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COMPETENCY AND CHALLENGES OF TRADITIONAL MEDICAL SYSTEMS IN POSTCOLONIAL SRI LANKA

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Abstract

Modern medicine maintains a hegemonic position not merely due to its empirical validity but also due to crucial role played by socio-cultural and political forces that integrated with the process. As in contrast to remarkable achievements, modern medicine faces a challenge in the context of social, demographic and epidemiological transition in postcolonial societies where Non-Communicable Diseases (NCDs) are on the increased due to non-medical courses. In this context, the main purpose of this paper is to explore competency and challenge of traditional medical systems in postcolonial Sri Lankan society to address emerging health hazards in contemporary society. The analysis of this paper is based on both primary and secondary data. A qualitative study was conducted to grasp provider perspective on the role of traditional medical systems in contemporary Sri Lanka. Findings suggest that traditional medical systems that based on Ayurveda philosophy have a greater competency to address root causes of contemporary health hazards. The paper concludes highlighting number of challenges face by traditional medical systems at the practical level.

Keywords: Health hazards; Modern medicine, Postcolonial Sri Lanka; Traditional medical systems

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INTRODUCTION

Most of the achievements in public health have been attributed to power of modern medicine that continues a hegemonic position not merely based on its empirical validity but also due to socio-political forces that associated with modern medicine. However, the modern medicine faces a challenge in responding towards emerging health hazards. The health sector in Sri Lanka is overburdened with emerging health hazards due to continuation of Communicable Diseases while there is an increasing trend of Non-Communicable Diseases (NCDs). Traditional medical systems played a crucial role in pre-colonial and colonial societies in Sri Lanka. However, these systems became marginalized with the introduction and expansion of modern medical system. The traditional medical systems started regaining its recognition in the context of emerging health hazards in postcolonial Sri Lanka. This paper explores competency and challenges of traditional medical systems in Sri Lanka to address issues related to emerging health hazards in contemporary society[1].

Traditional medical systems in Sri Lanka include Ayurveda, Siddha, Unnani and *Desiya Chikithsha.* In practice, all the above systems have been integrated into Ayurveda to a large extent and quite difficult to identify them as distinct systems (Wanninayaka, 1982). The modern medical system was first introduced into Sri Lanka to solve health problems of administrators who came to serve the country under the colonial rule. Gradually, the services were expanded to provide healthcare facilities for labourers who worked under plantation economy. Finally infrastructure facilities were developed to provide modern healthcare services for local people (Uragoda, 1987). It is important to examine the ways in which how modern medicine was introduced into Sri Lanka and its consequences on traditional medical systems that played a crucial role in solving local health problems for many centuries.

Modern medicine was introduced into Sri Lankan context rather contradictory to existing system/s than an integrated system function as complementary to each other. However, the traditional medical systems were not disappearing as a result of widespread accessibility for modern medicine though they became marginalized to a great extent due to various reasons (Uragoda, 1987; Hettige, 1991; Pieris, 1999). However, the traditional medical systems started re-gaining recognition with emergence of health hazards in contemporary society. The modern medicine faces a challenge in responding towards the growing hazards and a new medical pluralism is emerging where people search best therapeutic options as alternative or complementary to modern medicine (Cant and Sharma, 1999). This paper focuses on provider perspective and their behavioral patterns to assess competency and challenges of traditional medical systems in Sri Lanka to address issues related to modern health hazards that require a holistic perspective.

[1]Though there are different terms within the political discourse of medical systems, the paper uses ‘traditional medical systems’ and ‘modern medical system’ in this analysis as the two terms are most appropriate for comparative analysis.

