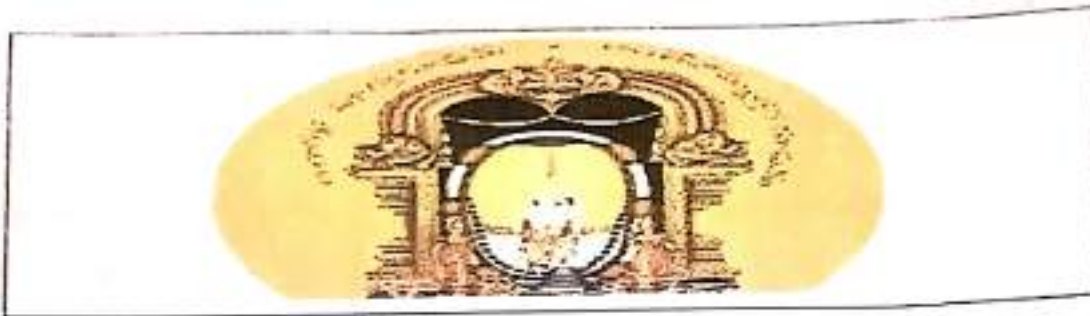


**COMMUNITY SERVICE PROJECT
"TRADITIONAL MEDICINES"**

**Submitted in the partical fulfillment for BSc(CBZ) intership
(Batch 2022-23)**



Submitted by

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Under the mentorship of

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SVLNS DEGREE COLLEGE

BHEEMUNIPATNAM

Dept of Botany

Bheemili: 531163 , Visakhapatnam (Dist). Accredited with B grade by NAAC

CERTIFICATE

Certified that this project report titled "A study on

"Traditional Medicine" is the bonafide work of KOLA DEVI

(Reg No: (720122205041) who carried out the project work under my
Supervision

Certified further, that to the best my knowledge the work reported here in does
not from part of my any other project report or dissertation on the basics of
which a degree or award was conferred on an earlier occasion on this or any
orther candidate

Mentor

S.SRINU

Date: 28-7-22

Declaration

I here by declare that the project titled "Traditional Medicine in Tallavalasa " is my original work and as not been published or submitted any degree diploma or other similar titles else where this has been undertaken for the purpose of partical fulfillment of BSc(bzc) ., in govt degree college Bheemunipatnam .

KOLA DEVI

(Reg No ;(720122205041)



ACKNOWLEDGMENT

It is really a matter of pleasure for me to get an opportunity to thank all the persons who contributed directly or indirectly for the successful completion of the project report, "TRADITIONAL MEDICINE IN TALLAVALASA".

I wish to express my gratitude to the Ward Member and Sarpanch of Tallavalasa to do a summer service Project. They provided me with their assistance and support whenever needed, which has been instrumental in completion of this project. I am thankful to **Dr. R. Manjula principal of SVLNS Govt Degree college and S.SRINU** Department of BOTany for their support and encouragement throughout the tenure of the project.

KOLA DEVI

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A. INTRODUCTION

1. History of Use of Traditional Herbal Medicines

By definition, 'traditional' use of herbal medicines implies substantial historical use, and this is certainly true for many products that are available as 'traditional herbal medicines'. In many developing countries, a large proportion of the population relies on traditional practitioners and their armamentarium of medicinal plants in order to meet health care needs. Although modern medicine may exist side-by-side with such traditional practice, herbal medicines have often maintained their popularity for historical and cultural reasons. Such products have become more widely available commercially, especially in developed countries. In this modern setting, ingredients are sometimes marketed for uses that were never contemplated in the traditional healing systems from which they emerged. An example is the use of ephedra (= Ma huang) for weight loss or athletic performance enhancement (Shaw, 1998). While in some countries, herbal medicines are subject to rigorous manufacturing standards, this is not so everywhere. In Germany, for example, where herbal products are sold as 'phytomedicines', they are subject to the same criteria for efficacy, safety and quality as are other drug products. In the USA, by contrast, most herbal products in the marketplace are marketed and regulated as dietary supplements, a product category that does not require pre-approval of products on the basis of any of these criteria. These matters are covered extensively in Section 3 below.

1.1 The role of herbal medicines in traditional healing

The pharmacological treatment of disease began long ago with the use of herbs (Schulz *et al.*, 2001). Methods of folk healing throughout the world commonly used herbs as part of their tradition. Some of these traditions are briefly described below, providing some examples of the array of important healing practices around the world that used herbs for this purpose.

