants in other areas, both the MHO's use of local non-biomedical practitioners in the RHU and the BHWs use of local herbs were considered unique and atypical.

5.1.1.4 Research Site 4: Bontoc



Figure 5.4: The Municipality of Bontoc

Bontoc (the capital of Mountain Province), is directly southwest of Sadanga. Although Bontoc is also rural, it is in a valley and the barangays are easily accessible to the town centre where a provincial hospital is located. Bontoc has a population of 24,798 with 16 barangays (National Statistics Office 2008). Bontoc was heavily influenced by American colonialism and American medical missionaries. Data was collected from the barangays of *Alab Oriente*, *Bontoc Ili*, *Guina-ang*, *Mainit*, and *Samoki*.

Formal Healthcare Integration Identified

I did not identify any formal or informal healthcare integration in Bontoc, beyond microlevel integration of individual barangay members. Thereby, Bontoc serves as a “control” municipality.

5.1.2 The Demographics of the Sample

The barangay informant samples (n=728) were restricted to convenience and snowball samples that were contingent on availability. As part of the methodology, the sample size was fairly evenly divided among the barangays of the four municipalities and among the barangays.

Men were more difficult to recruit for the sample than women. In total there were 633 female barangay informants (87% of total barangay informant sample) and 95 male barangay informants (13%).

Hence, with this sample bias, the sample may only be representative of the women of these particular barangays. Age was fairly evenly divided in barangay samples and in the total sample between informants who were 40 years of age and older (53%) and informants who were younger than 40 years of age (47%).

Table 5.1 Summary of Barangay Informant Demographics at the Municipal Level (n=728)

Criteria	Municipalities (<i>percentages in each Municipality</i>)				
	Bagabag	Murcia	Sadanga	Bontoc	% of Total
Number of Informants	187 (26%)	194 (27%)	168 (23%)	179 (24%)	728 (100%)
Age Groupings	20s (12%) 30s (34%) 40s (26%) 50s (24%) 60s (4%) 70s (0%) 80s (0%)	20s (7%) 30s (3%) 40s (13%) 50s (43%) 60s (23%) 70s (10%) 80s (0%)	20s (21%) 30s (35%) 40s (18%) 50s (7%) 60s (6%) 70s (10%) 80s (3%)	20s (24%) 30s (9%) 40s (15%) 50s (19%) 60s (18%) 70s (15%) 80s (0%)	20s (21%) 30s (26%) 40s (17%) 50s (18%) 60s (10%) 70s (7%) 80s (1%)
Sex	93% Female 7% Male	90% Female 10% Male	96% Female 4% Male	87% Female 13% Male	87% Female 13% Male
Annual Income in Philippine Pesos (PhP)	<10,000 (7%) <30,000 (70%) <50,000 (20%) <100,000 (3%) >100,000 (0%)	<10,000 (4%) <30,000 (0%) <50,000 (26%) <100,000 (66%) >100,000 (4%)	<10,000 (51%) <30,000 (32%) <50,000 (8%) <100,000 (4%) >100,000 (4%)	<10,000 (81%) <30,000 (14%) <50,000 (0%) <100,000 (0%) >100,000 (4%)	<10,000 (34%) <30,000 (27%) <50,000 (14%) <100,000 (21%) >100,000 (3%)
Years of Education	Years 0 (6%) 1-6 (15%) 6-8 (40%) 8-12 (30%) 12+ (9%)	Years 0 (3%) 1-6 (10%) 6-8 (13%) 8-12 (53%) 12+ (20%)	Years 0 (18%) 1-6 (11%) 6-8 (18%) 8-12 (33%) 12+ (19%)	Years 0 (9%) 1-6 (14%) 6-8 (18%) 8-12 (18%) 12+ (41%)	Years 0 (11%) 1-6 (12%) 6-8 (23%) 8-12 (34%) 12+ (19%)

Annual income was more homogeneous within barangays and municipalities than across municipalities. Educational levels attained were generally heterogenous both within individual barangays and between municipalities. In general, informants over 60 years of age were identified to earn a lower annual income and have attained lower educational levels than younger informants. However, informants in their twenties with higher educational levels were also identified to earn lower annual incomes than other barangay members.

Hence, there was no general correlation between educational level attained and annual income. These trends were consistent among all barangays and municipalities studied. Because of the vast number of overseas workers who support their families in the Philippines, reported income may be more related to family member migration than to educational level attained.

5.2 The Perception and Representation of the Healthcare System

This section will review the results of the data concerning how informants perceived and used their healthcare system. For clarity the results will be grouped into three groupings of themes. The first grouping assesses how informants perceive their healthcare system. The next grouping studies how informants use their healthcare system. The last grouping examines the assumptions of normative healthcare integration.

5.2.1 The understanding of the healthcare system (who and what is the healthcare system)

Table 5.2 How Barangay Informants Perceive Their Local Healthcare System

Criterion	Barangays			
	Bagabag	Murcia	Sadanga	Bontoc
% of barangay informants who perceive their healthcare system as divided between formal and informal	4%	10%	0%	8%
% of barangay informants who perceive all practitioners in their barangay as part of their healthcare system	82%	96%	98%	78%

5.2.1.1 Barangay Member Results

What is the healthcare system

In assessing how healthcare integration is understood by all stakeholders, it would be important to establish an emic perception of the healthcare system. The majority of barangay informants in all municipalities identified their healthcare system as both the formal (state) and informal healthcare system. Regardless of barangay informant location or any other demographic, few informants generally perceived a division between formal and informal healthcare systems. Informants identified that their perceptions are based on their use of their healthcare system.

Who is the healthcare system

Barangay informants generally did not differentiate biomedical practitioners from local non-biomedical practitioners in their healthcare system. All practitioners, regardless of their practice or formal integration status were considered part of the healthcare system. Those informants who did not use local practices and practitioners at all, or reported to “not believe” in non-biomedical practices did not perceive those practitioners as part of their healthcare system. Thus, it appears how informants use their healthcare system and which practices and practitioners they employ, inform their perception of their healthcare system. Thereby, practising a plural use of healthcare informs a plural representation of the healthcare system. Table 5.2 illustrates that perceptions are fairly consistent regardless of municipality or barangay.

5.2.1.2 Local Non-biomedical Healthcare Practitioner Results

Table 5.3 The Distribution of Local Healthcare Practitioners

Practitioner Self-Designation	Barangay (number of informants interviewed) (n=49)			
	Bagabag	Murcia	Sadanga	Bontoc
Hilot	8	7	--	5
Albularyo	2	3	2	3
Supok/Faith healer	3	5	3	4
Bonesetter	--	1	2	1

Although a significant effort was made to interview as many local healthcare practitioners as possible, they were the least accessible group to interview. Approximately one-half to two-thirds of the local practitioners practising in each barangay were interviewed. *All* local non-biomedical practitioners interviewed consider themselves to be part of the healthcare system. Despite their great diversity, local non-biomedical practitioners did share certain perceptions about healthcare regardless of their self-designation, their practice, or their location.

Table 5.4 How local practitioners perceive their local healthcare system and their place in it

Criterion	Barangays			
	Bagabag	Murcia	Sadanga	Bontoc
% of local practitioners who perceive their healthcare system as divided between formal and informal	0%	0%	0%	0%
% of local practitioners who perceive themselves to be part of the healthcare system	100%	100%	100%	100%

5.2.1.3 Local and Municipal biomedical practitioner results

Table 5.5 The Distribution of Local Biomedical Practitioners

Biomedical Practitioner	Barangay (number of informants interviewed)			
	Bagabag	Murcia	Sadanga	Bontoc
Barangay Midwife	4 ¹⁸⁹	5	4	5
Barangay Health Workers	30	29	17	21
Municipal Health Officer (physician)	1	1	1	1
Municipal Health Nurse	1	1	0	1

Although devolution of healthcare resulted in barangay funding decisions being made at the municipal level, primarily by the municipal mayor and the municipal health officer, it also resulted in barangay midwives having more administrative decision-making capabilities.

For example, of the four MHO informants, only the MHO of Sadanga perceived that local non-biomedical healthcare practitioners were part of the healthcare system. Yet, the majority of midwives and BHWs in all of the barangays assessed perceived their local practitioners to be part of their healthcare system. And though the MHO of Bagabag does not perceive all non-biomedical practitioners to be part of the healthcare system, the municipal nurse who works with him does. Such foundational differences in the perception of the healthcare system, is a primary illustration of why healthcare integration cannot be understood to occur in a uniform manner across all levels of administration; especially in an administratively devolved healthcare system.

¹⁸⁹ Although I studied five barangays in Bagabag, two barangays shared one midwife. This was common, especially in more rural barangay health stations.

Table 5.6 How biomedical informants perceive their local healthcare system

Criterion	Barangays			
	Bagabag	Murcia	Sadanga	Bontoc
% of midwife informants who perceive all practitioners in their barangay to be part of the healthcare system	95%	68%	83%	73%
% of BHW informants who perceive all practitioners in their barangay to be part of the healthcare system	97%	85%	98%	92%
Does the MHO informant perceive all practitioners in their municipality to be part of the healthcare system	No	No	Yes	No
Does the municipal nurse informant perceive all practitioners in their municipality to be part of the healthcare system	Yes	No	Yes	No

This section reviewed the results of examining informant perceptions of their healthcare system. All of the results obtained appear to be influenced by how the healthcare system is being used by the informant.

5.2.2 The current practice and use of local non-biomedicine (who uses it, how, and why)

This section will review the results of the interview questions concerning how barangay informants use their healthcare system; what determines their choice for a particular practitioner or practice, and how use of healthcare is related to preferences.

5.2.2.1 Barangay Informant Reported Use of Local Non-biomedicine and Biomedicine

Determining the actual use of local healthcare can identify how plurality is practised by barangay informants, as well as the possible reasons the healthcare system is used in the manner it is used. This analysis also assists in providing an understanding of how integration occurs at the microlevel in communities. Informant's reported use of local healthcare varied significantly in the municipalities studied. In Murcia, **89%** of informants reported using local practices and practitioners. However, only **14%** said that they preferred to use local healthcare. **78%** of informants in Murcia reported that they preferred to be treated with biomedicine, yet **40%** of informants said that the cost of biomedicine prohibited its use. Whereas in Bagabag, **48%** of informants reported to use local healthcare, but only **3%** reported to prefer its use. **97%** reported to prefer the use of biomedicine and only **2%** reported that cost prohibited their use of biomedicine.

In Sadanga, **78%** of informants reported use of local healthcare and **16%** preferred to primarily use local healthcare. While **84%** preferred to primarily use biomedicine and **23%** of informants identified cost as prohibiting biomedicine's use. Finally in Bontoc, 63% of informants used local healthcare and **9%** preferred to use local healthcare as their primary source of healthcare. **91%** preferred biomedicine as the primary source of healthcare. And **9%** reported that the cost of biomedicine prohibited its use. (See Table 5.7)

Table 5.7 How Barangay Informants Are Using Their Healthcare System

Indicators of Healthcare Integration	Bagabag	Murcia	Sadanga	Bontoc
% of barangay informants who report use of local non-biomedical healthcare	48%	89%	78%	63%
% of barangay informants who prefer to primarily use local non-biomedical healthcare	3%	14%	16%	9%
% of barangay informants who prefer to primarily use biomedicine	97%	78%	84%	91%
% of barangay informants who prefer biomedicine, but cannot use due to cost	2%	40%	23%	9%
% of barangay informants who use the practitioners they prefer	98%	58%	73%	91%

Thus, though approximately half or more of informants reported using local healthcare, less than one-fifth preferred to use it as their primary source of healthcare, preferring biomedicine instead. Furthermore, the majority of informants reported to be treated by whom they prefer, except in Murcia (**58%**), which also displayed the most informants who preferred to use biomedicine but were prohibited to use due to cost (**40%**). And yet, for the majority of informants in other municipalities cost is not identified as prohibiting their use of biomedicine. It appears healthcare use cannot solely be understood as a function of cost; although cost was primarily identified as restrictive in terms of a private physician office visit, a visit to the physician at the RHU or the midwife at the BHS is free.¹⁹⁰ Furthermore, a visit to a local non-biomedical practitioner is paid in monetary or in-kind donations. Therefore, for these informants healthcare choice cannot be solely attributed to cost.

¹⁹⁰ Although usually it is necessary to purchase pharmaceuticals, which were reported to be too costly for some informants.

Informants identified other factors that affect their choice of practitioner including: distance to, and availability of, a given practitioner; the most appropriate practitioner for the perceived healthcare problem or illness; and whom informants perceive can help them the fastest. Some informants reported that they would prefer to go to a local non-biomedical practitioner first to see if their illness renders a visit to the physician. One 35 year-old female from Guina-ang, Bontock stated:

“I go to *supok* [faith healer] first, because the *supok* can tell if I really have a problem. Then I know whether I should go to the doctor”. #151

Further analysis showed that informants primarily use local non-biomedical healthcare for their perception of mild illnesses, and will use the barangay health unit or physician for what were perceived to be more serious illnesses. Fever, cold, headache, body ache, stomach ache, and cough were all identified as appropriate for local healthcare practitioners and practices. However, informants also reported that they would seek out local non-biomedical treatment if a given ailment was not resolved with biomedicine.

Similarly, the perceived cause of a health problem was also identified as affecting the choice of type of healthcare. Local healthcare was the first choice if the health problem was perceived to be a result of religious or socio-cultural sources, such as a curse, or alternatively if the cause was inexplicable.¹⁹¹

This complexity of reasons for the particular choices for healthcare use problematises much of the literature on medical pluralism depicting a bounded healthcare system. The representation of a uniform healthcare system which a community will use in a uniform manner is also problematised by these findings.

¹⁹¹ Several informants mentioned that illness can be caused by inadvertently stepping on the house of a small spirit.

5.2.3 Assessing the Assumptions of Beneficence of Normative Healthcare Integration

This section is primarily attempting to assess many of the assumptions of the beneficence of normative healthcare integration.

Table 5.8 Barangay informants' perception of relationship between healthcare access & integration

Indicators of Healthcare Integration	Bagabag	Murcia	Sadanga	Bontoc
% of barangay informants reporting <i>increased</i> cost of physician office visit (from 2005-2009) ¹⁹²	33%	6%	0%	2%
% of barangay informants reporting a <i>reduced</i> distance to their primary practitioner (from 2005-2009)	0%	2%	0%	0%

5.2.3.1 Assessing Perceived Changes in Access to Healthcare Related to Healthcare Integration

Changes in Physical and Financial Access to Healthcare

Integration of local practices and practitioners into formal healthcare systems was first identified in the Declaration of Alma Ata as a means to achieve health for all. But how is integration related to access to healthcare? Questioning barangay informants about their experiences with healthcare integration facilitates an assessment of many of the assumptions embedded in the normative healthcare integration discourse.

Firstly, improvements to physical and financial access to healthcare have not been demonstrated in these communities within the period since integration began in Bagabag and Murcia (2005-2009). In fact, of 728 barangay informants only five in Murcia reported any reduction in the distance to their primary practitioner in the past five years. However, their reason was due to a change in residence.

The cost of a primary care visit (relative to informants' weekly incomes in 2005 and 2009) either remained the same or was increased in the case of informants in Bagabag and Murcia.¹⁹³

220

¹⁹² For many of the comparative questions in this grouping, the five year period from 2005 through 2009 was used to determine identified changes, as healthcare integration was reported to have begun in Bagabag and Murcia at approximately the same time in 2007. Sadanga's informal integration has been ongoing since the 1990s.

¹⁹³ It should be noted that the majority of increases in consultation fees are for informants who went to private physicians. As mentioned, it is free to consult the RHU and BHS. Healthcare costs were only found to have been reduced if informants were covered by *Philhealth* in 2009, but not in 2005.

The fee for a private physician office visit was reported to have doubled from 2005 to 2009 for **33%** and **8%** of informants in Bagabag and Murcia respectively. All informants in barangays interviewed identified an increase in the cost of pharmaceuticals.

Some *hilots* who had previously received training in sterile birthing techniques from the DOHP and UNICEF were reported to now charge fees for service after training. Therefore, in this particular instance, healthcare integration has resulted in an increase in the cost of healthcare. However, in general neither changes in physical nor financial access to healthcare were identified to result from healthcare integration.

Table 5.9 Biomedical and local practitioner referral as a result of integration

Indicators of Healthcare Integration	Bagabag	Murcia	Sadanga	Bontoc
% of local practitioners who reported to refer their patients to biomedical practitioners	91%	93%	100%	86%
% of local practitioners who reported an increase (or decrease) in referrals <i>to</i> biomedical practitioners because of healthcare integration (from 2005-2009)	0%	0%	77%	0%
% of local practitioners who reported an increase (or decrease) in referrals <i>from</i> biomedical practitioners because of healthcare integration (from 2005-2009)	- 12%	33%	100%	0%
% of biomedical practitioners who reported to refer their patients to local practitioners	23%	96%	92%	67%
% of biomedical practitioners who reported an increase (or decrease) in referrals <i>to</i> local practitioners <i>as a result of</i> healthcare integration (from 2005-2009)	0%	4%	95%	0%
% of biomedical practitioners who reported an increase (or decrease) in referrals <i>from</i> local practitioners <i>as a result of</i> healthcare integration (from 2005-2009)	0%	0%	92%	0%

Practitioner Referral

According to Ha°klev (2005), to whom practitioners refer their patients can indicate the overall extent of integration. Additionally, referral can affect healthcare access. The results of referral also reflect the complexity of the healthcare system in the Philippines and healthcare integration as well. Although a high percentage of local practitioners reported to refer to local biomedical practitioners across all municipalities, the same is not true of local biomedical practitioners referring to local non-biomedical practitioners.

Nor is referral consistent even within a given municipality. For example, the MHO of Sadanga reported to always refer to local practitioners, yet all of her midwives and BHWs have not unanimously followed suit. The same (but opposite) is true for the MHO of Bagabag. Though his integration of the RHU resulted in no referrals, some midwives and BHWs in the Barangays (**25%**) under his jurisdiction, did choose to refer. Hence, as was reflected in the differing perceptions of the healthcare system; at different levels, activities such as referral can be contradictory resulting in multi-directional complex processes.

There are several different processes of integration that are occurring in the example of Bagabag. The MHO is engaging in an exclusive Othering and restricting all referrals to his own acupuncture. One result of his lack of referral to local practitioners is that *albularyos* and faith healers in Bagabag reported that the integration of acupuncture has reduced and marginalised their practices (**-12%**). However, several midwives in barangays of Bagabag report to continue to refer to local practitioners (**23%**). In addition to these processes of integration that are occurring simultaneously at higher local levels, barangay members in Bagabag may refer one another to local practitioners at the microlevel.

Hence, these contradictory results illustrate that regardless of what kind of healthcare integration may be occurring at any given level there will be multiple processes occurring simultaneously at multiple levels that may or may not be complementary. Thereby, the complexity of healthcare integration is revealed, which problematises the normative simple systems representation of healthcare integration.

5.2.3.2 Assessing the Normative Healthcare Integration Constructs of Quality and Safety

Safety

The biomedical construction of safety is assumed to be a universal construct in the literature reviewed and in the healthcare integration discourse. Lacking in this discourse, however, is the consideration that safety might also be socially constructed with understandings other than those of biomedicine and may change from one local context to another. Though safety is a primary concern identified in almost every WHO healthcare integration document, safety was a concept that was so foreign to many barangay informants, that many could not conceive why they would be concerned for their safety with their *albularyo* or their *supok*. Less than one-quarter of barangay informants reported any concern about the safety of local practices and practitioners. And less than **3%** of all informants in any barangay report ever having any concerns of safety specifically regarding *hilots*.¹⁹⁴

Table 5.10 Barangay Informant Perceptions of Safety and Quality of Their Healthcare System

Indicators of Healthcare Integration	Bagabag	Murcia	Sadanga	Bontoc
% of barangay informants who perceive the quality of their healthcare system has improved (from 2005-2009)	89%	89%	87%	71%
% of barangay informants who perceive the quality of their healthcare system has improved specifically as a result of (<i>formal or informal</i>) healthcare integration (from 2005-2009)	3%	22%	88%	0%
% of barangay informants that are concerned about the safety of local healthcare practices	13%	18%	5%	9%
% of barangay informants that are specifically concerned about the safety of <i>hilots</i>	3%	2%	1%	0%

The primary safety issues informants identified included: the perception that local practitioners did not have the proper diagnostic equipment to make a biomedical diagnosis and that they are not capable of handling “serious illness”. However, the predominant sentiment was that unless a local practitioner gives one reason for concern, there is no conception of risk with local practices. Moreso, the idea of considering their non-biomedical practitioners as a risk was completely foreign to barangay informants.

¹⁹⁴ See Chapter 6 for detailed discussion.

One 45 year old female from Bontoc Ili, Bontoc explained:

“Our barangay is like our family. You are not generally afraid of your family. When your mother picks herbs for you, are you going to worry that they are not safe? We grew up with our *albularyo*, why we would we be afraid of her?” #172

Therefore, safety may be a concept that cannot be assumed to be universally conceptualised in the same manner, but rather encompasses local meanings as well. Such local meanings inherently problematise the paradigm of global health policy, which is structurally designed to accommodate a singular universal biomedical interpretation of safety.

Yet , it also may not be completely accurate to think of safety or risk as defined solely by the Self's local [Bourdieuian] *field*. For example, one 46 year-old male informant from barangay Minoyan in Murcia, problematised safety in a personal manner. He identified safety was an issue with only certain local practitioners:

“Because they don't have laboratories how could they support their diagnosis without having laboratory results. They might predict or diagnose their patients by 'pre-assumptions' [sic] only...this is very dangerous”. Later in the interview he identified *hilots* as “the first choice of pregnant mothers and the most wanted [sic] because they are very skilled and confident to deliver”. #326

Thereby, this informant created his own idiosyncratic distinction between those local practitioners that should be judged according to a biomedical standard and those that do not need to do so because of their proven skill. Hence, safety may not only be understood to be socially determined, but individually determined as well.

Quality

Although the majority of informants in all barangays and municipalities identified an improvement in the quality of their healthcare system from 2005 through 2009, the majority of informants outside of Sadanga did not perceive the improvements in the quality of their healthcare system as related to healthcare integration, especially in Bagabag.

In Murcia, **22%** of all bnarangay informants perceived that CHWs improved the quality of their healthcare system, even though the CHWs were independent agents that were not recognised by the staff of the BHS or the RHU.¹⁹⁵ In Bagabag, **89%** of informants perceive the quality of their healthcare system improved since 2005. However, only **3%** of Bagabag informants perceived that integration improved the quality of their healthcare system.

Similar to the understanding identified that the perception of a healthcare system is related to how one uses it, is the perception that the quality of the healthcare system is related to what it supplies. Informants identified major purchases, such as an ambulance, or increased access to medication as improvements in the overall quality of the entire healthcare system. Quality was also related to free medication, the purchase of major laboratory equipment, major improvements to the BHS, and more BHWs or longer daily hours of BHS operation. The perception of the quality of the healthcare system was also affected by informant's preference for their midwife. It is interesting to note that there were no criteria mentioned in terms of the outcomes of treatment or improvements to health. These particular informant understandings of quality challenge the notion of a shared universal construct of quality.

The Integration of CHWs and the Perception of Quality

The bottom-up integration of CHWs in Murcia by the NGO *INAM*, is a special case that necessitates a discussion of the barangay data at the barangay level. CHW's were trained by INAM to work in the communities in which they resided. There were only three CHWs in the barangays of Murcia, however, I was only able to access two of the three barangays.

As discussed in Chapter 4, *INAM's* work was part of the CBHP groupings of local healthcare NGO's that based their model on China's barefoot doctor programme. However, unlike the barefoot doctors programme, these CHWs were completely apart from, and unrecognised by, the formal healthcare system.

225

¹⁹⁵ According to the MHO of Murcia, I was the first person to have told him about the CHWs in his barangays.

Although the CHWs reported to have supported one another, they each conducted their CHW work in separate barangays and were for the most part independent agents. Thus, the way they conducted their CHW work and their individual relationship with their communities may reflect the variation in findings from these two barangays.

Although from one-third to greater than two-thirds of informants were familiar with the work of CHWs; fewer informants perceived that CHW's work actually improved patient health outcomes. However, interestingly, informants from both barangays perceived the CHWs as improving the quality of their healthcare system.

Table 5.11 Perceptions of the Work of CHWs by Barangay Members of Murcia

Barangay Members' Perceptions of CHWs	Barangay Minoyan , Murcia (n=28)	Barangay Poblacion, Murcia (n=47)
% aware of CHWs in their barangay	89%	38%
% perceive CHWs are improving the quality of their healthcare system	89%	35%
% reporting barangay members are applying what they learn from CHWs	67%	29%
% reporting illness has decreased in their communities attributed to work of CHWs	40%	15%
% reporting people are more aware of their health and taking better care of themselves because of CHWs	12%	22%

In general, the work of CHWs was identified to influence barnagay members to use and grow more herbs.

5.2.3.3 Assessing the Assumptions of Local Practitioner Standardisation

In both the literature and in interviews (with the DOHP and WHO) it is either assumed (or not considered) if local non-biomedical practitioners will: a) be capable of being standardised; b) agree to participate in standardised training; and/or c) alter their practices according to their standardised training. The findings of local practitioner interviews problematise many of these assumptions.

Table 5.12 Standardisation of Local Non-biomedical Practitioners

Indicators of Healthcare Integration		Bagabag	Murcia	Sadanga	Bontoc
% of local practitioners who reported they received <i>any</i> formal or informal training for their practice	Hilot	100%	86%	--	100%
	Albularyo	50%	0%	0%	0%
	Supok/ Faith healer	0%	0%	0%	0%
	Bonesetter	--	100%	100%	100%
% of local practitioners who reported they would be willing to participate in standardised training	Hilot	100%	100%	--	80%
	Albularyo	50%	100%	100%	100%
	Supok/ Faith healer	67%	60%	100%	100%
	Bonesetter	--	100%	100%	100%
% of local practitioners who reported they would change their practice according to their standardised training	Hilot	100%	100%	--	100%
	Albularyo	0%	0%	0%	33%
	Supok/ Faith healer	0%	0%	0%	0%
	Bonesetter	--	0%	50%	0%

Although the majority of local practitioner informants reported that they would want to attend standardised training, many identified practical obstacles that would prohibit them from actual participation. These include getting to the trainings and understanding the trainings. Many of the local practitioners interviewed had no formal education and were illiterate. Hence, they identified they would be disinclined to attend trainings if literacy was expected.

However, several informants reported that even if they were willing and able to attend standardised trainings, they would not agree to simply alter or abandon their practices in order to comply with standardised training. Their reasoning identifies a fundamental misunderstanding or dismissal in the healthcare integration literature and discourse that is directly related to the ordered systems of understanding and meaning of these local practitioner informants.

Firstly all informants interviewed, regardless of their self-identified practitioner designation, understand their work in terms of a relationship to “God”. They do not separate their practice from their “religious convictions” as dictated by their shared *doxa* of the barangay Self. Their practice *is* their *habitus*. Regardless of their practitioner designation or their geographic location, almost every local practitioner interviewed relayed a similar story of how they became a practitioner. A 38 year-old female *supok's* story is illustrative.

“I was in my early twenties and I became very ill. I had a high fever for days. I don't remember if I was dreaming, but an old woman came to me. I think it was the Virgin Mary. And she said, 'You must do what God asks you to do or you will die'. I became more ill until, I was told, I died. I was told they put me in a casket and everyone came to mourn. And then, the next day before they were going to bury me...I 'woke' up. Almost right away everyone knew about this and there was a line outside my door of people waiting to be healed. I didn't know what to do, but I remembered what the old woman told me. Well suddenly, I started hearing this man whisper in my ear what I should do for each patient. And I would do what he told me and they would always get better. People come to see me from all over the Philippines. From all over the world. And I know if I stop doing what God wants me to do, I will die again”. #35

Although this particular informant's story was unique, the elements of her story were repeated by almost every practitioner interviewed. These elements include: a) an illness that is severe or life threatening creates a liminal state in the informant. b) They then experience a visitation from an elderly man or woman or Catholic Saint -or other religious representation of the Self- either in a dream or in a vision. c) In this visitation informants report they are told to comply with God's request for them to heal for their barangay or they will suffer and/or die. d) The original entity in the vision/dream or a new entity then teaches them how to practice, again through dreams or visions.

Hence, there are two fundamental issues with attempting to standardise these local practitioners. Firstly, the local practitioners interviewed are all practising in a very individual manner, which would problematise any attempt at standardisation that would normatively assume bounded healthcare practices or practices that could be systematised.

Secondly, and more problematically, is the assumption that etic (standardised) practices can and will be adopted, regardless if these practices alter or replace an emic practice that has quite specific meaning and understanding to each practitioner, as well as to their patients. From observations it was clear that local practitioners will do what is necessary to maintain the integrity of their practices and thereby the integrity of the Self's ordered systems of understanding and meaning.

Local practitioners stated that they would not simply do what they were told to do from the agents of the DOHP. They considered it impossible to comply with the DOHP, when they are beholden to answer to “God”, who is requesting that they practice as they were “taught”. Thereby, to not practice in the manner informants perceive they are meant to practice, or to refuse a patient in need, is perceived as akin to refusing “God's will” and thereby jeopardising the well-being of the practitioner, their family, and their barangay.

Furthermore, local practitioner informants found the concept of standardisation of their practices inherently ignorant, for they believed that what was given to them as a gift from “God” could neither be taught, nor standardised, nor should it be shared. However, the normative conceptualisation of healthcare integration cannot account for such socio-cultural variation.

What is also noteworthy in the data is that though all *hilots*, along with one bone-setter and *albularyo*, reported that they would change their practices according to their standardised training, no local practitioner informant interviewed would agree to completely abandon their own practices for the purpose of biomedical standardisation. Rather, they would agree to selectively choose what to incorporate into their own practice. Hence, such an integration would not conform to the etic criteria of biomedicine, the DOHP, or the WHO, but rather chosen biomedical information will be adopted and integrated into the local practitioner's practice as *they* see appropriate and according to their own criteria.

Douglas explains that the non-Western Other is not necessarily “striving for [Western] intellectual consistency” (1966: 111). Hence, it is not that the Other is inconsistent with *their* own ordered system, but rather with the ordered system of the Western Self.

Thus, biomedical standardisation insists on an exclusive Othering of local non-biomedical practices into a standardised form, fitting biomedical criteria, and thereby conforming to the ordered systems of understanding and meaning of the biomedical Self. Whilst local practitioners appear to engage in inclusive Othering, in which certain aspects of their biomedical standardised training, that they deemed appropriate and valuable to their practice, would be integrated according to *their* criteria of their ordered systems. Therein lies a foundational boundary in healthcare integration resulting from the inability of both Self and Other to compromise due to the potential threat to the integrity of their respective ordered systems of understanding and meaning.

However, the issues of standardisation and integration identified by local practitioners will also be identified in barangay members who share the same ordered systems as their local practitioners. Several barangay informants reported to primarily treat themselves and their families with herbs picked from their own garden, for which they claim they were directed to pick by “God”.

A 70 year-old female from Demang, Sadanga stated that she never went to a doctor or a local practitioner, but picks the herbs from her garden that “God taught me to use”. #689

This was not only identified in herbal use, but in all forms of self-treatment.

A 62 year-old female from Samoki, Bontoc delivered eight babies at home stating “God will help me at home. That is where I am intended to deliver”. #141

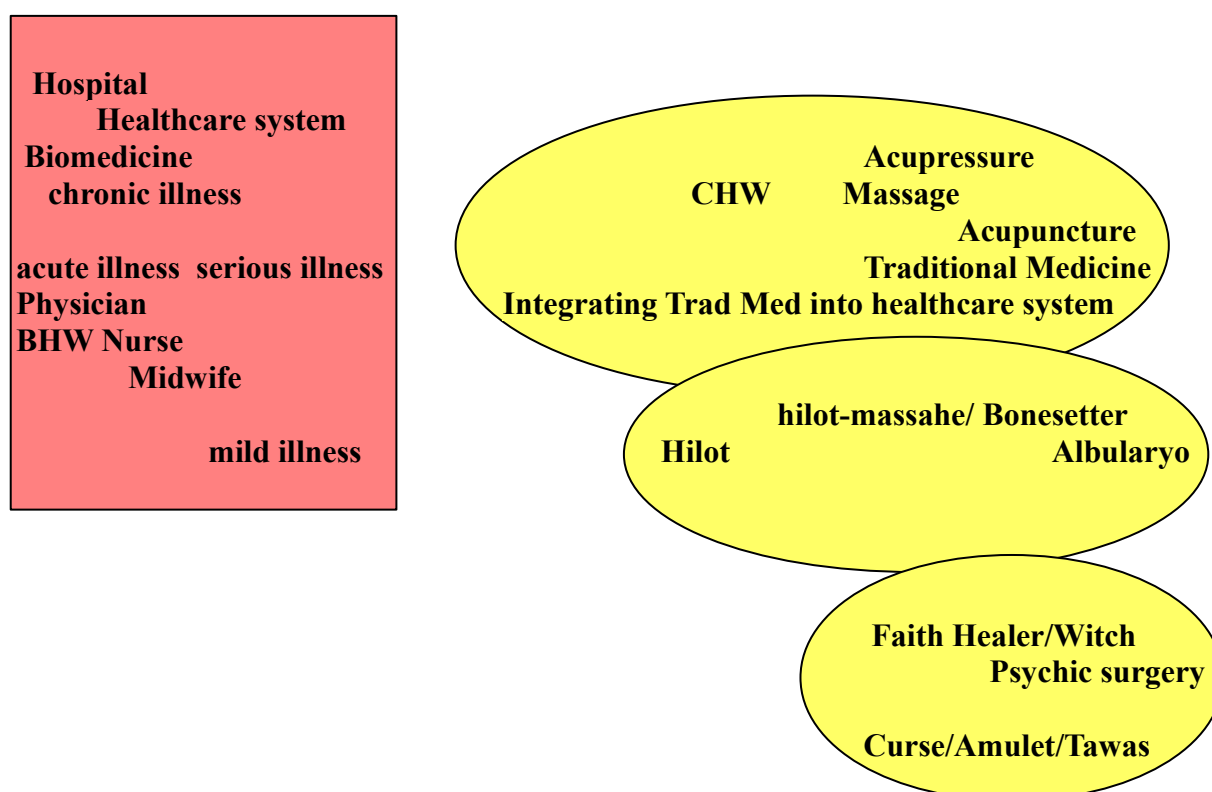
Both barangay informants and barangay council (and even many of the barangay midwives) identified that local practitioners serve important social and cultural functions in their communities.

Thereby, informants expressed concern that their local practices can be altered to the point of being no longer socially meaningful, or specifically able to address what would be etically understood as “culture-bound illnesses”. Yet these valid concerns are neglected in the current discourse on healthcare integration.

5.2.3.4 Assessing the Pile Sorts

This basic difference between the ordered systems of the barangay Self and the biomedical Self -in their ordering of the conceptual domains of healthcare, the healthcare system, and healthcare integration- is well defined in the multi-dimensional analysis of the pile sorts illustrated here as concept maps. In Figure 5.5 a concept map of the multi-dimensional analysis displays the distinct binary opposition understood between biomedical categories and all non-biomedical categories as perceived by biomedical informants.

Figure 5.5 A Conceptual Map of Multi-dimensional Scaling Results of Biomedical Informant Pile Sorts (n=77)



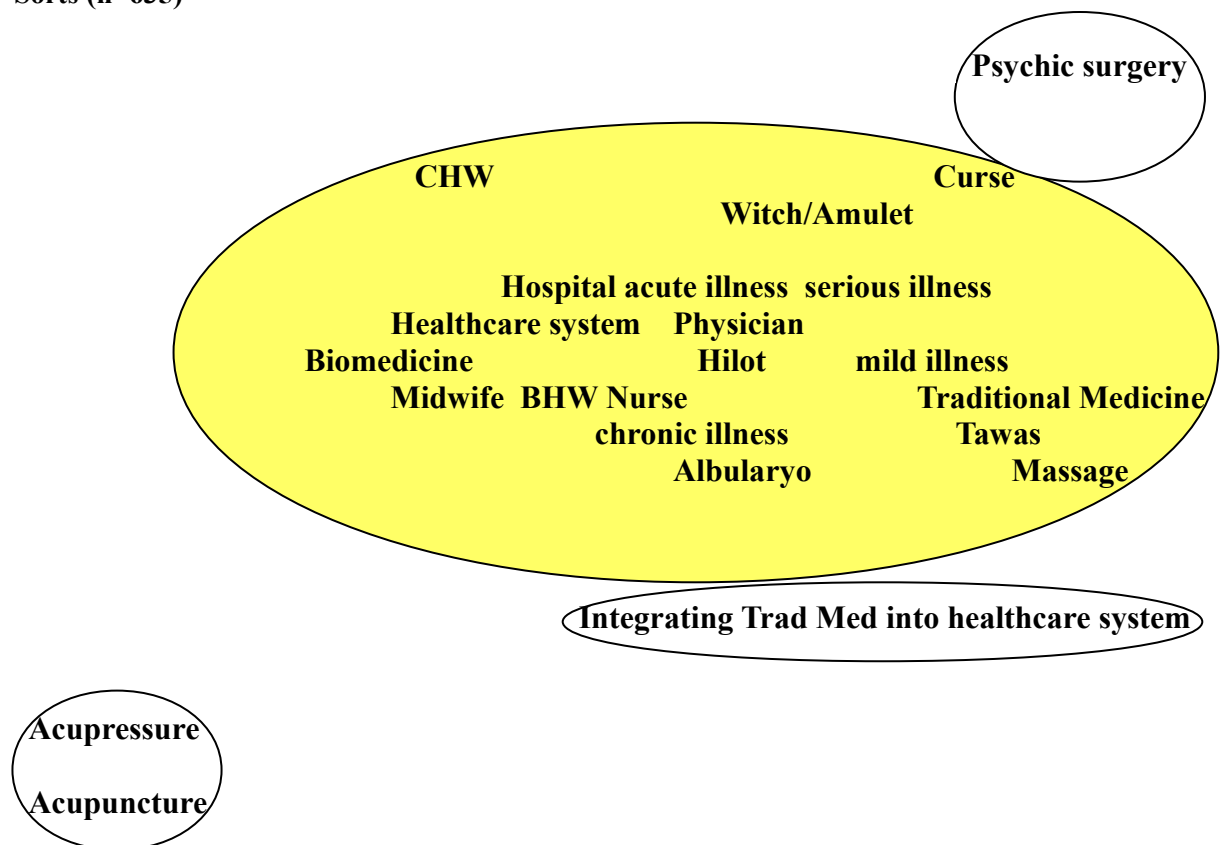
The above 27 terms were chosen from informant interviews. The Pile sorts of biomedical informants illustrate a sharp division in the perception of terms representing biomedicine and terms representing non-biomedicine. The map is “read” in three dimensions. Frequency of pairings is indicated by the closeness of the groups as a clustering. Then the map is read according to how close the clusterings appear in terms of the X and Y axes. Interestingly, the term “Integrating Trad med into healthcare system” is conceptually understood to belong to the Other group. Hence, paradoxically it would appear that integration is perceived (by the biomedical Self) as a process done *by* the non-biomedical Other.