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METHODOLOGY

Qualitative analysis of this paper bases on both primary and secondary data sources. Secondary sources were reviewed to get an overview of historical background of medical systems, characteristics and functions of medical pluralism in Sri Lanka. Primary data was collected through 90 qualitative interviews with different types of traditional medical practitioners in *Gampaha, Polonnaruwa, Hambantota* and *Matara* districts. The primary data was collected under two broad studies on traditional medical practitioners. The first study was on traditional practitioners' knowledge, perceptions and behavioral patterns in diagnosis, treatment and willingness to refer suspected leprosy patients into modern medicine. These included 60 traditional practitioners in three districts namely; *Gampaha, Polonnaruwa* and *Hambantota*, 20 practitioners from each district were selected for this study by using purposive sampling method. The study sample included 19 practitioners with Bachelor of Ayurveda Medicine and Surgery; 13 practitioners with Diploma in *Ayurveda Sasthri* and 28 registered practitioners who practice *Deshiya Chikithsa* based on his/her family tradition. 49 percent of the sample practice under government health care delivery system that included all the degree holders and 10 Diploma holders. 51 percent of practitioners provide their services in private clinics that include 03 Diploma holders and all *Deshiya Chikithsa* practitioners. Qualitative techniques such as in-depth interviews, key informant interviews and observations were used as data collection techniques. As part of the above study, the practitioners were interviewed to get their views on competency and challenges of traditional medical systems to face issues related to contemporary health hazards.

The second study was on sociological aspect of Ayurvedic medical system in Sri Lanka in the context of challenging health hazards. This study was conducted in *Matara* Divisional Secretariat Division. The practitioners were selected by using purposive sampling method that included 10 graduates with Bachelor of Ayurveda Medicine and Surgery; 10 Diploma holders in *Ayurveda Sasthri* and 10 registered practitioners who practice *Deshiya Chikithsa* system based on their family traditions. Scrutinizing perceptions and behavioral patterns of practitioners, the study examined competency and challenges of traditional medical systems to respond towards contemporary health hazards in Sri Lanka. In-depth interviews, key informant interviews and observations were used as data collection techniques.

MEDICAL SYSTEMS IN PRE-COLONIAL AND COLONIAL SOCIETIES IN SRI LANKA: AN OVERVIEW

Sri Lanka has a medical history going back to over 2000 years. It has been fashioned over the centuries by a synthesis of several intrinsic and extrinsic factors, some of which were unique to the country. Being an island, Sri Lanka was insulated to a large extent from external forces influencing medicine but India, Portugal, the Netherlands and Britain succeeded at different times in penetrating this natural barrier. The diseases, the systems of medicine and the cultures they were introduced by largely determined the state of medicine in the country today (Hettige, 1991; De Silva, 1950).

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Historical evidence clearly shows that Sri Lanka had a well-developed traditional medical system that played a significant role during pre-colonial and colonial periods in Sri Lanka (Uragoda, 1987). Sri Lanka enjoyed self-rule from the inception of its written history until 1815, when British annexed the Kandyan Kingdom. There was a juxtaposition of Sinhala sovereignty and foreign rule from 1505 to 1815. This millennia long continuum of reign by kings of Sri Lanka makes it appropriate that one should consider ancient and medieval history of medicine in Sri Lanka in the context of the entirety of period rather than restricting the coverage to only the pre-Portuguese era (Hettige, 1991). There are hardly any studies which have attempted to draw comprehensive representation of the pre-colonial situation based on detailed historical data. Many contemporary researchers however, have attempted to synthesize the elements of traditional practices which not only existed in the past but also survived at present (Hettige, 1991; Uragoda, 1987). Traditional healing practices were not based on a single theory of disease causation, for different healing modes resorted were based on diverse ideas, concepts and beliefs (Hettige, 1991).

The earliest system of medicine that existed in Sri Lanka before the advent of Ayurveda was *Desiya Chikitsa* or *Sinhala vedakama* which was handed down from generation to generation. This system was officially recognized when the Ayurveda Act of 1961 was adopted. Accordingly Ayurveda includes the Siddha, Unnani and *Desiya Chikitsa* systems of medicine and surgery (Wanninayaka, 1982). In the course of time these systems became so integrated with the Ayurveda which has lost its identity to a considerable extent. Ayurveda system of medicine was introduced to Sri Lanka from North India, where it flourished for over three thousand years. Before introduction of modern medicine in the form of dispensaries, hospitals, mobile clinics and grass root level paramedical personal, rural people resorted to Ayurveda and other forms of herbal remedies (Hettige, 1991; Uragoda, 1987). The diversity of early immigrants to Sri Lanka meant that they introduced, apart from Ayurveda, many other curing and healing practices that included Unnani medicine based on Arabic texts, Siddha, a tradition from South India and homeopathy (Uragoda, 1987).

