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南アジア及び太平洋島嶼地域のガバナンスと持続可能な開発

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はじめに

本プロジェクトは、開発途上国における「持続可能な開発」と企業の成長戦略のあり方について、産官学協働のガバナンス構築という観点から研究を行い、その成果をとりまとめたものである。

本プロジェクトの実施にあたっては、国際社会科学研究科において開発問題を研究している3名の若手研究者（カヤスト・ラガブ、ウニクリシュナン・パパナリマヤ、鴻巣玲子）で構成する研究会を設置し、2009年春より海外現地調査を順次実施して調査研究を行った。

本報告書に収録した論文は、いずれも南アジア及び太平洋島嶼地域におけるガバナンスと持続可能な開発について報告者のそれぞれの研究関心にもとづいて執筆されたものである。本報告書が今後のアジア太平洋諸国ガバナンスと企業成長戦略の研究にあたって、多少なりとも貢献することを切に願うものである。

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Governance in Microfinance Institutions in Nepal
Ragab KAYASTHA

Introduction

Nepal is one of the least developed countries in the world having US$ 392.00 GDP per capita income (ADB, 2007). The Nepalese economy is predominantly an agricultural economy. Around 80 percent of the population lives in the rural area of the country engaging in the agricultural sector. GDP growth of Agricultural sector is 1.0 percent (ADB, 2007). Although more than 80% of the population involve in agricultural sector, the growth rate is comparatively low. By the end of Tenth Plan, about 31 percent of the population was found to be living below the poverty line which was 42 percent before the Ninth Plan (Sigdel 2007).

Nepal has been witnessing planned development efforts since the last more than five decades. The objectives envisaged in most of the plans aim at reducing poverty. However, the intensity of poverty in the country calls for massive and genuine efforts. Microfinance is one of the effective tools for poverty reduction. The microfinance sector in Nepal has expanded considerably in recent years.

The earliest initiatives for establishing microfinance services in Nepal can be dated back to the 1950s when the first credit cooperatives were established and primarily intended to provide credit to the agricultural sector (Sinha 2001). The establishment of Small Farmer Development Program (SFDP)\(^1\) implemented by the Agriculture Development Bank (ADBN) in 1975, and Intensive Banking Program (IBP) implemented by two national level commercial banks (CBs) and one joint-venture private commercial bank in 1974 are the distinguished development of microfinance in early stage. Moreover, from 1990s was more effective period as the establishment of Grameen Bikas Banks (GBBs), Microfinance Development Banks (MFDBs), Financial Intermediary Non-government Organizations (FINGOs), and Savings and Credit Co-operatives (SCCs).

Generally, the microfinance institutions (MFIs) in Nepal can be divided into two types: i) Community Based MFIs, such as SCCs and SFCLs; ii) Commercial Oriented MFIs, such as MFDBs, GBBs, FINGOs, etc. So there are several modalities of MFIs in Nepal. There are several factors which affect the sustainability of Microfinance Institutions (MFIs). Governance is one of them. The objective of this paper is to discuss theoretically how the

\(^1\) SFDP has been transferred to local community under the Cooperative Act,1991 and converted into Small Farmer Cooperative Limited (SFCL)
microfinance governance looks like and give the practical insight of the governance in Nepal.

Review of Relevant Literatures

Microfinance Governance
Governance is the process by which a board of directors, through management, guides an institution in fulfilling its corporate mission and protects the institution’s assets over time (Rock, et al. 1998). A board of directors is established to provide oversight and give direction to the managers of an institution. The board carries out this function on behalf of a third party, referred to as shareholders in the case of for commercial oriented corporation. But, there are no owners in non-profit corporations, third party is not easily identified and had been defined to include the corporation's clients, staff, board and donors (Rock, et al. 1998).

In the microfinance field, governance has assumed increasing importance for several reasons. First, as microfinance institutions (MFIs) grow in their outreach, the size of their assets, as reflected in their portfolio, also grows to considerable size. Ensuring effective management of this growth requires added input and involvement by a board. Additionally, increasing numbers of MFIs are becoming regulated and assuming the responsibilities and challenges of a regulated entity. Capturing deposits from savers and investors is perhaps their most important challenge and requires the greatest oversight. Finally, MFIs are operating in increasingly competitive markets, and maintaining or increasing market share has become an important component of their strategic objective (Rock, et al. 1998).

Types of Boards
There are some types of boards and conditions exist to achieve effective governance (Rock, et al. 1998). Not all types of boards will have the same level of involvement in operation of the institution. For a successful microfinance bank, there is one clearly preferred board structure. Those structures are:

i. The Rubber-Stamp Board that only reacts to and supports management;

ii. The Hands-on Board that engages directly in operations taking on some of management’s role;

iii. The Representational Board made up of highly influential individuals with access to sources of power and funds;

iv. Multi-Type Board that balances representational members with microfinance expertise, and are generally better equipped to make informed decisions on a timely
and efficient basis. This is the recommended board structure for a good MFI wishing to convert and be regulated.

**Relationship between Board and Management**

Board and management deal with the same issues, but at different levels. The board deals with policies while management deals with practical implementation. The relationship between the board and management is defined by partnership, particularly between the board chair and managing director (Rock, *et al.* 1998). This partnership must be based on mutual support, trust and respect forged them. Overall, the Board governs management. A good microfinance institution boards understands its role and responsibilities, and maintains a clear separation with management of the organization, if it cannot effectively assess management’s performance, the role of oversight suffers.

Effective governance requires boards to focus on three major areas of responsibility: i) management accountability, ii) strategic planning and policy-making, and iii) self-regulation.

**Analysis and Interpretation**

Microfinance in Nepal is governed by Banks and Financial Institutions Act 2006 (BAFIA). BAFIA has classified the financial institutions into four groups, in which the financial institutions providing microfinance service are located in Type D. As governance concerns, BAFIA states following features (Mathema 2008):

- Expedient to amend and consolidate forthwith the current legislation relating to banks and financial institutions and thus make it suitable to the times in order to promote the trust of the public in the overall banking and financial systems of the country.
- Protect and promote the rights and interests of depositors.
- Provide reliable and quality banking and financial intermediary services to the public through healthy competitions among banks and financial institutions.
- Minimize risks relating to the banking and financial sectors.
- Liberalize the banking and financial sectors and further boost and consolidate the economy of the country.
- Make necessary legal provisions relating to the establishment, operation, management and regulation of banks and financial institutions.

For the establishment of banks and financial institutions, the concerned person must apply for registration in Nepal Rastra Bank (NRB) under Company Act (2005), with all the documents as specified in the BAFIA for prior approval as public limited company according
to current law. There are 15 MFDBs under this Act.

In addition, there are Co-operative Act (1992) and Financial Intermediary Societies Act (1998) for governing SCCs, SFCLs and FINGOs respectively.

Later in 2007, Government of Nepal (GON) promulgated Microfinance Policy (2007) with the slogan of sustainable microfinance service to the poor and make easy to access to them.

**Key Findings and Conclusions**

The legal procedure of MFIs in Nepal is quite complicated. Even BAFIA has distinguished the MFIs as Type D, the legal framework is divers. As client’s point of view, it is bit confusing for getting microfinance services because of the various legal procedures. It may cause difficulty in sustainability of microfinance services and institutions.

In Nepal, the legal framework of microfinance is bit strange. Generally, there should be need of microfinance policy to make act, rules and directive related to microfinance. But, several acts have made before the establishment of Microfinance Policy (2007). It is quite interesting.

Government of Nepal (GON) has made commitment about the policy of poverty reduction and promotion of microfinance in paper, but lack in the practice.

Sometimes Government arbitrarily announced the policy considering the poor people i.e. exemption of loan, which affect the management system of MFIs.

**Recommendations**

It is necessary to have good microfinance governance, but also it need good governance to guide the appropriate operating environment for the MFIs.

Effective governance strikes the appropriate balance in the relationship between a board of directors and management in their combined efforts to move the institution forward. Moreover, a clear articulation of the function of microfinance boards is essential for their effective governance.
References

Health System Development and Medical Pluralism in Kerala State in India

Unnikrishnan Payyappallimana

Introduction
India has taken an inclusive, pluralistic view towards traditional medicine (TRM) although health system integration is still in an ambiguous situation. However, within the country Kerala State represents a special model for such integration. This model is unique even in the international healthcare development context. This State has a high level of medical pluralism consisting of both formal and informal traditional medical systems, with several unique characteristics. Kerala has a high social and political patronage for TRM. While studies on high health status of the state suggest a relation between the health status and cultural traditions in the state, this relation has not been studied adequately. The relationship between various medical systems and inter-cultural issues related to medical pluralism in Kerala also remain unexplored.

This article attempts to describe the evolution of medical pluralism in Kerala and its relation to high health status with a focus on the inter-cultural medical issues at various levels of social organisation. In doing so, it seeks to examine how an integrated approach can be a factor to achieve public health objectives. The article describes the historical path of health system, as well as TRM development, features of health pluralism in both India and Kerala. By identifying specific areas of traditional medical culture in Kerala, and challenges, it explores the contribution of such practices to the high health status in the State. It then tries to identify the role of and priority areas in strengthening TRM in order to develop strategies for replicating this appropriately in areas of need especially in developing countries.

Kerala State and the Development Enigma
Kerala state was formed in 1959 by merging two regions in southern India called Malabar (part of former Madras state) and Travancore-Cochin. The present land area of Kerala is 38,863 km² which forms 1.18% of India and has a population of 31.8 million (Govt. of India, 2001 census). It is one of the most densely populated states in the country. Kerala has always caught the attention of social scientists due to its paradoxical high human development at a per capita GDP that is below the national average, which is often cited as Kerala phenomenon or Kerala Model development. Kerala’s GDP has improved after 1990 and it stands above the national average today.
The state has a literacy rate of 96.9% and it is one of the least corrupt states in India as per the reports of Transparency International (2005). Kerala has typically alternated its government every five years between two major political parties—the Communist (Left Democratic Front) and Congress (United Democratic Front).

By 19th century different regions of Kerala progressed in social sector development and by mid 20th century it was on a development trajectory. The state is often praised for its good public distribution system, high political awareness, social engagement, extensive primary health care facilities, high literacy, successful land reforms, high public participation in political process, strong labor unions and gender equity. These have also been indicated as the reasons for high health status in the state by several researchers (Ramachandran 1997).

