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Report of the
**CONSULTATION ON APPROACHES FOR POLICY DEVELOPMENT FOR
TRADITIONAL HEALTH PRACTITIONERS, INCLUDING TRADITIONAL BIRTH ATTENDANTS**

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at the
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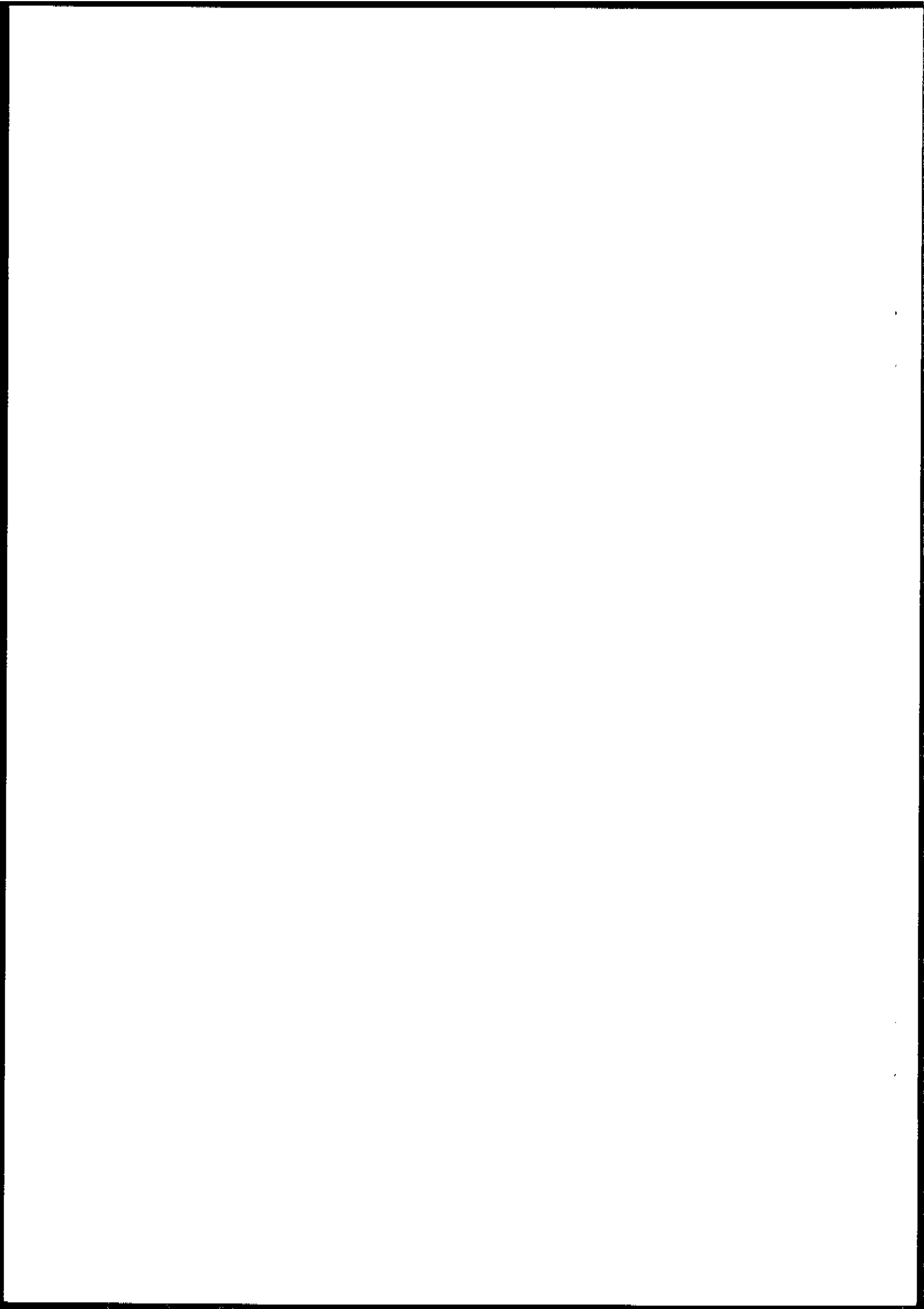


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1. Introduction

1.1 Background of the Consultation

Traditional health practitioners,* including traditional birth attendants, have looked after the health of their communities for generations, and will undoubtedly continue to do so for many years to come, given the scarcity of modern health care personnel and other geographical, cultural, social, and economic factors that have both a direct and indirect bearing on the quality and availability of health care services.