Anuradhapura and *Polonnaruwa* were the two successive capitals of Sri Lanka during the golden period of history and therefore, they were specially favored with medical institutions. Specialized hospitals were built by kings at different times. According to *Mahavamsa*-the great chronological of Ceylon, *Anuradhapura* which had the longest tenure as the capital city was favored with many medical institutions. The numerous studies on inscriptions lend support to the *Mahavamsa* in this respect, as there is epigraphic reference to several institutions, namely hospitals, dispensaries and medical halls at *Anuradhapura*. The physicians in ancient times were highly respected. The ancient medicine reached its heights during the *Anuradhapura* and *Polonnaruwa* period (Uragoda, 1987).

Though the advent of the Portuguese brought the first real contact with modern medicine to Sri Lanka, their influence on traditional medical systems were marginal but Dutch especially towards the latter part of their rule made some impression (Uragoda, 1987). The Dutch completed the capture of the Maritime Provinces by defeating Portuguese in the long drawn out siege of Colombo in 1656. The Dutch built more hospitals than the Portuguese and that

again for the purpose of serving their forces, shipping personnel and other Dutch nationals in the country. The lack of exposure of the local population would have lessened the impact of modern medicine on the nationals of the country (Uragoda, 1987:61). There is no evidence that tread contacts afforded any significant exposure to the local medical systems in Sri Lanka. The British captured the Maritime Provinces from the Dutch in 1796, and annexed the Kandyan Kingdom in 1815. They ruled the country till 1948 when Sri Lanka achieved independence. Though the first contacts with modern medicine were through the Portuguese and Dutch, the system really became established only during the British period, during which it spread through the length and breadth of the county (Uragoda, 1987: 80; Fernando, 1969; Margaret Jones, 2004).

The early phase of British, modern medicine confined to the military and civil health institutions. With the creation of a separate civil medical department in 1858, the medical facilities were provided to the civilians by a department free of military control. This was a momentous event, which marked the beginning of a new phase that finally led to the creation of a sound health services. The British from very inception of their rule created a sound infrastructure on which the health services were subsequently built. When they finally relinquished their responsibilities in 1948, the country left with a comprehensive healthcare systems which change little in outline up to modern times (Uragoda, 1987: 81). As Margaret Jones (2004) argues, the development of modern medicine in Sri Lanka could be recognized as an outcome of 'imperialism' than 'Welfarialism'. Thus, the healthcare system was well developed in Sri Lanka as it was considered as one of the crown colonies by the British.

As mentioned earlier, the modern medicine was introduced into Sri Lankan context not as an integrated system but rather contrary to traditional medical systems that leads to disintegration between the modern and traditional systems (Arseculeratne, 2002). When introducing modern medicine into Sri Lanka, the existing practices related to health and wellbeing were categorized as good practices and harmful practices. In this process, most of the practices related to traditional medical systems were categorized as harmful practices and health education programmes were designed to discontinue such practices among local communities. Since from the beginning, the modern medical system has been developed in Sri Lanka as a dominant and segregated system that has no mechanism to address local health hazards from a collaborative and holistic perspective.

MEDICAL PLURALISM IN SRI LANKA

Basic components of medical pluralism in Sri Lanka can be broadly categorized as modern and traditional medical systems. The traditional system itself comprises two distinct systems, natural and supernatural. The natural system includes the medical system that indigenous to Sri Lanka known as *Desiya Chikitsa*, Ayurveda, Siddha and Unnani medicine. As mentioned earlier, an average person makes little distinction among these types and generally refers all of them as Ayurveda. Homeopathic and Chinese medical systems are also practice to some extend in Sri Lanka, but these two systems have a little space within the medical pluralism in Sri Lanka. The supernatural types of healing systems

include variety of religious, ritual and magical performances (Hettige 1991; Silva, 1994; Obeyesekere, 1984).

Healthcare system is made up of overlapping subsystems such as the professional, folk and popular sectors, within each sub-system beliefs about illness, appropriate healthcare practices and the social organizations and institutions relating to health are socially constructed and interrelated (Kleinman, 1980). Thus, people's health seeking behavior is explained by reference to their belief systems and explanatory models that include what they believe to be the cause of the illness, what explains the symptoms they suffer and what they believe to be the most appropriate treatment to ensure the cure (Kleinman, 1980). There are number of studies that focuses on the ways in which how medical pluralism is functioned in Sri Lanka (Kusumaratne, 2005: Liyanage 2000; Pieris, 1999: Silva 1991, 1994; Hettige, 1991; Nordstrom 1988; Waxler 1988; Wolffers, 1988, 1989; Caldwell, 1989).