Kerala’s culture is mainly Dravidian in origin, deriving from a greater Tamil-heritage state known as Tamil nadu. Later, the dominant culture underwent some changes through centuries of contact with overseas cultures. Malayalam became a distinct local language in 11th century. The coast runs 580 km, bound by the Arabian Sea to the west. Historically from the BCE period, Kerala has had trade relationships with Middle East countries, Europe, China and East Asian countries with many developed ports in the region. Interactions with foreign cultures resulted in the development of an eclectic culture since historical times in the region.

**Health System Development in Kerala**

Kerala coast has been known as a land of medicines and spices for many centuries and has a long history of a well nurtured health system. John Fryer, a British traveler to India between 1672-1681 mentions about the veterinary hospitals in Tanur, South of Kozhikode highlighting the then system of public physicians (Wujastyk 2005).

In early 19th century the dawn of modern medicine in Kerala began in Travancore region (one of the three regions of present Kerala) with the patronage of the royal family. Though the services remained available only to the elite sections in the beginning, soon the region progressed in an enviable way compared to other regions in India. By 1813 small pox vaccination was introduced in the region and a separate department of public health was formed in 1865, yet it was actively promoted among the public only in 1879 when a public proclamation was made making vaccination compulsory for public servants, prisoners and students (Ramankutty 2000). In 1837 a charitable clinic with a resident
physician was started which was subsequently developed into the general hospital (which is today 150 years old). Around the same period a missionary clinic was also started in Neyyur. In 1888 a separate hospital was started for women. In 1885 there were 31 medical centres in the region which slowly grew and by 1939 became 32 government hospitals and 55 clinics in addition to 21 private hospitals. In the same period a public health laboratory was also set up. Health awareness programs focused on conditions such as hookworm infestation, malaria, cholera, smallpox, tuberculosis, leprosy, plague, filariasis, venereal diseases, hygiene, nutrition and mother and child health. By the 1880s sanitation works were also initiated in the region. The cholera and smallpox epidemics in the region in 1890 gave further impetus to the public health programs and also became the basis for certain legislations. Civil registration system was also started shortly (Vinayachandran 2001).

In Cochin (Kochi) region too a charitable clinic was started in 1818 but did not continue for long. By the 1880s dispensaries were started in many places of present Kerala. By 1890 sanitation works were also initiated in Kochi. Though vaccination had started in 1803 in Kochi, the program became active only after 1893 following a series of epidemics. In Malabar the health facilities were underdeveloped and the first government hospital was started in 1845. But from 1800 there were quarantine measures in the port areas for preventing plague and other epidemics. By 1920 many small towns in the region had hospitals run by the government. In 1944 Travancore Medical Practitioners Act was passed which regulated qualifications to practice medicine, which later was merged as Travancore-Cochin Act in 1953. Medical associations in Malabar (1934), Cochin (1938)

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1 In 1928, parasite surveys were conducted in Travancore which led to measures to control hookworm and filariasis patronized by Travancore government and supported by Rockefeller foundation. A health unit incorporating many of the concepts of primary health care was also started with both preventive and curative focus. Another major development was the introduction of mission hospitals promoted by Christian churches. Young Christian girls increasingly took up nursing career (Ramankutty 2000).

2 In 1728, a hospice in Pallippurum for treating patients with major illnesses was started. Even prior to this there was also one in Castella, Kochi. But when the region was transferred to the British by the Dutch these did not get sufficient support.

3 According to Vinayachandran (2001) in Kochi region hospitals were started in Nenmara (1882), Chittoor (1885), Irinjalakkuda and Kunnamkulam (1888), Vadakkancheri (1891), Chalakkudy (1893), Nelliampathy (1893), Njarakkal (1907), Payyannur (1908), and Mattachery (1909). In Malabar Calicut, Kannanur, Ponnani, Manjeri, Mananthavadi were some of the towns with hospitals. There were special centres for women, children, leprosy or mental patients and so on.
and Travancore (1940) also came into existence all of which got merged in 1957. Following the formation of Kerala state, health service department came into existence. Super specialty hospitals like Sri Chitra medical centre, Regional Cancer Centre were started in the 1970s.

In 1956 when the Kerala state was formed a well developed health care infrastructure was already in place and in 1957 there were 277 hospitals and 9473 beds in the state and with steady progress the state achieved the target of 1 bed for 1000 people in 1971. In a survey conducted in 1948 considerable progress was found to have been made in reducing malaria and filariasis and Kerala became the first state in India to eradicate malaria by 1965. While the health service progressed well, Kerala was lagging behind in the field of medical education as the first medical college was opened only in 1950 till which period the students were educated in other states.

Although the governments alternated between two major political parties, both consistently supported health sector in major way and in 1980s health care expenditure formed around 13 % of the fiscal spending. From 1960 to 1990 period the government health infrastructure further grew and reached 36000 beds in 1986 (Ramankutty 2000).

Table 1. Medical Institutions, Beds and Patients Treated under Three Systems of Medicine in Kerala’s Public Sector during 2006 and 2007

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2006</td>
<td>2007</td>
<td>In patients</td>
<td>Out patients</td>
</tr>
<tr>
<td>1</td>
<td>Allopathy*</td>
<td>1279</td>
<td>1279</td>
<td>45405</td>
<td>45553</td>
<td>23.3</td>
</tr>
<tr>
<td>2</td>
<td>Ayurveda</td>
<td>871</td>
<td>871</td>
<td>3940</td>
<td>4020</td>
<td>0.57</td>
</tr>
<tr>
<td>3</td>
<td>Homeopathy</td>
<td>561</td>
<td>561</td>
<td>1170</td>
<td>1170</td>
<td>0.21</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2711</td>
<td>2711</td>
<td>50515</td>
<td>50743</td>
<td>23.78</td>
</tr>
</tbody>
</table>


Today Kerala has extensive, functional healthcare facilities both of Allopathic medicine and TRM. By 2004, the infrastructural development in the state corresponded with the United States and other developed regions with around 33 beds per 10,000 population.
Japan, Germany, UK are some of the countries which have a higher bed-population ratio. Even though there was a marginal reduction of number of modern medicine hospitals between 1986 and 2004 the bed-population ratio improved due to several new inpatient care units under the traditional medical systems, especially Ayurveda (Dilip, 2008:13). It is also worth noting that the presence of health insurance in Kerala is marginal.

**Table 2. Private Sector Institutions and Beds**

<table>
<thead>
<tr>
<th>System of Medicine</th>
<th>Institutions</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopathy</td>
<td>4825</td>
<td>57071</td>
</tr>
<tr>
<td>Ayurveda</td>
<td>4332</td>
<td>5502</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>3226</td>
<td>813</td>
</tr>
<tr>
<td>Total</td>
<td>15094</td>
<td>114129</td>
</tr>
</tbody>
</table>

Source: Economic Review 2007, Govt. of Kerala

The above table shows the government data on private sector. However a different study of private medical institutions (both inpatient and outpatient together) in Kerala shows that they constituted 34% Allopathy, 39% Ayurveda and 24.7% Homeopathy institutions. The presence of other systems such as Unani and Siddha are marginal. However the inpatient facilities of modern medicine far outnumber other systems as Ayurveda and homeopathy institutions are mostly dispensaries and clinics (Sankar 2001). Also in terms of the number of staff, the TRM hospitals are much smaller compared to allopathic medicine.

**Table 3. Number of Medical colleges and intake of students for undergraduate courses per year**

<table>
<thead>
<tr>
<th>System of Medicine</th>
<th>Number</th>
<th>Intake of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopathy</td>
<td>13</td>
<td>1600</td>
</tr>
<tr>
<td>Dental course</td>
<td>9</td>
<td>460</td>
</tr>
<tr>
<td>Ayurveda</td>
<td>14</td>
<td>680</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>5</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>2990</td>
</tr>
</tbody>
</table>

Source: Economic Review 2007, Govt. of Kerala
An Overview of the Health Status in Kerala

Over the years the health status of Kerala’s population has seen considerable improvement and now is at par with some of the developed countries despite slow economic growth and low per capita income. Kerala State accomplished social development with a per capita gross national product of US$275/person/year (in 1996). For the same period, the national average was US$350 for India, and US$23,090 in developed countries in 1996 which was the period when the health indicators reached the current phase\(^4\). Some of the prominent indicators of its development include high life expectancy, low infant mortality and low maternal mortality rate. Following are some of health indicators of Kerala along with figures for India, USA and Japan.

### Table 4. Health Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Kerala</th>
<th>India</th>
<th>USA</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita GDP (US$)*</td>
<td>930</td>
<td>740</td>
<td>46,716</td>
<td>34,099</td>
</tr>
<tr>
<td>Human Development Index</td>
<td>.773</td>
<td>.612</td>
<td>.956</td>
<td>.960</td>
</tr>
<tr>
<td>Crude Death Rate</td>
<td>6.8</td>
<td>7.5</td>
<td>8.3</td>
<td>9.26</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>13</td>
<td>57</td>
<td>7</td>
<td>2.8</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>110</td>
<td>301</td>
<td>8</td>
<td>7.3</td>
</tr>
<tr>
<td>Crude Birth Rate</td>
<td>14.7</td>
<td>23.5</td>
<td>14</td>
<td>7.87</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>74.6</td>
<td>63.9</td>
<td>79.1</td>
<td>82.7</td>
</tr>
<tr>
<td>Life Expectancy –Male</td>
<td>71.3</td>
<td>62</td>
<td>76.7</td>
<td>79</td>
</tr>
<tr>
<td>Life Expectancy –Female</td>
<td>76.3</td>
<td>64.9</td>
<td>81.3</td>
<td>86.2</td>
</tr>
</tbody>
</table>


The life expectancy has consistently improved from 1910-20 as per records when it was 25.5 for male and 27.4 for female (Ramachandran 1997: 225) to reach 71.3 (male) and 76.3 years (female) within the last one century. Infant mortality has also improved drastically over the period. Despite these indicators, Kerala has high morbidity as well as health care spending. Researchers have argued that this is a statistical artifact. Others argue that morbidity perception is high (Kumar 1993). Thus it remains a matter of ongoing inquiry.