The majority of developing countries realize that traditional practitioners represent a vital and relatively untapped source of health manpower, which must be sensitively utilized in national efforts to meet the basic health needs of populations. Indeed, it is now almost universally acknowledged that unless the traditional health practitioners are properly recognized, and articulated with the national health system to implement strategies to achieve health for all by the year 2000, countries will never be able to achieve adequate health coverage for all their populations.

The Declaration of Alma-Ata² implicitly acknowledges the significant role that traditional health practitioners could play in health systems based on the primary health care approach. It refers to the utilization of all appropriate and available local human resources as a means of achieving the social goal of health for all by the year 2000. This goal was accepted by WHO's Member States and expressed in a resolution adopted by the World Health Assembly in May 1977 (WHA30.43).

Since 1977, WHO has been collaborating with its Member countries in activities to determine how best traditional health practitioners could become involved in primary health care.¹ In the majority of developing countries, traditional health practitioners are still not formally recognized by governments. However, in many of these countries traditional birth attendants are being increasingly trained and utilized with proven success; the Organization has initiated and supported a number of these projects.

Yet, seven years after Alma-Ata, the commitment of WHO's Member States to use all appropriate and available local human resources is still not adequately reflected in national health policies and plans; furthermore, legislation that would positively promote the use of traditional health practitioners has been slow to develop.

1.2 Objectives of the Consultation

Recognizing the potential contribution of traditional health practitioners in the efforts of countries to extend basic and essential health care, and in order to maintain interest in its programme on traditional medicine, WHO arranged a Consultation on Approaches for Policy Development for Traditional Health Practitioners, including Traditional Birth Attendants. The objectives of the Consultation were:

- (a) to identify those issues and factors which impede or facilitate optimal involvement of, and collaboration with, traditional health practitioners in primary health care programmes and activities;
- (b) to suggest approaches that the health system can use to motivate traditional health practitioners to participate in national efforts to extend the coverage of primary health care; and

* Also referred to in the report as traditional practitioners or practitioners.

- (c) to make recommendations for the promotion and development of relevant health policies that would contain provisions on the coordination and better utilization of traditional health practitioners in national health systems.

1.3 Organization of the Consultation

For the purposes of the Consultation, WHO commissioned country case studies (Annex 4) to be prepared from India, Mexico, Sri Lanka, Sudan, Thailand, the United Republic of Tanzania, and Zimbabwe (See Annex 5). A working paper was also prepared; this was based on an analysis of six reports,* as well as other material devoted to the subject from other parts of the world, and on material produced by WHO.^{4, 19, 22}

To assist the authors of the case studies (whose opinions should be regarded as personal, and not necessarily reflecting the official position of their country's government), a set of guidelines for the preparation of country case studies was despatched to them (Annex 4) in an attempt to elicit some comparative information on policy issues. The case studies revealed a diversity of situations, reflecting each country's different sociocultural background, political history, geography, types of traditional health practitioner and systems of traditional medicine available, as well as the attitudes of official health systems and communities to them.

2. Proceedings of the Consultation

2.1 Participants, election of officers, and agenda

The participants included twelve temporary advisers and a consultant, drawn from various disciplines and countries and with different backgrounds and experience. Also participating were staff from the Secretariat of the World Health Organization, a consultant from WHO's Regional Office for the Western Pacific, and five members of WHO's Regional Office for South-East Asia. Also present were representatives from UNICEF, UNIDO, UNRWA, and the World Council of Churches. His Excellency, Mr W. J. M. Lokubandara, Honourable Minister of Indigenous Medicine, Sri Lanka, was elected Chairman. Mr K. Venugopal, Deputy Secretary, Ministry of Health and Family Welfare, India, was chosen as Vice-Chairman, and Dr Barbara Pillsbury, University of California, Los Angeles, California, USA, was elected Rapporteur (Annex 2).

The participants accepted the proposed agenda (Annex 3).

2.2 Opening of the Consultation

Following a brief opening ceremony, Dr U Ko Ko, Regional Director, delivered the inaugural address and re-stated the objectives of the consultation, emphasizing the role of traditional health practitioners as collaborators in primary health care. He also expressed the hope that the consultation would provide some concrete proposals for country-based action, and some basic guidelines that countries might follow when formulating and implementing policies on traditional health practitioners.