Although there are two separate groupings, within these groupings hierarchical Othering can be observed. Three separate sub-groupings can be identified in the non-biomedicine grouping with imported non-biomedical practices such as acupuncture and accupressure perceived as “more like” the biomedicine category. The terms least like the biomedicine category appear in the clustering in the lower right of the map, starting with the term “faith healer”. This grouping seems not even on the same map with the other groupings. This signifies that in pairings by informants these terms appeared together with the greatest frequency, but were the least commonly paired with any of the other terms. The local practices begin with the term “hilot”. The local practices are perceived as slightly closer to the biomedicine grouping according to the plane of the X axis, with the term “hilot” perceived as most like the biomedical grouping of the non-biomedical group.

Figure 5.6 is a concept mapping of the results of the multi-dimensional scaling for the barangay informants. The barangay informants perceive all of the terms except those in the lower left corner (of “acupuncture” and “acupressure”) to be one cohesive grouping with minor clusterings.

Hence, it appears that the barangay informants perceive their healthcare system as more of a complete cohesive system than the biomedical informants. If the pile sort analysis and interpretation are accurate, then it appears that barangay informants *already perceive their healthcare system as an integrated system*, whilst the biomedical informants perceive two separate systems that require integration. Therefore, these results would pose the question, if the barangay informants already perceive their healthcare system as integrated, then for whom is healthcare integration?

Figure 5.6 A Conceptual Map of Multi-dimensional Scaling Results of Barangay Informant Pile Sorts (n=635)



5.2.3.5 Assessing the Perceived Appropriateness of Normative Healthcare Integration

Table 5.13 Informants Perceived Appropriateness of Normative Healthcare Integration

Indicators of Healthcare Integration	Bagabag	Murcia	Sadanga	Bontoc
% of barangay informants who believe the normative representation of healthcare integration is appropriate for their barangay	63%	2%	4% ¹⁹⁶	41%

Although the word “appropriate” in relation to healthcare integration appears with great frequency in the WHO literature, “appropriateness” is never consistently defined. Furthermore, the perception of the appropriateness of healthcare integration by the recipients of healthcare integration is not considered.¹⁹⁷ Although **54%** of all barangay informants perceived healthcare integration to be a good idea, in general, barangay informants did not perceive normative healthcare integration to be appropriate for their barangay.

The most oft cited reasons that informants perceived normative healthcare integration to be inappropriate for their barangays included: the “beliefs” and practices of local practitioners and biomedical practitioners are too different to be integrated; and local practitioners are unlikely to comply and “give up their traditional ways of healing”. Several informants also cited concern that local practitioners might start charging a fee if they were integrated into the healthcare system. However the most frequently cited reason for the perceived inappropriateness of normative healthcare integration, was that people prefer to decide their healthcare for themselves. This concern, which problematises the representation of agency in the normative healthcare integration discourse, was voiced by one-fifth of all barangay informants and by one-third of the informants of Sadanga.

Informants from Sadanga were most noteworthy in distinguishing the appropriateness of normative healthcare integration from the informal integration they experience in the

¹⁹⁶ However, 88% of informants in Sadanga qualified their response that if healthcare integration was *informal*, as currently practiced by their MHO, they would then consider integration appropriate for their barangays.

¹⁹⁷ At the beginning of each interview I would introduce the research and explain normative healthcare integration according to the informant's understanding.

As discussed, the MHO of Sadanga integrates the bone-setters and *albularyos* into the RHU, as needed on a case by case basis.¹⁹⁸ The outcome of this heteronormative integration, is reflected in Sadanga's barangay informant perceptions; with **4%** of informants perceiving normative healthcare integration as appropriate for their barangay and **88%** perceiving their own informal heteronormative integration as appropriate.

For example, A 35 year-old male from Sacasacan, Sadanga stated: “Now the bonefixer and healers and doctors work together. I doubt that will go on if the DOH comes here”. #695

Hence, normative integration appears to be perceived to potentially disturb an informal relationship and referral system that is already working for the community.

The Perceptions of Barangay Council Members

Barangay council members demonstrated similar perceptions to those of their barangay members; with the majority of barangay council members perceiving normative healthcare integration as a “good idea”. However, the majority of barangay council members did not perceive integration as appropriate for their barangays. Nor did they think it feasible that they could oversee the implementation of healthcare integration in their barangays.

¹⁹⁸ Interestingly, this is similar to how TCM is integrated through its selective use by physicians in biomedical hospitals in China.

Table 5.14 Barangay Council Member's Perceived Appropriateness of Healthcare Integration

Barangay	Number of Council Member Informants	% of informants who believe normative (<i>formal</i>) healthcare integration is appropriate for their barangay
Bagabag	28	
Baretbet	8	38%
Careb	4	25%
Lantap	3	66%
Murong	7	43%
Paniki	6	17%
Murcia	27	
Blumentritt	9	22%
Caliban	5	20%
Damsite	6	0%
Minoyan	3	33%
Poblacion	4	25%
Sadanga	19	
Anabel	5	20%
Demang	3	0%
Poblacion	5	0%
Sacasacan	6	0%
Bontoc	24	
Alab Oriente	4	25%
Bontoc Ili	5	20%
Guina-ang	4	0%
Mainit	3	33%
Samoki	8	13%

5.2.4 Summary

The main research findings reviewed in this section problematise the normative healthcare integration discourse in relation to this sample. In general, normative healthcare integration was not perceived to be appropriate by most informants for their barangays, especially in Sadanga and Murcia. Hence, in general all of the assumptions of the beneficence of healthcare integration from improved access and referral, to improved safety, quality, and appropriate use of non-biomedical practices and practitioners are challenged by these findings.

5.3 Different types of Healthcare Integration are Perceived Differently: A Brief Comparative Discussion of the Findings

The research findings demonstrate that there is no single type of healthcare integration occurring in the sites studied. Examining the municipal level alone identifies three distinct types of healthcare integration being employed. In Bagabag, the municipal health officer is engaging in a formal top-down healthcare integration that conforms to the normative representation of healthcare integration. In Sadanga the municipal health officer is informally integrating local healthcare practitioners and practices according to the requests of the members of the barangays of Sadanga. Her choice of integration is unique to this particular context and would be considered a heteronormative form of healthcare integration. In Murcia, a NGO external to the barangays of Murcia engaged local volunteer CHWs in an independent bottom-up heteronormative form of healthcare integration that also does not conform to the normative model of healthcare integration.

5.3.1 Comparing Normative and Heteronormative Examples of Healthcare Integration

The normative healthcare integration exhibited by the MHO of Bagabag was not only practised differently from the heteronormative integrations identified in Murcia and Sadanga, but also illustrated different outcomes. Two identifiable outcomes can be understood in terms of community participation and marginalisation. In Sadanga, the barangay members decided which practitioners would be advantageous for them to have the MHO integrate into the RHU. Integration in Sadanga did not consist of standardisation or in any manner controlling the practices of the *albularyos* and bonesetters brought into the RHU to practice.

In Murcia, integration was completely community-led by members of the barangay. The function of *INAM* was to facilitate the education by which community members could initiate and practice their own healthcare integration.

However, the employment of the community in both of these forms of integration are markedly different from the normative healthcare integration identified in Bagabag. The integration in Bagabag was solely led by the MHO. The barangay members were not involved in the healthcare integration process. However, it is also common in Filipino culture to respect the decision making powers of a physician, whilst not necessarily complying with them (Tan Aloro and Lumitao 2008). The difference in the integration of Bagabag was illustrated in interview with the MHO. In discussing how healthcare integration is being implemented in Bagabag, the Municipal Health Officer reported:

“the goal is to completely retrain them to our standard of safety”. The MHO then outlined an explicit plan to render all local healthcare practitioners ‘safe’ by retraining chosen practitioners in those practices that have been approved as safe and effective by PITAHC, BFAD, and the DOHP. Thereby, *albularyos* that would normally use an abundance of local herbs for treatment will be retrained to only treat with the ten herbs approved by BFAD; practitioners using *massahe* employing spiritually-guided massage will be retrained in forms of massage approved by the DOHP, and *hilots* will assist midwives but no longer deliver. If the practitioner was unwilling to be retrained or was found to not comply with training, they would not be allowed to continue practising.

Hence, in the context of Bagabag, standardisation and integration are being utilised to narrow the practices that local healthcare practitioners can use or to completely eradicate them. As mentioned, this marginalisation was reported by several local practitioners in Bagabag who experienced markedly reduced patient visits, which they attribute to healthcare integration. This finding, contradicts the integration discourse, which perceives non-biomedical healthcare practices and practitioners as marginalised *until* they are formally integrated. For example, Dauskardt warns:

‘the absence of a decisive position by governments with regard to traditional medical systems does, however, leave traditional practitioners in an ambivalent and marginal position. This marginalisation can retard attempts by the government itself or other health groups to enhance the utilisation and the joint development of health resources’ (1990: 354).

However, as integration is context dependent, both scenarios of marginalisation are clearly possible depending on how integration is implemented relative to a given social context.

Another difference that can be understood in comparing the healthcare integration identified in Bagabag, with that of Sadanga and Murcia is the difference in the barangay's and individual's control of their healthcare. According to both CHWs in Murcia and *INAM* representatives, the function of *INAM's* bottom-up integration is primarily to educate barangay members in order to facilitate healthcare choice and self-determination of healthcare. This was particularly evident in the observed CHW focus on teaching the use of herbs available in one's backyard, which informants identified as particularly helpful in their ability to take care of themselves. Also, through her open-door policy for local practitioners to practice alongside her in the RHU, the MHO of Sadanga reduced barriers to physical access to local healthcare that fostered greater community control of healthcare. In both Sadanga and Murcia, it appears that local perspectives were granted more importance, than global perspectives.

In Sadanga, the issue of self-determination in healthcare choices appeared particularly important to barangay informants.

A 26 year-old female from *Poblacion*, Sadanga states that their informal means of integration is preferred by many barangay members because “there are sick people who prefer going to the *supok* without the doctor telling them to do something else”. #712

The implication being that in another type of integration these choices might be controlled by the physician instead of the patient. This can be understood if, for example, the patient was suddenly required to seek the approval or referral of their physician in order to see a local practitioner, rather than going directly on their own. Similarly, a 37 year-old female from Anabel, Sadanga stated:

“When you are sick, you can send for the *supok* instead of having to wait for a doctor to ok” #657

Self-determination was a concern of community informants not only in terms of their own ability to make healthcare choices, but also in terms of which local healthcare practitioners would be allowed to practice.

For example, one 56 year-old female from Demang, Sadanga was concerned that if Sadanga engaged in normative healthcare integration, local practitioners “may not be allowed to do what they can do”. #682

And a 23 year-old female informant from Sacasacan, Sadanga stated “If I want noodles, I’m not going to buy it from a box”. The informant explained that her concern would be that normative healthcare integration would result in a “watered-down” version of her local healthcare that would ultimately be inferior to “the real thing”. #718

Hence, informants identified concern that a different kind of integration from the one they have, might irrevocably alter local practices and thereby the potency and effectiveness¹⁹⁹ of these practices.

All of these concerns can be categorised as concerns of agency. Over the course of this fieldwork, I was consistently reminded of the centrality of agency in the local healthcare discourse. As mentioned, the barangay midwives are the gatekeepers of formal healthcare in the barangay and as such, do not necessarily follow the dictates of their superiors. Several barangay midwives reported that they commonly will ignore DOHP policy if they perceive it to be inappropriate for their barangays. For example, many midwives report to have “informal arrangements” with their local practitioners as needed. Although these arrangements vary from midwife to midwife, they also would qualify as a type of informal non-normative integration.

5.3.2 *Comparing Healthcare Integration as a Centralised or Decentralised Process*

Healthcare integration is normatively depicted as a centralised process of the national healthcare system. However, healthcare integration can also be a decentralised process as the CHW's in Murcia illustrate. However, there is a marked difference in the overall role of healthcare integration when comparing Murcia to Bagabag and Sadanga.

¹⁹⁹ Hence, effectiveness here is understood quite differently from the WHO literature, in which effectiveness is facilitated through integration into a biomedical system.

In both Bagabag and Sadanga, the centralisation of non-biomedical practices into the RHU had a more decisive influence on local healthcare, then the slower and hidden decentralised integration of the CHWs in Murcia. After three years of the bottom-up integration of CHWs in their communities, neither the Municipal Health Officer of Murcia, nor any of the barangay midwives reported awareness of the CHWs or their work. Hence, although the CHWs have integrated biomedical, local, and imported non-biomedical practices into their own practice, *they* have not been integrated in any capacity into the formal healthcare system. Hence, depending on the context, it appears that some degree of centrality may be beneficial and necessary for healthcare integration to be practised.

5.4 Conclusion

This Chapter has presented and discussed the results from interviews conducted in the barangays of four municipalities engaging in three different types of healthcare integration. The findings were compared along criteria of healthcare access; concerns of safety; perceived feasibility of formal integration; and concerns of autonomy and self-determination in healthcare choices. The communities' participation in the integration process offers yet another variable by which to examine healthcare integration.

The construction of the normative representation of healthcare and the healthcare system has been challenged by informants' reported use and understanding of their healthcare system. Informants' perceptions of access to healthcare; and quality and safety of healthcare were found to be uniquely understood outside of essentialised biomedical understanding. Furthermore, these criteria did not, in general, perceive to be positively affected by healthcare integration; thereby problematising the assumptions of beneficence of normative healthcare integration.

Beyond the practices of healthcare integration identified, there are also innumerable types of practices of healthcare integration simultaneously occurring at barangay and more microlevels of analysis that can all interact and result in unique and dynamic emergence of other healthcare integration processes.

Hence, what this analysis illustrates is that there are numerous ways to practice healthcare integration, none of which are necessarily equivalent or of a particular value, outside of their application to a specific context. The difference is how appropriate each type of integration is for a given context. Although informants from Bagabag identified normative healthcare integration as appropriate, informants from Sadanga perceived the opposite. Thus, as there are countless ways to practice healthcare integration there are also countless contexts for which some of these practices of healthcare integration will be appropriate and others will not. Recognising, firstly that there are as many ways of practising healthcare integration as there are contexts is imperative to reaching the next stage of determining which healthcare integration practice is appropriate for a given context.

The next Chapter provides a specific case example of the complexity inherent in integration processes, which was introduced in this Chapter, as illustrated through the reintegration of *hilots*.

Chapter 6

The Integration and Reintegration of Hilots in the Philippines

a case example of integrating a local practitioner through the eradication of their practice

6.1 Introduction

The research reviewed in Chapter 5 provides an overview of numerous challenges to the normative representation of healthcare integration. This Chapter reviews a specific case example of healthcare integration through one practitioner, the *hilot*, to provide a better understanding of appropriateness in healthcare integration. This Chapter will first review the global context of traditional birth attendant integration through trainings in the work of WHO and UNICEF. The justification of the failure of these trainings to reduce maternal and infant mortality is then assessed through an examination of the original data sets and data analysis employed. The 2008 DOHP Administrative Order requiring mandatory in-facility birthing with “skilled” birth attendants for all women in the Philippines, is assessed through informant interviews. Finally, potential outcomes of this particular example of healthcare integration is examined.

6.2 The Historical Context of Hilot Reintegration²⁰⁰

This section will review the historical, international, and Philippine context of the integration of *hilots* and the prohibition of their practices through reintegration.

6.2.1 *Fuzzy Data and Integration: The creative use of statistics to control TBA integration*

Traditional birth attendants (TBAs) were the first (and often only) non-biomedical healthcare practitioners to be integrated into formal healthcare systems internationally through trainings directed toward the reduction of maternal and infant mortality. These trainings, sponsored by UNICEF and WHO beginning in the 1950s, predominantly focused on pre- and post-natal care; proper biomedical delivery and sterile techniques; and the recognition of obstetric emergencies for referral (Kruske and Barclay 2004). However, some of the first formal trainings of TBAs can be traced to the Rockefeller Foundation's China Medical Board and the work of John Grant.

244

²⁰⁰ Note: This section that was written for this dissertation was published in the Journal *Biosocieties* in 2011 and was written solely by myself. In reproducing a section of this published article here, I do not breach any copyright rules attached with this publication according to the publisher's contract signed.

6.2.1.1 The Rockefeller Foundation and the early Training of “Old-type Midwives” in China

According to Johnson, the early integration of, what were referred to as, “Old-type midwives”²⁰¹ was rather aggressively enforced in China.

“Local and national governments began to regulate midwives as early as 1913. As part of this process, midwives who had received some formal medical training were required to be licensed, while simultaneously, those working without the prescribed training began to be forced out of the field and their once accepted skills and practices termed as deviant” (Johnson 2008: 283).

In 1930, the Rockefeller Foundation (RF) instituted training for midwives through the *First National Midwifery School* of the National Midwifery Board of China (RAC 1932a). Some of the students were identified as “old-type midwives who have received certificates and licenses and who are also members of the midwives association” (*Ibid.*: 1). In a 1932 letter to John Grant, Marion Yang²⁰², Director of the First National Midwifery School states:

“It is estimated that there are about 400,000 untrained midwives. The main responsibility for the excessive deaths among the mothers and babies may be laid on this untrained group” (RAC 1932a: 2).

Yang justified her position through a research study funded by the RF:

“Although the risk of infant death is no less among infants delivered by modern physicians or midwives than among those of old-type midwives, the differences in the causes of death in the first 14 days are noteworthy” (RAC1932b: 1v). Yang goes on to identify 33 total neo-natal deaths delivered by “Old-types” including 7 deaths attributed to birth injuries, compared to 14 total deaths by midwives and obstetricians with 2 deaths from birth injuries. Yang concludes: “This shows *clearly* the unnecessary harm being done by ignorant Old-type midwives” (RAC 1932a: 1v).

However the statistical analysis was not quite so clear for the category of “Deaths under 1 month and first two weeks”.

245

²⁰¹ The choice of this particular terminology, “Old-type”, may reflect the modernity and Self-Othering that was seizing China's institutions during this period.

²⁰² Note: In her correspondence to Gates, Yang lists her name as Marion Young. Hence, her citations are listed under “Young” in the bibliography. This section is from documents studied in the Rockefeller Archive Center abbreviated here as “RAC”.

In this category, the sample used to assess the “Old-type” (n=1,343 live births) was nearly three times as large as the sample used for the physicians and midwives (n=495) (RAC 1932b: 33). Thus, the mortality rates for physicians and midwives would actually *exceed* those of the “Old-type midwives” if the samples were of equal size.

Yang concludes: “The only way in which it is possible to do anything with training these Old-type midwives is by cooperating with them and through this cooperation try gradually to improve their methods” (RAC 1933a: 3). As of 1933, 246 “Old-type” midwives had been reported as registered and licensed. Yet, Yang noted: “the number of old-type midwives is gradually decreasing and the number of modern midwives is increasing” (RAC 1933a: 20). RF Funding for the First National Midwifery School ceased after July 1934 (RAC1933b: 2).



Figure 6.1 Training Exam of “Old-Type” midwives (from right to left) 1) cutting nails; 2) silver-nitrate eye-drops for infant; 3) tie umbilical cord; 4) infant bath; 5) cleaning hands before delivery.
Source: Rockefeller Archive Center

This early example of integration through exclusive Othering is relevant to this Chapter, not only for the further evidence of the RF's influence on healthcare integration, but also to illustrate the use of maternal and infant mortality data to justify the training or eradication of TBAs. This justification was to be revisited in the 1990s and in 2008. 246

6.2.1.2 Data and Dismissal: Sixty Years of TBA Trainings with WHO and UNICEF

According to WHO, initial assessments of TBA training programmes demonstrated a reduction in maternal and infant mortality that purportedly “reached a plateau” in the 1990s (Kruske and Barclay 2004: 307). The identification of this “plateau” in the data, triggered a dramatic shift in traditional birth attendant policy, that included the cessation of trainings and discouraged or prohibited use of TBAs worldwide (*Ibid.*: 307). This new policy toward TBA training and integration was formally announced in a 1992 joint WHO/UNFPA statement declaring that the training and use of traditional birth attendants should only be used as an interim measure until all women have access to “acceptable, professional, modern health services” (WHO 1992). “Four years later, WHO policy leaders insisted on 'skilled' rather than 'trained' birth attendants” (Kruske and Barclay 2004: 307). This was a significant policy change as it is believed that (globally) “two-thirds of all births occur outside health facilities” (Bergström and Goodburn 2001: 79).

The literature suggests that these reported stagnant reductions in infant and maternal mortality rates may not reflect a TBA's innate ability to learn specific birthing techniques, as much as what and how TBAs were taught and particularly how these trainings were evaluated. According to Bergström and Goodburn:

“One of the reasons for continuing debate over TBA training is the haphazard way the programmes have been evaluated...there are surprisingly few methodologically sound evaluations, even of programme outputs” (2001: 84).

The variety of training outcomes between countries corroborate this observation. For example, TBAs were considered to have been successfully integrated and demonstrated consistent marked reduction of maternal and infant mortality in both Malaysia and Samoa (Kruske and Barclay 2004).

Furthermore, the determination of the success or failure of TBA trainings is based on infant and maternal mortality data of questionable rigour.

There have been myriad issues identified with the unreliable data sets and inappropriate data analysis employed in these findings of stagnant maternal and infant mortality rates. An independent analysis of neonatal and maternal mortality from the *Institute for Health Metrics and Evaluation* (IHME) at The University of Washington, used “three times as much data as the previous researchers” and demonstrated that neonatal mortality rates fell by 57% from 53/1000 in 1970 to 23/1000 in 2010, with the greatest reduction in neonatal mortality in the period from 1970-1980; a period of intense WHO/UNICEF TBA training globally (Rajaratnam, *et al.* 2010). However, they noted a slight levelling in this reduction from 1990-2010; during the period when WHO/UNICEF TBA trainings had begun to cease (*Ibid.*).

Similarly in terms of maternal mortality, IHME identified “342,900 maternal deaths worldwide in 2008, down from 526,300 in 1980” or a 35% decrease in maternal mortality in 28 years (Hogan *et al.* 2010: 1609). If maternal deaths are statistically controlled for global HIV sero-prevalence, the maternal mortality would be further reduced from 526,300 in 1980 to 281,500 in 2008; or a 47% decrease (*Ibid.*: 1613). Hence, 12% of maternal mortality in this period may have been related to HIV/AIDS management in pregnant women. Therefore, a significant proportion of maternal mortality may, in actuality, be more a result of access to anti-retrovirals, than of delivery by TBAs.

These findings are in sharp contrast to a jointly sponsored WHO, UNICEF, UNFPA, and World Bank assessment reporting “576,300 maternal deaths globally in 1990, and 535,900 maternal deaths in 2005”; or a mere 7% decrease in maternal mortality in 15 years (Hogan *et al.* 2010: 1609). Numerous factors can contribute to maternal, as well as neonatal mortality. These factors include: malnutrition; infectious environment; and poor pre-natal/post-natal care. But although causality cannot be determined from this data, some correlations are noteworthy.

For example, IHME research does not specifically analyse TBA training as a factor in their research. However, both their findings and WHO's identify the most marked declines in maternal mortality rate from 1990-1995. Or during the final years when TBA training was still provided by WHO/UNICEF. They identify the highest increase in maternal mortality rates from 1995 to 2000; during the years after global WHO/UNICEF TBA training had ceased (*Ibid.*: 1612). IHME authors conclude “variation in the assessments of rates of decline indicates the availability and use of different data sets, different analytical methods, and different decisions about data quality by the analysts” (Rajaratnam *et al.* 2010: 1989).

At the same time this maternal mortality study was published online by The *Lancet* (i.e. March 2010), a report published by a global alliance hosted by WHO, *the Partnership for Maternal, Newborn and Child Health*, claimed progress in maternal health as having “lagged” (Cheng 2010).

“According to their detailed analysis, from 350,000 to 500,000 women still die in childbirth every year. The authors did not explain from where their data came or what kind of analysis was used to obtain this wide range of figures. However, in the same report, U.N. officials also claim needing \$20 billion every year between 2011 and 2015 to save women and children in developing countries” (Cheng 2010).

The editor of the *Lancet*, Dr. Richard Horton, reported to be: “disappointed when maternal health advocates pressured him to delay publishing the report until September, after several of their critical [maternal and child healthcare] fund raising meetings” (Cheng 2010). Hence, it appears the data collection and analysis substantiating TBA policies may, in actuality, be more of a reflection of global and multilateral politics, than of any statistical neutrality.

6.2.2 Integrating *hilots* by prohibiting their practices

“Almost all provincial and municipal health officials and service providers interviewed affirmed that training TBAs was both useful and necessary to reduce the risk of maternal mortality”
(ADB 2007: 19).

The change in global health policy for TBAs, may have influenced the change in *hilot* policy in the Philippines. Since 1952, UNICEF and the DOHP conducted trainings for *hilots* throughout the Philippines. In fact, these particular *hilot* trainings in the Philippines have been identified as the impetus for WHO's original interest in non-biomedical local healthcare.

*“WHO's interest in traditional medicine stems from the 1950s, when the Department of Health of the Philippines, with the assistance of WHO and UNICEF, initiated the training of the *hilots* as part of the country's midwifery programme” (Vuori 1982: 131).*

The trainings focused on sterile and hygienic techniques; pre-natal and post-natal education; and the warning signs of complications requiring referrals to hospital (WHO 1975). *Hilots* were especially discouraged from the practice of cutting the umbilical cord with bamboo and were given sterile birthing kits. *Hilots* interviewed found the trainings useful, reported to have practised what they were taught, and were eager for more trainings. Some informants revealed they have kept their birthing kits since their initial trainings in the 1950s.

One *hilot* from Guina-ang, Bontoc brought her sterile birthing kit to the interview. It was a silver tackle box with “UNICEF” emblazoned across the top. She smiled broadly as she opened it with great care and revealed the contents with pride. One by one she removed from the tackle box: cotton, iodine, an old used razor blade, a sutures, a packet of sterile gauze, surgical tape, surgical string, a lighter, and a scissors. She placed them before me almost ritualistically. She handled each object as if it was a priceless family heirloom. Then she looked and smiled and said “I've kept this for sixty years”. If this was accurate then she was one of the very first *hilots* to be trained in the Philippines, or TBAs to be trained in the world, in 1952. I asked, “Have you used this for sixty years?” She nodded as she walked away, “Yes...and I'm waiting for another”. #84²⁰³

In 1958, *Republic Act 2644, An Act Regulating Midwifery Training and Practice*, authorized *hilots* to practice in areas not served by professional health workers. Trainings conducted for TBAs concerned sterile delivery technique and germ theory, in attempts to reduce infant and maternal morbidity and mortality (*Ibid.*). 250

²⁰³ A picture of the sterile birthing kits supplied by UNICEF appears on the final page of the Appendix.

In 1981, with the adoption of Primary Healthcare, trained *hilots* were recognised as qualified members of the Women's Health Team (ADB 2007). I noted that in particular, trained *hilots* were considered part of the healthcare team even at the municipal RHU, and they often became BHWs. In the RHU of Murcia a roster was kept on a wall of all the healthcare workers in the barangays. The category of trained *hilots* was included in this roster. Vuori identifies:

“Hilots were encouraged to involve themselves in a wide variety of community health activities, such as notifying communicable diseases, organizing mothers' classes, registering births, helping to arrange mother and child referrals to health centres and hospitals, assisting in immunization and collaborating in family planning” (Vuori 1982: 131).

Hilots were quietly integrated into most local healthcare systems. *Hilots* have been identified to be used by women even if physicians and midwives were readily available in their area (USAID 2004). “Traditional Birth Attendants [in the Philippines] attend to 63% of deliveries by poor women versus only 23% for the non-poor” (*Ibid.*). However, Table 6.1 illustrates regional differences in the use of *hilots*. In certain regions of the Philippines half or more deliveries are identified to be attended by *hilots*. It appears from the table that the further from Manila, the higher is the reported use of *hilots*.

Table 6.1 Attended Births by Hilots and Biomedical Staff in the Philippines (1993; 1998; 2003)

Region	Medical Professionals (%)			Traditional Births Attendants (%)		
	1993	1998	2003	1993	1998	2003
Philippines	52.8	56.4	59.8	45.3	41.3	37.1
High Intervention^a						
CAR	52.3	48.1	59.6	21.8	16.3	14.1
Eastern Visayas	32.4	27.7	36.0	67.4	70.3	62.3
ARMM	—	15.5	21.7	—	81.9	76.6
Medium Intervention^b						
Cagayan Valley	36.6	42.1	53.2	56.3	49.2	42.9
Southern Tagalog	54.9	59.8	—	44.5	39.9	—
Calabarzon	—	—	74.7	—	—	24.4
Mimaropa	—	—	29.3	—	—	66.3
Bicol	30.3	44.2	47.8	68.7	55.1	50.2
Western Visayas	48.3	48.1	47.4	49.5	50.8	49.7
Zamboanga Peninsula	33.4	39.6	31.0	65.4	55.2	64.3
Caraga	—	40.3	42.5	—	58.5	55.4
Low Intervention^c						
Central Visayas	51.2	55.7	68.3	48.4	44.0	29.0
Socskargen	32.2	43.0	37.2	66.4	55.1	58.7
Non-Intervention						
NCR	88.5	91.5	87.9	10.6	7.8	11.6
Ilocos Region	64.9	66.4	74.2	34.6	33.3	24.6
Central Luzon	80.6	84.3	85.8	19.4	15.4	12.0
Northern Mindanao	38.4	34.6	41.0	60.3	61.0	49.4
Southern Mindanao	36.4	47.0	47.6	57.8	48.8	43.6

ARMM = Autonomous Region of Muslim Mindanao; CAR = Cordillera Administrative Region; Calabarzon = Cavite, Laguna, Batangas, Rizal, and Quezon; Mimaropa = Mindoro, Marinduque, Romblon, and Palawan; NCR = National Capital Region; Socskargen = South Cotabato, Sultan Kudarat, Sarangani, and General Santos.

^a High intervention = all provinces in the region were covered.

^b Medium intervention = more than half the provinces in the region were covered (in Calabarzon only two provinces were covered).

^c Low intervention = only one province in the region was covered.

Source: National Demographic Health Survey; 1993, 1998, 2003.

However, similar to the myriad factors affecting choice with other local practitioners, the choice of delivery by *hilots* may also be dependent on numerous factors, as the variation in regional data identifies.

From 2004 to 2008, the World Bank, USAID, The European Commission, and The Asian Development Bank (ADB) issued reports concerning the funding of a project to reduce infant and maternal mortality in the Philippines via “skilled” deliveries within in-birthing facilities (USAID 2004; ADB 2007; European Commission 2008). ADB's independent evaluation was the only report to recommend *not* funding the project. ADB identified the project as both infeasible and unsustainable; noting the seriously flawed data sets and statistical analyses provided by the DOHP (ADB 2007). Unlike the other evaluations, ADB's suggested that the development of in-birthing facilities, especially in rural areas, was a project that, even if implementable, could only be implemented in small stages over time and that *hilots* continuing to attend to at-home births, were essential for this process to occur (ADB 2007).

The director of this ADB evaluation stated, in interview, that their concern was that the cessation in trainings of, and the lack of a provision of a sterile birthing kit for, *hilots* would not dissuade women from seeking their help, nor would it encourage *hilots* compliance to the policy, by virtue of their priorities to community women as dictated by their cultural role. For, although several *hilot* informants reported to be relieved to be able to give up their roles, all stated that they would not be able to refuse a woman requesting their help.

Furthermore, contrary to the other reports' mentioned, the ADB evaluator identified numerous issues in the correlation of infant and maternal mortality rate with *hilot* deliveries.

She reported that when her team disaggregated the DOHP data, purportedly serving as the main data set for all of the above-mentioned reports, ADB found that the training of *hilots* substantially *reduced* maternal and infant mortality in the Philippines and that the far lower number of in-facility deliveries actually resulted in a *higher* relative proportion of infant and maternal mortality.

Although these conclusions appear counter-intuitive, Penwell (2009) commonly identified poor hygiene, lack of medical equipment, lack of sterile technique, and lack of appropriate care in labour and delivery, and neonatal intensive care units of selected Philippine hospitals.²⁰⁴ Furthermore, it has been identified that:

“there is no conclusive evidence that trained TBAs can prevent maternal deaths unless they are closely linked with existing health services, and are supported to refer women to functioning hospitals providing essential obstetric care” (Bergström and Goodburn 2001: 79).

Similar to the issues of scientific rigour identified in the global WHO/UNICEF data, in assessing the DOHP data, the independent evaluators at ADB identified that essentially all at-home deliveries that resulted in maternal and infant mortality, regardless of who assisted delivery, very often being a family member or the mother by herself, along with purposeful abortions by the mother, were statistically attributed to *hilots* (ADB 2007). Furthermore Bautista identifies:

“All of the [DOHP] program implementation review reports begin with the caveat that data on infant and maternal mortality are unreliable”. This is illustrated in the highly differing statistical projections for the National Statistics office and the DOH data obtained from health facility users (Bautista 1994: 69).

However, even at a basic level of data collection and analysis, the DOHP data may significantly underestimate the reductions in infant and maternal mortality since the inception of *hilot* trainings.

253

²⁰⁴ However, it is also feasible that facility-based and biomedical deliveries may been associated with higher maternal and infant mortality rates, because those mothers who went to hospital may have been at greater risk in delivery, than those who remain at home or with a *hilot*.

The ADB findings are corroborated by the data of the *Institute for Health Metrics and Evaluation*. In the IHME analysis of under-five mortality in the Philippines, a 67% reduction in the under-five mortality rate from 1970-2010 was identified; with a 10% reduction from 1970-1980; a 31% reduction from 1980-1990; a 29% reduction from 1990-2000; and a 25% reduction from 2000-2010 (Rajaratnam *et al.* 2010: 1989). Though, causality cannot be attributed, it is again noteworthy that the highest periods of child mortality rate reduction (1980-2000) were also the periods informants reported to have the highest number of *hilot* trainings.

IHME also identified a decrease in the maternal mortality rate for the Philippines from 443 to 174 per 1000 (or a 61% decrease) from 1980-1990; 174 to 103 per 1000 (41% decrease) from 1990-2000; and 103 to 84 per 1000 (18% decrease) from 2000-2008 (Hogan *et al.* 2010: 1614). Again, the periods with the largest decreases in the maternal mortality rate in the Philippines (from 1980-1990) were also identified as the periods with the highest number of *hilot* trainings.

However, regardless of the rigour of the data, the DOHP, with the help of substantial loans from the remaining project lenders, issued an Administrative Order in September 2008 to institute mandatory in-facility birthing (AO 2008-0029) (DOHP 2008a). This Order states that all women in the Philippines are to be considered at-risk during pregnancy and must only deliver in-facility by skilled professionals (i.e. physicians and biomedical midwives). *Hilots* are to be integrated into the maternal child health team only if they agree to not perform deliveries again. Hence, there are to be no more trainings of *hilots* and they will no longer be provided with sterile birthing kits. It is simply assumed that all *hilots* and all women will comply with the Administrative Order. Furthermore, the definition of the new role for these reintegrated TBAs and the specific activities they would be allowed to perform as part of the maternal child team is quite vague, primarily identified as assistance to the biomedical midwife without further elaboration (DOH 2008a).

In interviewing the Director of the Maternal Child Health Unit of the DOHP who developed the policy, the role of the TBA was not further clarified.

“They [*hilots*] will assist the midwives, and they will do the other things they do. Like helping the mother. Watching the children. Washing her clothes. But they will no longer deliver. If they agree to this, then they will be integrated into the Maternal Child Health team. And if she is under forty and literate, we will pay for a scholarship for her to be trained as a midwife”. When I asked her how this would be feasible especially in rural areas she replied: “We are already building birthing facilities all over the Philippines. We have five years to get this going. Furthermore, we have incentives we can offer”. She did not outline coherent plans beyond the fact that she perceived everyone would be eager to comply including *hilots*. When I asked the reason for the urgency in executing the project. She replied: “The MDGs [Millennium Development Goals] ...we *must* meet the MDGs”.

In listening to the Director speak for all women and all *hilots*, I was interested to learn what barangay women and *hilots* might had to say. I added questions to the general interview schedule that would address the perceptions of barangay members concerning this policy.

This section has presented a brief contextualisation of some of the issues identified in the processes of validating or invalidating the practice and trainings of *hilots* and TBAs.

6.3 Assessing the Reintegration of Hilots through Barangay Members' Perceptions

6.3.1 Introduction

In analysing the reintegration of *hilots*, it is important to examine the perceptions of barangay members concerning this policy. Barangay members were questioned regarding who delivered their children; who they preferred to deliver their children; where they preferred to deliver their children; their reasoning for these preferences; the advantages and disadvantages to home and *hilot* delivery; any negative experiences they had or heard from others concerning *hilots*; if *hilots* should be allowed to continue to deliver; and if they perceived mandatory in-facility birthing with the prohibition of the practice of *hilots* appropriate for their barangay.

6.3.2 Results²⁰⁵: Branagay Members' Perceptions of Appropriateness of Hilot Reintegration

In summary, nearly half of the total deliveries of all informants (**46%**) were handled by a physician or midwife and **36%** of infants were delivered by a *hilot*. But it is important to note that few informants delivered their babies exclusively with *hilots* or biomedical practitioners, rather a majority of informants delivered their babies with both *hilots* and midwives or physicians. Furthermore, **66%** of informants identified a preference for delivery by a physician or midwife, and **19%** preferred delivery by a *hilot*. Although **66%** of informants preferred to deliver with a physician or midwife, **63%** of informants identified that they would prefer to deliver at home. Thus, even though the majority of women preferred to deliver their babies at home, only a minority reported to prefer delivery with *hilots*. But home delivery is not necessarily equivalent to *hilot* delivery. Furthermore, it should be noted that informants identified myriad reasons why it was not always possible to follow their preferences. For example, physicians do not deliver babies outside of hospitals and midwives will only deliver at home when they were available to do so. Therefore, even if women did not necessarily prefer *hilots* to deliver their babies, *hilots* provided one of the few options for assistance in home delivery beyond the available midwife, family member, or self-delivery. This may explain why the rate of actual delivery by *hilots* (**36%**) is nearly double the preference for *hilot* delivery (**19%**).

Informants identified such reasons as cost (**26%**), comfort (**24%**), and lack of restrictions (**16%**) as the primary advantages of delivering at home, while **68%** of informants identified emergencies during delivery as a potential disadvantage to delivering at home. Similarly, cost (**58%**), comfort (**22%**), and lack of restrictions (**19%**) were identified as the primary advantages for *hilot* delivery.

²⁰⁵ Note: As this policy is being implemented across the state level and because this was a far smaller sampling than in Chapter 5 (n=238), as well as because many of the original barangays used in Chapter 5 were either not included in this sampling or had only several members that were included in this sampling, the research will be presented as a total average of the entire 238 informants.