1.1.1 *Traditional Chinese medicine*

Traditional Chinese medicine has been used by Chinese people from ancient times. Although animal and mineral materials have been used, the primary source of remedies is botanical. Of the more than 12 000 items used by traditional healers, about 500 are in common use (Li, 2000). Botanical products are used only after some kind of processing,

which may include, for example, stir-frying or soaking in vinegar or wine. In clinical practice, traditional diagnosis may be followed by the prescription of a complex and often individualized remedy.

Traditional Chinese medicine is still in common use in China. More than half the population regularly uses traditional remedies, with the highest prevalence of use in rural areas. About 5000 traditional remedies are available in China; they account for approximately one fifth of the entire Chinese pharmaceutical market (Li, 2000).

1.1.2 *Japanese traditional medicine*

Many herbal remedies found their way from China into the Japanese systems of traditional healing. Herbs native to Japan were classified in the first pharmacopoeia of Japanese traditional medicine in the ninth century (Saito, 2000).

1.1.3 *Indian traditional medicine*

Ayurveda is a medical system primarily practised in India that has been known for nearly 5000 years. It includes diet and herbal remedies, while emphasizing the body, mind and spirit in disease prevention and treatment (Morgan, 2002).

1.2 **Introduction of traditional herbal medicines into Europe, the USA and other developed countries**

The desire to capture the wisdom of traditional healing systems has led to a resurgence of interest in herbal medicines (Tyler, 2000), particularly in Europe and North America, where herbal products have been incorporated into so-called 'alternative', 'complementary', 'holistic' or 'integrative' medical systems.

During the latter part of the twentieth century, increasing interest in self-care resulted in an enormous growth in popularity of traditional healing modalities, including the use of herbal remedies; this has been particularly true in the USA. Consumers have reported positive attitudes towards these products, in large part because they believe them to be of 'natural' rather than 'synthetic' origin, they believe that such products are more likely to be safe than are drugs, they are considered part of a healthy lifestyle, and they can help to avoid unnecessary contact with conventional 'western' medicine.

While centuries of use in traditional settings can be used as testimony that a particular herbal ingredient is effective or safe, several problems must be addressed as these ingredients are incorporated into modern practice.

One problem is that ingredients once used for symptomatic management in traditional healing are now used in developed countries as part of health promotion or disease prevention strategies; thus, acute treatment has been replaced by chronic exposure (e.g., herbal products used for weight loss, Allison *et al.*, 2001). This means that a statement about 'thousands of years of evidence that a product is safe' may not be valid for the way

Tallavalasa Population - Visakhapatnam, Andhra Pradesh

Tallavalasa is a large village located in Bheemunipatnam Mandal of Visakhapatnam district, Andhra Pradesh with total 1138 families residing. The Tallavalasa village has population of 4298 of which 2161 are males while 2137 are females as per Population Census 2011.

In Tallavalasa village population of children with age 0-6 is 531 which makes up 12.35 % of total population of village. Average Sex Ratio of Tallavalasa village is 989 which is lower than Andhra Pradesh state average of 993. Child Sex Ratio for the Tallavalasa as per census is 945, higher than Andhra Pradesh average of 939.

Tallavalasa village has lower literacy rate compared to Andhra Pradesh. In 2011, literacy rate of Tallavalasa village was 64.93 % compared to 67.02 % of Andhra Pradesh. In Tallavalasa Male literacy stands at 71.98 % while female literacy rate was 57.85 %.

As per constitution of India and Panchyati Raj Act, Tallavalasa village is administrated by Sarpanch (Head of Village) who is elected representative of village. Our website, don't have information about schools and hospital in Tallavalasa village.

Tallavalasa Data

Particulars	Total	Male	Female
Total No. of Houses	1,138	-	-
Population	4,298	2,161	2,137
Child (0-6)	531	273	258
Schedule Caste	604	284	320
Schedule Tribe	3	2	1
Literacy	64.93 %	71.98 %	57.85 %
Total Workers	1,708	1,240	468
Main Worker	1,609	-	-
Marginal Worker	99	61	38

District → Visakhapatnam

State → Andhra Pradesh

About Tallavalasa

According to Census 2011 information the location code or village code of Tallavalasa village is 586142. Tallavalasa village is located in Bheemunipatnam mandal of Visakhapatnam district in Andhra Pradesh, India. It is situated 8km away from sub-district headquarter Bheemunipatnam (tehsildar office) and 25km away from district headquarter Visakhapatnam. As per 2009 stats, Tallavalasa village is also a gram panchayat.

