ABSTRACT
Inadequate health care delivery in the Indian trans-Himalayas arises from the harsh landscape and climate, poverty, the inaccessibility of health care centers, and a burden of chronic diseases and preventable acute illnesses that exceeds the number of traditional healers in the region. Systematizing a pluralistic healer network that integrates NGOs, international health organizations, mobile camps, district clinics, and traditional healers could address the issue of sustaining health care in this region. The backbone of this strategy would be a pre-existing resource relied upon by public and private health organizations: community health workers.

INTRODUCTION
NGOs and international health organizations report that accessing technology, offering comprehensive acute care, and ensuring chronic care follow-up is lamentably difficult in Ladakh. These organizations are only one type of health care model offered in this medically pluralistic society, where multiple forms of acquiring care for the body and the mind coexist. This ranges from interventions performed by family and community members (including herbalists, midwives, and acupuncturists) to help from practitioners of biomedical, ayurvedic, spiritual, or Tibetan amchi medicine. Of the public health facilities available, family welfare centers and traditional medicine dispensaries are the most accessible. Ladakhis do not appear to be unempowered participants in their health care system, but rather a pragmatic community proactive about visiting diverse healers depending on their perceptions of disease origin and financial/geographic accessibility. Communication and collaboration among healers would be in the population’s interest, but it is lacking.

ECOLOGICAL MODEL OF HEALTH BEHAVIOR
Intra- and Interpersonal Factors: one’s position in the household, profession, household size, role in the community; in the case of childhood illnesses, age and education level of the mother and perceptions about the severity of illness; overall pattern of health-seeking behavior appears similar regardless of income.1

Community Factors: cultural meanings of illness and beliefs about their causation; community health workers (CHW) are resources for preventive care interventions, education, community participation, and interpretation.2

Institutional/Infrastructural Factors: clean water, proper sanitation, nutritious food, a gathering space, education, employment, and physical facilities for health care services; the cost, accessibility, and diversity of treatments available, the opportunity cost, proximity to the health center, and perceived effectiveness of remedies.

INTERVENTION
The Ladakh Healer Network
Short-term goals: i) to strengthen the role of CHW as medical liaisons among diverse healers and ii) to systematically localize rural healers and monitor the frequency of their use. CHW would visit the amchis, Ayurvedic and spiritual practitioners, army clinics, and PHC centers in the local area to be included on a healer map. The CHW would also be trained to conduct and document one-time surveys with each adult about their personal healer history.

Long-term goals: i) to consolidate healer histories, chronic conditions, and the healer map into a database that would serve as a referral system from mobile medical camp servicers to traditional healers and PHC centers; ii) to conduct tri-annual updates to satisfy the need for more consistent chronic care interventions.

EVALUATION & POLICY DEVELOPMENT
Effectiveness, efficiency, and financial sustainability are key to evaluating public-private partnerships in rural health care delivery.3 The number of completed referrals from the NGO/international aid provider to another medical practitioner, the frequency of visits to traditional healers, and the consistency of tri-annual updates would quantify effectiveness. Efficiency could be measured by the additional time needed for CHW to conduct healer history interviews and tri-annual updates on care-seeking. Community opinions about the usefulness of the healer map during clinic visits could be gathered in survey form. This model is supported by a successful proposal in 1996 in West Bengal, where funding was dispersed to five NGOs that collaborated to deliver primary health care in the form of mobile services.4 If evaluation of the healer network demonstrates an increase in medical resource use and community satisfaction with CHW, then the community leaders could request governmental funding to establish a database in each community center and implement the CHW training method until a permanent health center is established.

CONCLUSION
The Ladakh Healer Network offers a means to maximize the collective expertise of healers in the trans-Himalayas, to promote partnerships in the monitoring of chronic conditions, and to preserve indigenous practices.

REFERENCES

Integrated Medical Pluralism to Sustain Health Care in the Indian Trans-Himalayas
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