3. Summary of discussions

The discussions covered the identification of traditional health practitioners and what approaches could be taken to develop effective policies favouring their mobilization for health development; a review of the current

* Excluding India.

situation on the utilization of traditional practitioners in primary health care; current policy and legislation governing the utilization of traditional practitioners; and approaches for developing policies to improve the collaboration and involvement of traditional practitioners with the national health system in primary health care.

3.1 Identification of traditional health practitioners

There may be great differences in approaches to traditional medicine, midwifery, and health care between countries, and even within countries, but in every developing country there are several types of traditional health practitioner. They constitute an enormous reserve of manpower that could be utilized if the health of populations were to be improved through extended coverage of primary health care. The vast spectrum of traditional practitioners includes at one extreme the practitioners in the formal and classical Ayurveda,⁶ Unani, Siddha, and Chinese systems, and at the other extreme, traditional birth attendants and traditional folk-healers, with spiritualists, diviners, and numerous others occupying different places between these two extremes.⁴

The participants described other types, and, in most instances, unorganized categories of traditional practitioners. In the majority of cases these people have no clear legal status and there is very limited systematized information about them and their practices. In Zimbabwe alone, according to the case study, six categories of traditional practitioner have been identified.

The complexities arising from attempts to identify, classify, and register all these categories of practitioner may be partly responsible for the absence of specific national policies to promote and develop indigenous systems of medicine, and to utilize them in the official health system. An exception has been the traditional birth attendant. She has been successfully utilized in primary health care in a number of countries. She has proved to be capable of being trained, both to improve existing functions and to undertake new tasks, such as family planning, immunization, nutrition, treatment of common ailments, and referral to modern health personnel when appropriate.

The participants identified four main categories of traditional practitioner. The first are those who have received training in both the modern and traditional systems of medicine, e.g., Ayurveda, Chinese, Unani. The second are those trained mainly in traditional medicine, although they often have elementary knowledge of modern medicine. They practise almost exclusively in rural areas but some have worked in government clinics in Burma, China, India, Nepal, and Sri Lanka. The third group practise only traditional medicine. They have no formal training, but possess diplomas in some traditional system, e.g., Ayurveda. The fourth category includes those practitioners without either institutional training or qualifications, e.g., traditional birth attendants, herbalists. They practise after several years' apprenticeship with an established traditional practitioner.

3.2 Current situation on the utilization of traditional health practitioners in national primary health care programmes

The degree to which traditional health practitioners have been involved in programmes and activities to deliver primary health care has depended on such factors as geography and sociocultural heritage, as well as the type of traditional practitioner available, the practices they use, and the characteristics and attitudes of their patients. Involvement and cooperation with the national health system hinges delicately upon the attitudes of professional health workers and administrators at all levels of the health system, the willingness and confidence of traditional practitioners to learn and exchange experiences with other health personnel, and the perceptions that communities have about the traditional and the Western-based or modern systems of medicine.¹⁰ The success and effectiveness of collaborative programmes require government sanction and adequate appropriations, as well as support from such groups as physicians, nurses, and midwives. When health administrators begin to understand that it will often take more than just the official health care providers to extend health coverage to an entire population, they would perhaps be more inclined to allocate the appropriate resources.

In Brazil, much headway has been made in the utilization of traditional practitioners through the Ceará project.³ In this north-eastern region of Brazil, anthropologists learnt that when illness occurs, the first care is provided by traditional birth attendants or faith-healers. These people were then instructed in oral rehydration treatment; this improved their status, since their new skills successfully rehabilitated many sick children. This project is exceptional in that it made an unrelenting effort to rely primarily on local communities and the people with traditional knowledge and skill to carry out essential primary maternal health services, and that it applied these same skills to solve other health problems and to develop other programmes: sanitation, immunization, and health education.