Reasons Stated for High Health Status

Large number of studies on Kerala’s health status have indicated that a highly developed health care infrastructure, access and affordability, increased health awareness among population and hygienic practices, control of many infectious conditions, decentralization of health services with good efficiency are some of the direct contributory reasons and an efficient public distribution system, high literacy and education, land reforms, gender equity (with matrilineal traditions), increased purchase power due to overseas remittances are some of the indirect reasons for high health status (Krishnan 1976 & 1989, Ratcliffe 1978, Panikkar & Soman 1984, Nag 1985, Halstead et al. 1985, Caldwell 1986, Kannan et al. 1991, Kabir & Krishnan 1992, Dreze & Sen 1995, Panikkar 1999, Kunhikannan & Aravindan 2000, Nabae 2003).

Several studies remark on the amazing achievements of the state in the past and attribute it to social sector development that happened in 1940s and 50s (Ramachadran 1997). According to Amartya Sen a prioritized planning in social services like health and education has contributed immensely to Kerala health status (Sen 1998). Some studies have compared similar societies across the world and compared the reasons. Caldwell (1986) compared Sri Lanka, Costa Rica and Kerala where achievements have been made at low cost with respect of low mortality. He indicates how the social and political will have transformed the region. He also mentions several peculiarities in these regions such as female autonomy, high inputs to health and education, accessibility and efficiency, nutrition, universal immunization, antenatal and post natal care etc.

Gunatilleke compared five countries/ regions such as Kerala state (India), Jamaica, Norway, Sri Lanka and Thailand and points to the intersectoral factors that have influenced developments. He also indicates the role of rich tradition in such development.

But most studies except for few (Gunatilleke 1984, Abraham Leena 1989, Shankar 2001) have not critically looked at the role of a rich traditional medical culture and pluralistic health system in the state.

Traditional Medical Culture & Historical Developments

Historical Developments

Historically the development of medical traditions in Kerala can be classified into three periods. 1. A period prior to the arrival of classical Sanskrit Ayurvedic literature
and tradition in Kerala. After their arrival. Modern period (Varier 2002). While
many peculiarities can be observed in the local traditions relating to such a period,
there are no sufficient historical studies about the first period. Historians speculate
that the mainstream literature made prominent influences between 5th and 7th century
AD. It is also opined that much before this, Buddhists and Jain travelers and monks
brought classical Ayurveda to Kerala who constructed nursing homes in the region
adjacent to their monasteries. The present institutionalized Ayurveda tradition in
Kerala owes its foundation to Vagbhata’s Ashtanga hridaya, a renowned text on
Ayurveda. While it may be seem perfunctory to attribute Ayurveda in Kerala merely to
the ashta vaidya tradition or any other community tradition, the Ashta vaidya and
the Ezhava family traditions have had enormous influence in shaping its current
form. Several texts and commentaries have been written on diverse aspects of
medicine between 7th and 18th century in Kerala.

Several anecdotes and documentations are available on the rich medical tradition in
the state. Maro Polo, a world traveler who visited Kerala in 1300 AD describes about
the rich medical tradition, healers, and medicinal materials on the coast. The first
modern medico botanical documentation of the region was by Henric Van Rheede who
codified the native traditions into a famous text in Latin called Hortus Malabaricus
which was compiled and published between 1674-1703 AD.

5 Caraka samhitam and Susruta samhita are the two prominent Sanskrit texts of Ayurveda
from around 300 BC and 200 BC on medicine and surgery respectively. The medical
tradition in Kerala has many unique aspects such as several local medicinal formulations,
treatment of poisons, psychiatric traditions, martial arts and vital points (marma), oil
treatments, elephant treatments, a rich folk tradition etc., not found in such classical
Ayurveda literature.
7 Ashta vaidyas are several healer namboodiri families in Kerala who have had training in
eight branches or Ayurveda. Few of the prominent today are Pulamanthole, Alathiyoor,
Kuttanchery, Thaikkattu (both Thrissur and Elayidathu), Chirattaman, Vayaskara,
Valloke, Alathiyoor and Vaidyamadhom.
9 See Varier 2002.
10 Hortus Malabaricus (meaning Garden of Malabar) is a comprehensive treatise that
deals with the medicinal properties of the flora in the Indian state of Kerala in 1676. The
book was conceived by Hendrik van Rheede, who was the Governor of the Dutch
administration in Kochi (formerly Cochin) at the time. Van Rheede was also assisted by the
King of Cochin and the ruling Zamorin of Calicut. Prominent among the Indian
contributors were Itty Achudan, Ranga Bhat, Vinayak Bhat and Appu Bhat. The
ethnomedical information was extracted from palm leaf manuscripts by a famous healer
named Itty Achudan. See also: http://en.wikipedia.org/wiki/Hortus_Malabaricus
**Developments in Modern Period**

In 19th and 20th century indigenous medicine, especially Ayurveda, was financially supported by the state even when Kerala was divided into three royal kingdoms. Due to its large presence and acceptability among masses, Travancore state supported Ayurveda which was the first impetus to development and increase in access to TRM in Kerala along with all other socio economic development processes. During this period there was a general decline of the indigenous traditions and mass industrial production and the state support gave thrust to its development (Panikkar 1994). Prior to this period, Ayurveda medicines were produced by vaidyas and dispensed to their patients. But around late 19th century, ideas of industrial production came into the field as the institutionalization of education and health care service of indigenous medicine began. The students who were trained in traditional methods were brought into this fold of new thinking. The first school of Ayurveda was started in Thiruvananthapuram in 1886 which was taken over by the government. Subsequently a department of indigenous medicine was opened. A grant in aid program was started in 1895 by the Travancore government for appointing successful practitioners trained in this college at Taluka level clinics under strict scrutiny (Harilal 2008). These physicians were also mandated to keep all the records related to the clinical and administrative matters. In 1868 an Ayurveda physician was appointed in the civil hospital mainly to investigate the efficacy of Ayurveda drugs and for incorporating them in efficacious drugs list (Vinayachandran 2001). The state support for Ayurveda was comparable to or was more progressive than European medicine during this period. Civil society groups and professional associations were also active in promoting TRM, since the early 20th century.

In the Malabar area, Arya Vaidya Samajam was a consortium of prominent physicians. P.S.Varier who was a prominent member started Kottakkal Arya Vaidya Sala, a renowned pharmaceutical industry in the country, in 1902 which was the harbinger of pharmaceutical production of medicines and more importantly, the current popular version of Ayurveda in Kerala. He also started at the same time, an Ayurveda college with an integrated curriculum in the region. A journal and regular conferences were also initiated by P.S.Varier who was amply supported by the local rulers. Two strategies were used by Varier for popularizing medicines, one introducing the agency concept in many towns, and secondly, bringing new formulations during epidemics (Harilal 2008). Kerala Ayurveda Samajam was also a similar initiative in middle Kerala which started a school in 1946. There was no state support for indigenous medicines in this region. At the same time several dispensaries were started by the physicians who came out of this school as well as by the
ashtavaidyas mainly in Cochin and Malabar region with small home level medicine production facilities. As there was a general improvement in the sector several ezhava and velan (two ethnic communities) healers also became widely known for their practice around the same time. Though some studies suggest that this created cultural hegemony of Ayurveda in Kerala (Panikkar 1994), the overall development of the sector seems to have nurtured other TRM systems and cultural knowledge as well. During the early period Ayurveda remained as an elitist system accessible to only certain sections of the society owing to strong caste practices in the state. It may be presupposed that this necessitated other support systems for a large section of population which might have been a reason that the diversity of other cultural medical knowledges remained intact in the state.

From the period of formation, the state has consistently had supportive policies for TRM. Several Ayurveda schools with diploma programs and subsequently with bachelor and masters programs were started. Regular production innovations were also introduced. The increased production facilities made Ayurvedic medicines easily available, accessible in Kerala which also resulted in increased awareness and demand. It was also cheaper compared to western medicine. At the same time regular epidemics, lack of enough western doctors and medicines also gave an impetus for increased use of TRMs.

Thus the development of traditional medical cultures in the state has been steady and incorporating most of the native cultural aspects in the last one century. It should also be noted that while there are small incidences of confrontation between western medicine and native medical traditions, largely the development has been pluralistic with both state as well as civil society support. In such a process TRM in the state has been able to retain a significant part of its holistic philosophy to health care.

Salient Features of a Unique Health Culture
There are several bio-geo-cultural factors that have nurtured traditional medical knowledge and contributed to the health situation in the State. It has four major physio-geographic zones and the land area is classified into four zones such as coastal, plains, midland and highland. There are 40 rivers (Ramachandran 1997: 208, 209) with each having rich cultural traditions along its course. A study conducted about healthy regions in India by an East India company surgeon John Clerk found Malabar (in present Kerala) to be temperate and healthy. Similarly several other colonial administrators have opined that the region is pleasant and fertile with the air even in summer months being conducive to health. The region's population is praised for
having immunity to many endemic diseases (Harrison, 1994: 38)

Marco Polo, a world traveler who visited Kerala in 13th century was amazed by the cleanliness and bathing habits of even the poorest in the state. The hygienic practice was reiterated in a national study by Aiyappan (1965) that Kerala state has a high standard of cleanliness compared to other regions in the country. Gunatilleke (1984) says that the high standard of cleanliness maintained in a Kerala household even when housing conditions are poor is worth mentioning.

Biodiversity – The Western Ghats which covers the entire eastern region of Kerala is one of the world’s biodiversity hot spots. Forested land covers 10,292 sq. km, including 1887 sq. km of private forests (Forest Survey of India, 1993) and houses a rich medicinal flora (around 1800 species) and fauna thus providing a highly conducive environment for TRMs. High presence of sacred groves and related healing traditions also make the region unique.

Home gardens · Homestead gardens in Kerala is a well documented topic. A 14th century traveler Shaikh Ibn Batuta says “we came to the country of Malabar which is the country of black pepper. Its length is a journey of two months along the shore from Sindapur to Kawlam. The whole of the way by land lies under the shade of trees….and in all this space of two months’ journey there is not a span free from cultivation. For everybody has there a garden and his house is placed in the middle of it; and around the whole of this there is a fence of wood, upto which the ground of each inhabitant comes”.