Inability to handle emergencies (**37%**) and lack of medical equipment or medicines (**25%**) were identified as the primary disadvantages of delivery with *hilots*. Yet, **2%** of all informants reported having any complications with a *hilot* delivery and **8%** reported ever hearing of anyone who had. And it will be recalled from Table 5.10 that 3% or less of informants reported any concern with the safety of *hilots*. Furthermore, **77%** of informants believed that *hilots* should be allowed to practice in their barangay regardless of the DOHP Administrative Order. Informants identified skill (**23%**), access (**29%**), and affordability (**29%**) as the primary benefits of *hilots*. Hence, the majority of informants believed *hilots* should be allowed to continue practising even though only **36%** of informants used hilots for delivery. Only **20%** of all informants thought the DOHP policy for mandatory in-facility birthing was appropriate for their barangay. The findings are summarised in Table 6.2.

Table 6.2 Results of Barangay Interviews Assessing Appropriateness of Hilot Reintegration

Indicator	% of total of barangay informants
<i>% of informants delivered by physician or midwife</i>	46%
<i>% of informants who prefer physician or midwife delivery</i>	66%
<i>% of informants delivered by hilot</i>	36%
<i>% of informants prefer hilot delivery</i>	19%
<i>% of informants prefer to deliver at home</i>	63%
<i>% of informants reporting any complications with hilot delivery</i>	2%
<i>% of informants hearing of others having complications with hilot delivery</i>	8%
<i>% of informants who perceive that hilots should be permitted to practice</i>	77%
<i>% of informants who perceive this policy to be appropriate for their barangay</i>	20%

6.3.3 Factors Identified Affecting the Appropriateness of Hilot Reintegration for Barangays

The appropriateness of this DOHP policy could be questioned by all of the informant responses; as more than a third of informants identified they were delivered by *hilots*. Furthermore, informants generally perceived that *hilots* should not be prohibited from practice. *Hilots* were identified by informants to be highly skilled; always available; trusted members of the community; and always made women feel comfortable.

Stauffer notes:

“Hilots reportedly were willing to give highly personal service, beginning to call at the end of the 4th month of pregnancy and visiting the prospective mother frequently from then on. They will come day or night and stay long hours if necessary” (Stauffer 1966: 22).

The primary reason why the informants found the policy inappropriate was the shared perception that women would ultimately do what they wanted, regardless of the DOHP's policy.

6.3.3.1 Financial Access to In-Facility Birthing

A predominant perception identified from interviews with policy makers at municipal, state, and multilateral levels was that all women, given the financial opportunity, would naturally want to take advantage of delivery in hospital or facility. In adopting this perspective, the only factor that could be understood to be preventing women from delivering in-facility is financial access. Thus, in order to replace at-home delivery by *hilots*, it is planned that in-facility delivery costs for indigent women will be covered by the national health insurance, *Philhealth*, for up to US\$130 per delivery, for a maximum of four deliveries.

However, community informants identified that this amount does not fully cover the cost of in-hospital delivery, and women still must pay for: medications (before reimbursement by *Philhealth*); transportation to the facility; and any costs beyond the allocated coverage; all of which may be well beyond a family's budget. Furthermore, if there are *complications* resulting in costs beyond *Philhealth* coverage, families would be responsible for the difference.

Yet, barangay informants did not generally identify financial access as the primary reason or even *a* reason they prefer to deliver at home. Table 6.3 illustrates that throughout the Philippines, home delivery was identified in from half to three-quarters of all deliveries; with a national average of 61% in 2003 (ADB 2007).

Table 6.3 Location of Delivery in Regions Throughout the Philippines (1993-2003)

Region	Place of Delivery (%)					
	Health Facility			Home		
	1993	1998	2003	1993	1998	2003
Philippines	28.2	34.2	37.8	71.5	65.5	61.4
High Intervention^a						
CAR	32.2	33.0	44.8	67.6	66.5	55.2
Eastern Visayas	19.9	17.0	20.7	79.9	82.6	79.3
ARMM	—	6.3	10.7	—	92.6	88.4
Medium Intervention^b						
Cagayan Valley	10.7	19.7	25.7	89.3	80.1	73.9
Southern Tagalog	24.1	34.0	—	75.7	66.0	—
Calabarzon	—	—	45.8	—	—	53.5
Mimaropa	—	—	15.7	—	—	83.0
Bicol	11.3	19.6	21.9	88.4	80.0	76.3
Western Visayas	26.2	32.0	33.4	73.6	67.8	65.9
Zamboanga Peninsula	11.2	18.5	15.6	88.5	80.8	83.8
Caraga	—	22.0	26.1	—	77.8	73.6
Low Intervention^c						
Central Visayas	26.9	26.7	39.8	73.1	72.4	58.8
Socskargen	15.6	21.7	23.1	84.4	77.8	76.2
Non-Intervention						
NCR	68.3	72.4	69.6	30.7	27.6	30.0
Ilocos Region	18.1	26.8	29.1	89.3	80.1	73.9
Central Luzon	40.3	49.1	49.4	59.6	50.7	49.3
Northern Mindanao	19.1	20.0	28.9	80.6	79.7	70.2
Southern Mindanao	23.1	33.6	41.0	76.7	66.2	59.0

ARMM = Autonomous Region of Muslim Mindanao; CAR = Cordillera Administrative Region; Calabarzon = Cavite, Laguna, Batangas, Rizal, and Quezon; Mimaropa = Mindoro, Marinduque, Romblon, and Palawan; NCR = National Capital Region; Socskargen = South Cotabato, Sultan Kudarat, Saranggani, and General Santos.

^a High Intervention = all provinces in the region were covered.

^b Medium Intervention = more than half the provinces in the region were covered (in Calabarzon only two provinces were covered).

^c Low intervention = only one province in the region was covered.

Source: National Democratic Health Survey; 1993, 1998, 2003.

Source: Asian Development Bank 2007

the perceived risk of leaving the home

One issue with making policies only from the biomedical Self's ordered system of understanding and meaning, is that Other's ordered systems, that are different, will often not even be considered. For example, Chapter 4 identified the relativity of the perception of risk. This relativity of risk can be identified in pregnancy as well. In interview, a representative of a NGO described an indigenous tribe in Mindanao in which the women adhered to the *habitus* that where ever they were in their household when they realised they were pregnant is where they are beholden to deliver. From this particular group's ordered system, risk was associated with not only delivering outside of the home, but delivering away from the exact spot in the home where the woman first realised she was pregnant. Hence, for these families, safety was perceived to be preserved by staying at home. Facilities would be considered an extremely high risk that would be avoided at all costs. The NGO representative explained that no matter how much education was offered, families would not deliver outside of their homes.

Hence, it is irrelevant if the Self's ordered system makes no sense to the biomedical Other. For the Other's order will usually not be adopted by the Self. Integrity of one's order, was observed to be preserved with flexible forms of resistance.²⁰⁶

6.3.3.2 The Perceived Restrictions of In-Facility Birthing

Only **37%** of all barangay informants identified a preference for in-hospital delivery and less than **1%** identified a preference for a local birthing clinic or barangay health clinic. The location of in-birthing facilities are chosen by a Municipal Health Officer with possible input from a provincial governor. However, facilities were not always planned for those communities furthest from hospitals; where women were least likely able to access emergent care. When queried how locations for birthing clinics were determined, one municipal health officer stated simply, "I just chose it". Another stated that the criteria was according to which community was most likely to sustain and utilise the clinic; which physicians could staff the clinic; and where greatest need was determined. From other interviews, the choice of which community receives an in-birthing facility appeared to be determined by a combination of political and feasibility criteria.

Regardless of the placement of the facility, several municipal health officers reported subsequent under-utilisation of in-birthing facilities. For example, informants from one rural barangay that opened the only birthing facility in Bontoc in 2009, reported that in that year thirty-one women delivered at home and only one delivered in the in-birthing facility. When the women were queried why they did not use the new in-birthing facility, they stated that the table was too uncomfortable. The one woman who delivered in-facility agreed, stating that in the future she would not use the facility again. Female informants stated that when they delivered at home they could deliver in whatever position they found comfortable. The least comfortable position for most women interviewed was reclining. And few identified ever delivering on their back. (Figures 6.2 and 6.4)

260

²⁰⁶ According to Scott: "everyday resistance is informal, often covert, and concerned largely with de facto gains...open insubordination in almost any context will provoke a more rapid and ferocious response than an insubordination that...never ventures to contest the formal definitions of hierarchy and power" (1985:33).



Figure 6.2 Birthing Table in Mainit, Bontoc



Figure 6.3 Birthing Facility in Mainit, Bontoc

Forcing the Other into an acceptable Western Self's order of appropriate positioning of the body for bodily functions, is also reflected in Anderson's description of the American colonial obsession with forcing Filipino's to use toilets. But use of the toilet was not sufficient. The Filipino had to position his body on the toilet in the proper manner of the ordered colonial Self. For Heisser, of the Rockefeller Foundation, this became a mission:

“Heiser urged the local Rockefeller emissary, Dr. C. H. Yaeger, to modify the bowl design [of the toilet] 'to make it impossible to sit on except in the desired position' ” (Anderson 2002: 687).

Hence, in a non-Foucauldian manner, Filipinos have historically resisted the docile bodies that were planned for them (Foucault 1977).



Figure 6.4 Staff of BHS in Bagabag demonstrating birthing table

Beyond the lack of comfort of the table or the position they must maintain, many women complained about the restrictive environment of hospitals.

A 68 year-old female from Caliban, Murcia delivered four children by herself and preferred this because “others hurry me...I like to take my time”. #381

A 29 year-old female from Baretbat, Bagabag stated “if you go to hospital you will be forced to deliver immediately or you will be given a caesarean”. #230

Several women stated that they preferred to stay home because they specifically did not want a Caesarean delivery²⁰⁷ and they did not want to “get cut”; referring to the procedure known as an episiotomy.²⁰⁸ Food restrictions; lack of privacy; not being allowed to bathe; being treatment poorly; male obstetricians; and not having children near or restricting how many family members could visit; were all perceived as further problems that would dissuade women from delivering in hospitals or birthing clinics.

One 30 year-old female in Anabel, Sadanga stated that the policy would be feasible only if the “government forces women into the facility”. #644

When questioned how communities would handle the situation of women who desired at-home deliveries with *hilots*, and did not comply with the DOHP policy, some community members and community administrators reported tactics from persuasion and coercion to outright threats and apparent harassment. As of this writing, infants who are delivered by a *hilot* are not issued a birth certificate, as only a skilled professional is authorised to sign the certificate. That a woman's choice of how, where, and by whom she would prefer delivery should be removed and dictated to her by a devolved department of health, did not appear to be introduced into the consciousness of this discourse except by a very few of the barangay women interviewed (less than 8%) .

262

²⁰⁷ Informants reported that Caesarean deliveries were commonly preformed in Philippine Hospitals, regardless of women's wishes.

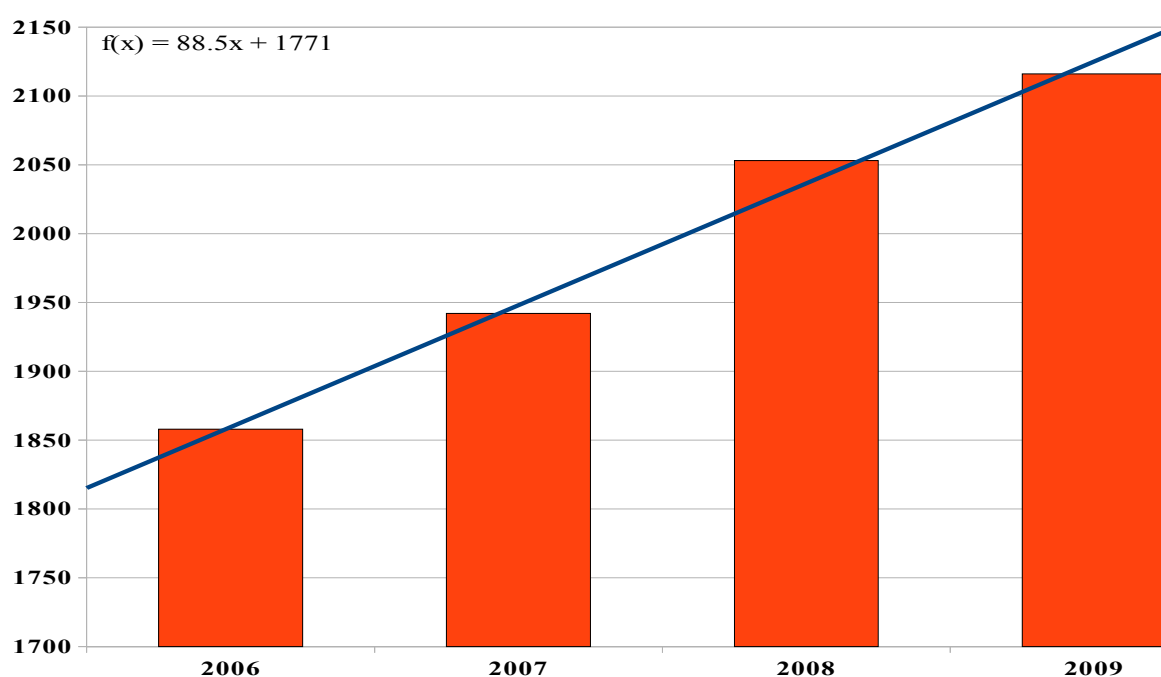
²⁰⁸ In an episiotomy, a surgical incision is made on the posterior vaginal wall prophylactically in order to reduce vaginal tears as a result of childbirth (Thacker and Banta 1983). Informants' primary complaint of an episiotomy is that it resulted in significant post-partum pain.

6.3.3.3 Capacity and Human Resources

The feasibility of the capacity for increased hospital deliveries is also challenged by this policy. Several chiefs of hospitals who were interviewed, reported that their number one admission of normal spontaneous deliveries was overtaking an already overcrowded hospital system and that hospital obstetric staff have had to encourage women deemed not at-risk to deliver at home. Thus, women are more apprehensive to make, what is for some, a difficult and expensive journey to the hospital only to risk possibly being turned away. For example, in one regional hospital, normal spontaneous deliveries increased from 1,858 deliveries in 2006 to 2,116 deliveries in 2009 (or a 12% increase in 4 years), whilst the number of medical staff has remained constant or decreased. (Figure 6.5)

Furthermore, though this policy has slashed the healthcare workforce by prohibiting *hilots* from delivering, it is of particular concern that no provisions have been offered for increasing the number of “skilled” birthing professionals. Nor does the policy address the issue of physicians who refuse to work in rural areas. And, as discussed in Chapter 4, this professional human resource imbalance may prove particularly difficult to overcome in a country with a well-documented mass migration of medical professionals (Choy 2003).

Figure 6.5 Normal Spontaneous Deliveries in Veterans Regional Hospital (Bayombong) 2006-2009



Source: Veterans Regional Hospital 2010

A majority of biomedical midwife community health unit administrators interviewed (83%) believed the DOHP policy was neither appropriate, feasible, nor sustainable for their barangays. Although many midwives reported to be unaware of the policy (62%) the remainder identified that they ignore it. Considering that some midwife administrators can be responsible for as many as three to four different BHSs; additionally having to be available around-the-clock for deliveries in several different barangays may stretch them beyond a functioning capacity.

Furthermore, many midwife administrators reported good collaborative working relationships with the *hilots* in their barangays and reported few if any *hilot* delivery complications. Midwives identified that *hilots* made appropriate referrals either to them or to the hospital when complications did arise. However, several *hilot* informants on separate occasions relayed a similar story of taking their patient to hospital during an emergency, and physicians refusing to admit the patient, specifically because the patient was treated by a *hilot*.

When I questioned physician informants about such practice, one 48 year-old male physician in Manila, shrugged his shoulders and said “Can you blame them? Obviously, they don't want to be sued.” #13

Yet, according to Bergström and Goodburn, even with appropriate *hilot* referrals:

“a significant proportion of their patients do not comply with the referral advice. Reasons for non-compliance with referral by *hilots* include financial constraints, lack of transportation and fear of disrespectful or painful treatment from medical staff” (2001: 85).

6.3.4 Considering Potential Unintended Outcomes of the Reintegration of Hilots

In general, appropriateness, feasibility, and sustainability for a given local context appears to have been neither assessed nor fully accounted for in this policy, as much as assumed.

A 23 year-old Female in Paniki, Bagabag stated: “The DOH policy will not work because most women currently seek a *hilot* and they will continue to do so”. #219

Hence, if the outcome of this policy is that Filipino women will continue to have at-home births with *hilots*, who are now no longer being trained nor supplied with a sterile birthing kit, then there is a justified concern for possible increases in maternal and infant morbidity and mortality and for the well-being of barangay women. This would especially be true for the most vulnerable women in remote, impoverished, and inaccessible areas. Thereby, the primary objective behind healthcare integration, to improve healthcare access and outcomes, could potentially be severely compromised by this particular form of healthcare integration.

6.4 Conclusion

In summary, the integration of *hilots* through their prohibition to deliver appears to be neither justified as necessary, from a closer examination of the global and local data sets for maternal and child mortality rates, nor does it appear to be appropriate for the barangays studied. Hence, the research conducted in these barangays appears to corroborate the determination of the independent evaluation of the Asian Development Bank.

The unchallenged conception of the inherent beneficence of reducing healthcare disparity in the discourse of healthcare integration is not substantiated by the data presented here or in Chapter 5. Even basic healthcare access appears to be problematised with this reintegration of *hilots*. For, in addition to substantially decreasing the healthcare workforce by prohibiting *hilots* from delivering, it is of particular concern that no provisions have been offered for increasing the number of “skilled” birthing professionals. According to Walraven and Weeks:

“Not training TBAs who are willing and capable to learn skills of prevention, early recognition, and management of life-threatening obstetric complications will cause more harm than good” (1999: 529).

Chapter 7

Integrating the Data to Analyse the Normative Representation of Healthcare Integration

7.1 Introduction

This chapter will examine the normative representation of healthcare integration in terms of the research conducted and the contextualisation of the Philippines. This representation is partially a result of the normative understanding of, what I have distinguished as, the conceptual elements of healthcare integration. These conceptual elements include: the healthcare system; traditional medicine; and medical pluralism. Therefore, in order to examine the normative representation of healthcare integration it is necessary to first examine these conceptual elements of healthcare integration.

7.2 Problematising Conceptual Elements of Normative Healthcare Integration

7.2.1 Conceptual Elements of Healthcare Integration I: The Healthcare System

This research has identified that, in practice, several healthcare systems can be described, depending if the healthcare system is being examined as a function of a representation of municipal and higher levels of analysis or a function of its use by individuals and communities. In the Philippines, the state and WHO representations of the healthcare system were rarely found to correspond to the myriad healthcare systems perceived by informants and reified by their use of healthcare.

At the local level of analysis, barangay members identified that their healthcare system would usually consist of both the formal and informal healthcare systems, depending on the individual plural use of healthcare employed. Barangay informants have identified that their perception of the actual healthcare system is the one they use, regardless if use correlates with the state or WHO representation of healthcare. Barangay informants generally were not concerned with differentiating between the formal and informal healthcare systems. Nor was a boundary drawn between what might be differentiated as “religious” and “scientific” belief.

The representation of the healthcare system by informants at higher levels of analysis was not reflective of how healthcare was actually being used, but rather how it was *meant to be* used or prescriptively *should* be used. For example, a majority of informants from the DOHP (most of whom were public health physicians) only recognise the formal healthcare system as *the* healthcare system. Paradoxically, although DOHP informants typically did not include the informal healthcare system in their representation of the healthcare system, many still identified that local non-biomedical practitioners should be controlled.

At the barangay level of analysis, the majority of both barangay and local biomedical and non-medical practitioners acknowledged that both biomedical and non-biomedical local practitioners were part of their healthcare system. However, at municipal and higher levels, biomedical informants typically did not identify local practitioners as part of the healthcare system.

If the representation of the healthcare system is quite different from the way the healthcare system is actually being used, there may also be discrepancies between healthcare policy and implementation, as was identified in this research. Furthermore, at higher levels of analysis the healthcare system was represented as something that must be controlled, and when needed, altered in order to reduce risk. The universalisation of risk justifies healthcare integration as an imperative. However, barangay informants generally reported no concern of risk with any part of the perceived healthcare system, especially in relation to their local non-biomedical practitioners.

Thus, the healthcare system is being defined according to how one actually uses the healthcare system, rather than by how one is supposed to use the healthcare system. This difference is illustrated both in informant responses to perceived healthcare system and in comparing pile sorts results in which barangay informants perceived one cohesive [already] integrated healthcare system.

State and global representations of the healthcare system appear to result in a coherent network of institutions that are linked through a biomedical paradigm, from medical schools through public and private clinics and hospitals, and that can include formalised non-biomedical systems, such as acupuncture and chiropractic. Anything beyond this purview appears to not be considered part of the healthcare system.

This exclusive and hierarchical Othering, is a mechanism by which biomedicine has historically maintained its global hegemony and supremacy. This mechanism also provides a means of controlling all Other healthcare practices and practitioners, by dictating who and what will be considered part of the healthcare system. WHO literature identifies this form of Othering as an important mechanism for integration:

“...in this way we shall bring them [traditional practitioners] closer to the mainstream²⁰⁹ of our official healthcare system and elevate their level of training; in addition, we will get better control of their activities” (Vuori 1982: 131).

However, such a position assumes that the informal healthcare system, or the community, or the individual *can*, in fact, be controlled. Both the normative representation of the healthcare system and of healthcare integration are based on the perception that the informal healthcare system can and should be controlled by the state. But as was reviewed from the data in Chapters 5 and 6, the local levels studied were not conducive to global, state, or even municipal control as an result of everyday forms of resistance.

Another important difference that can be identified in the multi-dimensional analyses of the pile sorts is the division between local and imported non-biomedical practices by the barangay informants. Therefore, even though a practice is etically constructed as “traditional” does not mean that emically it will be identified as Self.

²⁰⁹ The term “mainstreaming” was noted to appear in the Filipino literature in reference to healthcare integration.

This can be contrasted to the tendency for biomedical informants to cluster all non-biomedicine together with the primary division being between what is identified as biomedical and everything else. This tendency to group all non-biomedicine together as a category of “traditional” is another element of healthcare integration that will be examined next. Thus, there is no essentialised, agreed-upon representation of the healthcare system amongst healthcare integration stakeholders, but rather myriad understandings of the healthcare system.

7.2.2 Conceptual Elements of Healthcare Integration II: “traditional medicine”

7.2.2.1 Essentialising the Other's Order: The Other is “Traditional”

Said (1978; 1993) argues that the lens of Orientalism is essential to construct the Other, in order to suit the purposes of the Self. This argument could also be applied to the representation of “traditional” suiting the purposes of the biomedical Self. The understanding of what exactly “traditional medicine” is and how this construction is used, is central to the discourse of healthcare integration. The use of the term “traditional medicine” both at WHO-WPRO and in the DOHP will be examined here.

“Traditional medicine” is an historically inconsistent designation. The term has been used in WHO documents and the general literature to refer to: healthcare practices that are specific to a particular geographic location and indigenous group; healthcare practices that are specific to particular ethnic groups, regardless of geographic location; and/or all non-biomedical healthcare practices, regardless of geographic, temporal, or cultural origin. These different understandings have often appeared simultaneously in any given WHO document²¹⁰.

²¹⁰ For example see WHO 1984; 2002a; 2002b; 2002c; 2003a.

WHO documents have also differentiated “traditional medicine” from “complementary and alternative medicine”. “Traditional medicine” has been used to refer to those non-biomedical healthcare practices which are practised outside of “developed” countries. “Complementary and alternative medicine” refers to non-biomedical practices in the West, regardless of their country of origin. A 2002 WHO publication states:

“Traditional medicine is an ancient medical practice which existed in human societies before the application of modern science. It is based on indigenous theories, beliefs and experiences that are handed down from generation to generation. In the West, the umbrella term complementary and alternative medicine is widely accepted as including both traditional medicine and more recent forms of non-standard medicine” (WHO 2002a: 1).

There are numerous issues with this definition, but in general this definition is inconsistent with past WHO definitions. The literature poorly distinguishes between “traditional medicine” and “complementary and alternative medicine” or CAM. CAM has been widely identified as standardized non-biomedical practices that have been exported to other countries, regardless of their country of origin (e.g.; acupuncture, Āyurveda, and reflexology). However, conflicting understandings of CAM have appeared in both WHO documents and the general literature.²¹¹ A recent WHO document defines traditional medicine as specific to a given location and complementary and alternative medicine as a non-biomedical system imported from elsewhere (WHO 2009). However, in WHO-WPRO documents, traditional medicine has also been used to refer to all non-biomedical healthcare practices (WHO 2003a). This was observed to be reiterated at WPRO international meetings (see Appendix 3). It appears from both the literature,²¹² as well as the findings noted from the participant experience at WHO-WPRO, that WHO never reached a consensus on what traditional medicine actually is or is meant to be.

²¹¹ For example see WHO 2002a; 2002b; 2003a; 2009.

²¹² See Hyma and Ramesh 1994.

TAMA clearly distinguishes between traditional medicine (i.e. those healthcare practices local to the Philippines) and alternative healthcare modalities (i.e. imported non-biomedical healthcare practices). Yet, in printed literature and communications from PITAHC the two categories are merged. This has resulted in acupuncture, acupressure, and chiropractic now being typically identified as “Trad Med” (PITAHC 2009). This particular use of the term traditional medicine can present challenges in determining whether imported or local traditional medicines are subsequently standardized and integrated. Furthermore, as identified in Bagabag, the designation of Trad Med for an imported practice such as acupuncture, could potentially contribute to the marginalisation of local healthcare practices and practitioners via a designation that renders both local and imported non-biomedical practices interchangeable. Therefore, problematising the use of the term “traditional” is not merely an issue of semantics.

7.2.2.2 Traditional As A Representation Of Invented Traditions

Hobsbawm and Ranger (1983) proposed that traditions are often invented for the functional ends of social cohesion and the legitimization of social action and institutions in the creation of modern nation states. They define “invented tradition” as:

“a set of practices of a ritual or symbolic nature, which seeks to inculcate certain values and norms of behaviour which automatically implies continuity with the past” (1983: 1).

Hence, invented traditions can serve as a means by which to justify desired social changes by linking them to a real (or invented) past, thereby granting them validity, honour, and automatic obligatory veneration.

Tradition can also be an invented conception of the traditional Other, as “primitive”, “backward” or “archaic”, stuck in a kind of static time warp of the past (Fabian 2002).

In relation to non-European culture, this may be understood as a Western invention of a romanticized, mysticized, and orientalised parallel world, that can then be contrasted, and thereby rendered inferior, to modern European beliefs.²¹³ The associated valuations then maintain ethnocentric standards of Western intellectual and scientific superiority, along with the continued justification for the modernization of, and paternalism toward, lower-income and non-European countries (Said 1978). In terms of traditional medicine, these purported links with the past can imply that healthcare practices have remained unchanged from the past²¹⁴ and are indigenous to a given locale; neither of which were found to be true of the local healthcare practices in the field sites studied.

7.2.2.3 Reifying Power: The Use of “Traditional” as Justification for Domination

Designating practices as “traditional” identifies practices not by what they are, as much as by what they are not: (i.e. not modern and biomedical). The post-colonial theorists distinguish language as a reflection of a colonial logic of power between the inherent superiority of the colonial Self and inherent inferiority of the colonised Other (Ashcroft *et al.* 2000). Hence, as the essentialisation of the binary distinction of White/non-White asserts, reifies, and, possibly more importantly, justifies a relation of dominance, so too does the binary of biomedical/traditional. Hence, essentialising all of the local forms of healthcare practices into the category of “traditional” facilitates a universal devaluation of these practices for not being biomedicine. Ernst argues:

“Terms like 'indigenous medicine', 'folk medicine' and 'healer', for example...are redolent of those features that they have for long been thought of as lacking in comparison to their binary opposites (namely 'Western medicine' and 'medical expert')” (2002: 3).

²¹³ Ironically “traditional” medicine in the Philippines, as well as in the West, is commodified as an alternative to the harshness of biomedicine and, though in actuality a product of modernity, is packaged as providing an escape from modernity.

²¹⁴ In traditional Chinese medicine, formalised techniques such as acupuncture anaesthesia and electrical acupuncture are, in actuality, late 19th and early 20th century inventions.

Furthermore, Vuori notes such distinctions are artificial:

“All medicine can be considered 'modern' in so far as it is satisfactorily directed towards the common goal of providing healthcare despite the setting in time, place and culture” (1982: 130).

7.2.2.4 Time and The Other:

Problematising a Universal Valuation of Western Temporality and Progress

A reverence for past knowledge is patently antithetical to biomedical education, where only the most current and most technologically advanced knowledge is cherished. What can be identified as the march of progress of biomedicine also distinguishes it from the purported stasis or backwardness of non-biomedicine.²¹⁵ Yet, contrary to the teleology of the liberal enlightenment paradigm, progress and skill in, for example, Chinese medicine is attained by reaching backward, not forward. The centrality of Confucianism to Chinese education and life, with its emphasis on filial piety and ancestral worship, may partly explain the reverence toward historical knowledge. However, this historical search for skill from “the source” has been far more nuanced since the twentieth century and the advent of the Chinese Communist Party (CCP). For this reverence of the past appears to be in complete contradiction to the CCP's predominant concern with modernity; particularly since Mao's insistence on the modernisation of Chinese medicine. This debate continues into the present.²¹⁶

Interestingly, this quest to “master the source” was also identified in the Philippines. In participant experience with the Department of Health of the Philippines, I taught acupuncture to physicians. The students who were excelling as practitioners and had already generated a substantial following of patients, were also those most eager to study the ancient texts of Chinese medicine. In this particular instance, neither nationalism nor adherence to Confucian values would explain this reverence, from biomedical physicians, for past knowledge, rather than valuing the most recent or future discoveries in TCM. 274

²¹⁵ Modernity is neither sought by local healthcare practitioners in the Philippines nor is even a consideration.

²¹⁶ See Scheid and MacPherson 2011.

According to Lo this reverence for the past is about “authenticity”.

“Each practitioner must interpret the texts anew. Some will represent this as doing 'true' Chinese medicine according to the ancients, but in reality a tradition has to change to be strong and alive in every situation and that is a dynamic process which involves the appropriate use of history” (Lo in interview 2011).

In this conceptualisation, mining the past for authoritative medical knowledge in the present links temporality with healthcare integration through the authenticity sought by individual practitioners.

In sharp contrast to the West, temporality was identified to be neither considered nor valued by barangay informants in the Philippines. Informants did not divide a Filipino identity between pre-colonial, colonial, and post-colonial categories. Most informants expressed normative Western temporal dichotomies as experienced in an ever-present.

Therefore, past and future appeared to not be valued teleologically by a majority of informants. Informants identified that “the power of healing” does not lay in mastering the future (as in the West), or the past (as in Chinese Medicine), but in the ability to be present before a higher power. Hence, “traditional” in the Philippines might be better understood as being “in the moment”. Most of the informants I spoke with lived in rural areas and farmed. Their daily lives were dictated by moment to moment circumstances of the unpredictable Philippine environment. Their relationship with a higher power was not understood as “in time” but “out of time” in the present, and thereby capable of being “in the presence of” a higher power. This sense of being out of a Western perception of time was examined in terms of chanting and the lack of a Western sequence in the serving of meals in Chapter 4.

Thus, the use of the term traditional is further problematised by the assumptions of a universalised or even agreed upon understanding of temporality, which was simply not identified in the field sites of the Philippines.

7.2.2.5 Purity and Boundedness:

Representing the “Traditional” Other as a Mirror of the Biomedical Self

In this research, a pattern was identified of representing the Other through one's own ordered system of understanding and meaning. This logic would assert that if biomedicine is distinctly bounded and engages in an exclusive Othering, then so too must non-biomedicine. In interviewing the physicians who manage PITAHC, they commonly reified *hilots*, *albuaryos*, *supoks*, and *bonesetters* as essentialised groupings, with each particular group practising in a uniform manner. At first I thought there were using a shorthand representation of quite complex and sometimes arbitrary groupings. However, when I would probe further in interviews, I found that these informants, did not consider problematising these groupings necessary. Hence, from the perspective of the biomedical Self (of PITAHC) traditional medicine is bounded in the same manner as biomedicine. Therefore, if what is labelled traditional medicine is actually an invented tradition, and if medical systems are normatively represented as a pluralism of bounded traditional practices with biomedicine, then the representation of medical pluralism must also be examined.

7.2.3 Conceptual Elements of Healthcare Integration III: Medical Pluralism

7.2.3.1 Examining the Normative Conception of Medical Pluralism in the Philippine Context: Binding that Which is Unbound

In the literature, medical pluralism has often been characterised as a grouping of multiple, discrete, bounded health practices along with biomedicine (Hsu 2008a). Thereby, all components of healthcare are depicted as equal, automatically thwarting any inquiry into power relationships (Baer 2004). Furthermore, unstructured combinations of healthcare practices that are dynamic and altered according to cultural, environmental, and social, particularly political and economic, pressures are similarly unaccounted for in this conceptualization. For example, Adams (2003; 2008) demonstrates how the integration of non-biomedical health practices in Tibet can result in pressures for economic competition of Tibetan medicine with biomedicine, as these practices enter into the formal economy. 276

In accordance with the diversity of local healthcare identified in the Philippines, it appears that there is no perception of a single essentialised system of local healthcare or medical pluralism in the Philippines (Tan 1987). Medical pluralism is an ongoing process that results from complex historical, socio-cultural, political, and economic forces that include: public demand, individual choice, competing medical systems, affordability of competing healthcare practices, and socio-cultural needs. Attempts to classify medical pluralism in the Philippines has been incomplete and may only contain certain practices and practitioner labels specifically pertaining to the locale studied. For example, PITAHC has categorised local healthcare practices and practitioners under the headings of “herbal preparations” and “prescriptions or massage for bone setting” (Ordoná 2009). However, far more nuanced and overlapping categories of local healthcare practices and practitioners have been identified²¹⁷.

Medical pluralism is also an outcome of the plurality of the practices of practitioners. This is especially true in the Philippines where, in the field, practitioners were observed to have adopted a given practitioner designation, yet actually shared few commonalities with their designation and more often than not used practices reserved for practitioner designations other their own. For example, in Bontoc, I interviewed and observed three different local practitioners, who lived and worked no more than two to three short streets from one another. All identified themselves under the practitioner label of *hilot-massahe* (interpreted here as masseuse). I observed little correlation in how these practitioners diagnosed or treated patients. One predominantly used herbs topically. Another prescribed them internally and did very little *massahe*. And the third did not use herbs at all. Although they all used some form of bodywork or physical manipulation, they each performed this completely differently. One informant put pressure on one area with a circular motion, slowly boring deeper into tissue; explaining that she only worked on internal organs. 277

²¹⁷ See Tan 1987; Jocano 2004; Bryan 2007.

Another performed long strokes with topical herbs from the top of the body down. And the third informant identified that she only massaged the head and neck, which she did so barely touching the patient. One of the informants was taught by family elders and the other two reported being visited by an “old woman” in their dreams; a commonly reported method of instruction in local healthcare practices amongst the local practitioners interviewed. And yet, each informant was self-defined under the same practitioner designation.

The fact that such completely distinctive practitioners with markedly unique practices have been categorised under the same practitioner designation, illustrates how loosely the boundaries of these practitioner categories are delineated. Furthermore, this diversity in practice was found within a very small area of three neighbouring streets of a barangay. Thus, with such marked diversity and unboundedness in practices at the sub-community level, it is questionable if greater boundedness or cohesiveness in any designated practice would be possible at more aggregated levels of analysis.

Nor was this identified as a unique observation. Practitioner designations often did not correlate with practice. This problematises not only a bounded etic understanding of medical pluralism, but an emic understanding, as well. However, emically informants were not concerned with understanding or using their local healthcare in such a bounded or defined manner. The pluralism of any healthcare system is as much a product of the patient's plural use of healthcare as the practitioner's plural practice.

One apparent misunderstanding of medical pluralism is that it is thought to be emically ordered according to etic understandings of difference. However, at least in the case of the barangay informants interviewed, the distinctions between practitioners are made according to differences in patient use, not necessarily differences in practice. Nor, in most instances, was there a one-to-one correlation between practitioner and illness.

Although *hilots* are specifically used for pregnancy and bonesetters for fractures, other practitioners overlap. A person diagnosed with cancer may see a *supok*, or a psychic surgeon, or an *albularyo*, or any combination of the above. Informant decisions appeared to be contingent on several factors including physical access. Hence, since all local practitioners are perceived as a medium for “the healing of God”, they can be used interchangeably.

As previously discussed, the practitioner's abilities as a medium for a higher power was considered far more relevant to barangay informants than the outward manifestations of their treatment in their given practice. An emic understanding of medical pluralism in these field sites assumes an ongoing “borrowing” amongst, what etically may appear to be, seemingly contradictory ordered systems. For example, I interviewed an *albularyo* who according to his title was an herbalist, but after reading a book on reflexology, he predominantly practised reflexology as an *albularyo*.

The unboundedness of the local practitioners studied is also significant, in that they challenge the idea of integration that is based upon bounded practices which are, or can be, standardised and taught. Furthermore, as discussed, the vast majority of practitioners I studied received no training of any kind, but report to have been “spiritually guided” through dreams and visions. Thus, with these self-taught individual practices, there was no observed “standard” for many of these practices beyond the standard of the powers of the practitioner as a medium. However, shared cosmology or shared ordered systems of understanding and meaning are not sufficient criteria to be recognised as categories by the current construction of medical pluralism and thereby would unlikely be afforded any possibility of integration according to the normative representation of integration.

Though practice can occur at any level of analysis,²¹⁸ the practice of healthcare often occurs at the microlevel of patient and practitioner. Baer states: “Regardless of their degree of complexity, all medical systems are based upon the dyadic core consisting of a healer and a patient”²¹⁹ (2003: 42). Scheid, (2001; 2002) identifies the importance of analysing practice both as collective socio-cultural group action of practitioners and as individual practice. Scheid (2002) and Farquhar (1994) note that even in the apparent boundedness of traditional Chinese medicine, boundaries disintegrate when the plurality of individual practitioners is considered. Unlike biomedicine's rigid emphasis on standardised practice, Chinese medicine has historically emphasised the value of the scholar-practitioner in finding unique methods of diagnosis and treatments from a combination of empirical practice and the mastery of ancient texts (Farquhar 1994).

However, Chinese medicine is not unique in this regard. Standardised biomedical knowledge is also a representation that may be altered by the practitioner's individual practice. Thus, in overlooking the individual level of practice, the primary level of pluralism and the practice of integration, which is to a certain extent uniquely employed by each practitioner, may also be overlooked. The circuitous logic that being a science renders biomedicine beyond the influence of social construction is based upon the false proposition that science is not socially constructed.²²⁰

Yet, the cultural and individual interpretations, or the “art” of biomedicine, which more accurately would be labelled “biomedicines”, challenges the conception of a global uniformly interpreted coherent practice²²¹ (Berg and Mol 1998).

²¹⁸ Healthcare projects are often executed by a team, rather than an individual practitioner, with the community or target population as “patient”. Hence, healthcare practice cannot be assumed to only refer to a patient-practitioner dyad.

²¹⁹ However, this is but one healthcare relationship that includes the treatment between a patient and his/her self, between a parent and child, and between members of a family or a community.

²²⁰ See Kuhn 1962; Latour 1987; Searle 1995; Hacking 1999.