Each country needs to identify its priority health problems where collaborative work with traditional practitioners can be carried out. For example, the following health problems could be managed through collaborative activities, adapted to different country situations:-

- (a) Cancer prevention and management
- (b) Management of infertility
- (c) Diagnosis, treatment, and rehabilitation of tuberculosis and leprosy
(Traditional health practitioners are close to the people; they are therefore the most likely individuals to be aware of such cases, which in general are associated with cultural taboos and usually subject those afflicted to some form of social stigma, and prevent them from seeking help from the official health system.)
- (d) Family planning
(Successful programmes involving traditional birth attendants in family planning could be extended to other traditional health practitioners.)
- (e) Infant feeding practices
 - (1) Diarrhoea management, i.e., by oral rehydration
 - (2) Immunization
 - (3) Sexually transmitted diseases
 - (4) Prescription of drugs, including traditional herbal medicines (through kits for community health workers)
 - (5) Mental health, e.g., psychosomatic illness

In Bangladesh, Bhutan, India, Nepal, and Sri Lanka, the traditional practitioner has already begun to collaborate with the national health system at all levels. This collaboration has increased over the past several years;^{13, 17, 19} the facilitating factor for this cooperation and collaboration is the existence of a very organized system of indigenous medicine whose infrastructure parallels the national health system. The traditional system could support more training programmes, and students with the same aptitudes as those studying allopathic medicine should be encouraged to pursue careers in traditional medicine. There would be ample work for them, and, because they are practitioners of systems which are for the most part unique to particular regions and cultures, their talents would not be easily exported to other countries, thereby adding to the problem of "brain drain".

Yet, even in these and many other countries there are still traditional practitioners who practise outside the institutional framework of the national health system. They have learnt their skills as apprentices of older traditional practitioners or through family members. Efforts are now being made to identify these healers and involve them in primary health care. In India, for example, there are other forms of traditional medicine that do not fall in the category of classical system. There are also several thousands of unregistered Ayurvedic healers practising in villages who are now being motivated to participate in activities for health development.

In Africa and Latin America, the categories of healers are more diverse, and their functions, including the spiritual dimension of health care, are more difficult to describe and assess. Associations of healers, such as those in Zaire⁵ and Zimbabwe have been vigorous in the task of identifying those healers whose energies can be effectively harnessed for the delivery of basic health services.

Traditional birth attendants have been successfully trained and utilized in many countries where they are working in the rural and peri-urban areas.¹² They are acceptable and accessible to communities. Apart from being cost-effective, they are essential for extending health coverage, and are therefore an invaluable asset in the community health team.

While the traditional practitioner enjoys a certain status in his own community, the potential contribution that he can make to improve and extend community health services has not been fully accepted in countries where there are no provisions to articulate this type of health worker with the health system. Nevertheless, the experiences of Brazil and Zimbabwe, as well as that of countries where the classical systems of indigenous medicine still prevail, indicate that the effective involvement of traditional practitioners in the national health system can benefit communities and improve the health status of the nation's citizens.

3.3 Current policy and legislation governing the utilization of traditional health practitioners

The legal regulation of health care, as a monopoly of organized health professions, has followed a similar if not uniform pattern since advances in modern scientific medicine began. Legislation was designed to protect the health of the population and to protect them from unqualified healers; it also authorized the right to practise to those properly qualified in their area of responsibility, and protected them as part of a professional group. Such regulation of health care spread from developed Western nations to the rest of the world through the colonial system.

Yet, at the same time, people of many different cultures in most countries of the world relied on, and still do rely on, various treatments and practices that we call traditional medicine, from the application of herbal medicine to faith healing, and even to other practices based on the supernatural. In many parts of the developing world, where access to organized modern medicine is minimal or totally lacking, traditional medicine is, and will no doubt continue to be, the only form of health care available to millions of people.

Thus, governments of developing countries, recognizing that an exclusive reliance on a formal Western-based system of health care was an inadequate response to meeting the essential health needs of entire populations, have begun to review their colonial inheritance of health legislation.¹⁵ In some cases, they have relaxed legal prohibitions against indigenous healers and other traditional practitioners, and have even incorporated them in a more flexible system of health care delivery.²¹ Almost everywhere, attempts to upgrade the skills and knowledge of traditional health practitioners and to mobilize them to play an effective role in the health system have met with resistance from organized groups of health professionals with vested interests in maintaining the status quo.

Briefly, the global situation can be described as follows:

Four broad categories of policies on traditional practitioners can be discerned.^{11, 20} These categories are not necessarily rigid or conclusive; there is some overlapping in the distinctions between one category and another. However, the categorization serves only to approximate those different policies and legal regulations on traditional practitioners that have similar distinguishing features.

- . Complete prohibition, by restrictive legislation
- . Toleration and non-intervention, allowing for medical pluralism
- . Formal recognition following training, registration, and licensing
- . Formal recognition and official action to integrate traditional medicine in the formal health system.