A study conducted in a central district of Kerala found that home gardens house up to around 153 species with an average number of 36 plants in such gardens. Home herbal gardens in South India have demonstrated that many simple primary health care problems like fever, upper respiratory tract infections, gastro-intestinal problems such as diarrhea, dysentery, worm infestations, hepatitis, anaemia, arthritic conditions, and certain

11 The forests in Kerala are classified as southern tropical wet evergreen and semi-evergreen, southern tropical moist deciduous, southern tropical dry deciduous, montane sub tropical, and forest plantations.
Gynecological conditions can be managed at household level through simple herbal home remedies and early identification and interventions. Reproductive health and nutrition forms two important aspects of household care. Considerable health cost saving has been found through this program apart from health and nutrition benefits (Hariramamurthi et al. 2007).

Certain unique physical characteristics of Kerala population are also worth mentioning. The calorie and nutritional intake in Kerala is less than the national average with the exception of calcium. Even with such low calorie diet the state has been prominent in athletics, martial arts, other physical activities which by itself a topic worthy of further study. While this quite perplexing in comparison with other states where intake is more than recommended and scientists suggests that the nutrients are better utilized in the state (Soman 1992). This warrants serious study about the food culture of Kerala.

Highly Evolved Folk Tradition – Kerala has highly evolved folk medical systems (Rajagopalan 2009, Unnikrishnan 2009). In the folk traditions, each community group is specialized in a particular form of healing viz. Velan, Ganakan or Kaniyan in pediatric care, Mannan, Kuruppu in massage techniques, vital points and so on. There are several health related rituals, customs that have been documented and still followed by Kerala communities. There are several temples such as Thiruvizha, Thakazhi, Chottanikkara that offer ritual medicines or oils to patients especially with psychiatric conditions or other physical ailments.

Diverse tribal health practices belonging to around 36 tribal communities in the state have been studied (Nair 2008). The Government of Kerala has set up the Kerala Institute for Research, Training and Development Studies of Tribals which is doing laudable work in reviving the tribal healing practices of the state. Through this work a significant part of tribal medicine is still alive. In terms of utilization, in a comparison of data on usage of indigenous health practices between 1987 and 1997, a 10% reduction in utilization of such practices was observed (Kunhikannan and Aravindan 2000: 31). This reduction may be owing to the strong influence that institutionalized systems such as Ayurveda or modern medicine may be exerting on the folk medicine.

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15 These are various ethnic communities in Kerala.
Traditionally a large section of Kerala society was matriarchial which has been stated as a major reason for development of women and low infant mortality rate. At the same time one can presuppose that this has also had a high positive impact on traditional knowledge of various sectors including health, nutrition, agriculture which is held by women.

Intersectoral linkages of such development are also a point worth mentioning. Gunatilleke in his study (1984) says that in Kerala modernity and tradition are interacting in very complex ways. An important point is that the state has been pluralistic in most areas be it religion, political ideologies or health care. Sen (1999) also points that such a progressive and dialectic situation in most sectors has been conducive to the state’s development.

The influence of a vibrant traditional culture which influences seasonal health care practices, nutritional practices has also not been adequately studied. Conversely, literature generally tends to portray such knowledge systems as an impediment to progress.

**Specific Aspects of Traditional Medicine and Cultural Knowledge and Contributions to High Health Status**

A World Health Organization supported study on Inter-sectoral Linkages and Health Development (Gunatilleke 1984) has compared five countries such as Kerala state (India), Jamaica, Norway, Sri Lanka and Thailand. The study says “The interaction of tradition and modernity in the field of health in developing countries manifests itself in very diverse forms as is shown in the five case studies. It is, therefore, dangerous to form generalised conclusions. Nevertheless, those responsible for health policies have to be fully sensitive to this type of problem.” By citing Kerala, he says, “perhaps more than any other society included in the study, Kerala state provides an illuminating example of the complex way in which modernity can interact in the case of health. A highly developed system of indigenous medicine remains popular to this day and has acquired a reputation in certain branches of medicine, which extends throughout India and to countries abroad. Such a system although it may in some respects have run counter to the western medical system, promoted attitudes to healthcare, diet, personal hygiene, and sanitation conducive to the acceptance of more modern
approaches. Other cultural elements such as the practice of yoga, which perceives health as a total system – physical, emotional, mental, and spiritual – and prescribes elaborate procedures for achieving total well being, influenced the concerns for health.”

Gunatilleke points that, “The elements of traditional culture have therefore combined in Kerala state, in a manner quite different from the ways in which similar elements have interacted in most other traditional communities of India. Again as in Kerala state, traditional knowledge, and attitudes and practices regarding health, derived from indigenous system of healthcare, promoted an intelligent awareness and concern in regard to health, and in many ways created a receptive environment for the acceptance of the modern healthcare system. This is illustrated by the fact that both the indigenous and the western systems of healthcare continue in parallel, and a large part of the population makes use of both systems selectively for different ailments and diseases”.

He also says “…new health problems associated with the lifestyles of affluent societies are emerging in both Kerala state and Sri Lanka as a result of the cultural dislocations and the changes in lifestyles and values.” This is corroborated by findings from other studies that identified that the per capita expenditure on health reduced with traditional lifestyle (Suneetha 1998).

Based on this argument, using a descriptive approach, the following section of the paper attempts to highlight the contributions of TRMs to high health status. The representative examples are related to public health, preventive, curative and promotive health care. Apart from this, the section also looks at how the health care infrastructure has enabled equal access to different systems of medicine. One of the major problems in establishing a relationship between traditional medical systems and high health status is the quantitative data inadequacy in the TRM sector on such aspects.

1. **Traditional Medical Health Services**

A large portion of Health infrastructure in the state is contributed by traditional medical systems viz. number of hospitals, dispensaries, physicians, colleges, industries, products and so on. However most developments in TRM has taken place in private sector.
1.1 Healthcare Infrastructure in Government Sector for Traditional medicine

There is wide presence of traditional medical hospitals and dispensaries in the state (Table 3). Traditional government hospitals were under utilized due to poor infrastructure, lack of medicines and competent health personnel and such TRM centres had low image. But today with increasing public financing and integration of such centres in the national rural health mission programs they are better utilized. With such huge numbers the contribution to high health status by such machinery has completely been ignored in current scientific literature.

1.2 Health care Infrastructure in Private Sector for Traditional medicine

A high percentage of TRM hospitals are in private sector (See table 4). Most of these hospitals are panchakarma17 centres which attract patients both from within the state and outside. Today these centres form major part of tourism promotion in the state and is a big revenue generator. There are comprehensive accreditation systems for these centres based on the facilities available.

1.3 Education

There are 14 Ayurveda colleges in the state of which three are directly managed by government, two are aided by the government and nine are in private sector. An annual intake of students for undergraduate courses is 890 (see table 5). There are also today masters and doctoral programs in four colleges. Pharmacy courses and panchakarma therapists/nurses courses are also becoming popular and available in most of these institutions. Following the training most physicians undertake their internship with any of the above centres or traditionally qualified physicians and thus there is a harnessing of institutional education along with traditional orientation which make them unique practitioners in the country. There are also 5 homeopathy colleges with intake of 250 undergraduate and 18 post graduate students.

17 Panchakarma is a major treatment method in Ayurveda and the word literally means five actions or techniques viz. vamana (induced vomiting/emesis), virechana (purgation), kashaya vasti and sneha vasti (two kinds of medicated enemas with decoction and unctuous material), nasya (nasal medication) and raktamoksha (blood letting). A major therapeutic use of panchakarma is purification (sodhana) of the body, though it is also widely used for pacifying and rejuvenating purposes (Unnikrishnan 2000 Amruth, FRLHT, Bangalore).
1.4 Research
Though there are few dedicated research facilities for TRM such as the Panchakarma Institute, Shornur and the Regional Research Institute, Thiruvananthapuram, there are many research centres conducting studies on TRMs. Tropical Botanical Garden and Research Institute, Regional research laboratory, Regional Cancer Centre, Rajiv Gandhi Centre for Biotechnology, (all four in Thiruvananthapuram), Aromatic and Medicinal Plants Research Institute, Kochi, Kerala Institute for Research Training and Development Studies of Tribals, Kozhikkode, Kerala Forest Research Institute, Amala Cancer Research Centre, Kerala Agriculture University (all in Thrissur), Centre for Medicinal Plant Research, Kottakkal, Pappinisseri Poison Treatment Centre are some of the institutes studying Ayurveda, medicinal plants and other natural medicines. Some of above centres are also doing specific research studies on homeopathy.

There are some academic and clinical research programs attached to the Ayurveda colleges as well apart from some manuscript research centres in the state. Some other research programs are attached to pharmaceutical industries and are in mostly private sector, but mainly focused on drug development. Indian Institute of Diabetes (IID) and Ayurveda Sports medicine research initiative bring hope for new programs in the field of TRM research. However such research programs are not centrally coordinated or guided for state’s priorities. Research and documentation still remains a less focused area in TRM development in the state.

1.5 Pharmaceutical Industries
The following data shows the growth of a largest government owned Ayurveda company in India, which is indicative for the industry. Available data also indicates that Ayurveda and homeopathy industries have grown at a compound growth rate of 12% and 26% respectively.
Table 7. Medicine Sales of OUSHADHI\textsuperscript{18}, Government of Kerala (In million rupees)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Sales &amp; Growth Percentage</th>
<th>For Government Hospitals, clinics</th>
<th>Private Outlet Sales</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-01</td>
<td>108.28</td>
<td>27.19</td>
<td>81.09</td>
</tr>
<tr>
<td>2001-02</td>
<td>104.59 (-3.40)</td>
<td>24.38</td>
<td>80.21</td>
</tr>
<tr>
<td>2002-03</td>
<td>117.57 (12.41)</td>
<td>29.45</td>
<td>88.12</td>
</tr>
<tr>
<td>2003-04</td>
<td>130.46 (10.96)</td>
<td>39.36</td>
<td>91.1</td>
</tr>
<tr>
<td>2004-05</td>
<td>142.53 (9.25)</td>
<td>45.80</td>
<td>96.73</td>
</tr>
<tr>
<td>2005-06</td>
<td>193.38 (35.68)</td>
<td>72.01</td>
<td>121.37</td>
</tr>
<tr>
<td>2006-07</td>
<td>220.00 (13.77)</td>
<td>70.15</td>
<td>149.85</td>
</tr>
<tr>
<td>2007-08</td>
<td>253.73 (15.33)</td>
<td>72.81</td>
<td>180.92</td>
</tr>
<tr>
<td>2008-09</td>
<td>323.41 (27.46)</td>
<td>68.29</td>
<td>255.12</td>
</tr>
</tbody>
</table>

