

Correspondence

Dismantling the feudal structure of global health by promoting traditional medical knowledge in global health ecosystem

'All things are subject to interpretation. Whichever interpretation prevails at a given time is a function of power and not truth.' This quote by Friedrich Nietzsche reminds us of the role of the power structure in any system. The global health ecosystem is no exception to this phenomenon. The editorial published in *BMJ Global Health* 'The feudal structure of global health and its implications for decolonization' by Vikash Keshri and Soumyadeep Bhaumik,¹ compares feudal structure to the contemporary global health ecology. They also use an apt word *Zamindari* to describe the hierarchical structure. Destruction of traditional knowledge is also cited as a key effect of the hierarchical thinking on the global health environment. This is of some concern *vis-a-vis* the role of traditional knowledge in the public health context. By adopting a restricted, reductionist and monotheistic framework, this stringent hierarchy precludes the entrance of a new knowledge ecosystem.

We advocate the adoption of traditional medical knowledge, such as Ayurveda (the Indian system of medicine), as one of the ways to create an open structure of the global health ecosystem. The greatest obstacle in this process is the lack of acceptance and mainstreaming of traditional medical knowledge in order to retain the predominance of high-income countries in the process of knowledge development. Instead of accepting the broader foundation of traditional knowledge, it categorically disregards it as unscientific. On the contrary, the same ecosystem uses this traditional knowledge to identify novel active molecules for various elements and to reject the world view of these traditional medicine systems on the body, health and illness.² From a traditional medicinal perspective, focus on active components may not be applicable; for instance, ayurveda prescriptions frequently involve holistic yet personalized or therapeutic approaches.³

Traditional medical systems such as Ayurveda and Yoga conceptualize the human and nature interaction differently than western biomedicine. Western medicine's dichotomies are not suitable for integrating these indigenous knowledge systems into the global health ecosystem. To accomplish this, stakeholders from low- and middle-income countries (LMICs) with a rich history of traditional medical knowledge should open themselves to the value of their traditional knowledge. The reductionist evidence-generation techniques of biomedicine may not be always suitable for traditional knowledge systems. Researchers should develop innovative methods to generate data to establish the efficacy of utilizing traditional knowledge systems as a whole.⁴

The governments in LMICs should improve the ease of conducting research by increasing funding and building research capacities to boost local health knowledge systems. The initiative by the Ministry of Ayush (MoA), Government of India is important in this context. The MoA systematically implemented steps to promote the study and use of traditional medicine in India during the Covid-19 pandemic. The ministry formed an Inter-disciplinary AYUSH Research and Development Task Force that facilitated several studies on Ayush interventions. These involved over 150 institutions and investigators from diverse disciplines. This is an important example of integrating ayurvedic medicines into the global health environment.⁵ The stakeholders from LMICs involved in research and development of traditional medicine must build a unified front to expedite efforts to mainstream traditional medical knowledge in the global health ecosystem. It

is a difficult journey filled with ontological, epistemological and linguistic challenges that will require the creation of a new vocabulary to explain the critical and complex world views expressed by various traditional medical systems. Interdisciplinary and inclusive approach is required in order to prevent global health from succumbing to this feudal structure. The real challenge is the mindset. It needs an open mind to transform the global health ecosystem. We need to embrace traditional knowledge systems to end *Zamindari* in the global health ecosystem.

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Satisfaction and reasons for participation in a Covid-19 vaccine clinical trial

We would like to share ideas on the publication 'Evaluation of satisfaction and reasons for participation in a Covid-19 vaccine clinical trial: A single-centre, observational study'.¹ After receiving informed consent, Kudyar *et al.* delivered a validated three-domain questionnaire to individuals who had taken both doses of COVOVAXTM in a phase 3 trial and recorded their binary categorical responses (yes/no).¹ Participants in a Covid-19 vaccination trial in Mumbai were generally satisfied with the care they received, according to Kudyar *et al.*,¹ despite the fact that altruism was not their main motivation for signing up.

In general, public health organizations all around the world continue to struggle with the delivery of vaccines. A person is less likely to have confidence in their community's healthcare system if they have a history of anti-vaccination sentiment. Numerous variables affect vaccination acceptability, and the pattern might alter over time.² The current report by Kudyar *et al.* may reflect the situation at an early stage of the Covid-19 outbreak, when vaccine is still in short supply. As a result, participating in a clinical trial

may be the quickest way to receive vaccination. However, when the situation of vaccination availability changes, the pattern and reasons may change. The public's trust in local public health crisis response will have a major impact on the success of Covid-19 public health activities.³

Conflicts of interest. None

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Authors' reply

We thank Kleebaon *et al.*¹ for their comments on our paper. Uptake of a vaccine and more so in the context of a pandemic is influenced by several factors some of which include age, gender, socioeconomic strata, cost, access, perception of risk of the disease

and hesitancy among others. It was during the alpha wave of the Covid-19 pandemic that we conducted our first Covid vaccine trial on Covishield™ (September 2020 onwards with the adenovirus vector vaccine/Astrazeneca vaccine where technology was transferred to the Serum Institute of India).² Altruism was the primary motivating factor for participants in this trial study (data on file). The next Covid-19 vaccine study that we did was with COVOVAX™ almost a year later (June 2021) wherein we published the reasons for participation addressed in their letter by Kleebaon *et al.* At this time, vaccine availability in India was challenging due to the long waiting period at the public sector and major out-of-pocket expenses for paid vaccines in the private sector. Also, vaccination against Covid-19 had become mandatory by that time for travel and access to public and workplaces. It is no wonder that we identified access to vaccines as the principal reason for participation. Kleebaon *et al.* are right in associating vaccine availability (or lack thereof) with the reasons for participation and enrolment in a clinical trial as a means to gain access to vaccines and protect themselves and their families during the pandemic as we saw with the COVOVAX™ study. As regards the country, approximately 68% have received the full vaccination,³ though there would be variation between states and between age groups and the uptake of the booster remains low. Vaccine hesitancy is a spectrum and something countries around the world grapple with⁴ and each country must find its own unique ways to address this challenge.

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