Conducting a survey on illness behaviour among two Sinhalese communities, Wolffers (1988) concluded that there is a pattern of treatment seeking behavior among users where they go to modern medicine for childhood disease and life-threatening conditions while resorted to traditional medical systems for less serious conditions, chronic diseases, snakebites, fractures etc. Thus, the choice of therapy influenced by the type of illness and beliefs about the illness that supports the argument of treatment seeking behavior is determined by explanatory models (Kleinman, 1980). However, a greater weight of evidence from user perspective suggest that treatment seeking behavior is not governed deterministically by the beliefs in a given medical system, the choice of therapy determined by more pragmatic factors such as financial cost, distance and time cost, previous experience of effectiveness, familiarity with the practitioner, social network of patients and the family, etc. (Liyanage, 2000; Silva, 1994; Caldwell, 1989).

There are number of studies on provider perspective that attempted to explore different behavioural patterns of practitioners in the context of medical pluralism in Sri Lanka (Nordstrom, 1988; Waxler, 1988; Wolffers, 1989). Nordstrom argues that there are a wide variety of traditional practitioners in Sri Lanka, working in a variety of ways and the therapeutic options are highly pluralistic (Nordstrom, 1988). However, Waxler argues that there is a little difference between cosmopolitan and traditional medical practitioners that indicate simply an institutional separation and behavioural convergence. A study based on a purposive sample of 768 healthcare providers that included both traditional and modern medical practitioners, Waxler found that behavioural pattern of both traditional and modern practitioners were similar to a great extend though the two categories were trained to practice different systems (Waxler, 1988). Woffers attempted to clarify the above contradictory arguments and explores behavioral adaptation of traditional medical practitioners in responding towards changing demands of patients (Wolffers,1989). The findings suggest that traditional practitioners have adopted in various ways to face changing needs of people where some of the Ayurveda practitioners do practice cosmopolitan medicine to cater to the growing demand.

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Both user and provider perspectives suggest that certain traditions in the medical domain in Sri Lankan could be described as systems but others remain unsystematic, use a mixture of traditional and modern traditions. From user perspective, people do not compartmentalize medical systems that fit with their belief systems but rather pragmatic and flexible to adapt and innovate when new health related opportunities arise. Many aspects of medical domain in Sri Lanka are diverse and unsystematic because of recurring changes in the knowledge and practices negotiated between different actors in the local setting. Medical systems in Sri Lanka could be better approached from structural and social relations perspectives that explained by Last (1981) that includes both formalized medical systems and unsystematic practices of users and popular and folk domains.

COMPETENCY AND CHALLENGE OF TRADITIONAL MEDICAL SYSTEMS

Disease pattern in Sri Lanka has been changing over the last few decades due to socio-cultural, demographic and epidemiological transition. The country faces a double burden of diseases, the prevalence of communicable diseases have been continuing while Non Communicable Diseases (NCDs) are dramatically increasing due to life-style changes and behavior related issues. The modern medicine faces a challenge in responding towards the emerging health hazards in contemporary society. As mentioned in methodology, 90 traditional practitioners from four districts were interviewed under two broad studies to get their views in this regard. Following table provides a distribution of study population by their training and the setting of practice.

Table 01: Distribution of study sample by their training and setting of practice

Type of Training	***Gampaha District***	***Polonnaruwa District***	***Hambantota District***	***Matara District***	**Total**
Bachelor of Ayurveda/ Siddha Medicine & Surgery	6	6	7	10	29
Diploma in *Ayurveda Sasthri*	5	4	4	10	23
Desiya Chikitsa	9	10	9	10	38
Total	20	20	20	30	90

As shown in the table 01, this study represents a diverse group of traditional practitioners that included Ayurveda practitioners with a Degree or Diploma and Desiya Chikitsa practitioners who obtained their training from his/her family tradition. All degree holders and 75 percent of diploma holders in the study sample have

been integrated into the government healthcare delivery system. All Desiya Chikitsa practitioners and 25 percent of diploma holders provide their service in their own private clinics. All practitioners come under Desiya Chikitsa have been registered either as a specialist or general practitioner. These practitioners play an important role in remote areas where there is a shortage of health care services. However, these categories of practitioners have not been integrated into national healthcare delivery system. Thus, the contributions made by these practitioners were not taken into account in evaluating health outcomes of the country.