Source: Economic Review 2009, Govt. of Kerala (adapted)

Table 8. Production of Homeopathic Medicines (Govt. of Kerala) in Value (in millions rupees)

<table>
<thead>
<tr>
<th>Year</th>
<th>Production Value &amp; Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2003-04</td>
</tr>
<tr>
<td>2</td>
<td>2004-05</td>
</tr>
<tr>
<td>3</td>
<td>2005-06</td>
</tr>
<tr>
<td>4</td>
<td>2006-07</td>
</tr>
<tr>
<td>5</td>
<td>2007-08</td>
</tr>
<tr>
<td>6</td>
<td>2008-09</td>
</tr>
</tbody>
</table>


\textsuperscript{18} See Economic Review 2009 (Govt. of Kerala) - The institution originally established as Sree Kerala Varma Ayurvedic Pharmacy in 1941 by His Highness the Maharaja of Cochin was for taking care of the Royal family, and for supplying medicines to Govt. Ayurvedic Hospitals. In 1959, this unit was converted and registered as Co-operative Pharmacy & Stores Limited, Thrissur. On 8th September 1975, this was incorporated under the Companies Act, 1956 and was renamed as The Pharmaceutical Corporation (Indian Medicines) Kerala Limited, Thrissur. Now OUSHADHI is the largest manufacturer of Ayurvedic medicines all over India in Government sector functioning especially as a profit making public sector undertaking.
It can be understood that even though the number of major industries are low, the industry has a steady growth. More than 200 Ayurvedic drug firms in Kerala have GMP certification and many have ISO 9001: 2000 quality certification. Most Ayurveda industries follow an approach of agencies in small towns for distribution of their medicines and it is estimated that there are over 50000 such outlets across the state (Suneetha 1998).

1.6 Budget Support

Table 9. Annual Plan Outlay and Expenditure on Medical and Public Health During Eleventh Five Year Plan (In millions rupees)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Allopathy – Health Services</td>
<td>5768.7</td>
</tr>
<tr>
<td>2</td>
<td>Medical Education</td>
<td>2175</td>
</tr>
<tr>
<td>3</td>
<td>Ayurveda</td>
<td>165</td>
</tr>
<tr>
<td>4</td>
<td>Ayurveda Medical Education</td>
<td>460</td>
</tr>
<tr>
<td>5</td>
<td>Homeopathy</td>
<td>88.2</td>
</tr>
<tr>
<td>6</td>
<td>Homeo Medical Education</td>
<td>160</td>
</tr>
</tbody>
</table>

Source: Eleventh Five Year Plan, Economic Review, 2008, Govt. of Kerala (Adapted)

Kerala is the major supporter of TRM among Indian states. However the proportion of support within the health budget of around 9.4% does not justify the high development that has taken place in the TRM sector.

1.7 Cost of Medicine-System Wise

Table 10. Medical Expenses per Person per Episode by System 1987 and 1996

<table>
<thead>
<tr>
<th>System</th>
<th>1987</th>
<th>1996</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modern Medicine (Allopathy)</td>
<td>20.72</td>
<td>197.19</td>
<td>852</td>
</tr>
<tr>
<td>Ayurveda</td>
<td>10.80</td>
<td>98.97</td>
<td>816</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>7.47</td>
<td>66.44</td>
<td>789</td>
</tr>
<tr>
<td>Other</td>
<td>Not available</td>
<td>45.57</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Kunhikannan & Aravindan, 2000: 35
According to this study Ayurveda and homeopathy continues to be far cheaper compared to modern medicine\textsuperscript{19}. However the percentage of increase in price across the years is almost comparable among systems. This indicates that TRM continues to be cost effective.

2. Disease Based Health Seeking Behaviour

Health seeking behaviour in Kerala is peculiar, given a highly pluralistic health system. Unlike other regions or countries TRM in the state is sought for its inherent strengths and not due to inaccessibility or high cost of modern medicine. Disease based health seeking behaviour indicates a clear understanding of strengths and weaknesses of each of the systems of medicines among the population. Cross referrals across physicians of various medical systems is a unique feature unlike in many other societies.

There are a number of estimations on the extent of services provided by traditional medical systems. According to a Kerala Sastra Sahitya Parishat\textsuperscript{20} study (Kunhikannan and Aravindan 2000: 26), 21% of the population seek healthcare through alternative forms of medicines. Around 9% of the population surveyed is reported to have resorted to self treatment in the above study which may not have been reflected in the extent of population seeking alternative therapies. It is worth mentioning that self care through home remedies is still popular in the State. According to the authors, cost of care, emergence of new diseases such as congestive heart disorder, diabetes, cancer may be prompting people to seek alternatives given that TRM has better management in such conditions. Thus Ayurveda and Homeopathy enjoy high level of confidence among people for specific illnesses. Based on a government of Kerala survey around 40% of health care is serviced by traditional medical systems such as Ayurveda and Homeopathy (Government of Kerala 1996). Yet another study indicates that the 30% service is rendered by TRMs (Sankar 2001).

Utilization of TRMs for chronic ailments is significantly higher compared to acute treatment, where the preference is for allopathy. Health seeking behaviour is also

\textsuperscript{19} Though in the recent past there has been high increase of cost of Ayurvedic medicines.

\textsuperscript{20} Kerala Science and Literary Society (KSSP) is an organization which has been highly influential in many environmental movements, science popularization and awareness creation in Kerala.
specific to age groups. For instance in paediatric conditions homeopathy is highly preferred compared to other systems while the elderly use much more of ayurveda care. It is also noted that patients with pains and aches approach more traditional systems in comparison (Sankar 2001). Sankar notes that the chance of using TRM increase with improved access and short distance for travel. Education has a positive correlation for usage of homeopathy and ayurveda in respective order. The study clearly indicates the preference for Ayurveda both in rural and urban areas.

A study by Pillai says that there is rural-urban and gender difference in preferred choice of systems (Pillai et al. 2003: 788). The study considers utilization of health services as an indicator of TRMs contribution to health system. Since there is no whole state wise data pluralist health seeking specific sample study data is taken here to highlight the issue.

One important feature noted in this health seeking is that the choice is not made in a hierarchical way but at the same level and TRM is used not as an alternative. Disease, service quality, age and gender, cost or accessibility have relatively less impact on system preference.

3. Traditional Pharmacopoeia
TRM approach to health care is based on the premise that for a person living in a particular place, local medicinal, dietary resources and approaches are most useful. It also says that even if one is living outside one's native place home grown materials will be most suited.21 Such a philosophy is literally integrated into the TRM development in Kerala. The usage of a special local resource based pharmacopoeia22 and treatment

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21 A famous verse on this philosophy in Ayurveda goes like this “Yasya dose to yo jatah tasya tadhitam ausadham, desenyatrapि vasato tattullya guna janma ca”.
22 Sahasrayoga, chikitsamanjari, Chikitsanool, Vaidyamanorama, Dhara kalpam, Chikitsakramam, Sindooramanjari, Alathiyoor Manipravalam, Yogaratnaprakasika, Vaidyamanjari, Sannipata cikitsa, Netrarogacikitsa, Yogamritam, Yogasaram, Vaidyamanjari, poison treatment literature such as Jyotsnika, Prayogasamuccayam, Sarvagarala pramocana, pediatic treatment literature such as Arogyaraksakalpadrumam, Arogyacintamani, Garbharksakrama, Vaidyajivana, eye treatment literature such as Netra cikitsa, orthopedic texts like Marm Darpanam, veterinary texts like Matangalila are some of the most prominent vernacular texts of Ayurveda.
approach which is prevalent among the healers of Kerala and the native traditions of poison treatment, paediatrics, martial art related therapeutics, temple related traditions of psychiatric treatments reveal that even before arrival of organized Ayurveda in Kerala there was a well evolved local health system (Varier 2002: 482).

Several locally available medicinal plants, different formulations (ilaneer kuzhambu, ilaneer preparations etc), various classical texts, diverse treatment methods (dhara, thalam, thalapothichil, navarakizhi etc) all make the local tradition quite unique. Based on such a comprehensive and sophisticated method, a local pharmacopoeia has also evolved. The majority of formulations produced by the industries across the state are based on this pharmacopoeia and using local resources. The relationship between morbidity patterns in the state and this pharmacopoeia is yet to be studied well.

4. Drinking Water and Hygienic Practices
Water related diseases form up to 80% of public health problems in India. Despite the formulation of a National Water Policy (1987) focused on improving drinking water access the situation has not changed substantially. According to an all-India survey on conditions of drinking water, sanitation and hygiene prevailing (carried out as part of the 54th round of the National Sample Survey Organization, 1999, Government of India), Kerala is one of the states which has the lowest access to potable drinking water viz. rural - 12% and urban - 40.4%. In 2001, the figures were 16.9% (rural) and 42.8% (urban) respectively (Economic survey of the Government of India (2008-2009)). A large percentage of households use drinking water from own water source such as open wells (Kunhikannan & Aravindan 2000: 11). Such water sources are considered susceptible to contamination as the state has latrines that are made with septic tanks (26% rural, 48% urban) and pour flush pit (29.3% rural, 25.5% urban) which is highest in India.

23 Several formulations used today in Kerala is not found in the classical literature of Ayurveda, a typical example is the several coconut based formulations (Varier 2000).
26 However this view that susceptibility of water contamination is high in the state might be contested.
Water borne vector diseases like dengue fever, malaria, chikungunya are on the rise due to urbanization and deteriorating environmental conditions and perception of increase in mosquito population is reported high in Kerala in the National Sample Survey. However, the state has substantially controlled diseases such as cholera, other diarrhoeal diseases, hepatitis and other waterborne diseases that spread through consumption of water (Kunhikannan & Aravindan 2000:14,Ekbal 2006).

Kerala has developed some natural adaptations to an environment filled with water bodies and high prevalence of water borne diseases. It is reported that the state has highest percentage of households boiling drinking water with rural - 49.3% and urban- 65.3%. The hygienic handling of water is also high in the state (NSSO 1999).

This practice is highly related to the historical culture of Kerala in consuming medicated boiled water. This cultural knowledge has continued as a popular social practice even in the context of modernization. Nag Moni (1989) in a comparative study of Kerala and Bengal remarks that “Kerala tradition of drinking water that has been boiled with cumin seeds (jeerampani) and the water remaining after rice has been boiled (kanji) may have contributed toward lower morbidity and mortality.”