The participants discussed in detail the existing policies and legislation in a number of countries, including Brazil, China, India, Philippines, Sierra Leone, Sri Lanka, Syria, and Zimbabwe.

A sharp distinction could be drawn between those countries accommodating one or more of the classical systems of traditional medicine and those where traditional health care and its practitioners are informally recognized.¹⁶ The classical systems enjoy both great popular acceptance and in some instances formal, legal recognition. Provided they have received formal training, the practitioners of these systems are registered and licensed. Arrangements for their training, functions, and regulation (normally through their own professional councils) are set out under specific legislation.

Most of the South-East Asian countries have introduced more or less substantial changes in their health legislation that tolerate or even recognize the practice of traditional medicine. However, some countries that have indicated their desire to utilize traditional practitioners in their official health system still have restrictive laws and regulations. Several countries have included traditional birth attendants in health activities as part of their national strategies to achieve health for all, e.g., Bangladesh, India, Indonesia, Nepal.

In Bangladesh, India, Pakistan, and Sri Lanka, the Ayurvedic, Unani, and Siddha systems of medicine are institutionalized, with a large network of facilities for education, research, and health care, including hospitals, clinics, and pharmacies exclusively for these branches of traditional medicine.

In India, the Government provides considerable financial support for the development of Ayurvedic, Unani, and Siddha systems of medicine and its continually increasing participation in the delivery of health services.⁹ The Central Council of Indian Medicine was established in 1971 by Act of Parliament to evolve uniform standards in education, to make mandatory the maintenance of a central Register of Indian Medicine, and to promote research.⁸ The national health policy, as manifested in the Seventh Five-Year Plan, ensures provision of required resources so that these systems can play the vital role assigned to them in the Indian health system. Nevertheless, the experience in India of attempting collaboration between both systems has not been encouraging, and the policy has undergone a change towards medical pluralism. The recommendations of the 1948 Committee on Indigenous Systems of Medicine, calling for a synthesis of modern and traditional medicine, were never fully implemented. Now, with the enactment of the Indian Medical Council Act of 1970, the government has declared its intention to use the indigenous systems as allies in the delivery of primary health care.

In Sri Lanka, an exceptional situation exists in that official acknowledgement of the existence of equal but distinct systems of medicine is demonstrated by the establishment in 1961, under the Ayurveda Act No. 31, of a separate Ministry for Ayurveda. This legislation also provides for the Siddha and Unani systems. Indeed, Sri Lanka appears to be the only country to have a separate Ministry for Traditional Medicine.

In most independent states of Africa, the colonial concept of a health system based on professional physicians, pharmacists, dentists, nurses, and midwives still persists, although the policies of some governments reflect to some extent their recognition of traditional health care practices. In many Anglophone and Francophone countries, the tendency has been to follow the colonial policies of noninterference with indigenous customs and to handle the situation of traditional healers by special exemption clauses. The struggle to achieve political independence has, in most cases, nourished in these countries a strong interest in indigenous medicine. But policies that keep in step with this revival of interest have not always been supported by legislation.

In Botswana, the Ministry of Health issued a broad statement in February 1984, positively promoting the utilization of traditional health practitioners in primary health care.

Zimbabwe has gone some way towards recognition of traditional practitioners through enactment of the Traditional Medical Practitioners Act in 1981, which established the Traditional Medical Practitioners Council. This body officially promotes the practice of traditional medicine and encourages research into it. Since 1981, the National Traditional Healers Association has run two medical schools and established a research department. Yet, even in Zimbabwe, where considerable progress has been made in efforts to ensure collaboration between the traditional health practitioners and the official health system, through, for example, the organization of joint seminars, the publication of a register of traditional practitioners, and some form of self-regulation, major difficulties continue to obstruct the development of a clear policy. These can be summarized as

hostility between the members of the two systems (based on mutual ignorance and mistrust) and lack of government support. Such barriers to the formulation and implementation of effective policies, including supportive legislation, as well as the gaps in knowledge about the identity, numbers, characteristics, and practices of the traditional practitioners, are common to all the countries represented at the consultation, and to those others that were the subject of the case-studies. The participants brought out that, while traditional practitioners play an active role in health care, it is in most cases outside the official health system.

In Central and South America, there has been little legislative action to complement the vigorous renewal of interest in folk medicine, except for occasional laws dealing with herbal medicine and the traditional birth attendant.