²²¹ “Medicine is not a coherent whole. It is not a unity. It is rather an amalgam of thoughts, a mixture of habits, an assemblage of techniques” (Berg and Mol 1998:3).

Biomedical clinicians will often practice differently from the way in which they were taught, according to what they find to work empirically for people. Biomedical practitioners were also observed to practice according to the culture of their practice. In the phenomenon labelled “floor culture” the variation of practices can be identified as a product of the practice culture on any given floor of a single hospital.

In observation of one critical care unit of a Philippine hospital, I observed that agitated patients were treated with the drug *haloperidol*, whilst on another critical care floor they commonly used *fentanyl* for the same purpose. One patient I observed was a young woman with cystic fibrosis, who was recently extubated from a respiratory support machine. After three days, the patient appeared agitated and the resident on the unit floor prescribed *haloperidol* as needed. After two administrations of the drug, the nurse informed the resident that the patient was getting more agitated and her oxygen levels were beginning to desaturate. The resident doubled the dose of *haloperidol*. The patient continued to desaturate and shortly thereafter required emergency re-intubation. Later that week, the nurse showed the resident a recent article stating that *haloperidol* can cause bronchoconstriction, and for an anxious patient with cystic fibrosis nebulised *fentanyl* was recommended. Two weeks later the same patient was observed to still be given *haloperidol* as needed for her anxiety. When I interviewed the resident about the nurse's article, he responded “Well, that's how we do it on this floor”.²²²

Therefore, it could be questioned if the normative conceptualisation of medical pluralism, with its assumptions of homogeneous practice within any given practitioner category, is an appropriate representation for any healthcare practice, including biomedicine.

7.2.3.2 Medical Pluralism:

The Representation of Boundaries that Exist Predominantly in Representation

According to Leslie, “Anthropologists cultivate an even-handed view of medical pluralism, in contrast to the normative view that characterizes health professionals” (1980: 191). And yet Ernst discusses the issues embedded in the anthropological construction of medical pluralism through, “dichotomising a reality that is multi-faceted, forever in flux, and never purely delineated” (2002: 5).

²²² These findings can also be compared with Latour and Woolgar's findings in *Laboratory Life* (1986).

To be bounded, a practice should be separate from others and maintain structural integrity when transmitted. However, if, as observed in the Philippines, practitioners often receive their training primarily through dreams and visions, and do not practice what a given practitioner category designates, but rather arbitrarily engage in practices reserved for other practitioner categories, or simply create their own version of a practice, then the conception of bounded practice is seriously challenged.

7.2.3.3 Rethinking Medical Pluralism: Unbinding That Which is Not Bound

Unschuld offers a more comprehensive definition of medical pluralism:

“A mutual penetration of different realities within one complex society is common and can be observed...Eclectic and syncretic healthcare behavior are mainly goal oriented, not cognition based” (1985: 14).

What is particularly noteworthy in this description is the identification that in practice, plurality is often based on immediate needs and not on an adherence to ontologies.

Therefore, the concept of medical pluralism may not be appropriate for depicting any healthcare system, regardless of the presumed boundedness of the practices found therein. West and Luedke (2006) attempt to remedy these shortcomings of medical pluralism with a model of what they call “medical landscapes”. This model facilitates both the influence of social processes on local healthcare and the movement across purported epistemological and practice boundaries. But even medical landscapes may be too bounded in its representation of practices. Although it facilitates a reflexivity in perception of local healthcare, it simultaneously suggests mutually regulating, albeit separate, practices.

A far more fluid conceptualization of local healthcare is therefore needed. To approach plurality as, what I am calling, “healthcare currents” may provide a more representative metaphor for the actual formal and informal healthcare observed in this research.

This metaphor can be depicted as countless tributaries of local and national, formal and informal healthcare practices all flowing into sometimes separate, but often intersecting, rivers of unequal sizes. These rivers represent the use of local non-biomedical practices, imported non-biomedical practices, local biomedicine, and global biomedicine. These rivers eventually empty into the sea representing the overall formal and informal local healthcare system. Thereby, with this metaphor a dynamic current of local healthcare is perpetually recreated.

7.2.4 Summary: Why the Conceptual Elements of the Normative Representation are Relevant

In this section, the relevance of the normative constructions of the healthcare system, traditional medicine, and medical pluralism were discussed. All three of these elements assist in reifying the normative representation of healthcare integration. The relevance of these can be understood from Ernst's critique of medical pluralism. Ernst warns that an emphasis on medical pluralism:

“may well give further credence to one of the persistent ideological ploys of biomedicine: that medicine is located outside the realms of power, domination and hegemonic strife...with the image of the medical market place and the sphere of healing...in which patients of all social and cultural backgrounds are supposed to have free choice and easy access to their favoured treatment; where medical professionals and itinerant healers... ply their trade alongside, and in mutual respect for each other” (2002: 4).

The potential harm of this equitable and poised representation, is that issues of the actual disorder and inequity of healthcare will be disregarded. These elements depict a singular healthcare system, with bounded practices, that are all interchangeable. Furthermore, these conceptual elements are constructed from the ordered systems of understanding and meaning of the biomedical Self. Thereby, these elements can justify the biomedical Self's Othering of the Other's ordered systems. Together these conceptual elements coalesce to form the normative representation of healthcare integration.

7.3 An Analysis of The Normative Representation of Healthcare Integration

Thus far, this Chapter has examined the conceptual elements of the normative representation that WHO adopted for healthcare integration. In this section, I will assess the normative representation of healthcare integration through the representational model of healthcare integration that WHO has adopted.

7.3.1 *The Normative Models of Healthcare Integration*

As stated, normative healthcare integration is understood as a single essentialised outcome occurring at the state level of analysis. The existing classification schemes for integration have addressed the extent to which the state promotes or prohibits non-biomedical healthcare practices and practitioners. The several overlapping classificatory systems that have been identified, structure the extent of healthcare integration at a state level of analysis into from four to seven categories (Green 1980; Pillsbury 1982; Bodeker 1994; Hyma and Ramesh 1994; Young 1994; Singer & Baer 2007).

In these models, healthcare integration is depicted as occurring on a continuum. At one end of this continuum is complete official sanction and total incorporation of non-biomedical healthcare practices and practitioners into a nation's healthcare system. This is most often classified as *integration* and is identified in the healthcare systems of Cuba and China (Bodeker *et al.* 2005). At the other end of this continuum is complete *prohibition* of all non-biomedical practices via restrictive legislation. Such suppression was identified in many colonial healthcare systems, with several African countries serving as well-documented examples (Last and Chavunduka 1986; Dauskardt 1990).

In between these extremes are gradations of acceptability of local non-biomedical practices and practitioners by state regulators leading to an informal coexistence with biomedicine labelled *parallelism* (Bodeker 1994; 2001). Parallelism has been exemplified by, for example, Āyurveda's historical coexistence with biomedicine in India since the mid-twentieth century (Leslie 1992; Bala 2007).

However, this unidimensional classificatory scheme of healthcare integration depicts local and imported non-biomedical practices and practitioners as a uniform, undifferentiated, unchanging, aggregate, state level category. Hence, such a model cannot accurately depict either the degree to which all of the possible non-biomedical practices and practitioners of any country may be individually integrated or the dynamic changing processes of integration. In a country such as the Philippines, where some local practices are actively integrated whilst many others are ignored, such a generalised model will misrepresent the extent of integration of all practices and practitioners by virtue of its aggregated structure.

The WHO-WPRO's *Regional Strategy for Traditional Medicine in the Western Pacific 2002 – 2010* encourages member states to use a particular adaptation of these classificatory models to assess member state healthcare integration:

“Countries are encouraged to conduct assessments to identify how far TM/CAM (non-biomedicine) has been recognized and integrated into mainstream health services. The extent of the integration of TM/CAM can be graded according to a typology of: Integrated, Supported, Recognized, Neglected” (WPRO 2002: 11).

According to WHO, non-biomedical practices would be categorised as *integrated* into the health service system if they are considered an integral part of mainstream health services (WPRO 2002:11). In a *supported* health service system, the government recognizes the role played by traditional medicine, supports its proper use, particularly as a community and individual practice, initiates efforts to bring proven traditional medicine into mainstream health services and takes measures to control its safe practice, though it is not considered part of mainstream health services (*Ibid.*).

Non-biomedicine would be categorised as *recognised* by the health service system if the government officially announces its awareness of the potential role played by traditional medicine (*Ibid.*). However, in a recognised classification there is no activity relevant to traditional medicine organized or supported by the government (*Ibid.*).

Non-biomedical practices and practitioners would be classified as *neglected* if the existing traditional medicine is totally ignored and only the practice of biomedicine by professionals and auxiliaries is recognized and supported (*Ibid.*).

Full Integration ◀▶ Supported ◀▶ Recognised ◀▶ Not Recognised ◀▶ Prohibited

Figure 7.1 The Stages of the Normative Model of Healthcare Integration

As this is essentially the same classificatory scheme adopted from the aforementioned models, the same shortcomings are illustrated in the WHO-WPRO typology. Particularly problematic is the dependence on one designation to apply to all of the non-biomedical practices and practitioners in a given country. This issue was identified as an outcome of the conceptual element of traditional medicine.

If this typology is employed to determine the extent of healthcare integration in the Philippines, *supported* would best describe the classification of certain imported non-biomedical practices (e.g.; acupuncture). The only local healthcare practice that could be designated as *integrated* are the ten indigenous herbs approved and regulated by BFAD. However, almost all local Filipino healthcare practices and practitioners would be best classified as *neglected* under this scheme; given that they have not been included or acknowledged in any healthcare integration planning.

Thus, in using this framework a country can be allotted only one general designation. Hence, healthcare integration in the Philippines would be classified as *supported*, or even possibly *integrated*, under this typology. Therefore, simply by virtue of using a framework that acknowledges only those practices and practitioners that have been integrated, the remaining practices and practitioners that are unaccounted for will, in essence, be rendered invisible by this framework and thereby, be further *neglected* as a result of this framework.

Furthermore, this classificatory system presumes that a national healthcare integration policy is somehow uniformly implemented across all levels of a nation or, alternatively, that one local level assessment can be generalised to an entire nation. Such an assumption is challenged in the Philippine context, an archipelago of 7,107 islands, in which only a few municipalities have implemented formal healthcare integration. Hence, a far more nuanced classificatory system is needed in order to generate a more accurate understanding of the extent of all non-biomedical practice and practitioner integration identified in this research. An alternative model is provided in Appendix 4 that accounts for the integration observed in this research.

7.4 Conclusion

This Chapter assembles the findings from the research to examine the normative representation of healthcare integration. Firstly, the representation of healthcare integration was analysed according to what I have designated as the conceptual elements of this representation. These include the concepts of the healthcare system; traditional medicine; and medical pluralism. These elements and their reification were each discussed according to how they were observed or perceived to affect healthcare systems. The examination of these conceptual elements facilitated a fuller understanding of integration, by which to examine the models adopted by WHO for the normative representation of healthcare integration. An analysis of these models in relation to the finding of this research was presented.

Chapter 8

Approaching the Border of Appropriate Healthcare Integration

8.1 Introduction

This Chapter will weave the broad themes of this research together in attempt to answer my final research question: viz. what this research reveals about healthcare integration and how these findings can be applied to inform healthcare integration, global health governance, and development studies in general. In order to answer this question, I will review my overall findings in terms of the research questions.

This Chapter will also propose recommendations, mined from the research, for both healthcare integration, and development studies, particularly in terms of the need for a paradigm shift from simple systems thinking to complex systems thinking. Needs-based approaches will be compared with assets-based approaches, especially in terms of the role of the interventionist, from expert planner to facilitator, and the shift from more vertical to more horizontal management of interventions.

This Chapter will conclude with a discussion on how these alternative approaches, in conjunction with an analysis of subjectivity and alterity, can inform global governance and international development interventions in general. These approaches may then engender a change from “I-It” to “I-Thou” interventions. Such changes can potentially lead stakeholders in any given intervention to the border of their given boundaries of understanding. Thus, instead of navigating around and past each Other's order, stakeholders can potentially learn how the Self can navigate along with the Other.

8.2 A Review of this Research Through the Findings to the Research Questions

This section will summarise and review the findings of this research in terms of the primary and secondary research questions. Firstly, I will review what this research reveals about healthcare integration and how the practice of healthcare integration identified in the field differs from the representation of healthcare integration. Next, I will summarise the multi-vocality of stakeholder perceptions of healthcare integration. Lastly, I will review if and how subjectivity and Othering have altered the processes of healthcare integration. 289

8.2.1 *The Primary Research Question: What is Healthcare Integration?*

Healthcare integration has been represented as a single outcome at a single [state] level of analysis in which all local and imported non-biomedical practices and practitioners are grouped.

8.2.1.1 The Practice of Healthcare Integration 1: Multiple Independent and Interdependent Processes

Firstly, healthcare integration in this research has been identified as a dynamic process, or more accurately, set of processes, in which outcome is but one part of this entire ongoing process. Secondly, integration can occur at any level wherein healthcare is practised; from the global to the state to the local down to individual levels. Furthermore, these simultaneously occurring processes of integration can either be completely independent of, or interdependent on, one another. For those integration processes that interact with one another, the *emergence* of new processes is possible.

Hence, this research examines what many of the process philosophies distinguish as a difference between “being” and “becoming”. A healthcare system is a dynamic, complex, socio-cultural system that is constantly in a state of becoming. Any representation of being will render a frozen snapshot that at best approximates a moment in history that has already passed. Thus, attempting to control these multiple processes at multiple levels may not be possible.

Furthermore, the need for the attempted control of the informal healthcare economy is challenged by these research findings. Informal local healthcare economies are organic, social relationships, which are unique to their given contexts, as was often observed from barangay to barangay. They serve imperative social and cultural functions beyond curing disease. Thus, the eradication, alteration, or attempted control of informal local healthcare practices and practitioners can potentially affect not only local population health, but local social structure, as well.

Although healthcare integration cannot be disaggregated from innumerable other factors affecting health in the populations studied, this research has identified that healthcare integration that is executed without consideration of the given local context can potentially negatively alter access to healthcare, healthcare outcomes, and social stability through interference in the informal local healthcare economy. For example, though I cannot conclude that the healthcare integration observed from the MHO in Bagabag or the DOHP integration of *hilots* through the prohibition of their practices has directly impacted population health, both of these forms of integration have, according to informants, resulted in marginalisation of some local practitioners and alterations in access to healthcare.

8.2.1.2 The Practice of Healthcare Integration 2: Multiple Independent and Interdependent Processes Simultaneously Occurring at Multiple Levels

Although the normative model and representation of healthcare integration focus on global and other higher levels of administration, the actual practice of healthcare integration most often occurs at what Baer *et al.* refer to as the “microlevel of health” (2003: 43). This primary level is where the practice of healthcare integration intersects with the practice of healthcare. For whether healthcare is practised in the dyad between the patient and the practitioner or the patient plus family and practitioner; or between family members; or in self-treatment; this microlevel is the level in which integration is actually being practised through diagnosis and treatment.

And yet this most important inter-subjective moment of integrative processing is often completely disregarded, not only in terms of its central importance to the practice of healthcare integration, but in terms of even being a part of integration at all.

For example, I visited several physician's offices and each one had boxes of the herbs that PITAHC produced (e.g.; *Legundi* and *Sambong*) in their dispensary. When I queried how often they would prescribe the herbs, one physician replied: “Never. I carry it, in case a patient asks for it”.

Hence, regardless that the DOHP and the BFAD have spent a substantial amount of time, money, and manpower to validate, approve, and manufacture these herbs; if the physician is not making these herbs a part of his/her practice, then these herbs will sit on a shelf. There they will remain solely a representation of healthcare integration, regardless that they have been fully integrated into the national healthcare system. Thus, the microlevel is the heart of where integration is or is not practised and merits consideration and examination in order to fully understand the practice of healthcare integration.

8.2.1.3 The Practice of Healthcare Integration 3: who and what are being integrated

It is imperative to differentiate not only how and where integration is occurring, but also in terms of which practices and practitioners are being integrated. Which are being ignored. Which are being marginalised. And which are being prohibited. As was identified in Bagabag, integrating only one practice (such as acupuncture) can potentially marginalise others, whereas, the integration of *hilots* was not reported or identified to affect other local healthcare practitioners.

8.2.1.4 The Practice of Healthcare Integration 4: a context-dependent practice

Finally, as identified in this research, it is important to consider that although there may be a single normative representation of integration, integration may be practised in as many ways as there are contexts. These contexts cannot be universalised simply to adopt to a convention or standard in the practice of healthcare integration. This research identified that what is particularly important to consider, is if the manner in which integration is practised is appropriate for the given context, rather than if integration is being practised according to a set of universalised criteria, which may be inappropriate for any given group. In this instance, the particular, is given precedence over the universal.

8.2.1.5 Integration and the Moral Imperative Toward (Western) Scientific Progress

Basic issues have been identified in examining the representation of healthcare integration, that have previously been ignored in both the discourse and former research. Research has distinguished that the normative representation of healthcare integration is firstly a misunderstanding of traditional Chinese medicine; which itself was an already integrated medical practice under Mao Zedong. Furthermore, by employing a fully standardised, already integrated, state-controlled healthcare practice such as TCM, the normative representation of healthcare integration will not be applicable to, for example, the local healthcare practices identified in the Philippines, which, unlike TCM, can neither be standardised nor assessed via a biomedical *doxa*.

Secondly, China's healthcare integration of TCM was executed in a specific political economic milieu in which marked government force and coercion were necessary. Although such contextualisation is absent in WHO's adoption of this model, it is imperative to consider in attempting to apply China's particular political economic historical circumstances of healthcare integration to other contexts.

Thirdly, the influence of the globally disseminated biomedical healthcare *épistème* of the Rockefeller Foundation, in both healthcare integration and embedded in many of the representational and practice paradigms of WHO, has heretofore remained a footnote in much of the literature. Whereas, this research has identified that the Rockefeller Foundation has influenced both the construction of the representation, and formal practice of, healthcare integration, as well as has been one of the primary influences in the normative construction of international and global health.

It is important to note here the correlation between the moral imperative toward a Western construction of progress in healthcare integration, identified in the international health work of the Rockefeller Foundation, with the same ideology embedded in many of the models of development, starting with the so-called Truman Doctrine in 1947.²²³ For example, whether considering the economic, demographic, epidemiologic, or nutritional transitions; it is assumed that the global South will inherently develop as the global North did. And thereby, development is a deterministic process that is completely dictated by a Euro-American construction of progress as the primary example of what a country should be developing toward. Norgaard distinguished this as “an extrapolation of past good fortune experienced in the North rather than...the actual conditions in the South”²²⁴ (1994: 54).

8.2.1.6 Summary

According to this research, healthcare integration is understood as multiple processes that are occurring simultaneously at multiple levels of analysis that are independent or interdependent of one another. Thus, the state and global representations of healthcare integration were not supported by what was observed in practice or reported by informants at the local levels. Nor was this normative representation appropriate or accurate in its ability to portray the manifold processes of healthcare integration observed.

8.2.2 Research Question # 2:

How is “Appropriate” Healthcare Integration Perceived by the Stakeholders?

The multi-vocality of integration is essential to consider for an understanding of healthcare integration that is appropriate from all stakeholder perspectives. The perception of the particular appropriateness of healthcare integration is very much a product of a given Self's ordered systems of understanding and meaning. Therefore, attempts of a universality of healthcare integration may prove problematic in given contexts.

294

²²³ Though Cowen and Shenton state that Truman's use of the term “underdeveloped...was not new. Bourdillon, the governor of Nigeria...in 1937, said: 'The exploitation theory...is dead and the development theory has taken its place' ” (1996: 7).

²²⁴ This is especially true at the time of this writing, during which several formerly developing countries are surpassing the growth of many of the developed nations and are now the creditors of the most developed nations.

For example, in discussing local healthcare practices, local level informants predominantly defined concepts such as safety, efficacy, and quality in terms of the potency derived from the practitioner's ability to act as a medium through a higher power. Practice is thereby a product of the practitioner's potency and their potency is a product of their relationship with a higher power. Thereby, the actual practice may not be as important in treatment, as the power of the practitioner as a medium.

Furthermore, the local practitioners observed in the field were unique and did not necessarily practice according to a given practitioner designation. Hence, standardisation would not only be impossible in these circumstances, but inappropriate. Because of the importance of the patient-practitioner dyad observed in local practices in the Philippines, both the practice and the illness are rendered as objects to the subjects of the practitioner, the patient, and ultimately a higher power; all of which are engaged in an I-Thou relationship.

Such relationships, adhering to religious-based orderings would be considered patently inappropriate for the biomedical construct of appropriate healthcare integration. Safety, efficacy, and quality of healthcare integration is understood, by the biomedical Self, to be achieved through the adherence to bioscientific ordered understandings that can only be facilitated through the scientific validation of local healthcare practices and their reducibility to “active agents”. Thereby, from a biomedical perspective, the practices of healthcare are what are considered potent and all that is needed to be considered. The practitioner is only important to consider to the extent that s/he demonstrates mastery of the standardised practice in the use of “active agents”.

This devaluation of the practitioner over the practice can be traced to the work of Gates and Flexner and the Rockefeller Foundation; who were instrumental in instilling a Fordist model of biomedical healthcare internationally.

In biomedicine, the practice and the disease become the subject, and the practitioner and patient become the interchangeable objects. Thereby, the clinical relationship in biomedicine is often rendered an I-It relationship.

Healthcare integration that would be considered appropriate for many local level informants, is that which would preserve the integrity of their I-Thou relationships. Thereby, the integration informally facilitated by the MHO of Sadanga, might not only be more appropriate for Sadanga, but possibly more appropriate at local and especially more rural levels in the Philippines in general. For in Sadanga, because of the I-Thou relationships between the MHO of Sadanga and barangay members, healthcare integration was based on the perceived needs of barangay members in compliance with local orderings, rather than adapting local orderings of understanding and meaning to fit biomedicine.

For the WHO, the DOHP, and the MHO of Bagabag, appropriate healthcare integration is facilitated by adherence to bioscientific standards, and those practices and practitioners that can be validated according to these criteria. Thereby, through this exclusive Othering, only those elements of the Other's ordered system that can meet biomedical criteria, for example, the herbs validated for use by the DOHP, may be considered. Hence, biomedical validation and normative healthcare integration is thereby engaging in what Mosse (2001) would identify as a “reshaping” of 'local knowledge' and Kothari (2001) has labelled the “purification of knowledge”.

Thus, appropriateness of healthcare integration is specific to a given ordered system of understanding and meaning. However with such different ordered systems as presented here, and contradictory perceptions of appropriate healthcare integration amongst stakeholders, the practices of healthcare integration appear destined to conflict in these contexts.

8.2.3 Research Question #3:

How Does Othering Influence the Processes of Healthcare Integration in the Philippines? The Commodification of the Other's Order

In order to maintain the respective integrity of their given ordered systems of understanding and meaning, a majority of the agents of the DOHP ignore the majority of local practices and practitioners in the Philippines. PITAHC has the dual responsibility of preserving bioscientific integrity whilst making integration profitable. The necessity to invest in practices that will not engender the disapproval of the Philippine Medical Association and will, above all else, be profitable is a central criteria dictating which practices and practitioners are formally integrated at the state level in the Philippines. Profitability is essential for PITAHC's survival as a government corporation, therefore those practices that have the potential for commodification and profit are focal, whilst the remainder were identified to be ignored.²²⁵

The integration of *hilots* via the eradication of their practices is an extreme example of this relationship between integration and commodification. Here, the commodification, and medicalisation, of pregnancy, is justified as necessary through the designation of bioscientific risk²²⁶ and the diplomatic truth²²⁷ of poor statistical data. The assignation that all women are at risk during pregnancy, and the requirement of mandatory in-facility birthing, medicalises and pathologises the normally non-pathological processes of women's bodies on a state-wide scale. In-facility birthing is part of the formal healthcare economy that requires in-facility pharmaceuticals; diagnostic tests; medical equipment; and other biomedical commodities understood from a biomedical order to reduce the risk of pregnancy. Pregnancy is thereby removed from the emic socio-cultural domains of the home, the *hilot*, the community, and normalcy, and placed in the [often] etic²²⁸ domains of the hospital, the birthing clinic, and the pathological.

297

²²⁵ In this instance, "authoritative knowledge" is primarily dictated by market forces and profitability.

²²⁶ As designated by the World Bank, the WHO, UNICEF, UNDP, USAID, and the European Commission.

²²⁷ See Appendix 3 for a full discussion of what I am calling "diplomatic truth".

²²⁸ To clarify, hospitals were not be considered etic by all barangay informants and thereby are part of the emic Self. However, for many women interviewed, pregnancy was emically understood as home delivery.

According to interviews with the DOHP, *hilots* are to be rendered non-existent unless they comply with the DOHP and thereby agree to refuse to answer the call of the women of their barangay to assist in delivery. Such a refusal would ultimately be perceived by the women, the community and the *hilot*, as a refusal to “God” to carry out one's social duties. Thus, barangay members are being told by the DOHP to ignore the integrity of their ordered systems of understanding and meaning, and, as one informant stated: “to turn our backs on God” in order to comply with a devolved DOHP, as well as the funders of this project. From Barangay informant interviews, few women would consider this request appropriate or remotely feasible for the women of their barangay to follow.

Although it is too soon to observe changes in maternal and infant morbidity and mortality, it is clear from barangay informants that they will continue to use their *hilots* and deliver at home. *Hilots* will continue to feel obliged to perform their religious and social duty to women that seek their assistance. And the DOHP will no longer train *hilots*, nor provide them with a sterile birthing kit.

Hence, in answering Kleinman's (1991) question posed in Chapter 1 of “what is at stake?”, we can hypothesise that maternal and infant morbidity and mortality could increase by this rigid adherence to a biomedical construction of appropriate healthcare integration. Thus, it can be understood that the commodification and medicalisation of pregnancy in the Philippines, resulting from biomedical risk aversion, is potentially creating a situation of greater biomedical risk at local levels. This potential unintended consequence through the rigid adherence to a biomedical *doxa*, despite its inappropriateness for the current context, is quite reminiscent of Ileto's (1988) description of the spread of cholera resulting from the enforced protective biomedical measures from U.S. colonials discussed in Chapter 4. Thereby, from order attempting to contain chaos, more chaos is created.

Thus, Othering is understood from this research to both influence and define healthcare integration. All of the categories of Othering by which I have analysed this research can be identified. Hierarchical Othering and Inclusive/Exclusive Othering have both a means of valuation of the Other's ordered systems according to Self's. Relational Othering can be identified in terms of which practices, such as commodifiable herbs, have been granted "Thou" status. Situational Othering can be very important to what is being integrated and how this is being executed. For example, although the MHO of Sadanga is a physician and follows a biomedical system of order and meaning, she was able to traverse both her biomedical and social Selves in order to facilitate integration that was more appropriate for the barangay's ordered system of understanding and meaning. Finally, Representational Othering is clearly illustrated in PITAHC's absorption of both local and imported non-biomedical practices into the essentialised terminology of "trad med".

8.2.4 Research Question #4:

Assessing the Assumptions of Beneficence of Normative Healthcare Integration

According to informants, integration, firstly, did not increase physical or financial access to healthcare (except in Sadanga, where patients could go to the municipal health office and see both their physician, midwife, and the bonesetter or *albualryo*).²²⁹ As access was the major impetus for integration since the Declaration of Alma Ata, the justification for integration is brought into question.

In the municipalities examined outside of Sadanga, integration was identified to neither increase referral amongst biomedical and local practitioners nor increase the use of local practices and practitioners. Nor did informants identify that integration increased the quality or safety of their healthcare. But possibly, most importantly, normative healthcare integration was not perceived to be appropriate for most local contexts.

²²⁹ Although this improved access was observed, it was actually perceived by few informants.

Informants commonly reported that they, and the people they knew, would continue to use the healthcare system as they wished, regardless of any formal healthcare integration by the agents of the DOHP. In other words, informants identified that they would continue to integrate their healthcare systems [themselves] as needed.

Normative healthcare integration, such as identified with *hilot* integration, was observed in this research to often result in obstacles that informants needed to navigate around in order to receive the healthcare they sought and perceived as appropriate. Barangay informants identified that even if local practices and practitioners were effectively banned, people would continue to seek and find the practices and practitioners that they perceive they need.²³⁰ In fact, it is questionable, if the integration which is sought by barangay informants extends beyond the greater facilitation of their own [personal] integrated use of healthcare, as was identified in Sadanga. That is, if etic healthcare integration can be considered to be something which is even sought by barangay members, which was not supported by informant data.²³¹

Therefore, in response to the fourth research question, the representation of healthcare integration as beneficent along the criteria examined is not supported by informant perceptions.

8.2.5 *Whose Healthcare Integration? The irony of integration in the Philippines*

If barangay informants identified that in general, they neither sought formal healthcare integration nor identified any benefits from healthcare integration, and in some cases are reporting deleterious circumstances from integration, then for whose benefit is normative healthcare integration? The irony of healthcare integration is revealed in an analysis of who is benefiting from integration.

300

²³⁰ However, this does not disregard that how integration is employed within a particular society affords a certain structure, and that how agency is enacted within this resulting structure may temper or limit healthcare autonomy.

²³¹ Although not a single informant actively sought the integration of their local healthcare, it was not clarified by the DOHP or the WHO why the wishes of local level recipients were not being considered.

Bodeker identifies:

“Some years ago in Madagascar, I was in a very remote rural area & came across a small dispensary, looking more like a food stall. Among other OTC's, they were selling *Madecassol*, a burn & wound cream produced by Roche and sold there for a few U.S. dollars [relatively] a very high price. However, people buy it as burns and cuts are common in rural areas. What was interesting was that Roche buys the crude extract of *Centella asiatica*, from which *Madecassol* is made, from Madagascar. And as I looked at the jungle across the road, I saw *Centella asiatica* growing all over the ground...there for free, but people were ignoring it and instead spending weeks of savings on *Madecassol*.”

(Bodeker in interview 2011)

Similarly, it could be queried how the DOHP is helping the disadvantaged of the Philippines access local healthcare, by packaging and commodifying herbs that used to be picked in one's backyard for free?²³² Hence, commodification, justified via biomedical understandings of purity and risk, control what was hitherto uncontrolled and freely available. *INAM* identified that the reason local herbs are part of their curriculum for CHWs is to reteach the use of commodified herbs that they discovered many barangay members had forgotten they had or how to use. Therefore, by externally controlling and formalising those practices that before were uncontrolled and not part of the formal healthcare system, it is identified, at least in this example, that healthcare *can potentially* be made more inaccessible to communities through integration. Such an outcome would completely contradict the WHO's primary justification for healthcare integration in improving healthcare access.

Thus, in this example, local knowledge has been co-opted by “experts”, repackaged in terms of biomedical safety, efficacy, and quality, and sold back to the original sources of this knowledge who are prescribed the local herbs by their physician or BHS midwife and gradually forget how to use what is available in their backyard free of cost.

²³² See Callope 2008 for the popular use of commodified herbs in the Philippines.

The Philippine government was identified to have spent “PhP20 million in order to research *legundi*” which it sold to Pascual Laboratories for PhP500,000; later earning “PhP12 million in profit within the first six months *legundi* was sold” (Miniano 2006: 15). The Chamber of Herbal Industries in the Philippines Inc., an association of fifty of the leading companies in the Philippine natural & herbal industry accounting “for 70% of the local natural and herbal market in the Philippines, estimated herbal sales for 2007 of US\$600million including exports” and continues to grow annually (CHIFI 2010).

Hence, though the original intended beneficiaries of healthcare integration may not actually be benefiting, what can be called the healthcare integration industry is benefiting in this particular example. However, what is important to consider here is if etic control of a local technology/knowledge and the subsequent commodification of this technology, remove it from the control of the original local source to the extent that dependency can be created for the reintroduced commodified technology, via a kind of legerdemain. It is a concern that appears throughout the intellectual property discourse. And can also be identified in the attempt of multinational corporations to control that which was not formerly considered property, such as the attempt to dominate and control renewable energy. In both situations it must be considered what etic control is doing to local control and if such etic control is even justified.

8.2.6 Summary

This section reviewed the findings of this research in relation to the original research questions. This research identified a marked discrepancy between the normative representation of healthcare integration and the practices of healthcare integration identified in the field. The perceived appropriateness of integration was identified as relative to any given ordered system of understanding and meaning. Local ordered systems were identified to often perceive appropriate healthcare integration differently from biomedical ordered systems of understanding and meaning.

Part of the difference lay in how local healthcare practices are being valued and Othered by the different stakeholders of healthcare integration. Whilst barangay members understand local practices as integral to socio-cultural meaning and to the integrity of their ordered systems; PITAHC, the Philippine government, and private enterprises benefit from the commodification of local practices, such as herbal use. The commodification of local practices was identified to potentially compromise their local accessibility. The final sections of this chapter will be directed toward the final research question concerning how this research can inform development studies and global health governance.

8.3 Meeting at The Border: How Might This Research Inform Development Studies

This section will address the final research question of how this research can inform healthcare integration, global health governance, and particularly development studies. An examination of how this research informs international development critiques will be followed by approaches identified in the field that may prove advantageous to both healthcare integration and development studies and that would be more appropriate for both the intervention recipients, as well as the interventionists. These approaches include assets-based approaches to group interventions; complex systems approaches; and the reflexive use of subjectivity and Othering.

8.3.1 Etic Prescriptions and the Perpetuation of Intellectual Colonialism: How to “do” integration.

The issues encountered in prescriptives for how to “do” healthcare integration, reflect many of the same issues in development studies and development interventions. How, for example, can “doing in the other's best interest”, be in the Other's best interest, if the Other's interests are never actually considered?

The justification of the etic “expert” knowing better than the local practitioner or barangay member remains at the heart of an expert Othering that will generate an expert policy, and subsequently an expert intervention, that was identified in this research to either be ignored and/or navigated around.²³³ Such Othering can invariably prohibit stakeholders from meeting at the borders of their ordered systems of understanding.

8.3.2 The post-development critique

According to the so-called post-development theorists,²³⁴ development interventions in low income countries cannot escape from a paradigm which is ethnocentric, teleological, and modernist. This paradigm is perpetuated by development experts. Parpart states:

“These experts became, and continue to be, essential to the development enterprise, as development policies and programs are largely predicated on the assumption that development problems can be reduced to technical, i.e. 'solvable,' problems which involve the transfer of Western technical expertise to the developing world” (1995: 225).

Alternative development, sustainable development, basic-needs approach, and any other modification to the original development paradigm do not overcome many of the shortcomings identified by these critiques. Regardless of their intentions, these development approaches share certain limiting features including: their construction by experts who are external to the locus of implementation; their dependence on closed-simple systems models that can be universalised; and their foundation on Western enlightenment values of liberal humanism. In other words, all of these approaches are limited by their ethnocentrism and inability to include the Other's perspective. The post-development theorists conclude that regardless of any modification, the idea of development itself is the wrong answer to the question of deprivation and disparity. Thus, the problem is the paradigm.

²³³ CHD identifies that the CBHPs were not able to succeed, partly because of their dependence on experts. “Too much importance was given to inviting 'expert' resource persons...to discuss how best to run the programs” (1998: 48).

²³⁴ See Chapter 1 for discussion.

The area of the development paradigm that is most challenged by this research is identified in the representations of the agentless agent, or the agent whose agency must be defined and delivered by an external expert. Such seeming contradictions especially problematise the participation discourse of development studies (Cleaver 1999). Although community participation has been identified as a potential *means* to overcome ethnocentric restrictions of development interventions (Nelson and Wright 1995), the concepts of “participation”, “empowerment”, and “capacity building” all share a connotation that something must be *done to* a community, with community members as participants, for their own betterment; all of which has been primarily determined by outside experts according to their ordered systems. Cooke and Kothari cast such a concept of participation as “tyranny” (2001). Nelson and Wright propose that: “ ‘participation’, if it is to be more than a palliative, involves shifts in power” (1995: 1).

However, a definition of community capacity as “the potential of a community to build on its strengths in order to achieve its goals”, offers an alternative to the normative community participation discourse (Jackson *et al.* 2003: 345). The concept of community capacity begins to address the importance of the assets that already lie within a group, rather than what is etically determined to be needed by the group that is external to the group. This distinction is central to the difference between needs-based and assets-based approaches to development.

8.33 Recommendations Identified from the Research Findings: assets-based approaches

In a needs-based approach, populations are assessed according to pre-determined criteria identified as the basic requirements of human development for any population. Thus, what is identified to be wrong or needed within a given group is according to a value system and criteria of basic needs that is usually external to the group assessed.

Furthermore, by asking “what is wrong”, a methodology is set in motion which presumes that knowledge of wrong and right is solely the domain of the external expert, who has the solution/intervention to rectify what s/he determines to be wrong. Right and wrong, which normatively follows a modernist paradigm, remains external to the values of most groups.

In Bagabag, the municipal health officer felt acupuncture was superior in safety, efficacy, and quality compared to what was being offered by local healthcare practices. In interview he reported that he purposely set about to alter the local healthcare system by introducing acupuncture in hopes of marginalising local practices and practitioners, which he felt were inferior. Thereby, the healthcare system was to follow his ordered system of understanding, regardless of what it was doing to the ordered systems of understanding and meaning of his patients or the social order of the barangays in his municipality.

In contrast, an assets-based approach assesses what answers already lie within the community using the community's own value system. The municipality of Sadanga provides an example of an assets-based approach to healthcare integration. The municipal health officer was flexible in inviting local practices and practitioners to the municipal health office according to what the communities communicated were their needs and according to what was found to work for this particular municipality. Furthermore, the herbal plasters that barangay health workers were using and teaching patients how to use for themselves, worked so well with one group of barangay health workers in Sadanga that the MHO instituted this practice with other barangay health workers in other barangays.

Hence, in Sadanga, the issues were identified by the community and the solutions were located within the community. Although both the MHOs of Bagabag and Sadanga could be identified as facilitators of change, the change that the MHO of Sadanga was facilitating is that which she observed and identified to be already rendering positive outcomes for the members of her municipality. Thereby, both the problem and the solution were emically generated within the barangays of Sadanga.

Positive deviance is an assets-based approach that can be particularly useful in development contexts. In a positive deviance approach, members of a group are distinguished according to who is thriving along a given criterion, to be determined by the group, in which the rest of the group is not (Beggren and Wray 2002). The member determined to be thriving is then facilitated in disseminating their given successful practice to the group (*Ibid.*). Hence, in a positive deviance approach, the solution and expertise, lies within the group and the external expert is present to help identify and *facilitate* the process, rather than *direct* the process with their expertise (*Ibid.*). Thereby, rather than providing a means to “do” an intervention “to” a community, a positive deviance approach enables a community to do for itself. Community participation is then an organic emic, rather than imposed etic, addition. Appropriateness for the context is self-determined by the community. Dependency on external knowledge or resources is thwarted or minimised. In this context, community participation may be more accurately depicted as expert/facilitator participating with the community on the community's project, rather than the reverse.

8.3.4 Recommendations Identified in this Research: complex systems thinking for Complex Adaptive Systems

“In actual daily practice, eclectic and syncretic systems of therapy emerge in complex societies with therapeutic plurality” (Unschuld 1985: 13).