Such prescriptions have several references in classical as well as vernacular Ayurvedic literature especially in sections on seasonal routines to be followed for maintaining health. This tradition has its roots in the regional Ayurvedic text books like Sahasrayoga, Chikitsa manjari which recommends enhancing water quality by boiling it with medicinal plants such as ginger, cumin seeds, Acacia catechu, coriander, Caesalpinia, Vetiveria among several others. There are two likely benefits of this practice. One is the palpable and well studied benefit of boiled water and the second being the unresearched, physiological and clinical benefits of medicinal substances that goes into treating such water. According to ayurvedic understanding most systemic diseases are caused by faulty metabolic processes and drinking water has a strong effect on mitigating such effects both in states of health and illness. Based on this specific preparations are made for specific illnesses.

There are several herbal products for water treatment available today in the market

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and the sales of such products are showing increasing trends. Though it is a marketed commodity today, most households also continue to use home made materials for boiling water. Since it shows an evident positive correspondence to the TRM prescription, this is an area worth further study. Several studies have been carried out on the physiological and therapeutic benefits of using green tea today. Similarly research on the culture of medicated drinking water needs to also be pursued.

5. **Daily and Seasonal Preventive Care**

There are several cultural practices in the state which are assumed to have direct implication on health though they may not have been studied systematically. Few of them are *Karkitaka kanji* (a medicated porridge used in June-July month), *karkitaka* special treatments, daily oil application on the body and head, seasonal foods, various fermented, probiotic foods, health related rituals, etc. While there are cogent explanation from Ayurveda for such practices, they may not be well explained from a

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29. The Malayalam month of *Karkitaka* (June-July month) is time for preventive therapies as per Ayurveda as during this month there is disease proneness and the immunity is low. Historically this period is utilized for preventive treatments and rejuvenation therapies.

30. S. Parvez, K.A. Malik, S. Ah Kang and H.-Y. Kim 2006. Probiotics and their fermented food products are beneficial for health. *Journal of Applied Microbiolog*, Volume 100, Issue 6, Pages 1171 – 1185. Most probiotics fall into the group of organisms' known as lactic acid-producing bacteria and are normally consumed in the form of yogurt, fermented milks or other fermented foods. Some of the beneficial effect of lactic acid bacteria consumption include: (i) improving intestinal tract health; (ii) enhancing the immune system, synthesizing and enhancing the bioavailability of nutrients; (iii) reducing symptoms of lactose intolerance, decreasing the prevalence of allergy in susceptible individuals; and (iv) reducing risk of certain cancers. The mechanisms by which probiotics exert their effects are largely unknown, but may involve modifying gut pH, antagonizing pathogens through production of antimicrobial compounds, competing for pathogen binding and receptor sites as well as for available nutrients and growth factors, stimulating immunomodulatory cells, and producing lactase. Selection criteria, efficacy, food and supplement sources and safety issues around probiotics are reviewed. Recent scientific investigation has supported the important role of probiotics as a part of a healthy diet for human as well as for animals and may be an avenue to provide a safe, cost effective, and 'natural' approach that adds a barrier against microbial infection.
modern approach owing to epistemological divergences.

Today there are considerable changes in such practices and their consequent effects, which needs to be studied. It needs to also be checked if the high morbidity is related to such changes. However the counter argument may be that Kerala has high morbidity since last few decades coinciding with changing lifestyles. In a similar case Todoriki et al. (2004) point out how life expectancy has reduced among Japanese population in Okinawa due to increased fat intake during the American occupation period between year 1945 and 1972.

6. Care of Chronic disorders

Today Kerala is going through a demographic transition and about 4.48 million persons in Kerala are reported to have one or more of the eight chronic diseases such as diabetes, cardio-vascular conditions, arthritis, cholesterol, hypertension, asthma and bronchitis, cancer and kidney diseases, apart from 1.78 million suffering from non-specified chronic diseases (Zachariah et.al 2003). High incidence of chronic diseases is generally observed in elderly and within them, women. At present there is concern if the public health system can service the needs of such an ageing population (Sureshkumar & Rajagopal 1996; Bollini et al. 2004).

According to Sankar (2001), Ayurveda is most sought after for treatment of chronic disorders. Ayurveda has unique methods such as panchakarma which have proven to be beneficial for such chronic conditions. While there is inadequate data on their clinical efficacy, such treatments are being utilized increasingly by the population in the state.

Few Emerging Challenges

General Health Sector Challenges

Though the state has accomplished a high health status, high morbidity, increase in healthcare costs, ineffective health support systems for poor population, neglect and under-utilization of primary health centres, deteriorating quality of health services; health conditions such as anaemia, low birth weight, occupational diseases, ageing related problems, vector borne diseases such as chikungunya, dengue; issues of environmental sanitation, inadequacy of drinking water, traffic accidents (trauma care), increasing suicides, high alcohol consumption are some of the partially
addressed challenges in health sector (Ekbal 2006).

Kerala has the highest public and private out-of-pocket expenditure of all Indian states (World Bank 2001). Privatization of health care is an important issue (Ramankutty 2000, Levesque et al. 2005) with around 60% approaching private hospitals for inpatient treatments (Varatharajan et al. 2002). Among outpatient care seekers, 77% depend on private facilities due to reasons such as choice, dissatisfaction with public facilities and problems of access and higher availability and better quality care by private providers. Non-availability of drugs and equipments is one of the reasons for under utilization of public services (Narayana 2001). Another area that merits a closer study is the trend in increasing marketization and rising cost of medicine in Kerala (Caroline Wilson 2009).

One of the paradoxes about health in the state is that despite the high health indices, there is high morbidity. Often it is mentioned that it is due to high awareness and resultant morbidity reporting. Earlier morbidity patterns were similar to less developed states in India and it was attributed to low nutritional intake in the states. But today some of common conditions reported are a mix of affluence and poverty and an ageing population (Kunhikannan & Aravindan 2000, Michael and Singh, 2003) The Human Development Report of NCEAR (India: Human Development Report, NCEAR, 2000) shows that Kerala is second in the country followed by Andhra Pradesh in the prevalence of major diseases. A comparison of morbidity load indicates that high morbidity rates of major diseases in Kerala requires interventions from secondary level institutes (Kunhikannan & Aravindan 2000: 12, 19). It capacity of the public health infrastructure to cope with the emerging needs of the population is a matter of concern (Sureshkumar & Rajagopal 1996, Bollini et al. 2004, Levesque et al. 2007, Narayana 2008).

**Challenges of TRM sector**

In such a situation, TRM has an increasing role to play as some of the modern sector also result in increasing care seeking through other methods. However TRM is also facing several challenges today. Increasing production and commercialization have led to questions about availability of raw drugs and quality of medicines. Since a large portion of medicinal plants are still collected from the wild, there is serious concern of sustainability. At the same time though the industry has grown manifold over the

31 Emerging needs of aging population in Kerala, UN report 1992.
years, production efficiency is low as technological innovations have been low.

A related issue is the limited existence of research programs in the sector. Pharmaceutical research is mostly confined to drug research while neglecting other aspects such as production efficiency, conservation, agrotechnology and so on. Sociological as well as clinical studies on specific health issues are also sparse. There are moves in the State to establish a new medical university that would bring various medical faculties under the same umbrella, which fosters hope that there will more prioritization and coordination for research. Inadequate clinical documentation subsumes most public health success stories in the state by TRM. For example during the chikungunya epidemic of 2007-2009 Ayurveda, homeopathy and other medical knowledge were actively sought by patients although such experiences have not been compiled and studied rigorously, and are largely confined to anecdotal literature.

While there are no detailed studies on health seeking behaviour through Ayurveda or homeopathy primary health centres, the ayurveda centres continue to be known as ‘decoction hospital’ approached by elderly population for buying oils for aches and other degenerative problems, thus confining the image to a section of population. This has resulted in neglect of public infrastructure.

A macro perception about such public health issues and strategies to respond to increasing population demands is clearly lacking in the Ayurveda fraternity. For instance there is no comprehensive vision on how to service the needs of an ageing population in the state when Ayurveda is the most sought after system by such users. Changing cultural traditions and dietary habits, increasing alcoholism are also few other challenges where Ayurveda needs to be alert.

There is a growing discord between different TRM streams. As Panikkar (1994) notes growth of Ayurveda has created a cultural hegemony in TRM field in Kerala and many cultural traditions have got subsumed into such a development. This has created unwarranted debates between non-institutionally trained physicians who continue to practice, with the institutionally qualified physicians in the state, given the dynamic interactions that the different classical and folk systems have had historically. Sustaining the folk practices therefore also needs to be given high priority.
Conclusion
The contention of the article has been that from the late 18th century there have been certain socio-political changes that have contributed to Kerala’s development. This also gave a strong impetus to the revival of traditional medical knowledge in the state. Through this process the inequities that existed in access to traditional medical knowledge diminished and traditional knowledge and products started becoming widely available across population through institutionalization. This in turn has had a strong impact on the health system development in the state. The objective of this paper was not to show that TRM has been the sole contributor, but to show how development of a pluralistic health culture has widened the choice and how it has influenced health seeking and improved health status. A important point to note is that, while there are arguments that TRM is generally accessed when there is lack of availability of modern health care, increase in cost etc., health seeking and choice of systems in Kerala is not made in a hierarchical way but with clear identification of strength and weaknesses by the population.

Several studies have shown that both in chronic diseases and elderly care the preferred choice of care is traditional medical systems. Given the rapid demographic change in Kerala and related morbidity, much more support should be provided for TRM especially ayurveda in the area. Alienation of folk knowledge and increasing pharmaceuticalization are issues to be tackled for sustaining a healthy system. Research inputs to the sector needs to be improved and there is a need to establish a coordinated vision with both public and private sector as partners for responding to the newly emerging needs of the population.

While the specific contributions made by traditional medical systems and their volume may be contested and is a matter of future study. Also the nuances of how such a pluralistic health culture has been in place in Kerala require further in-depth enquiry. However Kerala provides a good case for developing countries to learn from for a sustainable health system development as well as improving health status at low cost.