In China, where an ancient and highly complex system of health care has been in existence for around 4 000 years, the revival of traditional medicine that occurred in the early years of the People's Republic resulted in the incorporation to a wide extent of useful traditional practices within their general system for delivering health care. Chinese traditional medicine is a formal, structured system, with a long history and tradition, and with its own colleges, research institutes, and disciplinary controls. Modern technology and science are applied to the traditional system, and the government intends to develop legislation to promote further collaboration at all levels of the health system and in all its functions: health care delivery, research, education and training, and standardization and quality control of traditional remedies. There is also strong financial support for these activities. The structure and procedure of the health care apparatus are determined by policies laid down by the governing party, and they are implemented at all levels of the party infrastructure by representatives of the party throughout the country. Attempts to integrate the two systems of medicine failed in the period following Liberation. Traditional Chinese medicine therefore had to develop as an independent and parallel system of medicine before a stage was reached for mutual respect. Now, every Western-style medical school in China contains a department of traditional medicine and every school of traditional medicine contains a department of modern medicine; practitioners of both modern and traditional medicine are employed in modern hospitals, and they also work together in the commune health centres. The policy of the Chinese health system has always been to use those elements of ancient Chinese healing that are effective and to discard those which are not.

3.4 Approaches for developing effective policies to improve the collaboration and involvement of traditional health practitioners in primary health care

After considering the experiences of several countries in utilizing traditional health practitioners, it became clear that the collaboration and involvement of traditional practitioners with health systems based on the primary health care approach would need a well-defined government policy, supported by enforceable legislation.^{7, 11} Policies, or legislation, where relevant, are necessary to protect the patient from substandard care; to protect the practitioner from malpractice suits and prosecution under penal laws; and to protect the community from charlatans. In addition, the many and various activities necessary for the promotion of traditional medicine, including the utilization of traditional practitioners require policy support so that they can receive the necessary resources. A policy to utilize traditional practitioners in primary health care has to be spelt out clearly and disseminated widely. It should appear prominently in the national health

plan; in the five-year development plan; in the manifestos of political parties; and in all relevant official health publications, including community health workers' manuals. Wide publication and dissemination of the policy to the general public, as well as to the professional groups within the national health system, is one way to inform and educate the nation about the benefits that could result from implementing such a policy.

The first step would be to establish a working group on traditional health practitioners which would ultimately develop into a unit within the ministry of health or some other ministry. At the preliminary stage this group might be set up on an informal basis, i.e., not under any government auspices. For example, it could be organized in a university. It should be multidisciplinary in its composition, since its tasks would cover a wide spectrum of interests bearing on the utilization of traditional practitioners in health development and involve community development, law, education, finance, and administration, as well as health.

In China, for example, the Bureau for Traditional Chinese Medicine functions from the Ministry of Health, and accommodates a small working group set up to consider the formulation of legislation and regulation to facilitate the collaboration and coordination of modern and traditional systems of medicine.

In India, the traditional systems of medicine are managed directly by a division in the Ministry of Health and Family Welfare which includes technical officers representing their indigenous systems (Ayurveda, Unani, Siddha, plus Yoga, and Nature Cure). In Sri Lanka, a separate ministry was created in 1981. In Zimbabwe, the Traditional Medical Practitioners' Council registers traditional practitioners, and supervises and regulates their practice. It is now an offence for anyone to practise traditional medicine unless they are registered with the Council. Since the Council is not yet fully operative, the Zimbabwe National Traditional Healers Association, established in 1980 and recognized by the 1981 Act, manages much of the designated work.

The experience of Zimbabwe, as presented during the discussions, demonstrates forcefully the importance of involving the traditional practitioners themselves at an early stage in the activities to gather background information, formulate policy, and design regulatory mechanisms. Any working group or coordinating committee of this kind should include representatives of the traditional practitioners.

Initially, the responsibilities of a working group might be the following:

(1.) Identification and maintenance of a list of traditional health practitioners

Each country should develop a list of traditional health practitioners and gradually include all its practitioners in it. It will not be possible to identify and list each and every practitioner, but listing could be an essential component of a country's health monitoring and information system. This is the first step in the process of obtaining information upon which to develop policies and plans. The purpose of the list (not a register at this stage) is to document the existence of traditional health practitioners. The identification and listing should be done in such a way that it confers prestige, and enhances the status of the traditional practitioners; it should not give the impression that it is a form of control. The experiences of Zimbabwe in developing, maintaining, and publishing a directory of traditional health practitioners is a useful model: the directory is a means by which the association of traditional health practitioners can exercise some sort of professional supervision, and it assures the community that the practitioner is recognized by his peers.