The total geographical area of village is 575 hectares. Tallavalasa has a total population of 4,298 peoples, out of which male population is 2,161 while female population is 2,137. Literacy rate of tallavalasa village is 56.91% out of which 62.89% males and 50.87% females are literate. There are about 1,138 houses in tallavalasa village. Pincode of tallavalasa village locality is 531162.

Bheemunipatnam is nearest town to tallavalasa for all major economic activities, which is approximately 8km away.

Google Map of Tallavalasa

The Map data on this website is provided by Google Maps, a free online map service one can access and view in a web browser.

Population of Tallavalasa

Particulars	Total	Male	Female
Total Population	4,298	2,161	2,137
Literate Population	2,446	1,359	1,087
Illiterate Population	1,852	802	1,050

The Methodological Trends of Traditional Herbal Medicine Employing Network Pharmacology

1. Methodological Trends in Constructing the Herb-Compound Network

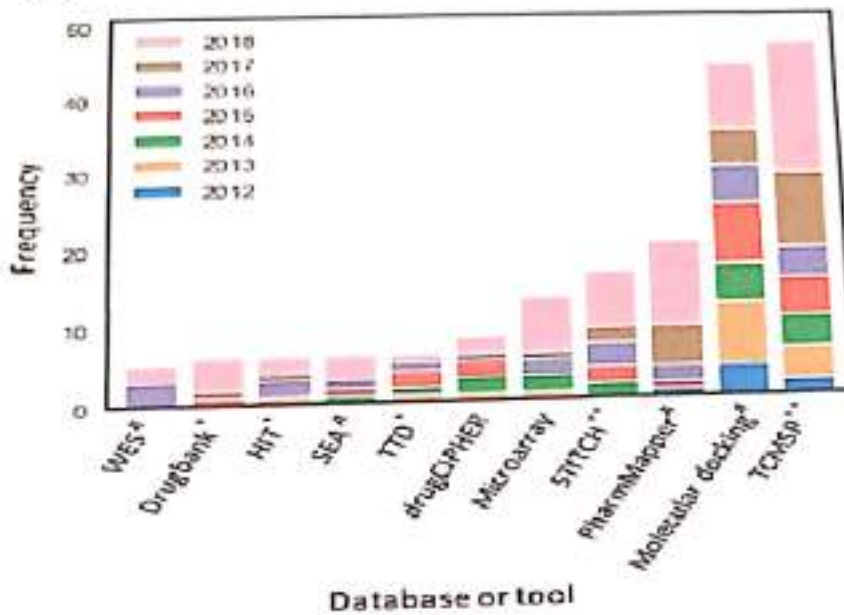
We next investigated the trends in employed methods in THM-NP studies. Commonly used databases and tools are described in [Table 1](#) (see [Supplementary Table S2](#) for complete lists). The construction of the herb-compound network is the first step of a THM-NP study. Among the databases for herbal medicines, TCMSP was most commonly used to construct an herb-compound network. Additionally, some THM-NP researchers used their own experimental results (e.g., Ultra Performance Liquid Chromatography (UPLC) or High-performance liquid chromatography) to identify ingredients of the herbal medicines in their studies ([Figure 4A](#)).

Because information on the absorption, distribution, metabolism, and excretion (ADME) properties of herbal medicines in humans are lacking, researchers have employed evaluation methods or machine learning tools to predict those properties. We counted the number of THM-NP studies that evaluated the drug availability of herbal ingredients. We found that approximately half of (72/147, 49.0%) THM-NP studies evaluated the drug availability of herbal ingredients, and the majority of the studies (54/72, 75.0%) employed Obioavail and drug-likeness in combination ([Figure 4B](#)). Obioavail is an in silico model that predicts the fraction of an administered dose of a drug that reaches the systemic circulation unchanged [[39](#)].