All the practitioners who contributed this study accepted that there is a health hazard in contemporary Sri Lanka with rapidly growing NCDs. They also viewed that traditional medical systems have a greater competency to address root causes of the above health hazards. All the practitioners in the sample follow basic principles and philosophy of Ayurveda as a foundation of their practice, though treatment methods and prescriptions are quite different from each other. According to their explanations, basic principles of Ayurveda include five elements of the universe, three humors and seven components of human body. Physical health is maintained when three humors are in a harmonic balance. Ill-health occurs when the three humors become imbalance. Philosophy of Ayurveda guides how to maintain an equilibrium and wellbeing while preventing diseases. Health promotion is the main task of Ayurveda that provides comprehensive guidance for everyday life of people that includes daily routine and appropriate behavior suitable for seasonal variations. It also provides necessary guidance during pregnancy and post-delivery situation to maintain wellbeing of both mother and the child. Ayurveda also has treatment mechanisms to cure ill-health with required behavioral modifications. Thus, the practitioners highlighted the importance of food related behaviour to ensure wellbeing of people. Natural body constitution is made up of three humours-wind, bile and phlegm. The proportion of each component varies according to individual characteristics. Ayurveda has a philosophy to guide maintaining harmonic balance among three humors. The system itself has a capacity to explain appropriate behavior for individuals to suit with his/her body constitutions. Thus, Ayurveda leads towards a comprehensive physical, mental and spiritual wellbeing. Main focus of Ayurveda is not simply to cure diseases but to ensure healthy life of the majority of the society.

The practitioners strongly believe that traditional medical systems that based on Ayurveda philosophy have a greater competency to address root causes of contemporary health hazards in Sri Lanka. They also view that most of the NCDs are preventable if people maintain an appropriate behavior that suitable for particular individual body constitution and seasonal variations according to the guidance of Ayurveda. Thus, they highlighted the fact that Ayurveda is one of the medical systems that predominantly focused on healthy life than diseases though there are mechanisms to address ill-health related issues. However, findings of this study reveal that both government and private traditional practitioners have a very little space to contribute in disease prevention and health promotion as most of them are primarily involved in curative services. 96 percent of practitioners pointed out that the demand for traditional medicine is increasing due to NCDs. The traditional

practitioners have more opportunity to interact with patients but hardly get an opportunity to work in the community to actively engage in health promotion though the systems have sufficient competency to address root causes of NCDs. Thus, the practitioners pointed out that the government is not prepared yet to utilize their services to address local health problems.

The government has introduced a new carder position as Community Medical Officer of Ayurveda (CMOs) into healthcare delivery system with a mandate of disease prevention and health promotion at community levels. They have been appointed at Divisional Secretariat level to work collaboratively with Medical Officer of Health (MOH). The study included 7 CMOs and their experience suggests that they can play a crucial role in disease prevention and health promotion by adopting culture sensitive behavior change communication strategies. As one of the CMOs pointed out

'We need to use simple language in conducting health education for lay people. For an example, we recommend people to eat foods with six tastes that includes sweet, sour, salty, pungent, bitter and astringent by providing examples from locally available food items rather than asking them to eat more fiber, protein or a balance diet. NCD prevention requires a practical and context specific approach. So, Ayurveda has competency for this purpose. It is impossible to prevent NCDs, without this natural health system' (A CMO with five years' experience).

CMOs have involved with various types of preventive programmes in pre-schools, schools, and in the community. They have both positive and negative experience in conducting programmes in collaboration with modern healthcare providers. CMOs pointed out that their involvement is successful when MOH is ready to accommodate them in their programmes. In some places, the MOH provided more opportunities for them to contribute collaborative actions that targeted on NCD prevention. The experience of CMOs suggest that they have actively participated antenatal clinics, well-women clinics, school and pre-school health programmes with the collaboration of MOH and the staff. However, some CMOs mentioned that they face some difficulties in delivering their service as they are not given an opportunity by MOH in the concern areas. They also lack essential infrastructure facilities to implement community level programmes. The narratives further reveal that though traditional medical systems have a greater competency to address issues related to emerging health hazards, the practitioners have very little space in the national healthcare delivery system to contribute their knowledge and experience in disease prevention and health promotion. They are very critique on modern medicine which has no strategies to collaborate with other medical systems that has a capacity to prevent NCDs. Thus, people face some difficulties as there is no formal referral system between the modern and traditional medical systems. The traditional practitioners are quite disappointed as they have not been consulted in national policy formulation process as well as in designing interventions for disease prevention and health promotion. The traditional medical systems have more focus on prevention than curative aspect but the practitioners were not given enough space to contribute their