Rihani calls for a paradigm shift in development studies from the normative “linear view of the development process that assumes a high level of order and predictability”, to a model that would more accurately address development as an “uncertain, lengthy and open-ended evolutionary process that is driven by chance as much as by science” (2002: 2-3). Thereby, the process of development itself is understood as an ordered system, as is healthcare integration. But, the activities of both would be more accurately represented by the processes of Complex Adaptive Systems.

Complex Adaptive Systems are open evolving non-linear systems that cannot be reduced to their component parts “because their behaviour is defined to a large extent by local interactions between their components”; known as emergence (Rihani 2002: 7). Complex Adaptive Systems (CAS) exhibit several properties. a) Chaos can be created by interfering with whatever order has been established in a CAS; b) For a CAS to survive and evolve it must be allowed to change according to changing conditions; c) CAS often change at their own leisurely pace independent of attempted outside intervention; d) CAS do not organically evolve toward an optimal endstate (thereby defying teleological interpretations, including those of Western progress); e) In CAS, complexity often increases with time (*Ibid.*: 7-9). Thus, all of these properties of Complex Adaptive Systems would seriously hinder any attempts to control them, which according to (a), may create chaos.

Therefore, the myriad issues that have been identified in this research as an outcome of attempting to control local informal healthcare systems can be better explained and assessed if the local informal healthcare system is understood as a Complex Adaptive System. Furthermore, this research demonstrates that healthcare integration represented as a linear simple systems outcome will, at best, be completely inaccurate. Rather, healthcare integration is identified here as multiple complex processes that are most accurately understood as Complex Adaptive Systems.

The application of CAS to healthcare integration is corroborated by statistical analysis of the research data. For example, there were no statistically significant correlations demonstrated between the use of local healthcare practices, the perceptions of informants concerning healthcare and healthcare integration and/or the demographic categories of education, income, or gender. Thus, the general categories that would befit a simple systems model could not afford this complexity.

Furthermore, no barangay informants interviewed could be accurately portrayed as part of a closed system, regardless of how geographically remote or culturally bounded they might have appeared.

Employing CAS for healthcare integration is essential for understanding the devolved healthcare system of the Philippines, as well as the plurality of informal local healthcare practitioners available at the barangay level. In this dissertation, I have attempted to demonstrate the need to overcome the theoretical boundedness and linearity in the current paradigms of healthcare integration. Firstly, there is the boundedness of the presentation of a healthcare system itself, which I identified as particularly problematic in the anthropological construction of medical pluralism. My own classification of the Philippine healthcare system (Chapter 4) is still, at best, an idealised approximation of a dynamically changing Complex Adaptive System.

Secondly, are the issues stemming from the boundedness of WHO's representation of healthcare integration, in which all non-biomedical practices and practitioners are grouped together at one highly aggregated level.

Even the Western conceptualisation of the discrete groups (or Bourdieuan *fields*) that make up the Self may be too much of a closed, simple systems depiction of a phenomenon which is ever dynamic. These bounded representations cannot accommodate the Filipino notion of identity as groupings of uncooked eggs bleeding into one another. Latour manages to obliterate the social, leaving only a changing web of networks to which a given actor is embedded in his actor-network-theory (2005).²³⁵ Unschuld maintains the social, but breaks the boundaries of groups out of the contingencies of space and time.

²³⁵ Latour states “when social scientists add the adjective 'social' to some phenomenon, they designate a stabilised state of affairs...that later may be mobilised to account for some other phenomenon. There is nothing wrong with this use of the word as long as it designates what is already assembled together, without making any superfluous assumptions about the nature of what is assembled” (2005: 1).

Unschuld proposes:

“even people living in separate geographic regions without any links, or in different historical epochs without the latter knowing of the former, may be part of one 'group' if the socio-cultural realities they experience are, in their essential structure, similar or identical” (1985: 14).

Thereby, ideas of self are extended beyond time and place to the shared adherence to particular ordered systems of understanding and meaning.

What both Latour and Unschuld are reaching toward is to break free from the seventeenth century representational box of simple, reductive, closed system, linear thinking in which Western thought has comfortably taken permanent refuge. And thereby, they have granted the representation of social phenomenon more dynamic freedom of movement. What is particularly noteworthy for this research is the link Rihani makes between complexity and the practice of “freedom”. “Self-organised complexity that lies between deathly order and wasteful chaos could only emerge if people were free to interact and capable of interacting” (2002:11). Rihani posits that such freedom, though essential for the complexity of development, is often thwarted by “chaos, brought about by constant shifting, unclear and often conflicting rules; or stifling order, created by arbitrary and rigid rules that prevent healthy interactions” (*Ibid*: 12).

If healthcare is understood as a Complex Adaptive System, an ecosystem, then any element introduced in to this system will in some way alter the system in unpredictable ways through emergence. The findings of this research, corroborate Rihani's argument. Complex systems thinking is not only essential to understand the processes of healthcare integration, but also applies to both the representation and practice of development.

8.3.5 How this Research Informs Global Health Governance

Healthcare integration is a global health policy that is being directed by a global health agency. By studying a universal policy that is assumed to be inherently beneficent the importance of assessing global health governance is warranted. Global health governance presumes an ability to universalise the governance of healthcare through rational policy making to any local context.²³⁶

Dodgson *et al.* identify three primary criteria of global health governance. 1) healthcare issues cross or ignore national boundaries; 2) identification of multi-sectoral factors affecting healthcare; 3) Both formal and informal involvement of a broad base of stakeholders and interests (2002: 17-18). However, the findings of this research challenge the appropriateness of these criteria for this policy at the local level.

Firstly, it would be reasonable to question why local healthcare integration would or should be an international issue...or even a national issue. It appears that in a devolved healthcare system, a local healthcare process, such as integration, would be a local policy issue, constructed at the local level. This was, at least the understanding of many informants and much of the domestic literature on healthcare decentralisation.

Secondly, from participant experience at WHO-WPRO, multi-sectoral factors in policy, if considered at all, were not considered beyond the state level. This is also reflected in WHO's data sets, which often are aggregated beyond the state level, to the regional level. However, I could not locate any WHO data sets that analysed healthcare integration at more local levels.

²³⁶ Shore and Wright ask: "Are normative claims used to present a particular way of defining a problem and its solution, as if these were the only ones possible, while enforcing closure or silence on other ways of thinking or talking?" (1997: 3).

Lastly, local level stakeholders and interests were not considered, in either the literature or observed in meetings, at the state level by PITAHC, much less by WHO at the global level. Hence, local healthcare integration does not meet the basic criteria listed above for global health governance. The further prescriptives of Dodgson *et al.* are illustrative:

‘If existing forms of health governance are seen to be undemocratic, alternatives that appropriately balance actors and interests are needed. Systems for ensuring accountability and transparency must be agreed. There requires greater clarity about what contributions different actors make to GHG, and what governance mechanisms can ensure that these roles are fulfilled’ (Dodgson *et al.* 2002: 21).

Although such criteria are undeniably worthy of pursuit, from participant experience at WPRO, it is questionable if any of these prescriptives are, in fact, capable of being pursued in actual practice.

Furthermore, this statement appears to codify the rationale for the already highly political health policy making process observed at WHO. Although the WHO represents their mission as one of technical support to member countries, I found in participant experience in the Traditional Medicine Unit of the Western Pacific Region Office of WHO that although the secretariat maintained that the meeting was self-directed by the experts they hand-picked to attend, the meeting agenda, the meeting decisions, and the outcome of the meeting were actually directed by the Secretariat. Furthermore, in analysing data for presentation at this international meeting for WPRO, I was told that only certain data could be presented and the remainder could not be analysed. Data analysis was predominantly restricted to what countries “achieved” according to WPRO criteria (See Appendix 3).

Such findings that challenge the construct of either a rational or evidence-based" policy making process of WHO were corroborated in the literature.

In their study of the WHO policy process, Oxman *et al.* identify that the WHO directors they interviewed: “singled out the use of evidence more commonly than any other area for improvement ...evidence is generally not retrieved, appraised, synthesised, and interpreted using systematic and transparent methods. Few directors reported using data about potential harms or explicitly considering values—ie, the relative importance or worth of the consequences (benefits, harms, and costs) of a decision. Using data about potential harms was not considered for public health or policy interventions” (2007: 1885-6).

In their critique of global health policy making Lee and Mills identify that commonly “simple and low cost technologies, appropriate for use in settings with few resources, are undervalued and hence inadequately researched” (2000: 775). Feasibility, sustainability and outcomes for a given local context are often not so much assessed as assumed in global healthcare policy making (Oxman *et al.* 2007).

These issues may be attributed to the fact that WHO, as a global multilateral institution, is thereby, inherently foremost a political institution; regardless of its designation and representation as a technical institution. Hence, WHO's structure may inherently restrict the activities of the organization according to political concerns, just as PITAHC's activities were restricted by its status as a government corporation.

By virtue of such structural restrictions, it appears that it would be advantageous for both of these institutions, as well as for higher level health governance in general, to build a broader network of stakeholders. However, such change would appear to require a comparable change in the hierarchical verticality of policy making and management embedded in such institutions.

8.3.5.1 Governance without Experts

*“There are, in truth, two different perspectives in most circumstances:
life as experienced by people at large, and life as envisioned by the experts”
(Rihani 2002: 238).*

Health governance without health experts would appear a contradiction. From the AMA's support of the hegemonic rise of the physician over the dominion of U.S. healthcare to the RF's internationalisation of this dominion and to the globalisation of this dominion by the WHO; all have been contingent on the reification of the need of the biomedical expert. According to Parpart, expert control over the development discourse: “reinforces and legitimates policies and practices that have strengthened Southern ties with the North and consequently Northern influence in the region” (1995: 226).

Global Governance is governance by the expert and, from the findings of this research, often governance for the expert. The Beijing Declaration is illustrative. This single page document was written thirty years after Alma Ata to formally reinstate WHO's commitment to the traditional medicine goals of Alma Ata. The Beijing Declaration states:

“The knowledge of traditional medicine...should be respected, preserved and promoted widely and appropriately based on the circumstances in each community” (WHO 2008).

But this statement is quickly followed by:

“Governments have a responsibility for the health of their people and should formulate national policies, regulations and standards, as part of comprehensive national health systems to ensure appropriate, safe and effective use of traditional medicine. Traditional medicine should be further developed based on research and innovation...Governments should establish systems for the qualification, accreditation or licensing of traditional medicine practitioners. Traditional medicine practitioners should upgrade their knowledge and skills based on national requirements” (WHO 2008).

But these two statements appear to be completely contradictory. Can local healthcare practices be “respected” and “preserved” whilst being regulated and controlled according to an expert definition of appropriate?

That this contradiction is not apparent to experts is a reason for concern regarding global governance. That local levels may simply ignore the experts, as identified in this research, is a reason to question the function of global governance.

Rihani faults the shortcomings of global governance to be the inevitable result of a linear reductionist paradigm embedded in all UN agencies executed through vertical top-down management. Rihani identifies the fact that “linear remedies and management styles are used to address nonlinear issues” is an irreconcilable problem in global health governance (2002: 108).

8.3.5.2 Complexity, Assets-Based Approaches, and Rhizomes: Vertical versus Horizontal Governance

The findings of this research, corroborate Rihani's critiques. It is not likely that good governance will suddenly be achieved by meeting criteria that are still embedded in the same historical organisational structure and “management styles”. Complexity addresses a means by which to more accurately represent and understand healthcare and development interventions. Assets-based approaches provide a means of how to execute interventions appropriately for any given context. What is missing though, is an organisational structure that can contain and link assets-based interventions with complex adaptive systems. The organisational structure of governance is normatively vertical. However, as observed in the community participation critique, “Simply desiring egalitarian relationships does not make them so” (Sitrin 2006: 4).

In order for change to be facilitated in governance, the normative organisation of governance and policy making may need to be reconsidered. As a result of a positive deviance analysis of the municipalities and barangays of this research, Sadanga was identified to be closest to the original promised and intended goals of decentralisation in terms of organisation.

What makes Sadanga different from the other municipalities studied is that change was facilitated through a more horizontal organisation, led by the Municipal Health Officer *with* the community, rather than in a vertical manner led solely by experts or by the MHO as in Bagabag.

This non-hierarchical approach to governance and policy making was observed to afford all participants the possibility of equal value in making decisions. This approach can be traced to the formalised social movements in Argentina of the past decade, labelled “*Horizontalidad*”. According to Sitrin, “*Horizontalidad* implies democratic communication on a level plane and involves, or at least intentionally strives towards, non-hierarchical and anti-authoritarian creation rather than reaction” (2006: 3). *Horizontalidad* has been described as both a goal, as well as a tool for organisation. In *horizontalidad*, state politics and the division of labour found in market economic systems are considered vertical relations, which are perpetuated to create centralized power over others. *Horizontalidad* replaces vertical structures and modernist relational systems by creating relations autonomous from state politics, market economics, and civil society.

Gilles Deleuze and Felix Guattari suggest that in order for state and global (or macro) representations to change, they must break away from hierarchical power relations, that subjugate through “apparatuses of capture” (1987: 468). They suggest this can be fostered by “reformulating systems of power relations into more horizontal, or rhizome-like, matrices” (1994: 208) that can thereby alter the macro-political “binary distributions of sexes, classes, parties” towards a fluctuation of identity resulting in a dynamic, constantly changing set of interconnected entities with individual fuzzy boundaries (1987: 216-7).

Deleuze and Guattari's description of the rhizome provides an apt metaphor of the representation and practice of horizontality as opposed to a bounded vertical organisation of power.²³⁷ The unique quality of the rhizome is found in its ability to “assume very diverse forms, from ramified surface extension in all directions...this is very different from a tree or root, which plots a point, fixes an order” (1987: 7). The concept of the rhizome grants Complex Adaptive Systems the multi-directionality and dynamic emergence they seek, whilst also providing a horizontal bridge of equality upon which assets-based approaches can thrive.

Furthermore, the metaphor of the rhizome also breaks though rigid Enlightenment constructs of teleology and progress, as rhizomes have “neither beginning nor end, but always a middle from which it grows” (Deleuze and Guattari 1987: 23). “The rhizome is an acentered, nonhierarchical, nonsignifying system without a General and without an organising memory” that is perpetually directed toward becoming (*Ibid.*). Hence, there is no endpoint to reach. No embedded idea of progress to develop toward. In other words, there is no singular ethnocentric ordered system by which to dominate the Other. Rhizomal horizontality effectively does away with pyramidal hegemonic order. The order of the rhizome is non-repetitive and thereby facilitates order that is not rigid; a kind of democratic disordered order. Instead, there is a “multiplicity of interconnectances. Nothing exists in and of itself, everything is interrelated” (Norgaard 1994: 132).

Furthermore, the rhizome metaphor is particularly pertinent to this research and to understanding the dynamic processes of healthcare integration. For example, the myriad practices of healthcare integration identified are more rhizome-like, whilst the normative representation of healthcare integration is more arborescent, vertical, hierarchical, and linear.

²³⁷ Even when international organisations create global technological networks in order to monitor disease that, at least in theory, resemble horizontal organisation (e.g.; WHO's Global Influenza Surveillance Network, Program for Monitoring Emerging Diseases, and Global Health Network) these are still expert led through top-down guidance (Lee 2003: 140).

Rhizomes facilitate infinite, complex, and dynamically changing plurality that is unbounded or whose borders are blurred and shifting. Deleuze and Guattari emphasise that a rhizome is neither easily controlled nor thwarted (1987). There is no “leader”. When you cut a rhizome it will continue to grow. It will grow and *navigate* around any obstruction. Its horizontal “community”, of dynamic connections in perennially changing groupings, is what perpetuates its growth, regardless of external obstructions. Rhizomes are thereby indivisible and defy the reductionist logic of boundedness and divisibility that this research has problematised in the normative representation of healthcare integration.

8.3.5.3 Is "Healthcare" the Concern of Global Health Governance?

However, before considering who's delivering the message or how to change the means in which a message is delivered, the message itself must be considered. Is population health even the primary consideration in global health governance? Although such a question may seem absurdly self-evident, the findings of this research demonstrate that stakeholder agendas may be as likely to be concerned with market profitability of healthcare products as with any healthcare outcomes for populations. At every level of analysis this was encountered.

For example, at the state level, PITAHC is obligated to be profitable for its own survival. Hence, its focus on herbal manufacturing; foreign acupuncture licensure; and medical tourism, replace the domestic concerns outlined in their mission statement and charter. Furthermore, many informants questioned the motivation of the DOHP's focus on the Administrative Order for mandatory in-facility birthing; that was clearly [to them] unimplementable in the context of the Philippines. However, informants suggested that it was no coincidence that the DOHP was receiving substantial loans from the World Bank, USAID, UNDP, and the European Commission in order to implement this policy.

Ironically, what is occurring in the Philippines is a state (DOHP) centralisation and control of the informal healthcare economy within a decentralised formal healthcare environment.

On a regional and international level, at TM/CAM conferences attended for this research in Hong Kong, Bhutan, and the UK, and in analysing the documents of recent ASEAN²³⁸ meetings, a focus on trade and marketability was particularly evident concerning herbal products. Predominantly, this discourse concerned scientific and often “high-tech” validation and standardisation of herbs and local healthcare products, specifically for the global marketing purposes of integration into both biomedicine and the growing wellness industry.

On the global level, WHO TRM unit guidelines, have been focussed for the past decade on issues of herbal production and manufacturing, that primarily address concerns of the herbal industry. These include comprehensive herbal manufacturing guidelines that were published in rapid succession on Good Agricultural and Collection Practices (WHO 2003b), Good Manufacturing Practices (WHO 2007a), and Herbal Quality Control (WHO 2007b). To be fair, this was not merely a WHO agenda but was also reflected in the recent concerns in the documents of WPRO member states. At the WPRO meeting I discuss in Appendix 3, the “expert” advisers were predominantly concerned with the purity and safety of imported herbs and raw herbal products.

That WHO is, in this instance, following the lead concerns of member states is an important distinction to identify. It would have been following a well-worn path to turn this dissertation into a polemic about abusive power and global governance. However, abuse signifies some amount of consciousness and understanding that what one is doing is inherently or potentially harmful to another.

319

²³⁸ The focus of the ASEAN member states is on economic development in the Southeast Asia region. Their key focus in healthcare integration concerns the “harmonization” of traditional medicine particularly in terms of herbal production (Kadetz 2010).

Instead of trying to make the research fit a message, I attempt to listen to the message of the research. This research reveals that the activities and practices carried out by WHO and the DOHP that were observed and analysed, were not executed with a conscious intention to uproot informal healthcare economies. Rather, these activities were executed as any community or members of a *field* would carry out their activities; by adhering to the integrity of a given *doxa* through a *habitus* that maintains the order of this *doxa*.

WHO, like any organisation is beholden to their *doxa*. Members of the field of WHO are beholden to uphold the maintenance of the *doxa* and of the representation of WHO through the *habitus* of what I call “diplomatic truth”. In adhering to their representation of healthcare integration, WHO's integrity of their ordered systems of understanding and meaning, as well as the multiplicity of functions which they must meet, are maintained.

However, this does not justify maintaining a status quo when the need and means for change are identified, as in this research. As Ferguson (1994) identifies development in Lesotho as a depoliticisation of poverty, normative healthcare integration can be understood as a deculturation of local health culture. Even though documents of the Traditional Medicine Unit of WHO and the TAMA of the DOHP refer to the importance of the preservation of culture, this importance appears to be rhetorical in a process that is attempting to replace a local cultural system with a hegemonic biomedical one. According to Cant and Sharma:

“integration of biomedical and non-biomedical systems of healing, whether initiated by the state or the healers themselves, does not...do away with medical hegemony” (1999: 183).

As the Director of the TRM at WHO stated in response to the question of spirituality in traditional medicine: “Traditional medicine is a science”. In the perception of traditional medicine as science, culture is understood to have already been removed in the normative representation of healthcare integration.

8.3.6 How this Research Informs Development Studies

“All planned change conceived of as development involves unequal power, and that power largely resides in control of the resources for change: knowledge and capital”
(Purcell and Onjoro 2002: 164).

Development interventions often depend upon high-technological solutions and the doctrines of scientism and progress. Such a development paradigm has been brought into question by the findings of this research.

Norgaard argues rather than technology arising organically out of social situation, societies instead “are being shaped by technology. New technologies are determining the kinds of social organization that evolve as well as the kinds that must be designed to control and offset technologies effects” (1994: 56).

However, Progress is a relative construction specific to a given ordered system of meaning and understanding. Thus, there is no singular, universal, shared understanding of progress.

According to Rihani: “complexity is founded on the principle that meaningful action takes place primarily at the level of the fundamental unit, the egoistic individual”. Therefore, he concludes, it is necessary “to enable ordinary people to determine which problems they wish to address, how the problems should be tackled, and by whom”²³⁹ (2002: 238).

However, to which individual is Rihani referring? The Western enlightenment individual, could not be located in the barangays studied in the Philippines. Norgaard argues that there is a problematic relationship between development and the liberal construction of individualism: “Through its emphasis on individualism, modernity is culturally disrespectful, even while respecting individual differences” (1994: 124).

What this research reveals in regards to development studies is that firstly local levels are not universalised Others. If the local level is turned into a universalised “It”, communities cannot be understood as separate entities and thereby interventions will not likely be able to meet context-specific needs or appropriateness.

321

²³⁹ One way to address this in terms of development is by asking: “Is the community participating on an external project or are they being facilitated to do their own project”?

Not all contexts follow a singular conception of risk, safety, efficacy, quality, appropriateness, etc. Furthermore, and more fundamentally, these are not even understood to be universal priorities. For example, according to CHD, the community-based health programs of the Philippines have prioritised healthcare which is “nationalist, relevant, accessible, and responsive to the needs of the people” (CHD 1998: 4). Hence, analysis at the local level is imperative to understand how healthcare is prioritised and understood in different contexts.

Development approaches can break from, what Sillitoe *et al.* identify as, the rigid dichotomies of “modernization/dependency” and “market-liberal/neo-populist” via complex systems thinking, assets-based approaches, and horizontal organisation (2002: 3). Although horizontal organisation can engender Purcell and Onjoro's call for parity, parity, as they propose in their model of knowledge integration, cannot be enforced²⁴⁰ (2002: 162-88). Attempting to enforce parity as part of development in a country such as the Philippines, where marked inequity is often tied not only to political economy, but also to elite control of economies often controlled through violence, can potentially lead to deleterious consequences that may harm the well-being of the beneficiaries of development interventions (*Ibid.*; Quimpo 2008; Gonzaga 2009).

Thereby, parity and horizontal organisation are changes whose direction and timing are best left to the discretion of the emic beneficiaries; who will better understand the complexity of local change and the myriad potential consequences that can ensue, than can any external expert. Hence, more fundamentally this research substantiates the worthiness of Sillitoe's question: is development “something outsiders have a right to impose?”(2002: 9).

²⁴⁰ “Parity is seen as the ability of a group to make autonomous decisions about its future based on a set of principles derived from its own collective ontology - its own truth” (Purcell and Onjoro 2002: 162).

This research asks if ordered systems are relative, then what can the various Selves in any development intervention learn from the various Others? Can exclusive Othering learn to receive valuable information from the Other? Can the “North” learn from “South-South” transfers? Can communication be multi-directional thereby facilitating the possibility of creative solutions and emergence? And can the various stakeholders not merely participate in integration but be integral and integrated into the integration process from its onset?

Sillitoe states, “In allowing local populations to inform the development process with their own knowledge and aspirations, we open up the prospect ultimately of redefinition of the meaning of development itself and its aims” (2002: 11).

Hence, the post-development riddle of how to change development may be answered by listening to and observing the local recipients of development. It is important to examine how an imposed foreign ideology of order affects societies. Anderson states:

“Indeed, one might argue that 'development' never quite discarded the colonial legacy...the old dichotomies of modernity and tradition, science and ignorance, global and local, purity and danger—only to characterize the subjects of development as arrested at stages in the traverse between these opposites. 'Development' remained, at heart, a 'civilizing' mission, dis-empowering local communities and demanding that the 'native' or the 'underdeveloped' person follow a single track toward a unique western modernity” (Anderson 2002: 690).

This research appears to support Anderson's argument. Thus, an understanding of the subjectivity and Othering embedded in development interventions, as well as in the entire development paradigm, are imperative to consider in development studies.

8.3.7 Recommendations Identified in this Research:

Problematising the Modernist and Post-Modernist Representations of Agency

*"The masses certainly do not passively submit to power;
nor are they tricked by ideological lure" (Deleuze and Guatarri 1987: 215).*

This dissertation has identified that several of the representations of healthcare integration have not been support by this research or have contradicted the findings of this research.

However, the representation that has presented the least coherence with the findings of this research is the representation of agency. Although human agency may not be present in most governmental and intergovernmental representations of a healthcare system, this research illustrates that local agency is a foundation of the practice of healthcare integration. Agency could be understood to transform healthcare integration from a two-dimensional representation to a three-dimensional reality in which individual plurality, creativity, and choice complicate healthcare integration beyond that which any simple, closed-systems model can represent.

Power in this research is neither identified as unidirectional nor as located in the sole possession of a dominant group. Hence, if this research employed a Foucauldian framework, WHO would be considered a structure of power, and integration would be the discourse of power exerted by “experts” who possess the specialised knowledge to manufacture integration onto the docile and compliant bodies of the barangays (Foucault 1977; 1980; 1982; 1988). However, such a depiction of power is problematised if the local level has essentially responded “so what?”; as have many of the informants of this research.

Maintaining the integrity of the Self's ordered systems of understanding and meaning is the engine of agency. Hence, there may be nothing for interventionists to gain by ignoring the agency of the local level. WHO's representation of healthcare integration assumes that the state will follow WHO's guidelines and the community will simply follow the state's.

This essentialised depiction, akin to the universalised body in biomedicine, is not only a modernist reductive convention, but is also prevalent in post-structuralist and post-modernist social theory.

Ardener (1989) speaks of the “muted” Other in the path of the dominant group. Spivak (1988) speaks *for* the mono, subaltern, agentless,²⁴¹ voice. Foucault's (1977) docile bodies do as they are told.²⁴² And Bourdieu's (1977) practical taxonomies generate power in the imposition of paradigms onto others. Many other structuralists, post-structuralists, and post-modernists can be identified who focus solely on the outcomes of higher levels of power, whilst consistently refusing to grant agency to the people for whom they speak.

In analysing my data and participant experience, I cannot interpret the findings of this research through a Foucauldian lens, or really any strict post-modernist lens, which in itself is reductive in its capacity to understand complex social processes, by focussing only on the singular level of analysis of what is being *done to* a given group. Such a unidirectional representation of social worlds does not facilitate an understanding of the agency of any given social group. Thereby a “post-modern Othering” is being perpetuated that renders the Other to be more impotent, voiceless, helpless, and agentless than possibly in the original modernist depiction. Such a depiction can be understood as a result of the failure to observe all stakeholders equally. Which is due, at least in part, to simple systems and reductionistic thinking.

These issues are identified not only in the post-modernist and post-development critiques, but also in the post-colonial critique. For example, Cabral (1994) constructs *what* the “liberation” struggle *is* for post-colonial Africa and how it should be executed.

“Consider these features inherent in an armed liberation struggle: the practice of democracy, of criticism and self-criticism, the increasing responsibility of the population for the direction of their lives..and many other achievements” (Cabral 1994: 53-65).

²⁴¹ In a presentation Spivak spoke of resistance that required infrastructure for recognition and agency as something requiring the validation of institutions (Spivak 2008). Such constructions, I would argue, are much more about representation and much less about practice. Spivak's subaltern yearns for an establishment or dominant Self's representation of agency. The informants I interviewed didn't seem to care about the etic representation of their agency, yet still fully exercised it.

²⁴² Ironically, in the Philippines, the docile bodies are not represented by the patient being told what to do, but by the elite and the purveyors of the standardised medical “gaze”.

Even though agency is being advocated for here, it is questionable if prescriptive agency from an external expert begets internal agency. Or if one is actually increasing their “responsibility and direction” when they are being told what their responsibility and direction is.

The same reasoning that justified the beneficence of colonialism is being perpetuated by the actions of interventionists that imply that they know what the Other's issues are and will tell the Other what their issues are, and what to do about it, and how to do it. Furthermore, not only is the Other then rendered incapable of having a voice and deciding what is best for themselves, but they are being further essentialised as a subaltern “It”; portrayed as a helpless cog in the wheel of the development machine (Deleuze and Guattari 1987; Ferguson 1994). Or a docile body represented and reproduced by the expert technocrats of modernity (Foucault 1977). Hence, an understanding of true agency that could be applied to this research, as identified, for example, in Scott²⁴³ (1985; 1990) and Vigh (2008), is absent in these discourses.

Thus, Escobar (1995) and many of the post-development and post-colonial theorists critique development for creating an impotent Other or a subaltern “It”. However, they may actually be reinforcing this weak, poor, dependent, helpless, and essentialised “It” representation of the Other, precisely by their refusal to grant agency in their representation of the Other, by virtue of their sole, or primary focus, on the power of the interventionists.

Barangay members in the decentralised Philippines did not appear to really be concerned with the rules imposed from higher administrative levels and continued to selectively ignore and/or navigate around policies that were deemed unfit and/or inappropriate for their ordered systems of understanding and meaning.

326

²⁴³ Scott identifies: “If behind the facade of behavioral conformity imposed by elites, we find innumerable, anonymous acts of resistance, so also do we find behind the facade of symbolic and ritual compliance, innumerable acts of ideological resistance” (1985: 304).

It is particularly unfitting to disregard agency in healthcare in a context such as the Philippines, wherein, there is not only resistance to inequitable healthcare, but long-term organised rebellion.

Healthcare is a political act in the Philippines. As described in Chapter 4, healthcare equity was a central concern of the New People's Army (NPA), and acupuncture treatments and classes were specifically utilised to introduce the NPA to communities and potentially attract followers. But even if we ignore the work of the NPA and other specifically political CBHP groups directed toward equitable healthcare in the Philippines; this research did not demonstrate that barangay informants simply follow the taxonomies dictated by WHO, the state, or the local municipal health officer. Informants demonstrated that they were fully capable to think for themselves and generate their own taxonomies, rather than blindly realise the imagined ones imposed upon them.

Hence, is the Other muted, mindless, caught in the dominant group's maze or are their voices and everyday day acts of resistance not being heard by the dominant groups? Merely because unorganised resistance may not be recognised does not render it less a form of resistance. Are “messengers” needed here as Spivak insists? Or is it possible that *all* stakeholders will require a translator until they are able to meet at the border of their respective boundaries and listen to the Other?

8.4 Conclusions

The heart of this research asks how do, can, and should ordered systems of understanding and meaning be brought together for appropriate healthcare use at local levels? Appropriateness is understood to be socially constructed and therefore context-dependent. Appropriateness can be better understood through social constructionist analysis and through a framework of perceived subjectivities.

Dudley states: “After a generation of promoting Appropriate Technologies no single widely-accepted definition has emerged” (1993: 142).

The manner in which power is then utilised in integrating knowledge systems will vary if Othering is exclusive and knowledge is integrated according to a dominant standard of authoritative knowledge. If Othering is inclusive, power may be understood to be gained as more knowledge is integrated into a system.²⁴⁴ Exclusive Othering as practised in this instance by the WHO and many of the agents of the DOHP is constructed according to a modernist, positivist, teleological, liberal humanist, and economically neoliberal agenda that can be traced back to the rational individual of the Enlightenment.

Otherness appears to have been evaluated by the WHO, the DOHP, and many of the healthcare integration stakeholders according to where the Other's ordered system ranks on a scale of global temporal hierarchies, in which current inventions in modern biomedicine is highly valued at one end and local knowledge and local technologies, which contradict biomedicine's order and hegemony, are ranked at the lowest end of the opposite pole. Whereas, local knowledge or elements of local knowledge that can conform to biomedicine, in terms of the “scientific” criteria of safety, effectiveness, and quality, will rank more in the middle.

The ideology that differentiates the processes of integration found in Bagabag, Murcia, and Sadanga is not merely a difference between global versus local frameworks, nor simply a function of modernity, but moreso a difference in how local knowledge systems are subjectively approached; on a continuum from exclusive to inclusive Othering. The type of Othering employed, along with the extent of vertical or horizontal organisation will affect how the dominant and local knowledge systems are valued and if and how they will be incorporated.

328

²⁴⁴ Cant and Sharma state: “Where such borrowing occurs it may be regarded as a product of vigour rather than decadence, and where the borrowing is from biomedicine we do not necessarily have to regard this as evidence of biomedical hegemony” (1999: 179).

8.4.1 *To Meet or Not Meet at the Border?*

The first word I learned in Tagalog, *depende*, was also the first lesson my informants taught me. This choice word that I heard in almost every interview, meaning “it depends”, appears to offer a key that opens onto a different paradigm, other than the universal one that provides the same answer for all. To embrace a framework of *depende* requires a movement away from the seventeenth century and into a more representative model of complexity and emergence. Post-foundationalism may offer the closest comparison, with its understanding of the multiplicity of grounds and plurality of *doxas* in which all can be considered reasonable within their given field.

I have attempted in this dissertation to reach beyond a normative framework and examine healthcare integration in a nuanced way that may then facilitate new understandings of what healthcare integration is and how it might best be facilitated for a given context. Thereby, with this dissertation I have sought to not merely challenge normative development and post-development discourses in general, but also contribute to new ways of understanding how to work at local levels with different ordered systems of meaning, value, and understandings. This research has not only asked “what is healthcare integration?”, but it has also considered “what is the purpose of healthcare integration?”. Furthermore, is healthcare integration something that should be done to a community, done with a community, or something a community should be left to achieve on its own? Is formal healthcare integration really necessary or can people assume their own integration as demonstrated in Sadanga?

This research was originally conducted in response to the post-development critiques and set about to respond to their questions. Does the practice of development need to be changed or abandoned? Is the entire paradigm of development ineffective?

Or might a critique of development be more explicitly directed toward the adherence to one ideology, one paradigm, one ordered system of understanding and meaning that cannot be either used to represent and/or neatly be put in place of, another. Hence, from this research, I understand the critique of development in the question, “can one ordered system of understanding and meaning simply replace another?” According to my informants the answer is no. They will continue to follow their own ordered systems of understanding and meaning out of specific socio-cultural needs, and navigate around any other ordered system that is being imposed at higher levels.

Thus, to represent healthcare integration as a process of what a dominant group does to non-dominant groups in either a favourable depiction (a modernist perspective) or in an unfavourable critique (a post-modernist perspective) is to only acknowledge one aspect of these complex processes, and thereby further perpetuate a representation of one group's complete control over other groups. This representation also perpetuates a rigid understanding in development studies of the need for the paternalistic ethic expert.²⁴⁵ Hence, the Self's representations, such as those of healthcare, would need to be conjoined with the Other's practice of healthcare in order to be representative. If representation and practice continue to remain separate, appropriate healthcare interventions may be compromised. But for healthcare integration to truly be appropriate for all stakeholders, then stakeholders must be integrated into the normative healthcare integration process from its onset.

This research identifies the importance of future research in healthcare integration, by demonstrating that the practice of integration in the communities examined neither correlates with the normative representations of healthcare integration (from WHO and the state) nor the assumptions of beneficence that justify any need for healthcare integration. 330

²⁴⁵ However many development critiques assert that such paternalism is embedded in development and thereby inescapable. Chambers states: “A stronger person wants to change things for a person who is weaker. From this paternal trap there is no complete escape (1983: 1421). And Dudley states simply: “All aid is paternalistic” (1993: 8).

Ultimately what may be demonstrated in this research, for all stakeholders involved, is the need to listen to, facilitate, and work alongside; rather than tell, direct, and dictate. One of the primary differences between Bagabag and Sadanga is that in the latter the Other was listened to, instead of told, spoken for, or in any other way purportedly protected from themselves. Murcia provides an intermediary example, because barangay members were, in effect, told or given options and then allowed to decide what to use or not use for themselves. Hence, each is an approach that may be appropriate for certain communities more so than others. Appropriateness is context dependent. According to Dudley: “An intervener’s criteria of appropriateness will only prove relevant if the intervention process generates options which also satisfy the criteria of the villagers” (1993: 148).

Listening to the Other takes time and possibly the priority of the time for listening would be an advantageous consideration for development projects. Sillitoe speaks of “the noble aim of affording a voice to the previously marginalised and post-colonialized” (2002: 20). But from the findings of this research, I would critique this, as I did with Spivak, that it is not that the Other does not have a voice. Nor that the Other needs to have their voice “afforded”, engendered, or even translated by the expert Self. But that the Other is not being listened to. According to Purcell and Onjoro:

“In the attempt to achieve parity, neither the proponents of scientific nor indigenous knowledge can ignore the cultural, material, or epistemological basis of the other’s knowledge” (2002: 163).

Etic impositions onto the Other’s ordered systems of understanding and meaning displays an ignorance of the emic value granted to preserving the integrity of ordered systems, identified in this research. When local practitioners were directed or coerced to give up or alter their practices, when patients were told certain local practices were unsafe, and when women were directed that they were all at risk for pregnancy and that it was mandatory that they deliver in-facility with skilled practitioners, shoulders were generally shrugged.

The response to integration that was etically imposed on local informants was essentially indifference and carrying on with life according to one's ordered systems. Hence, this research suggests that the agency that both modern and post-modern advocates have removed from the local Other does not need to be represented or spoken for. Rather, it needs to be returned to the Other, engaged with, attended to, and most of all heard, if development and healthcare interventions are to be of benefit to local populations.

Therefore, I conclude, if meeting at the border of one's ordered systems of meaning and understanding means that stakeholders will then be able to dialogue and listen to one another, then this process is something that may address many of the issues of healthcare integration identified in this research, as well as local level issues problematising development studies, in general. Thereby, instead of needing to navigate around each Other's order, stakeholders can potentially learn how the Self can navigate beside the Other.

BIBLIOGRAPHY

- Abinales, P. and Amoroso, D. 2005. *State and society in the Philippines*. Pasig City:Anvil.
- Adams, V. 2003. Integrating Abstraction: Modernising Medicine at Lhasa'a Metsikhang. in Schrempf, M. (ed.) *Soundings in Tibetan Medicine: Anthropological and Historical Perspectives*. Leiden:Brill.
- _____. 2008. Integration or erasure? Modernising Medicine at Lhasa'a Metsikhang. In Pordie, L. (ed.) *Tibetan Medicine in the Contemporary World. Global politics of medical knowledge and practice*. London:Routledge.
- Adams, V., Novotny, T., Leslie, H. 2008. Global Health Diplomacy. *Medical Anthropology*. 27(4): 315- 23.
- Adams, WR; Hawkins, JP. 2007. *Health Care in Maya Guatemala: Confronting Medical Pluralism in a Developing Country*. University of Oklahoma Press.
- Agoncillo, TA. and Guerrero, MC. 1977. *History of the Filipino People*. Quezon City.
- Akerele, O. 1987. The Best Of Both Worlds: Bringing Traditional Medicine Up To Date. *Soc. Sci. Med.* 24(2): 177-81.
- Anderson, B. 1983. *Imagined Communities. Reflections on the Origins and Spread of Nationalism*. London:Verso.
- _____. 1988. Cacique Democracy in the Philippines: Origins and Dreams. *New Left Review*. 169.
- _____. (ed.) 1998. *The Spectre of Comparisons: Nationalism, Southeast Asia, and the World*. London:Verso.
- Anderson, W. 1995. Excremental Colonialism: Public Health and the Poetics of Pollution. *Critical Inquiry*. 21(3):640-69.
- _____. 2002. Going Through the Motions: American Public Health and Colonial "Mimicry". *American Literary History*. 14(4):686-719.
- _____. 2006. *Colonial Pathologies: American tropical medicine, race, and hygiene in the Philippines*. Durham: Duke University Press.
- Andrews, B. 1996. *The Making of Modern Chinese Medicine, 1895-1937*. Unpublished PhD Dissertation. University of Cambridge.
- Ardener, E. 1989. *The Voice of Prophecy and other essays*. M. Chapman (ed.). Oxford: Basil Blackwell.
- Armada, F., Muntaner, C., Navarro, V. 2001. Health and Social Security Reforms in Latin America: The Convergence of The World Health Organization, The World Bank and Transnational Corporations. *International Journal of Health Services* 31(4):729-68.