The identification process may already be well developed in some countries, and therefore registration rather than listing may be more appropriate. Efforts to register traditional practitioners should preferably be managed by the practitioners themselves, otherwise they may regard it as a means of suppressing their activities or for purposes of taxation. Registration should not necessarily be contingent on examination and it should not on its own confer authority. There may be one register for several specific categories or there may be separate registers, one for each type of practitioner, e.g., the traditional birth attendant, the herbalist. The register should include the specific skills of the practitioner and the conditions treated. It may be useful to begin this process on an experimental basis in a designated geographical or administrative area with a view to replication in other areas. In this way different options for identifying the practitioners and establishing the register can be tested. For example, identification could be carried out through community leaders, and the register maintained by a practitioners' association and shared with all components of the health services.

Once this difficult process has been undertaken, it will become clearer to policy makers, health workers, health administrators, nongovernmental organizations, and other interested bodies who the traditional practitioners are, the nature of their present activities, and how best they can be motivated to cooperate with the official health system in improving and extending primary health care. Listing is not to be confused with registration, or with giving a "licence" to practise, although it would provide the basis for such a development in the future.

A working group would also be responsible for defining, obtaining, organizing, coordinating, and processing all additional types of information needed for effective policy formulation and implementation. Much of this work may best be delegated to other agencies, and here the universities could play a useful role in bringing together different though related disciplines - medicine, law, sociology, and anthropology - to speed the information-gathering process.

(2.) Review of existing laws and policies

The second priority task for a working group concerns a review of existing laws and policies directly or indirectly affecting the practitioners. This could be undertaken by a law reform commission, standing or ad hoc. The preliminary work could be assigned to university faculties of law or sociology, and then submitted to the Commission for examination.

The review process should include the following tasks:

- i) The identification and examination of all existing relevant legislation. For example: laws governing the practice of the health professions (medicine, nursing, midwifery, technicians), drugs and pharmacy laws; hospital regulations; criminal and civil laws; witchcraft legislation, etc. The types of legislation needing review and possible amendment or repeal will differ from country to country. Attention should also be given to case-law (law established by judicial decision in cases; by precedent), codes of practice, and state, provincial, or local legislation. Where conflicts between laws are revealed, those that are not favourable to traditional health practitioners should be identified for close examination and possible reform.
- ii) Identification and review of customary law to identify conflicts with statutory law. The duality of legal systems, common in developing countries needs to be reconciled. Most developing countries have inherited colonial laws which fail significantly to take account of indigenous customs. Yet, many traditional practices are based on spirit-belief, magic, divinations, and rituals. These might belong to a traditional and customary domain for which legislation may be inappropriate.

(iii) Study and reporting on the implementation and impact of existing laws on policies affecting the practice of traditional medicine.

The purpose of this kind of review is to make proposals for changes in legislation so that traditional health practitioners are unambiguously and officially recognized by law as having the right to practise. Therefore they could be utilized in the national health system, and their clients would have the right to consult them and, where necessary, be referred by them to other levels of the health services. In principle, traditional practitioners should be consulted when proposals for new or revised legislation are being drafted.

Basic legislation should not specify how to organize traditional practitioners or which place they should occupy in the health system. It should be flexible, not too detailed, and subject to periodical amendment, as the situation changes. One option is the enactment of "enabling" or "umbrella" legislation, which empowers a ministry of health to issue orders and make regulations as and when necessary.

A thorough review of legislation may reveal hidden inconsistencies. For example, Section 37 of the Unani, Ayurvedic, and Homoeopathic Practitioners Act 1965, in force in Pakistan (and formerly in Bangladesh) prohibits registered Ayurvedic practitioners from signing or authenticating any certificate required by law to be signed by a qualified medical practitioner. Whilst Ayurvedic practitioners may treat patients and hold appointments in hospitals of Ayurveda, they cannot issue a certificate to these patients indicating that they have done so. In Bangladesh, the 1965 Act was repealed and replaced with the Unani and Ayurvedic Practitioners Ordinance, 1983. While there is no provision such as Section 37, the right to sign or authenticate a medical or physical fitness certificate has still not been included in Section 30 of the Ordinance under privileges of registered Ayurvedic and Unani practitioners. A careful analysis of regulations affecting traditional practitioners may reveal ambiguities and inconsistencies, and therefore facilitate the drafting of corrective measures to better promote their utilization in the national health system and enhance their status in their communities.