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太平洋島嶼地域におけるガバナンス研究 ～その背景と関心の対象～

鴻巣玲子

1 はじめに

本レポートでは、私の研究関心分野である太平洋島嶼地域における開発を取り巻く諸問題の検討と、特にガバナンスについての研究を進めていくにあたり、まず、どのような課題を整理していくべきか、また、その背景にあるこの地域の文化的、政治経済的な特性をどのような形で研究に反映させていくべきか、主に既存の研究とその指摘内容を中心に整理していくこととする。

まず、研究対象地域である太平洋島嶼地域についてであるが、オセアニア地域に分類される地域のうち、先進国であるオーストラリア、ニュージーランドを除いた島嶼部の国及び地域を対象とする。したがって、研究を行っていく上で、この地域の呼称は地域も含め、「太平洋島嶼地域」を使用したい。なお、これに対応する英語表記は、「Pacific Islands」、「South Pacific Islands」、「Pacific」等となるが、必ずしも呼称が統一されているわけではない。

この地域は、通常メラネシア、ポリネシア、ミクロネシアの3つの地域の分類されており、現在、独立国、自由連合国、海外領土など、いくつかの形態に分類できる22の政治単位があるが、うち国家として独立しているのは12カ国である。なお、太平洋島嶼地域は、天然資源に恵まれ人口670万人を越えるパプア・ニューギニアを例外として、概して人口規模は小さく、国土も狭小である。世界銀行の所得分布では、域内の国家ではフィジー、パラオが最も高い所得分布となっているほかは、いずれも所得水準は低く、独立国はいずれも発展途上国として位置付けられている（表1）。

2 太平洋島嶼地域が抱える開発上の諸問題

太平洋島嶼地域における国や地域の社会構造や経済構造は実際のところ国ごとに大きく異なり、資源国であるパプア・ニューギニアや工業開発が進んでいるフィジーのような比較的規模の大きい国と、人口1万人に満たないツバルなどの国・地域を単純に比較することはできない。しかしながら、この地域の地理的・社会的な条件を背景に、開発を考える上で無視できない島嶼地域に共通したハードルとして、以下の5つの点を主にあげることができる。

1 一般的にポリネシア国家としてトンガ、サモア、ツバル、メラネシア国家としてパプア・ニューギニア、バヌアツ、ソロモン、両者の混合国家としてフィジー、ミクロネシア国家としてキリバス、マーシャル、ミクロネシア、パラオ、ナウルに分類される。なお、独立国ではないがニュージーランドと自由連合の関係にあるクック諸島やニウエ等が一地域として取り扱われるが、仏領ポリネシア、ニューカレドニアなどの海外領土も含まれる。

2 地域全体の人口は約984万人、うちメラネシア地域が約863万人、ミクロネシア地域が約55万人、ポリネシア地域が約66万人となっている（http://www.spc.int/prism/, 2010, May, 30）。
第1に、この地域の国々が抱える地理的な条件があげられる。代表的なものは、拡散性（国土が広大な地域に散らばっている）、狭隘性（国内市場が小さい）、遠隔性（国際市場から地理的に遠い）などの国土開発を行うにあたっての所与的地理条件の厳しさである（外務省2008：945）。例えばミクロネシアのキリバスは、国土面積は730k㎡、人口は10万人弱の東西に広がる環礁島で構成される国である一方、そのEEZの面積（約355万k㎡）は世界第3位の広さを持つ、広大な海洋国家である。国内での交通や物資の運搬、各種行政施策の実施、インフラの整備などに様々な障害が伴うことは避けられない。また、メラネシアの国であるパプア・ニューギニアは800以上の言語を持つ多言語国家であり、世界で最も断片的な（fragmented）国家である（Reilly2004：480）。地理的条件に加え、民族的な観点も考慮すれば、単一民族・言語で構成される同質的なポリネシアの国と比較し、メラネシアの国々における開発に伴う諸条件はさらに厳しいと言うことができる。

表1：太平洋島嶼国の所得グループの分布

<table>
<thead>
<tr>
<th>Economy</th>
<th>Income group*</th>
<th>Lending category**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiji</td>
<td>Upper middle income</td>
<td>IBRD</td>
</tr>
<tr>
<td>Kiribati</td>
<td>Lower middle income</td>
<td>IDA</td>
</tr>
<tr>
<td>Marshall Islands</td>
<td>Lower middle income</td>
<td>IBRD</td>
</tr>
<tr>
<td>Micronesia, Fed. Sts.</td>
<td>Lower middle income</td>
<td>IBRD</td>
</tr>
<tr>
<td>Palau</td>
<td>Upper middle income</td>
<td>IBRD</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>Lower middle income</td>
<td>Blend</td>
</tr>
<tr>
<td>Samoa</td>
<td>Lower middle income</td>
<td>IDA</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>Lower middle income</td>
<td>IDA</td>
</tr>
<tr>
<td>Tonga</td>
<td>Lower middle income</td>
<td>IDA</td>
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<tr>
<td>Vanuatu</td>
<td>Lower middle income</td>
<td>IDA</td>
</tr>
</tbody>
</table>

*lower middle income, $976–3,855; upper middle income, $3,856–11,905
**IDA countries are those that had a per capita income in 2008 of less than $1,135 and lack the financial ability to borrow from IBRD. IDA loans are deeply concessional—interest-free loans and grants for programs aimed at boosting economic growth and improving living conditions. IBRD loans are noncessional. Blend countries are eligible for IDA loans because of their low per capita incomes but are also eligible for IBRD loans because they are financially creditworthy.

なお、ここにはナウル、ツバルについては計上されていない

第2に、これらの地域の産業構造が、農業・漁業中心の1次産業依存型経済であること、また、そのために自然災害や国際価格の変動といった外的要因に対して脆弱であることがあげられる。歴史的には、植民地時代から商品作物であるコブラや砂糖きびの生産が行われてきているが、作付面積も小さく、機械集約的な生産方法ではないことに加え、その多くは旧宗主国への輸出割当などによりかろうじて外貨獲得産業として成立していることか
ら、基本的に第1次産業の国際的競争力は極めて低い。近年ではトンガのカボチャの日本への輸出などの成功事例もあるが、天候や市場価格に大きく左右され、経済のけん引となるほどのものにはなっていない。

第3に、第1、第2の特徴からも言えることであるが、伝統的に自給自足（subsistence）経済であり農業・漁業を中心とした生活様式がいまだ主要な地位を占める島嶼地域では、概して民間部門の発達が遅れており、相対的に公的セクターによる経済活動が主要な位置を占めている。人口2万人弱のクック諸島では、1990年代にニュージーランドとアジア開発銀行による行政改革が実行される前は、全人口の18％が公的セクターに雇用されており、公的支出はGDPの86％を占めていた（Larmour 1996:8）。このように小規模島嶼国で主要産業がない国・地域では、伝統的土地所有制度の存在や法制度の未整備等により、自由な企業活動が阻害されている。

第4に、いずれの国々も独立後歴史が浅く（その多くは1970年以降に独立）、国家の発展に必要な人材育成が遅れているという実態がある。オーストラリア政府やニュージーランド政府による奨学金を得て高等教育を受けた専門の人材が、より安定した生活や自国より高い給与を求め、海外へ移住することによる頭脳流出（Brain Drain）現象も無視できない。

そして第5に、科学的未だ解明できていない部分は多いものの、気候変動による海面上昇や温暖化などの影響によるマラリアなどの熱帯地域に特有の感染症の拡大、サイクロノンや津波などによる自然災害の被害などの脅威があげられる。地球規模の環境問題の顕在化によって、小さな環礁で形成されている島嶼地域では、国の存続やアイデンティティーそのものが脅かされていると言える。

このように、全世界における人口規模や面積規模からは極めて小さな割合を占めるにすぎない太平洋島嶼国地域ではあるが、この地域が抱える開発上の問題は、他の地域の発展途上国にも共通のものであるとともに、当該地域の研究を行っていくにあたって無視できない地域固有の課題であることを十分に認識しておく必要がある。

このような開発上の課題を抱える南太平洋島嶼地域に対し、ドナー国や国際機関が行っている開発援助額は決して小さくないが、その開発援助の実効性はどのようなものなのだろか。また、援助の効率性を高める上で、この地域の文化や政治的・経済的特性をどのように考慮していくべきなのだろうか。

3 太平洋島嶼地域の経済構造の特徴

ここでは、太平洋島嶼地域における開発を考察するにあたって、この地域の経済特性を端的に表すものとして、特に小規模島嶼国の経済的特性をもとに構築された MIRAB モデ

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3 フィジーにおける米国への衣類品輸出や EU への砂糖輸出などの事例があげられる。
MIRAB とは、Migration（移民）、Remittances（送金）、Aid（援助）、Bureaucracy（官僚制）の頭文字をとった造語である。MIRAB 経済とは、太平洋島嶼地域の小規模島嶼国に特有の上記 4 つの単語で象徴されるような経済的特性、すなわち、経常収支移転による受け入れ（送金、配当、利子所得、社会保障による収入、政府補助金等と海外からの政府開発援助）と非貿易財である公的サービス（通常政府によって独占されているため、官僚制という用語を用いている）が、世界銀行が推進する輸出産業の発展と民間投資が牽引する経済成長モデルに代わり、島嶼国の経済成長の先導的機能を果たしているという経済構造を示している（Betram 1999:105）。この研究の目的は、1980 年代当時のドナー国や国際機関が対南太平洋島嶼地域に対する援助の背景としていた考え方、すなわち、島嶼国独自の自然な資源配分のパターンではなく、東南アジアの経済発展やその背景にある古典派経済学者の理論から移転された経済成長モデルを導入するといった当時の援助理論に対し、島嶼地域の特性を背景とする経済モデルを提示することであった。5

ここでは開発にかかる経済理論を論ずるものではないが、MIRAB モデルの研究が紹介されて 20 年以上たった現在でも、ポリネシアの国やミクロネシアの国などでは依然としてこのモデルが適用できる。例えばトンガは、人口約 10 万人のポリネシア地域の国であるが、国内居住人口より多くの国民が海外に移住していると言われており、海外送金は 2008 年の時点で GNI の約 36%を占めている。6 1980 年代にはこの割合が 20%前後を推移していた状況を考慮すると、島嶼国、特に小規模島嶼国の構造経済特性には基本的には大きな構造変化がここ 20 年生じてこなかったか、むしろ構造が固定化してきていると考えられる。海外からの自国民による送金と開発援助が恒常的に資金として流入し、それに支えられて一定の経済成長が安定的に確保される限りは、MIRAB 型経済構造に依拠するシステムが、いわば国家公認のシステムとして機能することとなる。6