2. Methodological Trends for Constructing Compound-Target Networks

We next attempted to determine the frequency of each DTI method for constructing compound-target (C-T) networks (Note that some of the THM-NP studies combined several methods to identify DTIs. Therefore, the total frequency of the DTI method is greater than the total number of THM-NP studies). The results showed that TCMSP (47/222, 21.1%) and molecular docking (44/222, 19.8%) were the most frequently used. In addition, experimental methods, such as microarrays, were also applied ([Figure 5A](#)). It is noteworthy that DTI methods of TCMSP have existed for less than 10 years since its development but have been used most frequently in THM-NP studies [[16](#)]. More than one-third of THM-NP studies (54/147, 36.7%) combined several DTI methods for constructing C-T networks, and most of them included TCMSP (e.g., TCMSP-molecular docking and TCMSP-STITCH) ([Figure 5B](#)).

(A)



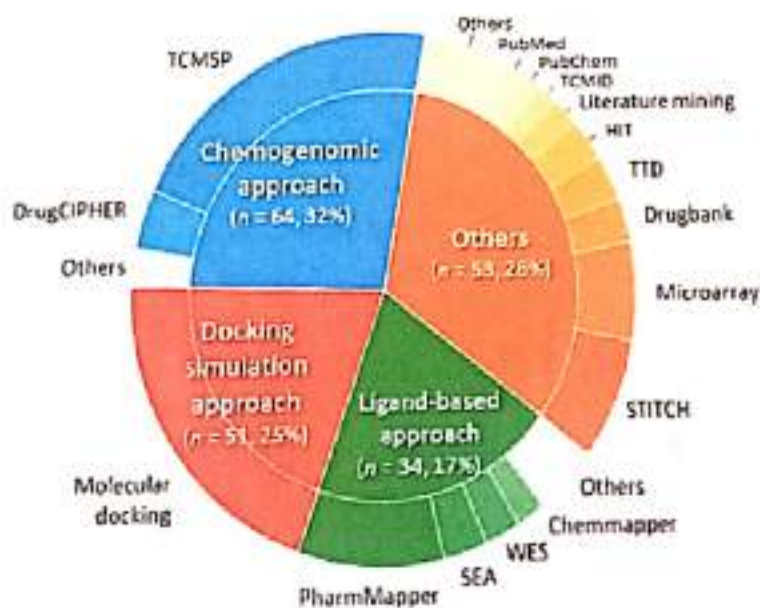
INTERPRETATION

From the table and graph above it can be seen that

- 8% respondents age are BELOW 20 years.
- 32% respondents age are 20 to 30 years.
- 42% respondents age are 30 to 40 years..
- 14% respondents age are 40 to 60 years
- 4% respondents age are ABOVE 60

TABLE DEPICTING CATEGORY ANALYSIS OF RESPONDANTS

CATEGORY	FREQUENCY	%	Cumulative %
SC	16	22	22
ST	10	16	38
BC	26	22	90
OC	10	90	100
TOTAL	112	150	



Conclusion

Approximately one-third of adults in the United States use complementary and alternative medicine (CAM) yet less than 40 percent disclose such use to their physician and other health care providers. Women are more likely than men to use CAM therapies; use appears to increase as education level increases; use patterns vary by race, depending on the type of CAM therapy considered; and those who use CAM generally use more than one CAM modality and do so in combination with conventional medical care (Barnes et al., 2004; Eisenberg et al., 1998; Mackenzie et al., 2003; Ni et al., 2002; Wolsko et al., 2002; Wootton and Sparber, 2001). Some forms of CAM are being incorporated into services provided by hospitals; covered by health maintenance organizations; delivered in conventional medical practitioners' offices; and taught in medical, nursing, and other health professions schools. Insurance coverage of CAM therapies is increasing and integrative medicine centers and clinics are being established.

What do patients and health professionals need to know to make good decisions about the use of health care interventions, including CAM? Of primary importance is determining that they are safe and effective. Cost-benefit and cost-effectiveness may be important to both the individual and to society. In this report, the committee has recommended that the same principles and standards of evidence of treatment effectiveness apply to all treatments, with the understanding that certain characteristics of some CAMs and some conventional medical interventions make it difficult or impossible to conduct standard randomized controlled trials. For these therapies, innovative methods of evaluation are needed as are measures and standards for the generation and interpretation of evidence.

The committee believes that it is necessary and desirable to use a variety of study designs to research CAM therapies. Given the limited funding, the committee suggests that the following criteria be used when considering the CAM therapies to be selected for testing. No intervention will meet *all* criteria, and a therapy should not be excluded from consideration because it does not meet any one particular criterion, for example, biological plausibility.