knowledge and skills in this regard. There is no structure within the health care delivery system of traditional medicine to involve in primary health care activities like in the modern system. As revealed by traditional medical practitioners, there are number of misconceptions with regard to traditional medicine among the modern medical practitioners. This is mainly due to their lack of awareness on traditional medical systems. It is a main challenge in integration of traditional medical practitioners into national health care delivery system that dominated by modern practitioners. Though Health Master plan 2007-16 have been highlighted the importance of integrating traditional practitioners in primary health care delivery system, in practice there are number of challenges in integration of traditional systems with the modern system that dominates national health care delivery system of the country.

The views of traditional practitioners with regard to competency and challenge of traditional medical systems reveal that they have a greater competency to address the root causes of contemporary health hazards that are mainly due to lifestyle and behavior related issues. Thus, their perspective highlighted the fact that traditional medical systems have a greater competency in prevention of many health hazards and managing ill-health related to NCDs. Ayurveda has comprehensive guidance for maintaining bahaviour of individuals that includes *Dina carya* (daily routine) *Ritu carya* (seasonal routine), some restrictions during pregnancy and after child birth. The recommended behavior includes dietary habits, personal hygiene and sanitation, spiritual dimension and strategies to maintain good relationship with others which are extremely important to maintain both physical and mental wellbeing. At the same time, the system has also developed some mechanisms to restore the wellbeing of people who get ill due to various reasons.

As one of the practitioners pointed out 'Ayurveda is not a medical system but a comprehensive healthcare system that focuses predominantly on how to promote wellbeing of healthy people while addressing ill-health related issues'. As another practitioner described in detail, Ayurveda provides a philosophy which has a capability to enhance healthy life of people with appropriate strategies for behavior modification. Such a system is very crucial to address root causes of contemporary health hazards. However, most of the practitioners were critique on the way that the healthcare delivery system operates in Sri Lanka where there is no proper mechanisms to formally integrate these systems with the dominant health care delivery system of the country. Though the traditional systems have a greater capacity to contribute towards prevention of diseases and health promotion, the service of most of the traditional medical practitioners were limited only to providing curative services.

CONCLUSION

This paper examined the competency and challenge of traditional medical systems in Sri Lanka to address emerging health hazards in postcolonial societies in transition. Historical evidence reveals that the country had well-developed traditional medical systems that played a decisive role during pre-colonial and colonial societies in maintaining wellbeing of population. Those systems became gradually marginalized after introduction and expansion of modern medicine. However, the traditional medical systems were not despairing but regaining their importance in contemporary society

where the modern medicine faces a challenge to address root causes of emerging health hazards. Empirical evidence of this study suggests that the traditional medical systems have a greater competency to address issues related to emerging health hazards. Thus, the experience of CMOs in Ayurveda reveals that the traditional medical systems can play an important role as complementary to modern system to prevent NCDs with behavior modification strategies if modern medical practitioners are ready to collaborate. However, the national healthcare delivery system is not yet ready to incorporate traditional systems to contribute in this regard. The evidence reveal that implementing a collaborative approach between the modern and traditional systems will be a challenge as there is a hierarchy between the two systems where modern practitioners continue a hegemonic position in healthcare delivery system of the country. In equal distribution of power and social status between modern and traditional practitioners, lack of mutual understanding, no referral system and miss-conceptions on traditional medical systems are some of the challenges to have an integrated system. There are number of gaps in health policy in Sri Lanka that requires a transformation from curative approach to prevention of diseases and health promotion where traditional practitioners can play a crucial role as they have a holistic approach towards health and ill-health. Policy alterations are also required not only to recognize the important role played by traditional practitioners at grass root but also to have an integrated approach with the collaboration of modern and traditional practitioners from bottom-up approach. Basically, the traditional medical systems have two types of challenges; some of them are inherited to the system itself and other challenges come from the dominant system of modern medicine. Further investigations are required to explore those challenges with necessary policy alterations.

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