Arnove, R. 1982. *Philanthropy and Cultural Imperialism: The Foundations at Home and Abroad*. Bloomington:Indiana University Press.

Ashcroft, B., Griffiths, G., Tiffin, H. 1998. *Key Concepts in Post-Colonial Studies*. New York. Routledge.

Asian Development Bank. 2007. *Philippines: Women's Health and Safe Motherhood Project. Performance Evaluation Report*. Retrieved on 1/5/10 from:
<http://www.adb.org/Documents/PPERs/PHI/27010/27010-PHI-PPER.pdf>

Atkinson, S. 2002. Political Cultures, Health Systems and Health Policy. *Social Science and Medicine*. 55:113-24.

Atkinson, S. and Haran, D. 2004. Back to basics: does decentralization improve health system performance? Evidence from Ceará in north-east Brazil. *Bulletin of the WHO*.82(11):822-32.

Azurin, AM. 1995. *Reinventing the Filipino. Sense of Being and Becoming*. Quezon City:University of the Philippines Press.

Baer, H. 1988. Review. *Medical Anthropology Quarterly*. 2(2):187-9.

_____. 2003. Contributions to a Critical Analysis of Medical Pluralism. in Koss-Cioino, J. and Greenway, C. (eds). *Medical Pluralism in the Andes*. New York: Routledge.

_____. 2004. "Medical Pluralism". In Ember, C. and Ember, M. *Encyclopedia of Medical Anthropology*.

Baer, H. Singer, M. Susser, I. 2003. *Medical Anthropology and the World System*. Westport:Praeger.

Bala, P. 2007. *Medicine and Medical Policies in India: Social and Historical Perspectives*. Lanham:Lexington.

Banks, M. 1996. *Ethnicity: Anthropological Constructions*. London: Routledge. (at least Chs. 1-4; Introduction; Ethnicity unearthed; Ethnicity and race in the United States; Ethnicity and race in Britain.)

Bannerman, R.H; Burton, J; Wen-Chieh, C. 1983. *Traditional medicine and health care coverage: a reader for health administrators and practitioners*. Geneva:WHO.

Barnes, L. 2005. *Needles, Herbs, Gods, and Ghosts*. Cambridge:Harvard University Press.

Barth, F. (ed.) 1969. *Ethnic Groups and Boundaries: The Social Organization of Culture Difference*. London: George Allen & Unwin.

Baumann, G. 1996. *Contesting Culture: Discourses of Identity in Multi-Ethnic London*. Cambridge: Cambridge University Press.

Bautista, V. 1994. *Area-Based Child Survival and Development Program:An experiment in Devolution*. U.P. Assessments on the State of the Nation. Occasional Papers. Series No. 94-004.

- _____. 1996. *A State of the Art Review of Primary Health care in the Philippines: Two Decades of Government Initiatives*. Quezon City:University of the Philippines.
- Bautista, V., Legaspi, P., Santiago, E. et al. 2002. *National and Local Government Roles in Public Health Under Devolution*. Quezon City:University of the Philippines Press.
- Beauchamp, T. and Childress, J. 2009. *Principles of Biomedical Ethics*. Oxford:OUP.
- Becker, E. 1973. *Denial of Death*. New York: Free Press.
- Beggren, SW. and Wray, J. 2002. Positive Deviant Behaviour and Nutrition Education. *Food and Nutrition Bulletin*. 23(4):7-8.
- Bello, W. 2009. *The Anti-Development State: The Political Economy of Permanent Crisis in the Philippines*. Pasig City: Anvil.
- Berg, M. and A. Mol (eds). 1998. *Differences in Medicine: Unravelling Practices, Techniques and Bodies*. Durham: Duke University Press.
- Berger, P. and Luckmann, T. 1966. *The Social Construction of Reality. A Treatise in the Sociology of Knowledge*. NY: Doubleday.
- Bergström, F. and Goodburn, E. 2001. The role of traditional birth attendants in the reduction of maternal mortality. *Studies in HSO&F*. 17:77-96.
- Bernard, R. 2006. *Research Methods in Anthropology. Qualitative and Quantitative Approaches*. Oxford:Alta Mira.
- Berry, N. 2005. *Emergency Obstetric Care Choice among Kaqchikel in Guatemala*. Unpublished PhD Dissertation. University of Michigan.
- Bhabha, H. 1986. Remembering Fanon: Self, Psyche and the Colonial Condition. in Williams, P. and Chrisman, L. (eds). 1993. *Colonial Discourse and Post-Colonial Theory*. New York: Harvester Wheatsheaf.
- Bibeau, G. 1982. New Legal Rules for an Old Art of Healing. The Case of Zairian Healers Association. *Soc. Sci. and Med.* 16:1843-9.
- Bishaw, M. 1991. Promoting Traditional Medicine in Ethiopia: A Brief Historical Review of Government Policy. *Soc. Sci and Med.* 33(2):193-200.
- Bodeker, GC. 1989. *A policy study on the World Health Organization's policy on traditional medicine. Comparative analysis of the incorporation of traditional medical systems into national health policy in India and China*. Unpublished PhD Thesis. Harvard University.
- _____. 1994. Traditional Health care and Public Policy. In Islam, A. and Wiltshire. R. *Traditional Health Systems and Public Policy*. 96-109. Ottawa: IDRC.
- _____. 2001. Lesson's on Integration from the Developing World's Experience. *BMJ*. 322:164-67.

Bodeker, G and Burford, G. 2007. *Traditional complementary and Alternative Medicine: Policy and Public Health Perspectives*. London: Imperial College Press.

Bodeker, G; Ong, CK; Grundy. *et al.* 2005. *WHO Global Atlas of Traditional, Complementary, and Alternative Medicine*. Kobe: World Health Organization.

Bourdieu, P. 1977. *Outline of a Theory of Practice*. (Translated by Richard Nice). Cambridge: Cambridge University Press.

_____. 1989. *Distinction: a Social Critique of the Judgement of Taste*. London: Routledge.

_____. 2004. *Science of Science and Reflexivity*. Translated by R. Nice. Chicago: University of Chicago Press.

Brass, P. 1972. The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization. In Rudolph, SH. and Rudolph L. (eds). *Education and Politics in India*. Cambridge: Harvard University Press.

Brillantes, A. 1993. Non-Governmental Organizations and Local development in the Philippines: An Overview. In Guzman R.P. Reforma, M.A. (eds) *Decentralisation towards democratization and development*. Quezon City: University of the Philippines Press.

Broad, R. 1988. *Unequal Alliance. The World Bank, The International Monetary Fund, And The Philippines*. 1988. Berkeley: University of California Press.

Brown, E.R. 1976. Public Health in Imperialism: Early Rockefeller Programs at Home and Abroad. *AJPH*. 66(9):897-903.

_____. 1979. *Rockefeller Medicine Men. Medicine and Capitalism in America*. Berkeley: University of California Press.

Brown, T., Cueto, M. and Fee, E. 2006. The World Health Organization and the Transition from "International" to "Global" Public Health. *AJPH*. 96(1): 62-72.

Brown Bullock, M. 1980. *American Transplant: the Rockefeller Foundation and Peking Medical College*. 1980 U of California Press.

Bryan, J. 2007. *Psychic Surgery & Faith Healing: In the Lowlands of Pangasinan*. Lompica Creek Press.

Bryant, J. 1969. *Health and the Developing World*. Ithaca, NY: Cornell University Press.

Buber, M. 2004 [1923]. *I and Thou*. London: Continuum.

Buse, K; Mays, N; Walt, G. 2005. *Making Health Policy*. New York. Open University Press.

Butler, J. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

Callope, J. 2008. *More and More Filipinos turning to Herbal Drugs*. Retrieved on 1/2/10 from:

<http://www.pchrd.dost.gov.ph/submitted-news/1-press-releases/295.html>

- Calvin, John. 1950. *Institutes of the Christian Religion*. Edited by John T. McNeill. Translated by Ford Lewis Battles. Philadelphia: Westminster Press.
- Cant, S. and Sharma, U. 1999. *A New Medical Pluralism? Alternative medicine, doctors, patients and the state*. London: Routledge.
- Casanova-Dorotan, F. 1996. *Traditional Health Care in Irosin, Sorsogon. Technical report for the Center for Community Services*. Unpublished PhD dissertation. University of the Philippines-Diliman.
- Chambers, R. 1983. *Rural Development: Putting the Last First*. London: Longman.
- Chapman, C. 1974. "The Flexner Report" by Abraham Flexner. *Daedalus*. 103(1):105-117.
- CHIFI. Chamber of Herbal Industries of the Philippines, Inc. 2010. *About Us*. Retrieved on 1/2/10 from: <http://new.chifi.org.ph/about-us/>
- Chan, LH. 2008. *China Engages Global Health Governance: A Stakeholder or a System-Transformer?* Unpublished PhD Dissertation. Griffith University.
- Cheng, M. 2010. Lancet: Sharp drop in Maternal Deaths Worldwide. *Associated Press*. Retrieved on 4/13/10 from: http://www.newsvine.com/_news/2010/04/13/4156796-lancet-sharp-drop-in-maternaldeaths-worldwide
- Choy, C.C. 2006. *Empire of Care. Nursing and Migration in Filipino American History*. Durham: Duke University Press.
- Cleaver, F. 1999. Paradoxes of Participation: Questioning Participatory Approaches to Development. *Journal of International Development*. 11:597-612.
- Clifford, J. and Marcus, G. 1986. *Writing Culture. The Poetics and Politics of Ethnography*. Berkeley: University of California Press.
- Cochetti, CS. 2008. *Integrating Traditional and Scientific Medicine in Cuba*. Unpublished MA Dissertation. University of London.
- Cohen, A. 2004. *Urban Ethnicity*. London. Routledge.
- Cohen, P.A. 1984. *Discovering History in China: American Historical Writing on the Recent Chinese Past*. New York: Columbia University Press.
- Cohen, M. and Bodeker, G. (eds). 2008. *Understanding the Global Spa Industry*. Elsevier Press, Oxford.
- Cook, B. and Kothari, U. (eds). 2001. *Participation: The New Tyranny*. London: Zed Books.
- Cortes, R.M. 1990. *Pangasinan, 1901-1986: A political, Socioeconomic, and cultural history*. Quezon: New Day Publishers.
- Council for Health and Development (CHD). 1998. *25 years of Commitment and Service to the People - Onward for the Struggle for Social Change*. Manila: CHD.

- Council for health and development (CHD). 2003. *Health of the People Health of the Nation*. Manila: CHD.
- Cowen, MP. and Shenton, RW. 1996. *Doctrines of Development*. London:Routledge.
- Crozier, R. 1968. *Traditional Medicine in Modern China: Science, Nationalism, and the Tensions of Cultural Change*. Cambridge:Harvard University Press.
- _____. 1975. Medicine and Modernization in China: An Historical Overview. In Kleinman, A.; Kunstadter, P.; Alexander, E.R.; and Gale, J. (eds) *Medicine in Chinese Cultures: Comparative Studies of Healthcare in Chinese and Other Societies*. Washington, D.C.:Geographic Health Studies.
- Cunningham, A. 1991. The Herbal Medicine Trade:resource depletion and environmental management for a 'hidden economy'. In Preston-Whyte, E. and Rogerson, C. (eds) *South Africa's Informal Economy*. Capetown:OUP.
- Dauskardt, R. 1990. Traditional medicine: Perspectives and policies in health care development. *Development Southern Africa*. 7:(3):351-8.
- _____. 1991. 'Urban Herbalism': the restructuring of informal survival in Johannesburg. In Preston-Whyte, E. and Rogerson, C. (eds) *South Africa's Informal Economy*. Capetown:OUP.
- DeFilippis, J. 2001. The Myth of Social Capital in Community Development. *Housing Policy Debate*. 12(4): 781-806.
- Deleuze, G. and Guattari, F. 1987. *A Thousand Plateaus: Capitalism and Schizophrenia*. NY: Continuum.
- Department of Health of the Republic of the Philippines. 2004a. Administrative Order 172. *Guidelines on the Registration of Herbal Medicines*.
- _____. 2004b. Administrative Order 184. *Guidelines on the registration of Traditionally-Used Herbal Products*.
- _____. 2008a. Administrative Order 2008-0029. *Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality*.
- _____. 2008b. Administrative Order No. 2008-0031 [0]- *Policies and Guidelines for the Accreditation of Training Institutions, Training Programs and Training Providers for Massage Therapy in the Philippines*.
- de Quiros, C. 1990. *Flowers From the Rubble*. Pasig City:Anvil Publishing.
- Dizon, J. and Miralao, V. 1973. *The Hilot in Oriental Mindoro*. Technical report for the Institute of Maternal and child health care. Manila:Institute of Philippine Culture.
- Djukanovic V. and Mach E. P. (eds.). 1975 *Alternative Approaches to Meeting Basic Health Needs in Developing Countries. A joint UNICEF/WHO study*. Geneva, World Health Organization.

- Dodgson, R., Lee, K., Drager, N. 2002. *Global Health Governance: A Conceptual Review*. Discussion Paper No. 1. Geneva:WHO.
- Douglas, M. 1966. *Purity and Danger. An Analysis of Concepts of Pollution and Taboo*. Abingdon: Routledge.
- _____. 1973. *Rules and Meaning*. Middlesex:Penguin.
- _____. 1992. *Risk and Blame. Essays in Cultural Theory*. London Routledge.
- Elman, BA. 2003. Rethinking the Twentieth Century Denigration of Traditional Chinese Science and Medicine in the Twenty-first Century. *The 6th International Conference on The New Significance of Chinese Culture in the Twenty-first Century*. Charles University in Prague, The Czech Republic. November 1-2, 2003.
- Dudley, E. 1993. *The Critical Villager: Beyond Community Participation*. London: Routledge.
- Ernst, E. 2008. *Healing, Hype, or Harm? A Critical Analysis of Complimentary and Alternative Medicine*. Exeter: Imprint Academic.
- Ernst, W. 2002. *Plural Medicine, Tradition and Modernity*. London: Routledge.
- Escobar A. 1995. *Encountering Development: The Making and Unmaking of the Third World*. PrincetonUniversity Press, Princeton.
- Estrada-Caludio, S. 2006. Lessons from the Philippines: Public Health, Privatization, and Women's Activism. *Presentation to Inter Pares Annual General Meeting on Democracy, Health and Justice: Health Care in the Public Interest*. Ottawa. April 24, 2006. http://www.interpares.ca/en/publications/pdf/Lessons_from_the_Philippines.pdf
- European Commission. 2008. *Mid-term review of the health sector policy support programme (ASIE/2005/017638) In the Philippines*. Commission of the European Communities.
- Fabian, J. 1983. *Time and the Other: How Anthropology Makes Its Object*. New York: Columbia University Press.
- Farquhar, J. 1994. *Knowing Practice. The Clinical Encounter of Chinese Medicine*. Boulder: Westview Press.
- Feldbaum H. and Michaud J. 2010. Health Diplomacy and the Enduring Relevance of Foreign Policy Interests. *PLoS Med.* 7(4).
- Ferguson, J. 1994. *The Anti-Politics Machine: 'Development', Depoliticization, and Bureaucratic Power in Lesotho*. Minneapolis:University of Minnesota Press.
- Fidler, D. 2010. Asia's Participation in Global Health Diplomacy and Global Health Governance. *AJWH.* 5:269-300.
- Filliozat, J. 1964. *The Classical Doctrine of Indian Medicine*. Trans. Dev Raj Chanana. Delhi: Munishiram Manoharlal.

Flexner, A. 1910. *Medical Education in the United States and Canada: A Report To The Carnegie Foundation For The Advancement Of Teaching*. New York: The Carnegie Foundation.

Florano, ER. 1996. *Towards and Equitable distribution of the Internal Revenue Allotment: A Policy analysis*. Unpublished MPA Dissertation. University of the Philippines-Dilliman.

Flower, A., Scheid, V., Lewirth, G. 2011. Constructing an Evidence Base for East Asian Medicines. In V. Scheid and H. Macpherson (eds.) *Integrating East Asian Medicine into Contemporary Healthcare: Authenticity, Best Practice and the Evidence Mosaic*. London: Elsevier.

Ford, MJ. and Cruz, A. 1957. The Rural Health Unit in the Philippines. *Public Health Reports*. 72(8):687-96.

Foucault, M. 1977. *Discipline and Punish: The Birth of The Prison*. Middlesex: Penguin.

_____. 1980. Two Lectures in C. Gordon (ed.) *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. New York: Pantheon Books.

_____. 1982. The Subject and Power. In. H. Dreyfus and P. Rabinow (eds). *Michel Foucault: Beyond Structuralism and Hermeneutics*. Chicago: University of Chicago Press.

_____. 1988. An Aesthetics of Existence. in L. Kritzman (ed.) *Politics, Philosophy, Culture: Interviews and Other Writings, 1977-1984*. London: Routledge.

Garcia, A. 2004. *Impact Assessment of Governance Devolution on Pubic Health: The Case of the city of Paraque*. Unpublished MS dissertation. University of the Philippines-Manila.

Giddens, A. 1990. *The Consequences of Modernity*. Palo Alto:Stanford University Press.

Goody, J. 1982. *Cooking, Cuisine and Class: a Study in Comparative Sociology*. Cambridge: Cambridge University Press.

Gonzaga, E. 2009. *Globalization and Becoming-Nation. Subjectivity, Nationhood, and Narrative in the Period of Global Capitalism*. Quezon City: University of the Philippines Press.

Gonzalez, JL. 1996. Evolution of the Philippine Health Care System During The Last Forty Years of Development Administration. *Asian Journal Of Public Administration*. 18(2): 168-200.

Gould, H. 1965. Modern Medicine and Folk Cognition in Rural India. *Human Organization*. 24:2001-8.

Gramsci, A. 1994. In F. Rosengarten (ed.), R. Rosenthal (Trans.). *Letters from prison*. New York: Columbia University Press.

Grant, J. 1919. *The most efficient manner in which the International Health Board may accomplish its fundamental purpose in China*. Midwifery Education, Midwifery Training School, Beijing (report), folder 372, box 45, series 601, RG1, Rockefeller Foundation Archives, Rockefeller Archive Center.

- Green, E.C. 1980. Roles for African Traditional Healers in Mental Health Care. *Medical Anthropology*. 4(4):489-522.
- _____. 1988. AIDS in Africa: An Agenda for Behavioral Scientists. in Miller, N., R. Rockwell (eds). *AIDS in Africa: The Social Impact*. New York: Mellen Press.
- Guillemin, M. and Gillam, L. 2004. Ethics, Reflexivity, and “Ethically Important Moments” in Research *Qualitative Inquiry*. 10(2) 261-80.
- Guangjun, C. and Lan, L. 2011. Sino-Philippine Trade to Double. *China Daily*. 01-09-2011. Retrieved from:http://www.evri.com/media/article.jsessionid=1ptqma650br5c?title=Sino-Philippine+trade+to+double&page=http://www.asianewsnet.net/home/news.php?id%3D21269&referring_uri=/organization/peking-university-0xbd2df%3Bjsessionid%3D1ptqma650br5c&referring_title=Evri
- Hacking, I. 1999. *The Social Construction of What?* Cambridge:Harvard University Press.
- Ha°klev, S. 2005. *Chinese barefoot doctors, a viable model today?* Working Paper. IDSC 11.
- Harvey, D. 1990. *The Condition of Postmodernity*. Oxford:Blackwell.
- Headland, T, Pike, K. and Harris, M. (eds). 1990. *Emics and Etics: The Insider/Outsider Debate*. NY: Sage.
- Hegel, G.W.F. 1977. *Phenomenology of Spirit*. translated by A.V. Miller. Oxford: Clarendon Press.
- Heidegger, M. [1927] 1966. *Being and Time*. trans. by Joan Stambaugh. Albany: State University of New York Press.
- Hewa, S. 2002. Rockefeller Philanthropy and the “Flexner Report” on Medical Education in the United States. *The International Journal of Sociology and Social Policy*. 22(11):1-47.
- Hewa, S. and Hove, P. (eds). 1997. *Philanthropy and Cultural Context: Western Philanthropy in South, East and Southeast Asia in the 20th century*. Ann Arbor: University of Michigan Press.
- Hobsbawm, E. and Ranger, T. (eds) 1983. *The Invention of Tradition*. Cambridge: Cambridge University Press.
- Hogan, M., Foreman, K., Naghavi, M. *et al.* 2010. Maternal Mortality for 181 Countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet*. (375): 1609–23.
- Holdcroft, D. 1991. *Saussure: signs, system, and arbitrariness*. Cambridge: Cambridge University Press.
- Horkheimer, M. and Adorno, T. W. (eds). 2002. *Dialectic of Enlightenment: Philosophical Fragments*. G. S. Noerr, trans. E. Jephcott. Stanford: Stanford University Press.
- Hsu, E. 2002. “The medicine from China has rapid effects”; Chinese medicine patients in Tanzania. *Anthropology & Medicine*. 9(3):291-313.

_____. 2006. Participant Experience: Learning to be an Acupuncturist and not Becoming One. In G. de Neve and M. Unnithan-Kumar (eds). *Critical Journeys: the making of anthropologists*. Hampshire: Ashgate.

_____. 2008a. Medical Pluralism. In Heggenhougen, K. and Quah, S. *International Encyclopaedia of Public Health* 1 (4): 316-21. Oxford:Elsevier.

_____. 2008b. Medicine as Business: Chinese Medicine in Tanzania. In C. Alden, D. Large & R. Soares de Oliveira (eds): *China returns to Africa: a Rising Power and a Continent Embrace*. London: Hurst, 221-235.

Hsu, E. and Høg, E. (eds). 2002. Countervailing Creativity: Patient Agency in the Globalisation of Asian Medicines. Special Issue. *Anthropology and Medicine*. 9(3): 205-363.

Husserl, E. 1960. *Cartesian Meditations: An Introduction to Phenomenology*. Cairns, D. (trans.). The Hague: Martinus Nijhoff.

Huang, Y. 2010. Pursuing Health as Foreign Policy: The Case of China. *Indiana Journal of Global Legal Studies*. 17(1).

Hyma, B. and Ramesh, A. 1994. Traditional Medicine: its extent and potential for incorporation into modern national health systems. In Phillips, D; Verhasselt, Y. (eds.) *Health and Development*. London: Routledge.

IBON Foundation. 2001. *Drug Industry in the Philippines*. Quezon City: Ibon Books.

_____. 2008. *Chronically Ill: An Overview of the Philippine Health Sector*. Quezon City:Ibon Books.

Ileto, R. 1988. Cholera and the Origins of the American Sanitary Order in the Philippines. in D. ArdnoId (ed.) *Imperial Medicine and Indigenous Societies*. Manchester: Manchester University Press.

ILO. 2006. Philippines: Extension Of Social Health Insurance Coverage To Workers In The Informal Economy Through Organized Groups. *International Labor Organization*. Sub-regional Office for Southeast Asia.

Jackson, S., Cleverly, S., Poland, B., *et al.* 2003. Working with Toronto Neighbourhoods Toward Developing Indicators of Community Capacity. *Health Promotion International*. 18(4):339-50.

Jeffrey, R. 1982. Policies Toward Indigenous Healers in Independent India. *Soc. Sci and Med*. 16:1835-41.

Jennings, M. 2005. Chinese Medicine and Medical Pluralism in Dar es Salaam: Globalisation or Glocalisation. *International Relations*. 19(4):457-73.

Jocano, L. 1969. *Growing Up In A Philippine Barrio*. New York: Hole, Rinehart and Winston.

_____. 1975a. *Philippine prehistory : an anthropological overview of the beginnings of Filipino society and culture*. Quezon City: University of the Philippines Press.

- _____. 1975b. *The Philippines at the Spanish Contact*. Quezon City: University of the Philippines Press.
- _____. 1998. *Filipino Social Organization. Traditional Kinship and Family Organization*. Manila: Punland.
- _____. 2004. *Folk Medicine in a Philippine Municipality : An Analysis of the System of Folk Healing in Bay, Laguna, and Its Implications for the Introduction of Modern Medicine*. Manila: Tamarind.
- Johnson, K. 2001. Whose Medicine Counts? Health, Healers and WHO in Kenya. In M. Jennings and O. Barrow (eds). *The Charitable Impulse: NGOs & Development in East & North-East Africa*.
- Johnson, T.P. 2008. Yang Chongrui and the First National Midwifery School: Childbirth Reform in Early Twentieth-Century China. *Asian Medicine*.(4):280-302. Boston:Brill.
- Jones, G. 1989. *Red Revolution. Inside the Philippine Guerrilla Movement*. Boulder: Westview Press.
- Jordan, B. 1997. Authoritative Knowledge and its Construction. In R. Davis-Floyd and C. Sargent (eds). *Childbirth and Authoritative Knowledge*. Berkeley. University of California Press.
- Kadetz, P. 2010. *A Situational Analysis of the Current State of Traditional Medicine in the Philippines*. Technical Report. Manila:WHO-WPRO.
- _____. 2011. Assumptions of Global Beneficence: Health care disparity, the WHO, and the effects of global integrative health care policy on local levels in the Philippines. *Biosocieties*. (6):88–105.
- Kadetz, P. and Perdomo, J. 2012. The integration of Traditional Chinese Medicine in the Cuban Health Care System. *Asian Medicine: Tradition and Modernity*. Boston: Brill Publications (forthcoming).
- Klein, N. 2007. *The Shock Doctrine: The Rise of Disaster Capitalism*. New York:Henry Holt.
- Kleinman, A., and Kleinman, J. 1991. Suffering and its professional transformation: Towards an ethnography of interpersonal experience. *Cult, Med and Psychiat*. 15(3)275-301:91.
- Kothari, U. 2001. Power, Knowledge and Social Control in Participatory Development. In Cook, B. and Kothari, U. (eds). 2001. *Participation: The New Tyranny*. London: Zed Books.
- Kruske, S. and Barclay, L. 2004. Effect of Shifting Policies on Traditional Birth Attendant Training. *Journal of Midwifery & Women's Health*. 49(4): 306-11.
- Kuan. LG. 1986. *Herbal Medicine and Drug Substitution: Perceptions and Attitudes of PGH Health Workers*. Unpublished MS Dissertation. U of Philippines-Manila.
- Kuhn, T. 1962. *The Structure of Scientific Revolutions*. Chicago:University of Chicago Press.

- Kwok, DWY. 1965. *Scientism in Modern China*. New Haven: Yale University Press.
- Lagaya, A. 2001. *The Current Philippine Experience in the Pilot Integration of Traditional Medicine with the Existing Health Care Delivery System*. Presented at WHO Centre for Health Development International Symposium on Traditional Medicine. 11-13 September 2000. Geneva: WHO.
- _____. 2005. The Philippines. In Bodeker, G; Ong, CK; Grundy. *et al. WHO Global Atlas of Traditional, Complementary, and Alternative Medicine*. Kobe: World Health Organization.
- Lakshminarayanan, R. 2003. Decentralisation and its Implications for Reproductive Health: The Philippines Experience. *Reproductive Health Matters*. 11(21):96-107.
- Lamont M. 1987. How to become a dominant French philosopher: the case of Jacques Derrida. *Am. J. Sociol.* 93(3):584–622.
- Lampton, D. 1974. *Health, conflict and the Chinese political system*. Ann Arbor:Center for Chinese Studies, the University of Michigan.
- _____. 1977. *The Politics of Medicine in China*. Boulder: Westview Press.
- Lantum, D.N. 2007. The Place of Policy in Applied Health Care and Technology with Special Reference to African Traditional Medicine. *ATPS Special Paper Series No. 31*. Nairobi:African Technology Policy Studies Network.
- Lao, F. 1999. *Pharmaceutical marketing in the Philippine Setting*. Unpublished MS dissertation. University of the Philippines-Manila.
- Last, M. 1981. The Importance of Knowing about Not Knowing. *Soc. Sci and Med.* 15B:387-92.
- Last, M. and Chavunduka, G.L. (eds). 1986. *The Professionalisation of African Medicine*. Manchester: Manchester University Press.
- Latour, B. and Woolgar, S. 1986. *Laboratory Life: The Construction of Scientific Facts*. Princeton: Princeton University Press.
- Latour, B. 1987. *Science in Action*. Cambridge: Harvard University Press.
- _____. 2005. *Reassembling the Social: an introduction to actor-network-theory*. Oxford:OUP.
- Lee, K. 2009. *The World Health Organization (WHO)*. London: Routledge.
- Lee, K. and Dodgson, R. 2003. Globalization and Cholera: Implications for Global Governance. In Lee, K. (ed.). *Health Implications of Globalization. Towards Global Governance*. Basingstroke: Palgrave Macmillan.
- Lee, K. and Mills, A. 2000. Strengthening governance for global health research: The countries that most need health research should decide what should be funded. *BMJ*. 321:775-6.

- Lee, S. 1997. WHO and the developing world: the contest for ideology. In A. Cunningham and B. Andrews (eds) 1997. *Western Medicine as Contested Knowledge*. Manchester: Manchester University Press.
- Lei, SH., Lin, CL., Chang, HH. 2011. Standardizing Tongue Diagnosis with Image Processing Technology: essential tension between authenticity and innovation. In V. Scheid and H. Macpherson (eds.) *Integrating East Asian Medicine into Contemporary Healthcare: Authenticity, Best Practice and the Evidence Mosaic*. London: Elsevier.
- Leslie, C. 1968. The Professionalization of Ayurvedic and Unani Medicine. *Transactions NY Academy of Sciences*. 30(4):559-72.
- _____. 1973. The Professionalizing Ideology of Medical Revivalism. in Singer, M. (ed.). *Entrepreneurship and Modernization of Occupational Cultures in South Asia*. Durham: Duke University Press.
- _____. 1980. Medical Pluralism in World Perspective [1]. *Social Science & Medicine*. 14B:191-95.
- _____. 1992. Interpretations of Illness: Syncretism in Modern Ayurveda. In Leslie, C and Young, A. (eds) *Paths to Asian Medical Knowledge*. Berkeley: University of California Press.
- Levinas 1989. *The Levinas Reader*. Sean Hand (ed.). Cambridge:Blackwell.
- Li, A. 2007. China and Africa: Policy and Challenges. *China Security. World Security Institute*, 3(3):69-93.
- Library of Congress. 2006. *Country Profile: Philippines*. Federal Research Division: Library of Congress.
- Liew, KK. 2006. *Wats & Worms: The Activities of the Rockefeller Foundation's, International Health Board in Southeast Asia (1913-1940)*. Asian Society for the History of Medicine Taniguchi Medal Paper.
- Liu, Y., Hsiao, W. and Eggleston, K. 1999. Equity in health and health care: the Chinese experience. *Social Science & Medicine* 49: 1349-56 .
- Loughlin, K. and Berridge, V. 2002. *Global health governance: historical dimensions of global governance*. Centre on Global Change & Health, London School of Hygiene & Tropical Medicine.
- Lucas, A. 1982. *Chinese Medical Modernization: Comparative Policy Continuities 1930s-1980s*. Praeger: NY, NY.
- Lopez, R. and Felix, A. 1965. *The Christianization of the Philippines*. Manila:Historical Conservation Society.
- Lorenzo, M.F., Galvez-Tan, J., Icamina, K., *et al.* 2007. Nurse Migration from a Source Country Perspective: Philippine Country Case Study. *Health Services Research*. 42:(3).

- McCarthy, M. 2005. Critics Slam Draft WHO report on Homeopathy. *The Lancet*. 366:705-6.
- Ma, Q. 1995. *The Rockefeller Foundation and Modern Medical Education in China, 1915-1951*. Unpublished PhD Dissertation. Case Western Reserve University.
- MacCormack, C. 1986. The Articulation of Western and Traditional Systems of Healthcare. In Last, M. and Chavunduka, GL. (eds). *The Professionalisation of African Medicine*. Manchester: Manchester University Press.
- MacDonald. 2008. *Sacrificing the WHO to the Highest Bidder*. Oxford:Radcliffe.
- Magnussen, L., Ehiri, J. and Jolly, P. 2004. Comprehensive versus selective primary health care: Lessons for global health policy. *Health Affairs*. 23(3): 167–176.
- Mahler H. 1977a. The Staff of Aesculapius. *World Health*. 3.
- _____. 1977b. WHO at the cross roads. *WHO Chron*. 31(219). November, 1977.
- _____. 1983. Foreward. in Bannerman, R.H; Burton, J; Wen-Chieh, C. *Traditional medicine and health care coverage: a reader for health administrators and practitioners*. Geneva:WHO.
- Marcelo, P. 2008. *Preparation of Traditional Knowledge Digital Library on Health*. Retrieved on 12/5/09 from: <http://www.pchrd.dost.gov.ph/submitted-news/1-press-releases/276.html>
- Mao, Z. 2007. *Practice and Contradiction*. London:Verso.
- Marana, MR. 1983. *A comparison of the Hilots pressure points and acupuncture points*. unpublished MS Dissertation. University of the Philippines-Manila.
- Mason, J. 1996. *Qualitative researching*. London: Sage.
- Meisner, M. 1999. *Mao's China and After*. New York: Free Press, 1999.
- Meissner O. 2003 *Traditional medicine and its accommodation in the South African national health care system with special attention to possible statutory regulation*. LLD dissertation, University of South Africa, 7-14.
- Mendoza, R.L. 2009. Is It Really Medicine? The Traditional and Alternative Medicine Act and Informal Health Economy in the Philippines. *Asia-Pacific Journal of Public Health*. 20(10): 1-13.
- Merleau-Ponty, M. [1945] 2002. *Phenomenology of Perception* trans. by Colin Smith. London: Routledge.
- Mills, A., Vaughan, JP., Smith, DL. et.al. 1990. *Health System Decentralisation. Concepts, Issues and Country Experience*. Geneva:WHO.
- Miniano, A. 2006. *Traditional Medicine as alternative health care in Pasay*. Unpublished M.S. dissertation. University of the Philippines-Manila.

Mosse, D. 2001. 'People's Knowledge', Participation and Patronage: Operations and Representations in Rural Development. In Cook, B. and Kothari, U. (eds). 2001. *Participation: The New Tyranny*. London: Zed Books.

Mulder, N. 1997. *Inside Philippine Society: Interpretations of Everyday Life*. Quezon City: New Day Publishers.

National Statistics Office. Republic of the Philippines. 2000 *Family Income and Expenditure Survey*. Manila:Philippines.

_____. 2008. Retrieved on 1/2/09 from:
<http://www.census.gov.ph/data/sectordata/datapop.html>

Navarro, V. 2007. *Neoliberalism, Globalization and Inequalities*. Amityville:Baywood.

Needham, J. 1969. *The Great Titration*. London: Cambridge University Press.

_____. 1970. The roles of Europe and China in the Evolution of Oecumenical science. In J. Needham (ed.). *Clerks and Craftsmen in China and The West*. Cambridge: Cambridge University Press.

Nederveen Pieterse, J. 1998. My Paradigm or yours? Alternative development, Post-Development, Reflexive Development. *Development and Change*. (29):343-73.

Nelson, N. and Wright, S. 1995. *Power and Participatory Development. Theory and Practice*. London:ITDG Publishing.

Nelson, R. 1968. *The Philippines*. London: Thames and Hudson.

Neumann, AK. and Lauro, P. 1982. Ethnomedicine And Biomedicine Linking. *Soc. Sci and Med*. 16:1817-24.

Nickels, G. 2002. *Philippines the People*. NY: Crabtree.

Norgaard, R. 1994. *Development Betrayed. The end of progress and a coevolutionary revisioning of the future*. London: Routledge.

Nye, J. 1990. Soft Power. *Foreign Policy*. (80):153-71.

Nys, S., Okeke, I.N., Kariuki, S. *et al*. 2004. Antibiotic resistance of faecal *Escherichia coli* from healthy volunteers from eight developing countries. *Journal of Antimicrobial Chemotherapy*. 54: 952-5.

Offiong, D. 1999. Traditional Healers in the Nigerian Health Care Delivery System and the Debate over Integrating Traditional and Scientific Medicine. *Anthropological Quarterly*. 72(3): 188-130.

Ordon 2009. *Report of State of Traditional Medicine in the Philippines*. Presented at ASEAN Conference. Bangkok. November 2009.

- Oxford English Dictionary Online (OED). September 2011. Oxford University Press.
<http://www.oed.com/viewdictionaryentry/Entry/5788> (accessed September 18, 2011).
- _____. September 2011. Oxford University Press.
<http://www.oed.com/viewdictionaryentry/Entry/263203> (accessed October 18, 2011).
- _____. September 2011. Oxford University Press.
<http://www.oed.com/viewdictionaryentry/Entry/263843> (accessed October 20, 2011).
- _____. September 2011. Oxford University Press.
<http://www.oed.com/viewdictionaryentry/Entry/63540> (accessed November 03, 2011).
- Oxman, A., Lavis, J. and Fretheim, A. 2007. Use of evidence in WHO recommendations. *The Lancet*. 369(9576):1883-9.
- Oyebola, DDO. 1986. National Medical Politics in Nigeria. In Last, M. and Chavunduka, GL. (eds). *The Professionalisation of African Medicine*. Manchester: Manchester University Press.
- Padilla, P. 1993. Decentralization toward democratization and development: The Philippine Experience In Guzman R.P. Reforma, M.A. (eds) *Decentralisation towards democratization and development*. Quezon City:University of the Philippines Press.
- Pamatian, PJ. 2004. *An analysis of the effectiveness of the “doctor to the Barrios” on improving rural health conditions*. Unpublished MA dissertation. University of the Philippines-Manila.
- Parpart, J. 1995. Deconstructing the Development “Expert”. In Marchand, M. and Parpart, J. 1995. *Feminism/Postmodernism/Development*. London: Routledge.
- Payer, C. 1974. *The Debt Trap. The IMF and the Third World*. Middlesex:Penguin.
- Pedersen, D. and Coloma, C. 1983. Traditional Medicine in Ecuador: The Structure of the Non-Formal Health Systems. *Soc.Sci. Med.* 17(17):1249-55.
- Peel, J.D.Y. 1968. Syncretism and Religious Change. *Comparative Studies in Society and History*. 10: 121-41.
- Pensar, J. 1988. *Manila Colonialism: The dark side of the flag*. Unpublished MS Dissertation. University of the Philippines-Manila.
- Penwell, V. 2009. Mercy in Action. Bringing Mother- and Baby-Friendly Birth Centers to the Philippines, In Davis-Floyd, R., Barclay, L., Daviss, BA., *et al.* (eds) *Birth Models That Work*. Berkeley: University of California Press.
- Petralba, RM. 2004. *Comatose: Assessing the impact of governance devolution on Philippine Public Health*. Unpublished MS dissertation. University of the Philippines-Manila.
- Piaget, J. 1977. *The Essential Piaget*. Howard E. Gruber and J. Jacques Vonèche. (eds.) New York: Basic Books.
- Pike, K. 1967. *Language in Relation to a Unified Theory of the Structure of Human Behavior*. The Hague: Mouton.