Ideally, potential new treatments go through a series of scientific challenges that, if met, lead to acceptance of the test or treatment and integration into clinical practice. Many CAM therapies and many conventional medical therapies, however, are already in widespread use without such validation. The committee therefore concluded that, in addition to research aimed at determining efficacy and uncovering mechanisms of action, research aimed at investigating what is occurring in practice (that is, effectiveness) is also needed. This report proposes that such research be conducted within a research framework with four major components: practice-based research networks, a sentinel surveillance system, CAM research centers, and input from national surveys.

Community Awareness Service

Expanding traditional medicine (TM) coverage in health care is a priority in Vietnam. Continuous medical education (CME) plays an important role in ensuring the quality of TM. However, evidence about TM CME in TM practitioners in Vietnam is insufficient. This paper aimed to evaluate the awareness, practice, and demands on TM CME among TM providers in district hospitals of Vietnam. This cross-sectional descriptive study was performed at the district level at TM hospitals and TM departments of general hospitals in Thanh Hoa Province. Demographic characteristics, awareness, practice, and demand for TM CME were collected via face-to-face interviews. Descriptive statistics and multivariable logistic regression models were applied to examine the factors associated with awareness, practice, and demand for TM CME. The majority of the respondents had ever heard of TM CME (87.5%). Only 60% received TM training in the last five years. Most respondents had a demand for CME (86.8%). The non-Kinh ethnic group (OR = 0.2, 95% CI: 0.1–0.8) and people who had a temporary contract (OR = 0.2, 95% CI: 0.1–0.7) were less likely to be ever heard about TM CME. Higher levels of education (college, OR = 14.1, 95% CI = 1.0–195.9; undergraduate, OR = 9.1, 95% CI = 1.9–44.6) are more likely to be ever heard of TM CME than the vocational training group. Those who regularly update their knowledge are more likely to have heard about TM CME (OR = 7.7, 95% CI = 2.8–21.7) and are more likely to have demands on TM CME (OR = 3.7, 95% CI = 1.2–11.5). Those who had heard about TM CME were more likely to take these courses in the last five years (OR = 6.9, 95% CI = 2.5–18.8). However, this result was the opposite for people with more years of experience (OR = 0.9, 95% CI: 0.8–0.9). There were limited awareness and participation in TM CME but was a high need for CME among TM providers at district hospitals in Vietnam. Promoting lifelong learning and providing promptly supports would be potential to increase the TM CME demands and participation among TM providers.

Traditional medicine (TM) has been encouraged to develop and become increasingly popular worldwide [1–3]. In many countries, such as India, China, and many other parts of Asia, TM can be concerned as folk medicine or alternative medicine [4]. TM practitioners may have undergone formal training or have accumulated only folk experiences or inherit heirloom remedies. Consequently, there is no uniformity in qualifications among TM practitioners. According to the World Health Organization (WHO), a large proportion of TM practitioners have low educational levels [5]. In addition, many TM workers received inadequate training for their practices [6]. Since using natural herbs has many potential risks associated with adverse reactions or drug interactions [7, 8], TM practice cannot solely rely on the traditional experience or beliefs [9]. Therefore, all of TM workers, including those who had undergone formal training, also need to update their knowledge or undergo additional intensive training regularly.

Recommendations

The regulation and registration of traditional medicines (TM) continues to present challenges to many countries regardless of the fact that an increased number of the population utilises TM for their health care needs. There have been improvements in the legal and policy framework of South Africa based on the WHO guidelines. However, there are currently no guidelines or framework for the registration of TM in South Africa. This article reviews literature and existing guidelines of specific countries and regions and makes recommendations for South African guidelines.

Traditional medicines (TM) and plant-based remedies are widely used in Africa. It has been estimated that 80% of the African population relies on traditional forms of medicine to meet their healthcare needs (World Health Organisation (WHO), 2004). Worldwide the trend has also shifted towards the use of TM due to concerns about the costs, invasiveness and potential for toxicity of conventional mainstream remedies (Cowan, 1999). Most of these TM are not well-researched, poorly regulated, may contain adulterated products, and may produce adverse effects (Mills et al., 2005). Traditional medicines are defined as the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in prevention, diagnosis, improvement or treatment of physical or mental illnesses (WHO, 2001). Over the last fifteen years the safety and efficacy of TM, as well as quality control, have become important concerns for both health authorities and the public (WHO, 2005).