5 また、MIRAB モデルでは、これらの地域の経済行動を把握するためにミクロの経済主体もマクロ経済に組み込むべきだとして、この地域における家族や親族関係（kinship）を中心とした経済活動の特殊性にも焦点をあてている。この「kinship」は、島嶼国においては伝統的に資源配分や意思決定にも影響を及ぼす要素である。


7 ポリネシア地域において MIRAB は経済を安定させ紛争を予防するための国家戦略であるという意見もある（ Ware 2005:445）。
財政援助を含む開発援助を行ってきているという事実も否定できない。MIRAB 型経済構造における島嶼国、経済と開発政策は、援助など外部からの資金流入によって歪み、主権的な国家としての自律的な戦略性や成長の機会を奪われているのではないか。特に小規模島嶼国では、外部からの資金流入と他律的な経済成長とが自立的な国家運営を長期間で阻害するという、MIRAB の馬とでも言うべき状況に陥っているとも考えられる。ドナーなど外部からのコンディショナリティの下、選択肢の幅がなくなる状況に陥るまで、構造調整は先延ばしされ、その結果、国家の主権が脅かされるとの主張は、現実味を増している（Macpherson and Macpherson 1998:75）。ここに、開発と援助の背景にある、この地域のガバナンスの現状を検討する必要性が求められてくるのである。

4 太平洋島嶼地域における開発とガバナンス

太平洋島嶼地域における開発を検討する際、そもそもガバナンスの問題をどのように扱うべきであろうか。また、その意味は、南太平洋島嶼地域ではどのように受け止められておるであろうか。

世界銀行は、ガバナンスを、「一国において経済的・社会的資源が開発に向け管理・運営される際に行使される権力の手法（manner）」と規定し、その対象分野を、公共管理部門の管理・運営、アカウンタビリティ、開発のための法制度、そして情報と透明性と定義した（World Bank 1992:3）。アジア開発銀行も、世界銀行によるガバナンスの定義を引用した上で、民間セクターにもその対象を広げ、広義ではガバナンスを「市民が市市民間及び政府のエージェンシーと相互に作用するする組織的環境のこと」であると位置付け、グッドガバナンスの基本的要素を、行政の応答性（アカウンタビリティ）、市民による参加、法の支配による予測可能性、情報の透明性の4つに分類している（ADB 1997:9）。また、OECD はガバナンスを、「問題、主体及び環境の変化に直面しつつ、公共の決定がなされる方法と公共の行動がなされる方式を、一国の憲法上の価値を維持するという観点から決定する公式・非公式の枠組みをさす。」（OECD 2006:26）としているが、また同時にガバナンスは現在進行中の作業であり、そのアイデア自体が常に流動的であるとしている（OECD 2006:26）。したがって、その定義は決して限定的ではなく、また、実務的には主体ごとにその対象分野が異なってくるであろう。しかし、少なくともドナー国や国際援助機関が援助の有効性を確保するため、「グッドガバナンス」を援助のコンディショナリティとして被援助国に対して課し、政策の改革を求めていっているのが、現在の開発援助における潮流であると言える（小池 2001:30）。

8 オーストラリア国立大学名誉教授 Helen Hughes は、上院外務・国防・貿易関連委員会への提出書において、大洋洲へのオーストラリアの援助の有効性に疑問を呈し、全ての援助を一度中止すべきとしているが、一方政府学では、「オーストラリアでの教育がすでに大洋洲の家族が求める移民への第1歩である、そしてオーストラリアへの移住は島嶼地域への送金を増額し、貯蓄と技能を生み出し、島国へ戻って事業を始めることにつながる」と MIRAB 構造を前提として主張を行っている（Hughes 2002:3）。

9 ガバナンスについての理論的な考察、その変容等については別稿にて検討する。
太平洋島嶼地域における援助国側及び被供与国側におけるガバナンス概念の捉え方についても、その定義付けに相違はなく、経済成長におけるガバナンスの必要性について広く認識されている。例えば、オーストラリアの援助機関であるAusAID は、ガバナンスが成長への重要な要素（Key Driver）であり、また同様に、成長は国連MDGs へ向けた前進のための要素であるとし、ガバナンスと経済発展の間にある程度の相関関係を認めている（AusAID 2009:37-38）。また、域内の国際機関である太平洋島嶼フォーラム（Pacific Islands Forum、以下「PIF」という。）11 は、経済成長及び政治ガバナンスを高め、地域の安全保障を図るための政策提言を行い、政策のモニタリングや評価を通じて地域の協力及び統合を強化していくことを目標としている機関であるが、2005 年に策定したパシフィックプランにおいて、域内の発展を促していくための戦略的枠組みとして、経済成長、持続可能な発展、グッドガバナンス、安全保障の4 つの柱を設定し、これに沿った形での域内協力、開発援助を進めていくとしている。具体的には、この4 つの基本的な柱のもと13 の具体的な目標を設定し、そのうちグッドガバナンスを、「あらゆる資源について透明で、説明責任と公正な管理があり、持続可能な開発と経済成長のために不可欠（prerequisite）なものである」とする（Pacific Islands Forum Secretariat 2005:2-3）。このように、太平洋島嶼地域における開発の現場においても、ガバナンスと経済成長の相関関係について、またガバナンス自体の開発政策における重要性について、強く認識されているということができるだろう。

5 太平洋島嶼地域におけるガバナンスの弱さ
太平洋島嶼地域に対する先進国からの援助金額は、その小さな国家規模に対し相対的に極めて大きく、1970 年以降にこの地域が受け取った援助額は500 億ドルにのぼり、世界で最も高い一人当たり援助額が流入している（Mellor and Jables 2004:5）。1992 年から2008 年の間における一人当たり純ODA 受取額について、世界銀行の調査による世界164 カ国の平均と、南太平洋島嶼地域の独立国10 カ国（ナウル及びツバルを除く）の平均を比較すると、世界平均の一人当たり受取額が98 ドルであるのに対し、太平洋島嶼国地域は534 ドルと、世界平均の約5 倍以上の額となっている（図1）12。

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10 AusAID（2009）では、ガバナンスの有効性指標を横軸に、一人当たりGNI を縦軸に、太平洋島嶼国における相関関係を示している。
11 島嶼地域全体の国際的な発言力の強化及び域内発展への協力体制の構築に向け、小国の集合体である島嶼地域の共通の利害を結集して先進国に共同体として対抗していくための首脳会議体がフィジーの初代首相カミセセ・マラの提唱により1971 年にPIF として発足した。加盟国は島嶼国12 カ国及びオーストラリア・ニュージーランド、2 地域（クック諸島、ニウエ）。

13 1992年－2008年における10カ国の平均値について、Indicators, GDP growth (annual %)については年平均成長率を、GNI per capita, Atlas method (current US$)については年平均値をそれぞれ算出した。
14 さらに2006年12月に4回目のクーデターが発生し、その後民主化のプロセスをとっていないという理由から、現在（2010年5月）PIF及び英連邦から資格を停止されている。
15 2003年7月、法と秩序回復を目的として、PIF加盟国の警察・軍隊からなるソロモン地域支援ミッション（RAMSI）がオーストラリア、ニュージーランドの主導で派遣された。
太平洋島嶼地域におけるこのようなガバナンスの弱さ（poor governance）は、どのような理由によるものなのだろうか。また、そのボトルネックは、援助の不適切さ、ドナー側の認識不足、被援助国側におけるキャパシティの問題、あるいは文化的相違など、開発援助に係るプロセスのうもろの部分に存在するのであろうか。

太平洋島嶼地域におけるガバナンスの弱さの状況について、ADB は 2000 年以降に行っている国別ガバナンス評価の結果及び太平洋島嶼地域のメンバー国のガバナンス評価の結果から、近代的なガバナンスのシステム・文化と伝統的な政治システムのモデルと文化的間の相互作用について考慮が必要であるとして、以下のような結論を導き出している（Mellor and Jabes 2004：x）。

・過去に行われた改革の目的と内容が複雑であり、この地域の文化と価値システムにとって概してまったくの異質のもの（foreign）なものとなっていた
・島嶼地域のメンバー国において過去のガバナンス改革が持続できなかったのは、部分的に国家のオーナーシップとステークホルダーのコミットメント不足によるところがあった
・技術力及びマネジメント力に乏しく研修プログラムが概して有効ではなかった
・首都以外のコミュニティに広がる文化的価値システムをよりよく理解し、政府の戦略的プライオリティと資源配分決定に反映させる必要があった
・市民文化は政府と市民間に価値あるつながりを提供するものであり、政府と公務員のアカウンタビリティを高めるためによりよい形で適用されるべきだった

さらに、この地域の草の根コミュニティがどの程度自らの政府システムについて理解しているかについてもあわせて調査し、その結果、伝統的慣習と価値がこの地域の政府と選挙の働きに対して極めて強力なインパクトを有すること、ほとんどの人々が政府機能について
いてあまりよく理解していないが、公的サービスの提供についての期待は有していること、伝統的地域価値とチーフ的な権威への尊敬は低下してきていること、の3点について言及している。

おわりに
開発援助政策を検討する際、ドナーにとってその有効性を問い、援助効果が適切にかつ効率的に行われることを確認するのは極めて重要であり、また納税者である自国民等に対する説明責任と情報開示も広く問われているところである。太平洋島嶼地域における援助効果が低いことの理由のひとつにガバナンスの弱さがあげられるとすれば、そもそも太平洋島嶼地域におけるガバナンスの現状は、具体的にどのような状況にあるのか。また、地域の文化環境や政策プロセスが十分反映されていないと、経済政策や開発戦略は失敗することになる（Macdonald 1996）との批判があるように、世界銀行をはじめとする国際機関やドナー国が提示するグッドガバナンスのアプローチは、その地域の文化や経済社会状況を十分に反映していない現実がある。先行研究ではしばしば、太平洋島嶼地域の考慮されるべき文化的特性・社会的特徴として、慣習的システムやチーフシステム、伝統的リーダーシップによる意思決定システムや、氏族や親族関係に影響を大きく受ける政治経済行動などがとりあげられているが、それらとグッドガバナンスの関係、あるいは開発政策との関係はどのように理解されるべきなのか。次稿では、以上のような研究目的の下、この地域におけるガバナンスの現状について、これまでの研究の蓄積を参考に研究を進めるとともに、その特性について明らかにする。

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