- Pillsbury, B. 1982. Policy and Evaluation Perspectives on Traditional Health Practitioners in National Health Care Systems. *Soc. Sci.Med.* 16:1825-34.
- PITAHC. 2004. Proceedings of the National Colloquium on Medicinal Plants Research. Manila:PITAHC.
- _____. 2009. Retrieved on 10/10/09 from: <http://doh.gov.ph/pitahc/Index.html>
- PLAN International. 2001. *Integrating Indigenous knowledge and practices in community-based maternal and child health project. Lessons learned and implications to health programs*. Philippines: Plan International.
- President Truman's Message to Congress; March 12, 1947; Document 171; 80th Congress, 1st Session; Records of the United States House of Representatives; Record Group 233; NationalArchives.
Retrieved 15/10/2011 from: <http://ourdocuments.gov/doc.php?flash=true&doc=81>
- Pricewaterhousecoopers. 2009. Investing in China's Pharmaceutical Industry. Retrieved on 9/15/2010 from : <http://www.pwc.com/gx/en/pharma-life-sciences/investing-china>
- Purcell, T. and Onjoro, EA. 2002. Indigenous Knowledge, Power and Parity: Models of Knowledge Integration. in Sillitoe, P. *et al.* (eds). *Participating in Development: Approaches to Indigenous Knowledge*. London: Routledge.
- Putzel, J. 1992. *A Captive Land: the politics of agrarian reform in the Philippines*. London:CIIR.
- Quimpo, NG. 2008. *Contested Democracy and the Left in the Philippines After Marcos*. New Haven: Yale.
- Quirino, C. 1978. *The Sugar Lands. Filipino Heritage, The Making of a Nation*. Unpublished PhD Dissertation. University of the Philippines-Diliman.
- Raedt, J. 1969. *Expansiveness and Restraint: A relational study of myth, ritual and cosmology*. Unpublished PhD Dissertation. University of Chicago.
- Rajaratnam, JK.; Marcus, JR, Flaxman, A.D. *et al.* 2010. Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970–2010: a systematic analysis of progress towards Millennium Development Goal 4. *Lancet*; 375: 1988–2008.
- Ramiro, L.; Tan-Toreres, L.; Castillo, F. *et al.* 1999. *Structure, Process, and Outcome of Decision-Making in Health*. Manila: DOH.
- Rappaport, H. and Rappaport, M. 1981. The Integration of Scientific and Traditional Healing. A Proposed Model. *American Psychologist*. 36(7): 774-81.
- Rees, L. and Weil, A. 2001. Integrated Medicine. *BMJ*. 162:133-40.
- Republic of the Philippines. 1958. Republic Act 2644, An Act Regulating Midwifery Training and Practice.
- _____. 1997. Republic Act no. 8423; The Traditional and Alternative Medicine Act. 349

_____. 1997. Presidential Decree 856 of The Sanitation Code of the Philippines by the Department of Health.

Rifkin, SB. 1985. *Health Planning and Community Participation. Case Studies in South-East Asia*. London:Croom Helm.

Rihani, S. 2002. *Complex Systems Theory and Development Practice. Understanding Non-Linear Realities*. London:Zed Books.

Rihani, S. and Geyer, R. 2010. *Complexity and Public Policy. A new approach to the 21st century politicis, policy and society*. Abington:Routledge.

Rizer, G. 2004. *The Globalization of Nothing*. London: Sage.

Rockefeller Foundation. 1917. *International Health Board Report of 1917*. Rockefeller Archive Center.

_____. 1923. *International Health Board Tenth Annual Report*. Rockefeller Archive Center.

Roemer, MI. 1993. *National Health Systems of the World: The Issues*. (Vol 2). New York. Oxford University Press.

Rohde, J. 2001. Early influences in the Life of James P. Grant in Jolly, R. (ed.) *Jim Grant UNICEF Visionary*. NY: UNICEF.

Rosaldo, M. 1980. *Knowledge and Passion: Ilongot Notions of Self & Social Life*. Cambridge:Cambridge University Press.

Roseberry, W. 1989. Political Economy. *Annual Review of Anthropology*. 17: 161-85.

Rosenthal, M. 1981. Political Process and the Integration of Traditional and Western Medicine in the People's Republic of China. *Social Science and Medicine*. (15A):599-13.

Roxas, M. 1988. Academic community Health and Health care services through Primary Health Care, Ministry of Health, 1988 in *Asian Seminar-Workshop on Primary Health Care Approach and Academic Community Health*. 7(1988). Manila: University of the Philippines Manila.

Ruger, JP. 2005. The Changing Role of the World Bank in Global Health. *American Journal of Public Health*. 95(1): 60-70.

Russell, B. 1922. *The Problem of China*. New York: The Century Co.

Sachs, W. (ed.). 1992. *The Development Dictionary; A Guide to Knowledge as Power*. London:Zed.

Said, E. 1978. *Orientalism*. NY: Vintage Books.

_____. 1993. *Culture and Imperialism*. New York:Knopf.

Saxer, M. 2010. *Manufacturing Tibetan medicine : the creation of an industry and the moral economy of Tibetanness*. Unpublished DPhil Dissertation. University of Oxford. 350

- Schaible, U., Kaufmann, S. 2007. Malnutrition and Infection: Complex Mechanisms and Global Impacts. *PLoS Med.* 4(5): e115. 806-12.
- Scheid, V. 2001. Shaping Chinese medicine: two cases from contemporary China. In E. Hsu. (ed.) *Innovation in Chinese Medicine*. Cambridge: Cambridge University Press.
- _____. 2002. Durham: Duke University Press. *Chinese Medicine in Contemporary China. Plurality and Synthesis*. Durham: Duke University Press.
- Scheid, V. and Macpherson, H. (eds) *Integrating East Asian Medicine into Contemporary Healthcare: Authenticity, Best Practice and the Evidence Mosaic*. London: Elsevier.
- Schneider, W. 2002. *Rockefeller Philanthropy and Modern Biomedicine: International Initiatives from World War I to the Cold War*. Bloomington: Indiana University Press.
- Schoppa, R.K. 2000. *The Columbia Guide to Modern Chinese History*. New York: Columbia University Press.
- Scott, J.C. 1985. *Weapons of the Weak: Everyday Forms of Peasant Resistance*. New Haven: Yale University Press.
- _____. 1990. *Domination and the Arts of Resistance: Hidden Transcripts*. New Haven: Yale University Press.
- Scott, W. 1984. *Prehispanic Source Materials for the Study of Philippine History*. Quezon City: New Day.
- Searle, J. 1995. *The Construction of Social Reality*. London: Penguin.
- Shabot, S. 2007. The Grotesque Body: Fleshing Out the Subject. *Thamris/Intersecting*. 15: 57-68.
- Shore, C. and Wright, S. (eds). 1997. *Anthropology of Policy: critical perspectives on governance and power*. London: Routledge.
- Shore, C. and Wright, S. 1997. Policy A new field of anthropology. In Shore, C. and Wright, S. (eds). 1997. *Anthropology of Policy: critical perspectives on governance and power*. London: Routledge.
- Sidel, V.W. 1973. *Serve the people: observations on medicine in the People's Republic of China*. New York: Josiah Macy, Jr. Foundation.
- Siddiqi, J. 1995. *World Health and World Politics: The World Health Organization and the UN System*. London: Hurst & Co.
- Sillitoe, P., Bicker, A., Pottier, J. (eds). 2002. *Participating in Development: Approaches to Indigenous Knowledge*. London: Routledge.
- Singer, M. and Baer, H. 1995. *Critical Medical Anthropology*. Amityville, NY: Baywood Publishing Company, Inc.

- _____. 2007. *Introducing Medical Anthropology: a discipline in action*. New York: Alta Mira Press.
- Sitrin, M (ed.) 2006. *Horizontalism: Voices of Popular Power in Argentina*. AK Press: Edinburgh.
- Solomon, SG. 2000. 'Through a Glass Darkly': The Rockefeller Foundation's International Health Board and Soviet Public Health. *Stud. Hist. Phil. Biol. & Biomed. Sci.* 31(3):409-18.
- Song, J.H., Jung, S.I., Ko, K.S. et al. High Prevalence of Antimicrobial Resistance among Clinical *Streptococcus pneumoniae* Isolates in Asia (an ANSORP Study). *Antimicrobial Agents And Chemotherapy*. 48(6): 2101–7.
- Spivak, G.C. 1988. Can the Subaltern Speak? in Williams, P. and Chrisman, L. (eds). 1993. *Colonial Discourse and Post-Colonial Theory*. New York: Harvester Wheatsheaf.
- _____. 2008. The Trajectory of the Subaltern in My Work. Lecture Presentation. February 7, 2008. University of California-Santa Barbara.
- Starr, P. 1982. *The Social Transformation of American Medicine*. New York: Basic Books.
- Stauffer, R. 1966. *The development of an interest group: the Philippine Medical Association*. Quezon City: University of the Philippines Press.
- Steinberg, D.J. 2000. *The Philippines: A Singular and a Plural Place*. Boulder: Westview Press.
- Stewart, C. and Shaw, R. (eds). 1994. *Syncretism/Anti-Syncretism. The Politics of Religious Synthesis*. London: Routledge.
- Strong, PT. 1999. *Captive Selves, Captivating Others: The Politics and Poetics of Colonial American Captivity Narratives*. Westview Press/Perseus Books.
- Tan, M. 1987. *Usug, Kulam, Pasma. Traditional concepts of health and illness in the Philippines*. Quezon City: AKAP.
- _____. 1996. *Traditional Medical Practitioners in the Philippines*. Professorial Chair Paper. Series 96-6. Diliman: CSSP Publications.
- _____. 1999. *Good Medicine. Pharmaceuticals and the Construction of Power and Knowledge in the Philippines*. Amsterdam: Het Spinhuis.
- Tan, M; Querubin, M.; Rillota, T. 1988. The Integration of Traditional Medicine Among Community-based Health Programmes in the Philippines. *Journal of Tropical Pediatrics*. 34:71-4.
- Tan Alora, A. Lumitao, J. (eds) 2001. *Beyond a Western Bioethics: Voices from the Developing World*. Washington: Georgetown University Press.
- Tapales, PD. 1993. *Devolution and Empowerment. The local Government Code of 1991 and Local autonomy in the Philippines*. State of the Nation Reports. Manila. University of Philippines.

- Taussig, M. 1993. *Mimesis and Alterity*. New York:Routledge.
- Taylor, K. 2000. *Medicine of Revolution: Chinese Medicine in Early Communist China 1945-1963*. Unpublished PhD Dissertation. University of Cambridge.
- _____. 2001. A new scientific and unified medicine: civil war in China and the new acumoxa, 1945-49. In E. Hsu. (ed.) *Innovation in Chinese Medicine*. Cambridge: Cambridge University Press.
- _____. 2005. *Medicine of Revolution. Chinese Medicine in Early Communist China*. London: Routledge.
- Tayo. E. 1965. *The reorganization of the Department of Health 1958-59: Problems in Decentralisation*. Unpublished PhD Dissertation. University of The Philippines-Dilliman.
- Tengson, B. 2003. *A look at the underground economy of Quiapo. The conditions of the herbal medicine vendors*. Unpublished MS dissertation. University of the Philippines-Manila.
- Testigo. 2011. Media Release. Morong 43 file countercharges for arbitrary detention; sue Gloria Arroyo, military, police for P15 million in damages. Retrieved 11/8/2011 from: <http://testigo-ph.org/mediareleases/morong-43-file-countercharges-arbitrary-detentionsue-gloria-arroyo-military-police-p15>
- Thacker S.B., Banta H.D. 1983. "Benefits and risks of episiotomy: An interpretative review of the English language literature, 1860-1980". *Obstet Gynecol Surv* **38** (6): 322–38
- Thomson, D. 2005. China's Soft Power in Africa: From the Beijing Consensus to Health Diplomacy. *China Brief*. 5(21).
- Todaro, M. and Smith, S. 2006. *Economic Development*. Boston. Pearson.
- Turner, J. 1999. *Formalizing "traditional" healing: Experience and practice on Samar Island*. Unpublished MA Thesis. Dalhousie University.
- Twumasi, P. and Warren, DM. 1986. The Professionalisation of Indigenous Medicine: a comparative study of Ghana and Zambia. In Last, M. and Chavunduka, GL. (eds). *The Professionalisation of African Medicine*. Manchester: Manchester University Press.
- UNDP. 2009. *Human Development Report 2009*. New York:UNDP. Retrieved from: <http://hdrstats.undp.org/en/indicators/161.html>
- _____. 2011. Millenium Development Goals Report 2011. New York:UNDP. Retrieved 7/2/2011 from: http://www.beta.undp.org/undp/en/home/librarypage/mdg/MDG_Report_2011.html
- Unschuld, P. 1985. *Medicine in China. A History of Ideas*. Berkeley: University of California Press.
- _____. 1992. Epistemological Issues and Changing Legitimation: Traditional Chinese Medicine in the Twentieth Century. In Leslie, C; Young, A. (eds) *Paths to Asian Medical Knowledge*. Berkeley: University of California Press.

USAID. 2004. *Newborn Health in the Philippines: A Situation Analysis*. Basics Support for Institutionalizing Child Survival Project (BASICS II). Arlington, Virginia:United States Agency for International Development.

Valencia, E. 1963. *The reorganization of the department of health 1958-1961 problems in implementation from the viewpoint of the department head*. Unpublished PhD Dissertation. University of the Philippines.

Van Der Geest, S. 2002. Integration or Fatal Embrace? The Uneasy Relationship between Indigenous and Western Medicine. *Curare*. 25(1+2):155-60.

Van Manen. 1990. *Researching lived experience: Human science for an action sensitive pedagogy*. Albany:SUNY.

Varela, AP. 1997. *Policy review and program evaluation of the generics law and national drug policy*. Quezon City: University of the Philippines Press.

Velimirovic, B. 1984. Traditional Medicine is not Primary Health Care: a polemic. *Curare*. (7):61-79.

Vigh, H. 2008. Crisis and Chronicity: Anthropological Perspectives on Continuous Conflict and Decline. *ethnos*,73:1.

Vuori, H. 1982. The World Health Organization and traditional medicine. *Community Medicine*. 4:129-37.

Wallerstein, I. 1974. *The Modern World System: Capitalist Agriculture and the Origins of the European World Economy in the Sixteenth Century*. NY: Academic Press.

_____. 1983. *Historical Capitalism*. New York:Verso.

Walraven, G. and Weeks, A. 1999. The Role of Traditional Birth Attendants with Midwifery Skills in the Reduction of Maternal Mortality. *Tropical Medicine and International Health*. 4 (8): 527-9.

Walsh J A. and Warren K S. 1979. Selective primary health care: an interim strategy for disease control in developing countries. *N. Engl. J. Med.*. 301:967-74.

Walt, G. 1994. *Health Policy: An Introduction to Process and Power*. London: Zed Books.

Weber, M. 1958. *The Protestant Ethic and the Spirit of Capitalism*. New York:Charles Scribner's Sons.

_____. 1978. [1922] *Economy and Society. Vol. I.* (eds.) G. Roth and C. Wittich. Berkeley:University of California Press.

Weindling, P. 1997. Philanthropy and World Health: The Rockefeller Foundation and the League of Nations Health Organisation. *Minerva*. 35: 269-81.

Werner, D. 2001. Elusive promise, Whatever Happened to 'Health for All'? *New Internationalist*. Jan/Feb(331): 22-24.

West, H.G. and Luedke, T.J. (2006). Introduction: Healing Divides: Therapeutic Border Work in Southeast Africa. In West, H.G. and Luedke, T.J. (eds). *Brokers and Healers: Brokering Therapeutic Resources in South East Africa*. Bloomington: Indiana University Press.

Witt, CM., MacPherson, H., Kaptchuk, T. *et al.* 2011. Efficacy, effectiveness, and efficiency. In V. Scheid and H. Macpherson (eds.) *Integrating East Asian Medicine into Contemporary Healthcare: Authenticity, Best Practice and the Evidence Mosaic*. London: Elsevier.

World Bank. 1980. *Health Sector Policy Paper*. Washington:World Bank.

_____. 1987. *Financing Health Services in Developing Countries: An Agenda for Reform*. Washington:World Bank.

_____. 1993. *World Development Report: Investing in Health*. Oxford:OUP.

_____. 2005. IDA Factsheet. Retrieved on 7/2/2012 from: <http://www.worldbank.org/ida/ida-factsheet.pdf>.

World Health Organization. 1975. *The Traditional Birth Attendant in Maternal and Child Health and Family Planning*. WHO Offset Publication no. 18. Geneva: WHO.

_____. 1977. Report of the WHO Meeting on the Promotion and Development of Traditional Medicine. Geneva: WHO.

_____. 1978a. *Declaration of Alma Ata*. Geneva: WHO. Retrieved on 22/6/10 from http://www.paho.org/English/DD/PIN/alma-ata_declaration.htm

_____. 1978b. *Primary health care, the Chinese experience. Report of an inter-regional seminar*. Geneva: WHO.

_____. 1979. *Formulating Strategies for health for all by the year 2000. Guiding Principles and essential issues*. Health for All. Series No. 2. Geneva: WHO.

_____. 1984. *Report of the Working Group on the Integration of Traditional Medicine in Primary Health Care*. Manila:WHO Regional Office for the Western Pacific.

_____. 1992. *Traditional Birth Attendants—A joint WHO/UNFPA/MCH statement*. Geneva: WHO.

_____. 1998. *Regulatory Situation of Herbal Medicines: A Worldwide Review*. Geneva:WHO.

_____. 2001. *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review*. Geneva:WHO.

_____. 2002. *WHO launches the first global strategy on traditional and alternative medicine*. Press Release WHO/38. 16 May 2002.

_____. 2002a. *Regional Strategy for Traditional Medicine in the Western Pacific 2002-2010*. Manila: WHO Regional Office for the Western Pacific.

_____. 2002b. *WHO Traditional Medicine Strategy 2002-2005*. Geneva: WHO.

_____. 2002c *Traditional Medicine – Growing needs and potential*, WHO Policy Perspectives on Medicines, WHO, Geneva. No. 2, May 2002.

_____. 2003a. *Second Consultation Meeting on Traditional and Modern Medicine: Harmonizing the Two Approaches*. Manila: WHO Regional Office for the Western Pacific.

_____. 2003b. *WHO Guidelines on Good Agricultural and Collection Practices (GACP) for Medicinal Plants*. Geneva: WHO.

_____. 2005. *National policy on traditional medicine and regulation of herbal medicines: Report of a WHO global survey*. Geneva:WHO.

_____. 2007a. *WHO Guidelines on Good Manufacturing Practices (GMP) for Herbal Medicines*. Geneva: WHO.

_____. 2007b. *WHO Guidelines for Assessing Quality of Herbal Medicines with Reference to Contaminants and Residues*. Geneva:WHO.

_____. 2008. Beijing Declaration. Geneva:WHO.

_____. 2009. *Traditional Medicine Definitions*. Retrieved on 3 May 2009 from: <http://www.who.int/medicines/areas/traditional/definitions/en/index.html>

_____. 2010a. *Benchmarks for Training In Ayurveda*. Geneva: WHO.

_____. 2010b. WHO Collaborating Centres for Traditional Medicine. Retrieved on 10/6/10 from: <http://www.who.int/medicines/areas/traditional/collabcentres/en/index.html>

_____. 2011. WHO. Global Health Expenditure Database. Retrieved 11/10/11 from: <http://apps.who.int/nha/database/DataExplorer.aspx?d=1>

Yip, K. 1982. Science, Medicine, And Public Health In Twentieth Century China Health And Society In China: Public Health Education For The Community, 1912-1937. *Soc. Sci. Med.* 16:1197-1205.

Yoingco, A.Q., Guevara, M.M. and Gracia, J.P. 1994. A Study on the Incidence of the Philippine Fiscal System. In Intal, P.S. and Bantilan, M.C.S. (eds). *Understanding Poverty and Inequity in the Philippines*. Pasig: United Nations Development Program and National Economic and Development Authority.

Youde, J. 2010. China's Health Diplomacy in Africa. *China: An International Journal*. 8(1):151-63. Retrieved on 15 November 2010 from: <http://www.thefreelibrary.com/China's+health+diplomacy+in+Africa-a0226162643>

Young, D. 1994. *Models of Healthcare Pluralism*. In Islam, A. and Wiltshire. R. *Traditional Health Systems and Public Policy*. 62-70. Ottawa: IDRC.

Young, M. 1932. First Annual Report First National Midwifery School, Peiping 1929-1931. Midwifery Training School 1930. Midwifery Education, Midwifery Training School, Beijing (report), folder 372, box 45, series 601, RG1, Rockefeller Foundation Archives, Rockefeller Archive Center.

_____. 1932a. *Letter to John Grant by Marion Young*. Midwifery Education, Midwifery Training School, Beijing (report), folder 372, box 45, series 601, RG1, Rockefeller Foundation Archives, Rockefeller Archive Center.

_____. 1932b. Third Annual Report First National Midwifery School Peiping. July 1931 – June 1932. Midwifery Education, Midwifery Training School, Beijing (report), folder 372, box 45, series 601, RG1, Rockefeller Foundation Archives, Rockefeller Archive Center.

_____. 1933a. April 28 1933, *Letter to John Grant by Marion Young*. Midwifery Education, Midwifery Training School, Beijing (report), folder 372, box 45, series 601, RG1, Rockefeller Foundation Archives, Rockefeller Archive Center.

_____. 1933b. *Fourth Annual Report First National Midwifery School*. Peiping. July 1931–June 1932. Midwifery Education, Midwifery Training School, Beijing (report), folder 372, box 45, series 601, RG1, Rockefeller Foundation Archives, Rockefeller Archive Center.

Zaslowski, C., and Lee, MS. 2011. International standardisation of East Asian medicine: the quest for modernisation. In V. Scheid and H. Macpherson (eds.) *Integrating East Asian Medicine into Contemporary Healthcare: Authenticity, Best Practice and the Evidence Mosaic*. London: Elsevier.

Zhang, X. 2000. Integration of Traditional and Complementary Medicine Into National Health Care Systems. *J Manipulative Physiol Ther.* 2000;23 (2):139-40.

Zhisui, L. 1994. *The Private Life of Chairman Mao*. New York: Random House.

APPENDICES

Appendix 1 Map of the Philippines



APPENDIX 2
Methodology (Interview Schedules & Informed Consent)

Table 2.2 Analysis of Barangay Member Interview Schedule

Section of Interview	Questions	Information Sought
I Demographic Data	Barangay Gender Age Income Education Chronic Illness(es)	Can informant responses be differentiated according to demographic criteria? Analysed with regression analysis.
II Use of HealthCare System	<u>Part 1 General local healthcare</u> - When you get sick to whom do you go first? - Which practitioner(s) do you prefer to go? - Do you primarily see the practitioners you Prefer to see? If Not, why not? - Do you use to local health practitioners? For what ailments? - Approximately how often were you sick in 2005? How often this year? <u>Part 2 Local Traditional Birth Attendants</u> - Who has delivered your children? - Who do you prefer to deliver your children? Why? - If discrepancy, why are you <i>not</i> going to whom you prefer? - Do you prefer at home delivery or in facility? Why? Why not?	How are informants using their healthcare system and what are their preferences? Analysed with SPSS
III Perceptions of HealthCare System	<u>Part 1 General local healthcare</u> - On a scale of 1-10 how would you rate the <i>quality</i> of your healthcare five years ago? and today? - What has improved in your healthcare system? - What can be improved upon? <u>Part 2 Local Traditional Birth Attendants</u> - What are the advantages to home delivery? Disadvantages? - What are the advantages to hilot delivery? Disadvantages?	How do informants perceive their healthcare system and what do they perceive as the advantages and disadvantages of their system? Analysed with SPSS
IV Perceptions of Appropriate HealthCare Integration	<u>Part 1 General local healthcare</u> - Do you think healthcare integration is good/appropriate for your barangay? Why or Why Not? - What would make integration appropriate for your barangay? - Are you concerned with safety of local practitioners? - If so what is your concern, if not, why?	How do informants perceive appropriate healthcare integration?

	<u>Part 2 Local Traditional Birth Attendants</u> - Have you had any negative experiences with Hilots? - Do you know first hand of any maternal or infant deaths directly linked to hilots? - Should hilots be allowed to deliver? - What do you think of the new DOHP policy that states all women must deliver in-facility with skilled birth attendants and women will no longer deliver at home with hilots? - Is this appropriate for your barangay? Why or why not?	Do they share the same standards of appropriateness as WHO and the state level? Analysed with SPSS
V Identified Changes to HealthCare System Since Integration	<u>Part 1 General local healthcare</u> - How many (total) practitioners were in your community in 2005? How many today? If this has changed, why has it changed? - How many different <i>types</i> of practitioners could you see in 2005? How many today? - How far (in Meters or KM) is the main practitioner you see in 2005? How far today? - How much did it cost for a visit to your practitioner (fee) in 2005? How much today? - On a scale of 1-10 how would you rate the quality of your healthcare in 2005? And today? - What has improved in your healthcare system? What can be improved?	Does healthcare integration change access to, or the perceived quality of healthcare for barangay informants? Analysed with SPSS

Table 2.3 Analysis of Local Non-biomedical Practitioner Interview Schedule

Section of Interview	Questions	Information Sought
<u>Part A All Local Practitioners</u>	Barangay	Can informant responses be differentiated according to demographic criteria? Analysed with regression analysis.
I Demographic Data	Gender Age Income Education	
II Emic Classifications of Local Practices and Practitioners	- How do you categorise what you do? (what practitioner label) - What practices do you use to treat a patient? - How did you learn this/these? - What kind of ailments do you generally treat? - Are you a part of this healthcare system?	How do local practitioners classify themselves and how does this compare to etic classifications? Analysed with SPSS
III Identified Changes to healthcare System Since Integration	- How many patients did/do you generally see in a week 2005/today? - If changed, why do you think? - Is your practice closer to or further from your patients since 2006? Why? - Do you refer patients to other practitioners (including biomedical)? If so, under what conditions? Has this changed since 2006? - Do other practitioners (including biomedical) refer patients to you? If so, under what conditions? Has this changed since 2006? - Do you know how many other practitioners are in your community? Has this changed since 2006? - Can you rate your local healthcare system's effectiveness for community health on a scale of 1-10 in 2005? And today?	Do informants perceive any changes in their practice since integration? Analysed with SPSS
IV Training and Changes as a Result of Training	- Did you receive any formal training, for example from DOHP? -If so, what were you trained in? - What did this training do for you? - Do you practice what they trained you in? - How do you feel about this training? - Did you complete the training? - Did you receive a certificate or some notice of training? - If so, does anyone ask to see this? - Has anything changed for you in terms of the types of patients you see since training? ...the number of patients? ...where you see	What is practitioner's perception of the appropriateness of any training received? Analysed with SPSS

	these patients? ...the outcome with patients? ...how you are paid? ...how much you are paid?	
V Perceptions of Appropriate healthcare Integration	- What do you think of integration? Is it appropriate for your barangay? - Do you approve of the way integration is being carried out in your barangay or do you think it should be done differently? - Are you willing to undergo standardised training and classes to be integrated into the healthcare system? - If not, would incentives help you to undergo standardised training?	How do informants perceive appropriate healthcare integration? Do they share the same standards of appropriateness as WHO and the state level? Analysed with SPSS
<u>PartB Only Hilots (hilots)</u>	Barangay	Can informant responses be differentiated according to demographic criteria?
I Demographic Data	Gender Age Income Education	Analysed with regression analysis.
II Emic Classifications of Local Practices and Practitioners	- What do you call yourself? - What do you do other than deliver? Any other healthcare roles? - Do you do pre- and post-partum care? - specifically what do you do? - What else do you do as a hilot?	How do local practitioners classify themselves and how does this compare to etic classifications? Analysed with SPSS
Section of Interview	Questions	Information Sought
III Identified Changes to healthcare System Since Integration	How many deliveries did you do in 2005... approximately how many in the last year?	Do informants perceive any changes in their practice since integration? Analysed with SPSS
IV Training and Changes as a Result of Training	Were you ever trained? By Whom? What did your training consist of? Did you feel this training was adequate? Did you want to learn more? How much longer would be adequate for a training? Were you given a sterile birthing	What is practitioner's perception of the appropriateness of any training received?

	kit? For how long did the kit last? Did you find the kit useful? Did you want another kit? Would you use it? If yes, Why did you not get another kit?	Analysed with SPSS
V Perceptions of Appropriate healthcare Integration	- Of all the deliveries you have done how many have had complications? - What have you done in circumstances of complications? - If you have not referred, why not? - Have you brought women to hospitals and they were refused treatment because you cared for them? - How many instances of maternal or child mortality were patients of yours? - In general what do you think is the most frequent cause of maternal/ child mortality? - Are you familiar with the 2008 Administrative Order from the DOH concerning in-facility deliveries and no at-home deliveries or deliveries by hilots? - How do you feel about this? Do you feel it is appropriate for your barangay? Why or why not? - They are calling this “integration”, is this your interpretation of integration? - Will you give up your role to deliver? - Do you want to be trained by the DOH as a midwife? - If so will you give up what you know as a Hilot? - What do you think the outcome of this [policy] will be in your barangay?	How do informants perceive appropriate healthcare integration? Do they share the same standards of appropriateness as WHO and the state level? Analysed with SPSS

**Table 2.4 Analysis of Biomedical Practitioner Interview Schedules
(Barangay Health Workers/Midwives/ Municipal Nurse)**

Section of Interview	Questions	Information Sought
I Demographic Data	Barangay Gender Age Income Education	Can informant responses be differentiated according to demographic criteria? Analysed with regression analysis.
II Training and Identified Role in healthcare System	- What do you practice? Where did you learn this? - For BHWs: How long was your training? How long was your birthing training? - What kind of ailments do you generally treat? - What do you use to treat patients?	How do practitioners identify their role in healthcare system and their qualifications for this role? Analysed with SPSS
III Identified Changes to healthcare System Since Integration	- Approximately how many patients do you generally see in a week? How many patients did you see weekly in 2005? - To whom do you refer patients? - Do you ever refer patients to local healthcare practitioners? Why or why not? If so, under what conditions? - Has this changed at all since 2006? - Do local healthcare practitioners refer patients to you? If so, under what conditions? Has this changed at all since 2006? - What did/do you think about the local healthcare system in 2005/today? - Do you think it is effective for the communities' health? Can you rate its effectiveness (1-10) 2005/today? - How could it be improved? - Do you consider yourself a part of this healthcare system?	Do informants perceive any changes in their practice or in the healthcare system since integration? Analysed with SPSS
IV Etic Perceptions of Local Practices and Practitioners	- Do you know how many types of practitioners are in your community? Has this changed since 2006? - What do you think of the local healthcare practitioners in your community? - Do you interact with them at all? Has this changed since 2006? - Do you think some are more competent than others? Which ones and Why? - Which local practitioners would you categorise as safe and effective? - What would make them safe and effective? Is	How do biomedical practitioners perceive the local healthcare practitioners and how does this compare to the emic perspective.

	this relevant to you? <u>Questions specifically regarding Hilots</u> - What percentage of your mothers have at-home deliveries? and in-facility deliveries? - How many infants have you delivered unassisted? in 2005? And today? - How many complications or maternal/infant deaths have you had? - How many of your home deliveries are attended by hilots? Trained? Untrained? - How many cases of maternal and infant mortality were attributed to hilots? Trained? Untrained? - How many cases of maternal and infant mortality have been due to skilled birth attendants?	Analysed with SPSS
V Perceptions of Appropriate healthcare Integration	- Are you aware of local healthcare practitioners being trained and integrated and into the healthcare systems? - How do you feel about this? - Do you feel differently about them when they complete a training programme? Do you feel differently about their competence and effectiveness? - Do you approve of this integration or do you think it would be more appropriate for your local healthcare system to do this differently? - Does this integration policy meet your needs? Why? - What would need to be changed in order for it to meet your needs? <u>Questions specifically regarding Hilots</u> - Are you familiar with the new DOHP Administrative Order for All deliveries to be in-facility and delivered by skilled birth attendants ONLY? - Is this appropriate for your barangay/Municipality? - Do you have enough midwives and trained professionals to staff? - How will you be able to attend to both your regular duties and new duties at a birthing facility? - How many of the women in your Barangay would follow this policy? Why or why not? - How many of your Hilots will follow this? - Is this integration policy appropriate for your barangay/municipality in terms of infant and maternal mortality, for example, if the community does not follow and the hilots that are used are no longer being trained? - Do you think this policy is ultimately helpful or harmful for your barangay?	How do informants perceive appropriate healthcare integration? Do they share the same standards of appropriateness as WHO and/or the local level? Analysed with SPSS

Table 2.5 Analysis of Barangay Council Interview Schedule

Section of Interview	Questions	Information Sought
I Demographic Data	Barangay Gender Age Income Education	Can informant responses be differentiated according to demographic criteria? Analysed with regression analysis.
II Information Regarding the Administration of the Barangay (related to health)	- What is your annual working budget? - What percentage is allocated to healthcare? - What does this cover? - Do you have an ambulance? - If not, what do your barangay members do in emergencies? - Is your budget adequate for the administration of healthcare in your barangay? - How is sanitation paid for? - Approximately how many flush toilets are in your community? - How is garbage disposed? Does the barangay pay for this? - Is water potable? Who pays for the water treatment? - How is the health of your barangay? - How has healthcare devolution affected your barangay? Have there been challenges due to inadequate resources? Can you specify these challenges? - Do you think the barangay should be responsible for the health of its community or should the department of health?	Contextual information that identifies barangay healthcare administration and needs. Analysed with SPSS
III Perceptions of Appropriate healthcare Integration	- Do you think healthcare integration is appropriate for your barangay? If so Why? If not Why? - Could your barangay help to monitor or enforce the regulations of standardised local practitioners? - Are you aware of any maternal or infant deaths directly linked to hilots? - Are you aware of the new policy from DOHP prohibiting at-home deliveries by hilots? - How do you feel about this? Is it appropriate for your community? Why/Why not? - How will your pregnant women get to hospital in an emergency? - Can you afford to help with facilities for in-facility birthing? - Will you be able to staff facilities or will your midwife be missing from regular duties? - Do you think the majority of your women will refrain from at-home deliveries with hilots? - Will your hilots refuse women who ask for their	How do informants perceive appropriate healthcare integration? Do they share the same standards of appropriateness as WHO and the state level? Analysed with SPSS 368

	services? - Do you foresee any problems with this integration? - Is this policy appropriate for your barangay?	

Table 2.6 Summary of Research Methodology

Level of Analysis	Location	Sample Group	Sample Size (n=)	Sampling Method	Type of Data Collected	Data Analysis
Municipality	Bagabag	Municipal Health Officer	1	Purposive	Semi-structured Interviews	NVivo
		Municipal Nurse	1			
Barangay	<i>Baretbet</i>	Barangay Members	38	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	8			
		Barangay Health Workers	7			
		Local Health Practitioners	4			
		Midwife	1			
Barangay	<i>Careb</i>	Barangay Members	37	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	4			
		Barangay Health Workers	6			
		Local Health Practitioners	2			
		Midwife	1 ²⁴⁶			
Barangay	<i>Lantap</i>	Barangay Members	37	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	3			
		Barangay Health Workers	6			
		Local Health Practitioners	2			
		Midwife	1			
Barangay	<i>Murong</i>	Barangay Members	36	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	7			
		Barangay Health Workers	5			
		Local Health Practitioners	2			
		Midwife	1			
Barangay	<i>Paniki</i>	Barangay Members	39	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	6			
		Barangay Health Workers	6			
		Local Health Practitioners	3			
		Midwife	1			

²⁴⁶ One midwife works in the BHS for both *Careb* and *Lantap*.

Municipality	Bontoc	Municipal Health Officer	1	Purposive	Semi-structured Interviews	NVivo
		Mayor	1			
Barangay	<i>Alab Oriente</i>	Barangay Members	38	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	4		PileSorts	
		Barangay Health Workers	5			
		Local Health Practitioners	3			
		Midwife	1			
Barangay	<i>Bontoc Ili</i>	Barangay Members	37	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	5		PileSorts	
		Barangay Health Workers	5			
		Local Health Practitioners	4			
		Midwife	1			
Barangay	<i>Guina-ang</i>	Barangay Members	34	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	4		PileSorts	
		Barangay Health Workers	3			
		Local Health Practitioners	2			
		Midwife	1			
Barangay	<i>Mainit</i>	Barangay Members	32	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	3		PileSorts	
		Barangay Health Workers	3			
		Local Health Practitioners	1			
		Midwife	1			
Barangay	<i>Samoki</i>	Barangay Members	39	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	8		PileSorts	
		Barangay Health Workers	5			
		Local Health Practitioners	3			
		Midwife	1			
Municipality	Sadanga	Municipal Health Officer	1	Purposive Sampling	Semi-Structured Interviews	NVivo
Barangay	Anabel	Barangay Members	38		Structured	371

		Barangay Council	5	Convenience Snowball	Interviews	SPSS
		Barangay Health Workers	4		PileSorts	
		Local Health Practitioners	1			
		Midwife	1			
Barangay	Demang	Barangay Members	40	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	3		PileSorts	
		Barangay Health Workers	5			
		Local Health Practitioners	1			
		Midwife	1			
Barangay	Poblacion	Barangay Members	44	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	5		PileSorts	
		Barangay Health Workers	5			
		Local Health Practitioners	3			
		Midwife	1			
Barangay	Sacasacan	Barangay Members	45	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	6		PileSorts	
		Barangay Health Workers	3			
		Local Health Practitioners	2			
		Midwife	1			
Municipality	Murcia	Municipal Health Officer	1	Purposive	Structured Interviews	NVivo
		NGO Director	1		PileSorts	
Barangay	Blumentritt	Barangay Members	44	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	9		PileSorts	
		Barangay Health Workers	7			
		Local Health Practitioners	4			
		Midwife	1			
Barangay	Caliban	Barangay Members	38	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	5		PileSorts	
		Barangay Health Workers	6			
		Local Health	3			

		Practitioners				
		Midwife	1			
Barangay	Damsite	Barangay Members	36	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	6		PileSorts	
		Barangay Health Workers	5			
		Local Health Practitioners	4			
		Midwife	1			
Barangay	Minoyan	Barangay Members	37	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	3		PileSorts	
		Barangay Health Workers	5			
		Local Health Practitioners	2			
		Midwife	1			
Barangay	Poblacion	Barangay Members	39	Convenience Snowball	Structured Interviews	SPSS
		Barangay Council	4		PileSorts	
		Barangay Health Workers	6			
		Local Health Practitioners	3			
		Midwife	1			
Provincial	<u>Mountain Province</u>	Governor	1	Purposive	Semi-Structured Interviews	NVivo
		Provincial Health Officer	1			
Provincial	<u>Neuva Vizcaya</u>	Governor	1	Purposive	Semi-Structured Interviews	NVivo
		Chief of Regional Hospital	1			
State	Manila	DOHP	2	Purposive	Semi-structured Interviews	NVivo
State	Manila	PITAHC	2	Purposive	Semi-structured Interviews Participant Experience	NVivo
State	Manila	Bureau of Food&Drug	1	Purposive	Semi-structured Interviews	Nvivo 373

State	Manila	Senator Juan Flavie	1	Purposive	Semi-structured Interviews	NVivo
State	Manila	Undersecretary of Health	1	Purposive	Semi-structured Interviews	NVivo
State	Manila	Minister of Culture	1	Purposive	Semi-structured Interviews	NVivo
State	Manila	University of The Philippines Researcher	1	Purposive	Semi-structured Interviews	NVivo
INGO/NGO	Manila	Philippine Medical Association	1	Purposive	Semi-structured Interviews	NVivo
INGO/NGO	Manila	INAM	2	Purposive	Semi-structured Interviews	NVivo
INGO/NGO	Manila	Philippine Acupuncture Association	1	Purposive	Semi-structured Interviews	NVivo
Multilateral/Regional	Geneva	WHO-Geneva	1	Purposive	Semi-structured Interviews	NVivo
Multilateral/Regional	Manila	WHO-WPRO	2	Purposive	Semi-structured Interviews Participant Experience	NVivo
Multilateral/Regional	Manila	World Bank	2	Purposive	Semi-structured Interviews	NVivo
Multilateral/Regional	Manila	Asian Development Bank	1	Purposive	Semi-structured Interviews	NVivo
Multilateral/Regional	New York	UNICEF	1	Purposive	Semi-structured Interviews	NVivo
Multilateral/Regional	Washington DC	USAID	1	Purposive	Semi-structured Interviews	NVivo

Annex 2

Informed Consent

Consent to Participate in Research

Name of Researcher: Paul Kadetz, MSc, MSN, MPH

Supervisors: Professor Dawn Chatty, Professor Gerard Bodeker, University of Oxford

Department of International Development

Queen Elizabeth House

University of Oxford

The researcher, Paul Kadetz (a DPhil Candidate in the Department of International Development, University of Oxford) is conducting research on the policy for the integration of local healthcare practices and practitioners into state biomedical healthcare systems in the Philippines.