S.V.L.N.S. GOVERNMENT DEGREE COLLEGE
BHEEMUNIPATNAM- VISAKHAPATNAM

Community Service Project Survey Questionnaire

Respondent Number

PART A: SOCIO-ECONOMIC AND DEMOGRAPHIC PROFILE

Village Name....Tallavalasa

House No/Flat No....6-142/a

Name of the Respondent: Kola Rambabu

Address: D/O Rambabu, 6-142/a, gollalatalavalasa, tallavalasa visakhapatna
-Andhra Pradesh, 531162

46

1. Sex: Male

Female

2. Age (in completed years)

3. Religion: Hindu

4. Cast: Yadava

5. Sub Caste BC-D

6. Do you have a Phone:

1. Yes.

2. No

7. Do you have a Mobile:

1. Yes.

2. No

If yes, Number: 9182954090

If yes, Number:

8. Do you have transport?

1. Car

2. Jeep

3. Tractor

4. Bullock Cart

5. None

Average consumption of fuel per month

9. Education of the respondent:

Instruction: TICK ONLY ONE

1. Illiterate

2. Literate but no formal education

3. School up to 5 years (Class 1-5)

4. School up to 6-9 years (Class 6-9)

5. SSC/HSC

10. Occupation of the respondent

Instruction: TICK ONLY ONE

1. Farmer

2. Wage labourer

3. Skilled worker

4. Petty Trader (shop keeper)

5. Self employed

20. Indicate your economic status

Instruction: TICK ONLY ONE

- 1. BPL
- 2. APL
- 3. Red Card

21. Electrical appliances owned by the Household

Instruction: TICK AS APPLICABLE

- 1. Television Old/LCD/LED
- 2. Music player
- 3. Electric Mixer/Grinder/Food Processor
- 5. Air cooler
- 6. Washing Machine
- 7. Computer
- 9. Air conditioner
- 10. Refrigerator
- 11. Geyser
- 12. Fans number
- 13. Tube light LED/CFL/Incandescent Numbers
- Iron box
- Setup box/DTH
- Whether the appliances star rated Yes/No
- Any other.....

22. Family members

S No	Name of the family member	Relation with head	Age	Education qualification	Occupation	Blood Group
1.	K. Rambabu		45	5 th	daily labour	A ⁺
2.	K. Lakshmi		37	NO	house wife	O ⁻
3.	K. Devi		20	Degree	education	A ⁺

23. Name five most pressing problems faced by your community?

(Indicate area and issue: e.g. Health, Epidemic, Environment, Pollution, Education, Drainage, Roads, Electricity, drinking water, sanitation, service delivery of Government Programmes etc)

	Area	Issue
1.	Tallavalasa	Drainage, Roads,
2.		Electricity, Government
3.		Programmes.
4.		

5.

24. Property/ Land owned (Area in Sq feet)
Agriculture land
Crop cultivated

PART - B

Village Profile: Golakotavalasa

Area Population: 80

District: visakhapatnam

State: Andhra Pradesh

Any other Information :

25. Which of the following are there in the survey area: Provide a brief description, indicating number, type etc.

A) Anganwadi / Play School:

B) Primary Schools:

C) Secondary Schools:

D) Colleges:

E) Health Centre (PHC/CHC):

F) Hospitals:

G) Youth clubs:

H) Sports clubs:

I) Environment clubs:

J) Village Knowledge Centre/Common Multi Media Centre/Common Service Centre:

K) Krishi Vigyan Kendra:

Name of the investigator: K. Devi

Date:

Name of the supervisor:

Date: 26-6-22



GPS Map Camera

Primary Health Centre (PHC)

R Tallavalasa, Andhra Pradesh, India

VCV5+W83, R Tallavalasa, Andhra Pradesh

531163, India

Lat 17.894445°

Long 83.409266°

25/06/22 09:10 AM

Google



Primary H
Centre (P

R Tallavalasa, Andhra Pradesh, India

VCV5+W83, R Tallavalasa, Andhra Pradesh

531163, India

Lat 17.894526°

Long 83.409175°

25/06/22 09:06 AM





Visakhapatnam, Andhra Pradesh, India

Unnamed Road, Visakhapatnam, Andhra Pradesh 531163, India

Lat 17.883561°

Long 83.406679°

12/07/22 03:00 PM



GPS Map Camera



Scanned with Oken Scanner