You have been asked to participate in a short interview regarding your personal perspectives regarding this policy as well as possibly questions about how this policy may have affected you, your practice, or your health and/or access to health in your community. You may choose to participate or not. Your participation is completely voluntary. In order to participate in this study; you must be an adult of at least 23 years of age and able to understand this form in order to give consent to participate in this research. All the information obtained and related to the study, will be kept strictly confidential and only the researcher will have access to the responses from participants. Your name will not be asked and will not appear on any form. No other identifying information will appear on any other form except your gender, your age, your barangay, and your income if you choose to provide. Your consent is verbal and there will be no need for your signature. If any description of the study and its outcomes is published or presented, your privacy will be fully protected and you will not be identified in any manner. No individual information will ever be released. There are no costs to you for participating in this study. Your participation in this study is completely voluntary. Even after having providing verbal consent and the study has begun, you can elect to withdraw at any time. All information will be strictly confidential. After the data from this study is analysed all documents will be destroyed by shredding.

For any further questions or concerns regarding this study, please ask the researcher now or feel free to address your questions to a Supervisor of this research:

Professor Dawn Chatty
University of Oxford
Department of International Development
Queen Elizabeth House
3 Mansfield Road
Oxford, OX1 3TB
UK
United Kingdom
Email: dawn.chatty@qeh.ox.ac.uk

Professor Gerard Bodeker
Nuffield Dept of Medicine
Division of Medical Sciences
University of Oxford
Green Templeton College
43 Woodstock Road, Oxford, OX2 6HG,
United Kingdom
Email: gerry.bodeker@gtc.ox.ac.uk

APPENDIX 3

Excerpts from Ethnography: A Participant Experience of the policy making process in the Traditional Medicine Unit of WHO-WPRO

“Man differs from other animals in that he is one of the most given to mimicry (mimetikotaton) and learns his first lessons through mimesis (dia mimeseos)”.
Aristotle Poetics 1448

This section will illustrate the construction of the representation of healthcare integration at the level of policy making via “participant experience” (Hsu 2006) in the Traditional Medicine Unit of the Western Pacific Regional Office of the World Health Organization (WPRO).²⁴⁷

Throughout this dissertation I attempt to distinguish between representation and practice. Although each can influence the other, and at times it is difficult to distinguish practice from representation, I attempt in this section to analyse the construction of the representation of healthcare integration through participant experience. By participating directly in the policy making process at WPRO, as a researcher and facilitator/rapporteur for a regional meeting, I was able to not only cognitively understand the process of healthcare integration as a representation, but to actually experience this representation via my phenomenological role in assisting in the further construction and maintenance of this representation.

Learning to Become the Other and The Voiceless voice: From Absolute Other to expert “It”

I originally went to WPRO to interview the director of the Traditional Medicine Unit (TRM) for this research. I had queried her by e-mail with an abstract of my research. The director stopped me before I could ask any questions: “I am not going to answer any of your questions, because I have nothing to say, I am new to the position”. She then proceeded to spend the next hour questioning me about my research, about what I had found in the Philippines thus far, and what I thought about these findings, and then it was agreed upon that I would consult with WPRO on several small projects. Before I left she said, “You are the 'expert' ”.

377

²⁴⁷ The WHO-WPRO participant experience was conducted as a consultant on two projects from August 2009 - September 2010.

The experience rather puzzled me as I did not think of myself as “an expert”. In fact, at that juncture I had only been conducting this research in the Philippines for several months. However, I was told that I was an expert and it was clear to me in the way in which this was communicated, that part of my requirements as an expert was to reify the representation of being an expert. To, in essence, play the part.

There was something inherently theatrical that I found I had unwittingly and unpreparedly stepped into as if in a dream. Bourdieu uses the metaphor of spectacle and theatre in terms of practice and I felt as though I was taking an actor's role that I was not quite sure how to play.²⁴⁸ Hence, I was not only starting to play a part in this representation, but I, myself, became a representation. And my sense of my own alterity was in constant flux according to my ability to play this part and play it well, with mimesis serving as my primary guide. Taussig states: “The ability to mime and mime well, in other words, is the capacity to Other” (1993: 19). Therefore, I am given the opportunity here to understand both the construction of these representations, as well as the practice of constructing these representations, which is valuable for this research.

I was given four main tasks to complete over the year. I was not given criteria or parameters on how to carry out any of these tasks or what was expected of me beyond completion of the stated project.

Learning the abcs of the WPRO Doxa and The Centrality of Representation

My first assignment was to construct a new questionnaire for a future strategy in traditional medicine for member states. I sent the director a rough draft and she called me in. “You can't say this” she pointed to a question. “Is the question bad?”

²⁴⁸ “This point of view is the one afforded by high positions in the social structure, from which the social world appears as a representation and practices are no more than 'executions', stage parts, performances of scores, or the implementing of plans” (Bourdieu 1977: 96).

“No, you can't say this word. You can't say 'problem' ...and here, you use 'issue'. You can't say 'issue'. These people don't have 'issues' and 'problems'...You're writing this for the M.O.H. [Minister of Health]...they have 'Challenges' ...we...give...'recommendations'. We don't solve 'problems'”.

And this was true. In assessing the discourse, I could find no one in the WHO literature that is identified as having a “problem” or an “issue”. Problems and issues simply do not exist in the WHO construction of the world. Member states only have challenges. I considered the difference. In a challenge it is implicit, that it is not insurmountable and can be overcome with the appropriate effort and correct action. Hence, a challenge is merely a brief detour on the WHO map to correct action. Any word stronger than the word “challenge” might appear negative and thereby WHO could be misconstrued by member states to be passing judgement. However, WHO cannot pass judgement. There are several reasons for this. Firstly, WHO is a “technical organisation” that lends “technical support” to member states. Hence, it exists to provide “scientific” and “evidence-based” recommendations.

Secondly, WHO was, and still is to a certain extent, financially supported by member states (Siddiqi 1995). Hence, WHO finds itself in the interesting quandary of being a leader in the world at the feet of its funders (i.e. the member states, especially those with larger donations).²⁴⁹ But in practice this was not clearly distinguishable and it often was confusing [to me] who was telling [or rather not telling] who to do what. Clearly, there is no room for valuation in this particular ordered system. A word that can be interpreted to have any judgement or valuation or worse, opinion, is most definitely the Other and will be excluded in order to not pollute the purity of the technical language of WHO's printed representations.

²⁴⁹ See Siddiqi 1995; and MacDonald 2008.

Hence, I quickly learned that WPRO, and possibly WHO, as well as possibly all the UN agencies, have their very own language with quite rigid boundaries of acceptability. Eager to not repeat these errors, I asked for any possible guidelines or a kind of WHO manual of style. She looked at me quizzically and said “You're the expert.” These assurances, however, did not reassure, as much as make me feel like a fraud.

I was given several documents to use as guides. Hence, neither knowing how to carry out a given task nor what the criteria were, I was forced to use the prior WHO documents I was given among others in a mimetic fashion. In order to prepare to improve my representation of “expert”, I first analysed the discursive elements of the Unit's documents and I realised that WHO language itself is a representation. Throughout my year of participant experience at WPRO, the phrases “You are the expert”. “You are a scientist.” were repeated at every meeting for any question I asked. I realised that I would need to depend solely on the resources of past WPRO projects as a guide and mimesis alone would be needed to move from Other to expert. In studying WHO documents, I quickly learned the WHO language and reflexively I observed myself mimetically adopt this language in order to conform to the appropriate WHO style. However, this “style” is not merely for the writing of WHO documents, but for WHO powerpoints; WHO presentations; WHO speeches; and of particular note WHO data and data analysis. As over the year I constructed each of these for WPRO, I developed an acumen for how these were to be appropriately done according to WHO standards.

Although I was not given instruction on what specifically to do, I was sometimes told what not to do. I understood that this direction by way of non-direction partly was done out of necessity due to the highly visible and inherently political nature of WHO, as well as for risk control. WHO is not supposed to have opinions or critiques, but rather offer technical support.

Thereby, any research that formulates anything resembling a critical finding is external to WHO and not the opinion of WHO, yet it must be within the field of possible acceptability of WHO. Hence, telling me what I could do, would be akin to WHO lending its approval and voice, where it is supposed to remain voiceless and without the ability to approve or disapprove.

The voiceless voice of WHO, which directed without directing and opined without opinions was remarkable to experience first-hand. Anything that was published by me through WHO, was not given specific authorship, yet contained the disclaimer: “Note: The views expressed in this report...do not necessarily reflect the policy of the World Health Organization” (Kadetz 2010). This was after I had carefully and mimetically adopted the WHO “style” of writing, analysing data, and, essentially, thinking. And after the document had gone through several expert edits. Hence, my voicelessness was essentially subsumed into the representational voice of WHO, that, according to WHO's own representation, was not really their voice. Thus, there is no real authorship and the document, if one considers this, appears to have written itself. Thereby, in this relationship, I am rendered an “It”, the WHO is represented as an “It”, and the product of this “It-It” relationship is a document that is a parentless “It”. This appears to be a very complex means in order to produce a message without assuming any accountability for the message or even acknowledging the fact that this is, in fact, a message being produced. However, this was the *habitus* to which I needed to adapt and adopt in the *doxa* of the *field* of the TRM unit of WPRO.

Constructing appropriate knowledge in the TRM Unit of WPRO entailed several processes meant to ensure the quality, validity, and appropriateness of the document. However, I realised that these terms were relative to the order of WPRO's understanding of the meaning of these terms. For example, the second document I produced was a situational analysis of local healthcare in the Philippines that was sent to several other external expert researchers; including several of which were conducting similar analyses and told to adopt to my style. This seemed an odd request, as my *style* was my own adoption of WHO's style. The questionnaire I compiled for the entire region was sent through tiers of the WPRO hierarchy up to the TRM unit at WHO headquarters in Geneva. I was told to do several rewrites and then I was told nothing more of that project.

In the first project, I worked only with the director of the TRM unit and the voiceless voices of past WPRO documents. However, the second project, which will be discussed for the remainder of this section required engagement with several divisions at WHO and many external “expert” advisers. Two directions were repeated to me by the Director at every meeting. Firstly, the member states must choose the direction for the future strategy for traditional medicine themselves and secondly, data or information that could potentially insult, humiliate, or in any manner upset any of the member states could not be presented in the research or at the meeting. The first restriction appeared simple and direct. However, the second restriction was a bit of mystery to me as I did not know what information might in any way upset the representatives present. I interpreted this second directive to mean: “tell the member states what they want to hear”. Well, even that might be difficult as I was not quite sure what member states wanted to hear. So, again I would count on past WPRO documents and being told when I was wrong.

The first restriction actually helped me to understand the second. I reviewed both WPRO and ASEAN documents pertaining to healthcare integration and “traditional medicine” of the past ten years. I analysed the frequency with which certain concerns were reported by member states. The second restriction appeared to flow from the first. Countries who voiced a particular concern would then not be identified individually, but only as a numeric value. For example, the format employed was: “ten out of 37 member states reported concern with the safety and good manufacturing practices of imported herbs and herbal products”. The truth of this statement, is that though several member states identified this as a concern, the documents studied revealed that Japan was particular concerned with the raw herbal products that they were receiving from China, which were identified to have large amounts of heavy metals. This is a markedly different statement from the one above, but working within the given restrictions, this knowledge would need to remain unspoken and understood through a vague reference to it, in order to essentially save political face. Thereby science intersects with diplomacy in what I shall refer to as “diplomatic truth”; or the construction of representations of “truth” that serve specific diplomatic, political, or economic purposes.

Abiding by diplomatic truth, no country would be able to be identified under any criteria examined and therefore, I could only conduct a proportional analysis. In analysing the data sets of WHO, I identified a third, fourth, and fifth restriction. The third restriction I encountered from the data sets themselves was that WHO did not have in its possession a complete data set of the 37 member states for any of the criterion I was analysing going back ten years.²⁵⁰ The fourth restriction magnified the third; data sets in any given period often conflicted with one another along the same criterion in the same country.

²⁵⁰ “One of the specific objectives of the programme [the TRM unit] is to collect information on the extent and nature of traditional medicine in the member states. So far, the information is scanty” (Vuori 1982: 133).

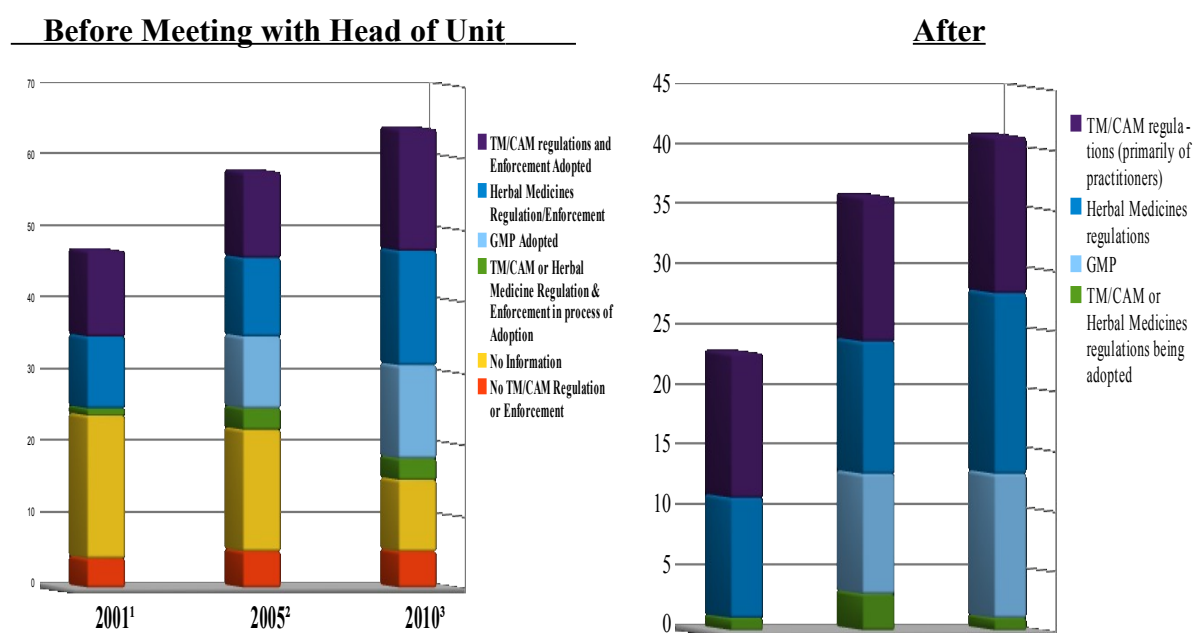
For example, though country X was identified as having a policy for healthcare integration in a 1995 data set; the same country was identified as never having had said policy in 1998, but may again be identified in a 2000 document as having adopted the policy in 1985. This was a common occurrence and I received no instruction on the course to take. Hence, I decided in instances where the data was conflicting, to use the earliest set of data as a guide, unless it was a criteria in which such a conflict was possible over time. In choosing this methodology, I cannot say I was following any evidence-based criteria. The only thing I can attest is that I followed this chosen method consistently, thereby if I was making an error it would be a consistent error.

The best solution for both of these restriction would have been to contact the countries with missing data and/or conflicting data. However, I was prohibited from contacting any countries. I was told the member states “should not be bothered”, as they usually had neither the manpower nor the ability to respond to questions regarding missing or conflicting data. This was the fifth restriction. My solution to these restrictions was to do a proportional analysis along the criteria chosen that were proportionally assessed according to how many states demonstrated the said criteria; how many states were in the process of adopting the criteria; how many states have not adopted, nor have any plans to adopt the criteria; and for how many states data is missing. I analysed the data and graphed the results on colour coated bar graphs illustrating the values obtained for each criterion from 2001 to 2010. The results of one of these graphs appear below on the left half of the page.

When the director of TRM presented these to the head of the department, in which the TRM unit was housed, he was livid. “This is terrible”, he said. “Awful!”. “You cannot show them [member states] what they haven't done. And you definitely cannot show them what data WHO doesn't have....WHO is not supposed to have missing data!” “Why do we have missing data anyway?!”

He directed the question to me, an external non-staff member of the Secretariat. Protecting my superiors, I said nothing. I intuited my place in the hierarchy of the *doxa* of WPRO and realised at that moment that the reason I was a temporary external “expert” and not permanent, was to some extent, precisely so that there could be someone to [safely] blame for inefficiency. “You have to redo this”, he said. “You have to make it positive....just get rid of the yellow and red”. The colours he was referring to, were the colours on the graph for WHO's missing data (Yellow) and the country not having the given criterion (red).

Hence, within this particular *doxa* of Diplomatic Truth, results were meant to be positive. To not identify WHO shortcomings. And in no manner be potentially controversial. To abide by this, I needed to alter my *habitus* of how to conduct research and yielded the results acceptable to the WPRO Secretariat (see example below on right hand side). Thereby, I could only identify how many countries adopted a given criterion or planned to adopt a given criterion from 2001 to 2010. Since few countries newly adopted or planned to adopt the criteria assessed, I was told to make the difference [from 2001-2010] “look bigger”. Which was only possible by changing the scale of the graphs as illustrated in the example below.



“Let's Just Call it Traditional”: The Construction of Labels

On the second day toward the end of the meeting, the head of the Unit, who also was the dominant voice of the voiceless WPRO secretariat, and someone who admitted to the group at the beginning of the meeting that he “knew nothing about traditional medicine”, said: “Yeah, and what about this TM/CAM....traditional medicine...complementary...etc....it's quite a mouthful. Frankly I can't say traditional medicine etc. etc. Why don't we just call it traditional medicine?” The rest of the secretariat and the advisers and representatives all nodded...The Korean advisers called out...“Yes, let's just call it traditional!” Several other advisers and representatives voiced their approval. And shortly thereafter all the delegates were in agreement for this shortened category by which to essentialise all local healthcare practices of the world. It was instructive to witness that such an important decision that could render serious ramifications at local levels was introduced and agreed upon without any consideration of possible consequences of this action; beyond that it would now be easier to pronounce.

The Experienced and Perceived Priorities of the Traditional Medicine Unit at WHO-WPRO

This last participant experience in many ways represents the entire participant experience over the year at WPRO, in which practice and representation were often conflicted or representation controlled practice rather than the opposite. But more importantly the representation that WPRO understood it must follow in order to maintain the integrity and potency of their *doxa*, dictated not only the *habitus* of their policy making and protocol, but also the construction of what constitutes evidence and an evidence base, as well as what constitutes an expert and expert opinion. In this participant experience I did not perceive that the members of WPRO were aware of what they were doing beyond fulfilling the expectations of their position by maintaining (through *habitus*) the diplomatic truth (or *doxa*) needed to preserve the integrity of the ordered *field* of WPRO.

As in any "community", Members of the *field* of the TRM unit of WPRO are beholden to uphold the maintenance of the *doxa* and of the representation of WPRO through the *habitus* of diplomatic truth.

This participant experience facilitates a greater understanding of both the policy making process at the Traditional Medicine Unit of WPRO and how the healthcare integration discourse is being constructed. This also facilitates an understanding that can be used to critique this discourse and particularly the normative representation of healthcare integration as produced by WHO. This research appears to corroborate the critiques of WHO as a political organization.²⁵¹ For WHO is identified in this participant experience as a political organisation first and possibly, secondarily, a technical healthcare organisation.

²⁵¹ See Sidiqqi (1995); Lee (1997); Navarro (2007); MacDonald (2008); Lee (2009).

Appendix 4

Revising the Model for Healthcare Integration

Excerpts

Revised Model for Healthcare Integration

Assessing the Extent of Integration

I have adapted the various classificatory schemes of WHO's healthcare integration model to more accurately reflect the integration identified in the communities examined. In this section I will present what I am calling the extent of integration. However, it must be emphasised that the extent of integration is merely a snapshot describing the stage of any given integration at a given moment. Moreso, healthcare integration needs to be understood as a collection of myriad dynamic processes that are independently capable of moving in any direction. Hence, depending upon social and cultural factors, the stages of healthcare integration can and do change at any time.

Therefore, for the purposes of this dissertation: *Fully integrated* will be used to represent those practices and/or practitioners that have been completely integrated into the formal healthcare system; are regulated by the DOHP or one of its divisions; and may be either practised by agents of the formal healthcare system or practised by a local practitioner that has been incorporated into the formal healthcare team. These fully integrated practices may also be eligible for the national healthcare coverage; *Philhealth*. As previously identified, the ten BFAD approved herbs that are local to the Philippines would be classified here as *fully integrated*.

The stage of *supported* identifies local practices and practitioners that are either trained and/or regulated by the DOHP or any of its agents. Trainings and certification in these practices may be offered to non-biomedical practitioners or biomedical practitioners by the DOHP. Acupuncture is an example of an imported non-biomedical practice that is currently *supported*. The stage of *supported* suggests preparatory steps for advancement toward *full integration*. But as illustrated below, integration processes do not necessarily progress from one stage to the next in a linear or purposeful direction.

The stage of *recognised*, identifies that biomedical practitioners are aware of local practices/practitioners and may informally refer their patients or collaborate in patient care. However, in this “stage” there is no formal mechanism by which the agents of the DOHP control, educate, standardise, or incorporate any of these practices or practitioners into the formal healthcare system. This unregulated stage of co-existence is representative of the majority of the informal local healthcare systems examined in the Philippines at the barangay level.

Moving from the stage of *recognised* to *not recognised* corresponds to a change from little interaction between the formal and informal healthcare systems to virtually no interaction or acknowledgement between biomedical and local practitioners. Again, the extent of integration only addresses integration into or out from the formal healthcare system. Hence, this would not account for any integration that may be occurring informally. For example, although the NGO *INAM* (in Murcia) is engaging in informal bottom-up integration, this integration is *not recognised* as integration by any agent of the DOHP. This mutual unacknowledged coexistence was found in many communities that did not integrate, such as in the barangays of Bontoc; wherein any integration that took place, occurred outside of the formal healthcare system; primarily at the microlevel of integration.

However, an important unintended consequence can be identified here. When local healthcare practices go unrecognised, pluralism is less controlled by the agents of the formal healthcare system and there can be more self-determination in community plural healthcare choices. Such individual choice is more difficult when the state actively prohibits a local practice or practitioner, as exemplified by the the current DOHP *hilot* policy. *Prohibition*, like *full integration*, can be understood as the state's extreme control of the the informal healthcare system.

Representing integration as non-linear and non-ordered dynamic processes provides a more accurate representation of the dynamic processes of healthcare integration identified in this research. This representation challenges a linear, ordered, simple closed systems representation of healthcare integration processes as having discrete starting and ending points or needing to occur or “progress” in any given order or direction. Integration is to be understood as a series of dynamic processes whereby, for example, *supported* local practices and practitioners can suddenly be *prohibited*, as illustrated in the case of the formerly trained *hilots*. See Figure 4.1

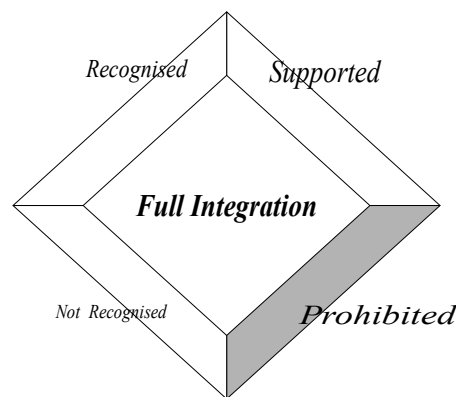


Figure 4.1 A Representation of the “Extent” of Processes of HealthCare Integration Identified in Practice

Hence, by critiquing the current representations of health care integration, this section has attempted to identify the shortcomings of representing health care integration as a single, unidirectional state level process that neglects to differentiate who or what is being integrated. This model was adapted to represent a more accurate depiction of the processes of healthcare integration identified in this research. However, what I am referring to here as the extent of integration, illustrates only a single dimension of the integration process. Therefore, further exploration is warranted to distinguish what other criteria need to be included for a more complete and accurate representation of healthcare integration processes as identified in this research.

Integration Status: accounting for who and what are being integrated

This section will differentiate among the non-biomedical practices and practitioners involved in integration processes; in a typology I will refer to as integration status. This differentiation will provide a more accurate representation of the integration processes identified in this research. Firstly, it is necessary to distinguish exactly which practice(s) is/are being integrated. By not addressing exactly what is being integrated, all non-biomedical practices are essentialised into one aggregate category of “traditional medicine”. This results in an inaccurate representation of integration and potentially marginalises those practices that are not identified.

Secondly, it is important to differentiate if integration is referring to practices or practitioners or both. The two categories are not the same. Integration can include certain local practices, but exclude local practitioners. For example, although herbs are being integrated by the DOHP, *albularios* are not.

Next, it is necessary to identify if the practice and/or practitioner that is being integrated is local to the Philippines or is imported. For example, the practices that are being *supported* by the DOHP are primarily imported non-biomedical practices. This distinction is relevant because the import of practices and practitioners may effect the informal local health care economy and access to local level health care, as well as access to local practices that are socially and culturally valuable for health and well-being.

This typology, which I refer to as integration status, differentiates between which practices and practitioners are being integrated. Integration status also offers a means to differentiate between practices and practitioners that are local to the Philippines and those that are imported.

Differentiating Integration: according to how the process is implemented

Another significant issue with the normative classification scheme for integration is that it does not identify how integration is being carried out. Integration can be implemented in different ways, and different outcomes can result from healthcare integration depending on how integration was understood and implemented in relation to a given context. Therefore, the manner in which integration is implemented is essential to distinguish for this research. The design of this research necessitates a classification scheme by which to distinguish the various ways in which the processes of health care integration were identified to occur. Hence, the following classificatory framework was devised according to what was observed in practice in the Philippines.

Firstly, it is important to distinguish the manner in which integration is implemented. Is integration implemented in a formal manner through policy, law, and formal agreements or is integration occurring informally through acknowledged or unacknowledged agreements between particular stakeholders? The *formal/informal* classificatory variable may identify the commitment of the various stakeholders involved in healthcare integration, as well as the extent of the state's involvement in local and imported non-biomedical health care.

Next, because this research is studying community level changes as a result of integration, it is important to identify if the source and/or agent(s) of integration is/are internal or external to a given community. Hence *internal/external* may thereby provide information concerning the context appropriateness of health care integration.

Lastly, this research demonstrates that it is necessary to consider how health care integration is implemented. Is integration hierarchically implemented from top-down or does integration occur bottom-up from the community, and potentially through a more horizontal (than vertical) distribution of power?

Identifying this variable may provide information concerning the locus of control of the integration process and how this may affect self-determination, agency, and ultimately the sustainability of the integration process. Therefore, *top-down/bottom-up* would provide a third classificatory variable.

Hence, this proposed classificatory scheme provides a framework by which to better represent the diversity of integration witnessed in this research. Thereby, for example, two or more different processes of integration simultaneously affecting a given community can then be identified and understood. For example, the Municipal Health Officer of Sadanga has informally integrated the local bonesetter and *albularyo* into the municipal health office and the barangay health offices as needed in a top-down manner, whilst Barangay Health Workers within several of these communities use local herbs (that are not part of the National drug formulary) to make topical pastes for skin conditions. Hence, both *informal external top-down* integration and *informal internal bottom-up* integration can be identified as simultaneously occurring in these communities. A summary of this typology is illustrated in Table 1.

Table 1 Determining the Type of Integration

<i>Manner of Integration</i>	<i>Integration relative to community</i>	<i>Agent Dissemination of integration</i>
Formal	External	Top-Down
Informal	Internal	Bottom-Up

Differentiating Integration: according to the administrative level of analysis

Finally, it is necessary to differentiate integration according to the level of analysis at which it is occurring. Although the normative models of integration only consider the state level of analysis, state level processes of integration can be transferred to lower levels and thereby be potentially implemented in a different manner at each level.

For example, in the Philippines context essentially one policy for integration is being implemented from the global level (WHO) to the regional (WPRO/ASEAN) to the national level (PITAHC) and then to the provincial, municipal and barangay levels. However, the policy is being interpreted differently by the stakeholders at each level and thereby implemented differently.

Furthermore, different processes of integration are frequently occurring simultaneously at different levels or even within the same level. For example, whilst the Municipal Health Officer in Bagabag is implementing *formal external top-down integration* of acupuncture and tui-na to the barangay level, a midwife administrator of one of the barangays of Bagabag is implementing *informal internal top-down integration* of TBAs into her rural health unit. Hence, ignoring the different processes of integration that may be simultaneously occurring within and between each level will result in an incomplete understanding of integration and potentially thwart the ability to address the issues and challenges that may arise as a result.

Hence, to summarise thus far: the current framework for representing and understanding health care integration is inadequate for the purposes of examining and discussing the research of this dissertation and I would argue for healthcare integration in any setting. Therefore, I have problematised this current typology and understanding of integration for a more exhaustive and nuanced understanding of these processes. To achieve this, I am proposing a new classificatory framework to represent the myriad processes that comprise the domain of health care integration. The elements of this proposed framework include:

A) a typology that describes a health care system according to differentiations between :

- i) formal or informal
- i) biomedical or non-biomedical
- ii) practices or practitioners

B) a classificatory scheme of health care integration according to:

- i) the extent of the processes of integration (or the stages of integration)
- ii) the integration status of each practice and practitioner
 - iii) the type of integration
(either: formal/informal; top-down/bottom-up; external/internal)
- iv) and the levels at which integration processes are occurring

Thereby, how integration is being carried out and exactly who and what are being integrated at myriad levels of analysis can be fully identified. Table 2 summarises all of these various potential typologies of health care integration into a classification framework using examples identified in this research.

Table 2 Classification Framework of Health Care Integration for the Philippines

Research Example (Municipality)	Types of Integration	<u>Integration</u> Types of Practice	<u>Status</u> Types of Practitioner	Stages of Integration	Levels of Integration
Bagabag	<i>Formal</i>	<i>Biomedical</i>	<i>Biomedical</i>	Fully Integrated Supported	Global (WHO) Regional/ International (ASEAN)
	Formal External Top-Down	Biomedicine	Physicians		
		Nursing	Nurses		
		Biomedical Midwifery	Midwives		
		Nursing Assistance	Barangay Health Workers		
		Non-biomedical	Non-biomedical		
		<i>Local standardised</i>	<i>Local standardised</i>		
		Midwife assistance	TBA		
			herbalism		
		<i>Imported</i>	<i>Imported</i>		
		Acupuncture	Acupuncturists		
		Acupressure	Acupressurists		
		Tui-na	Tui-na Practitioners		

		Western Massage	Massage Therapists		State/ National (PITAHC)
		Reflexology	Reflexologists		
		Homeopathy	Homeopaths		
		Chiropractic	Chiropractors		
		<i>Local standardised</i>	<i>Local standardised</i>		
		Pranic Healing	Pranic Healers		
Other Formal Types Formal External Bottom-Up Formal Internal Top-Down Formal Internal Bottom-Up					
	Informal	Non-biomedical	Non-biomedical	Recognised	Regional
Sadanga	Informal External & Internal Top-Down	<i>Local unstandardised</i>	<i>Local unstandardised</i>		Provincial
		Bonesetting	Hilot-Bonesetters		
		herbalism	Albularyos		
		Hilot	Traditional Birth Attendant (TBA/Hilot/Com adrona)		
		Massage	Hilot Massahe		
		Faith Healing	Supoks (Faith healers)		
		Psychic Surgery	Psychic Surgeons		
		Medico healing	Medicos		
		<i>Local standardised</i>	<i>Local standardised</i>		Municipal
		herbal use	herbalism		
		Hilot	Trained TBAs	Prohibited	
		Mixed Standardised (Non-biomedical and biomedical)	Mixed Standardised (Non-biomedical and biomedical)		Community

Murcia	Formal External Bottom-Up	Community Health Work (Herbalism, Acupressure, Massage, biomedical evaluation, biomedical sanitation and hygiene)	Community Health Workers	Not Recognised	(Barangay)
Other Informal Types Informal Internal Top-Down Informal Internal Bottom-Up					
Bontoc	No Integration				

APPENDIX 5

Publications & Presentations of Doctorate Research

Papers from DPhil Research

1. **Kadetz, P.** 2011. Medicine for Rebels: The political economy of acupuncture in “rebel” groups. *Asian Medicine: Tradition and Modernity*. Boston: Brill Publications. (submitted)
2. **Kadetz, P.** 2012. A Simple Systems Model will not address Complex Systems Thinking. in McCarthy, P. and Langweiler, M. (eds.) *Complementary and Alternative Medicine: Evaluating Methods and Assessing Effectiveness*. MA: Jones and Bartlett. (commissioned to write two chapters)
3. **Kadetz, P.** 2011. Global Health Policy and Standardisation: integrating health care as if context mattered. *East Asian Science, Technology, and Society*. (In publication)
4. **Kadetz, P.** and Perdomo, J. 2011. Slaves, Revolutions, Embargoes, and Needles: The Political Economy of Chinese Medicine in Cuba. *Asian Medicine: Tradition and Modernity*. Boston: Brill Publications. Dec. 2011.
5. **Kadetz, P.** 2011. Endangered Practices: Challenging the discourse of health care integration. In V. Scheid and H. Macpherson (eds.) *Integrating East Asian Medicine into Contemporary Healthcare: Authenticity, Best Practice and the Evidence Mosaic*. London: Elsevier.
6. **Kadetz, P.** 2011. Assumptions of Global Beneficence: Health care disparity, the WHO, and the effects of global integrative health care policy on local levels in the Philippines. *Biosocieties*. (6):88–105.
7. **Kadetz, P.** 2010. *Report of Meeting for Future Directions for Traditional Medicine in the Western Pacific Region*. Manila: World Health Organization.
8. **Kadetz, P.** 2009. *WHO-Western Pacific Region Office Report on the State of Traditional, Complementary, and Alternative Medicine in The Philippines: A Pilot Study of the WPRO 2002-2010 Strategic Objectives*. Technical Report. Manila: World Health Organization.

Conference Presentations and Papers Presented from DPhil Research (2012 -2010 only)

1. Keynote Speaker. TCM in International Health Interventions: South-South Transfers and the Importance of Context Appropriateness. *British Acupuncture Council Conference*. London. September 2012.
2. Invited Speaker. Problematising Integrative Health Care: a lesson in complexity. *AGTCM Rothenburg Conference*. Rotenberg. May 2012.
3. Invited Panelist. Constructing the Traditional at the Exclusion of the Local. *American Anthropological Association*. Montreal. November 2011.
4. How to Create an Epidemic: Antibiotic Access and Drug Resistance in the Philippines. *American Public Health Association*. Washington, DC. November 2011.
5. Invited Speaker. Blind Men and Elephants: A critical analysis of the simple systems paradigm embedded in the integrative medicine policy discourse. *The Quest for Personalised Health*. University of Westminster. June 2011.

6. Invited Speaker. Formal or Informal Integration of Health Care. *The Speedwell and Well-Being Trust*. Oxford. March 2011.
7. Assets-based and Context Specific Approaches to Development. *Sheffield International Development Network Conference*. University of Sheffield. March 2011.
8. Keynote Speaker. The Context-dependence of the Integration of TCM. *European Traditional Chinese Medicine Association Symposium*. February 2011.
9. Devolving Health Care in the Philippines: decentralisation and health care reform. *American Public Health Association Conference*. Denver, Co. November 2010.
10. Developing the strategies and objectives for TCAM for WHO-Western Pacific Region Member States 2010-2015. *American Public Health Association Conference*. Denver, Co. November 2010.
11. Impact of training Traditional Birth Attendants on maternal and infant mortality in the Philippines. *American Public Health Association Conference*. Denver, Co. November 2010.
12. Standardisation of acupuncture training in the Philippines: An assessment of WHO guidelines. *American Public Health Association Conference*. Denver, Co. November 2010.
13. Invited Speaker. Challenges to the Regulation of Herbal products in the Western Pacific Region of The World Health Organization. *Potent Substances: on the Boundaries of Food and Medicine Conference*. University College London. September 2010.
14. Sponsored Presenter. The Globalisation of TCM and its Integration into Local Philippine Health Care. *Consortium for the Globalization of Chinese Medicine*. Hong Kong. August 2010.
15. Invited Speaker. Assumptions of Beneficence: Health care disparity, the WHO, and the effects of global integrative health care policy on local levels in the Philippines. *Medicine Across Asia Series*. Wellcome Trust History of Medicine. University College London. May 2010.

Research Affiliations for DPhil Research

Visiting Research Fellow. University of the Philippines-Manila. Department of Social Science. January 2011 - February 2011.

Affiliate Scholar. The East – West Center, Manoa, Hawaii. July-August. 2010.



The Unused In-Birthing Facility Mainit, Bontoc with Birthing Kit from UNICEF