(3.) Associations of traditional health practitioners

An association of traditional practitioners would enable them to collaborate collectively and individually with different government bodies in the task of developing policies and plans in support of national primary health care programmes. It would also facilitate the collection and dissemination of information on traditional medicine and its practitioners. This information would reveal to officials of the national health system and to the general public the current status of traditional medicine and its utilization in health care services. The organization of practitioners into groups that establish, regulate, and monitor job performance would undoubtedly protect the patient and the community, and improve the standards of practice through the development of a code of ethics that would also upgrade the status of the practitioner. It would accelerate and enhance collaboration between indigenous practitioners and the country's health sector. The characteristics and composition of such an association will depend upon the types of practitioner, as well as the social, cultural, and geographical factors in each country. It may be necessary to have more than one association if the separate categories of practitioners are unable to organize themselves collectively; where there are several associations, they may form part of a larger federation.

Practitioners need to be motivated to form their own associations. Incentives could include participation in decision making concerning the planning, implementation, and evaluation of health services; membership, in action-oriented research bodies; financial support for education and training programmes; financial support for the association itself; and the lifting of repressive or restrictive national and local regulations, such as the prohibition of the marketing of herbal medicines.

An organized group can facilitate dialogue between the traditional practitioners and representatives of the government so that when legislation is under consideration there would be more assurance that the provisions drafted are realistic and appropriate insofar as they soundly regulate the practice of traditional medicine. When regulations on remuneration or supervision are being proposed, discussions should also include the people who will be affected, to ensure that the regulations will be applied and respected. Legislation should equally support the creation of associations of traditional practitioners, the same as it supports councils of physicians, nurses, health auxiliaries, and other health personnel. Legislation should also lend authority to the codes of ethics set by the associations.

(4.) Education and information

Before the development of any effective policies calling for cooperation and collaboration between practitioners of the traditional and Western-based health systems, there has to be an understanding of, and mutual respect for, each other's system. Practitioners in both systems will need to understand each other's philosophy of health and disease and knowledge of health care procedures. Traditional practitioners do not only dispense herbal medicines and prescribe curative treatments; they also perform divinations - rituals through which social relations within and between communities and individuals are improved. In many developing countries there is ignorance, hostility, and distrust of each health system for the other. Health personnel trained in modern medicine are conditioned to regard traditional medicine as harmful, and without any rational base. This same attitude often holds true for bureaucrats, politicians, and some segments of the general population.

In China, however, Western-style medical schools teach their students the basic principles and elements of traditional Chinese medicine; and the traditional practitioners are instructed in allopathic medicine. And, in Zimbabwe, the policy since 1982 has been to instruct medical students and social science students in aspects of traditional health care.

Respect and understanding between the two systems of medicine might be achieved through multiple strategies which include the following activities:

- 1) The introduction of subject matter on traditional medicine and its practitioners in the educational programmes for physicians, nurses, midwives, and social scientists. Students should also be encouraged to participate in action research on traditional health care.

- 11) A series of educational workshops or seminars for practitioners of both systems. The experience in Zimbabwe shows that these must be carefully planned and carried out, observing the following points: neutral location; equal number of participants from both systems and perhaps no more than 25 altogether; a traditional health practitioner as chairman, carefully selected speakers; a seating arrangement that mixes traditional and modern health care personnel; and content that is arranged to begin with discussions on the need for sharing experiences and showing mutual respect, as well as social issues affecting health. Medical topics should only be discussed later.

The public at large merits a vigorous information campaign, but key target groups should be identified for special educational activities or campaigns. These might include the modern health care personnel, particularly physicians, nurses, and midwives who tend to be most vocal in their opposition to policies calling for collaboration; politicians and bureaucrats; and teachers. The media should be enlisted to explain the rationale for the policies through articles in newspapers, magazines, and programmes on radio and television. These educational campaigns need careful orchestration; sometimes the involvement of a leading public figure may create the necessary momentum to the information and persuasion exercise. A statement by the head of state, or a minister of health, explaining the government's policy and its reasons can be a powerful element in forming positive public opinion.

The preparation and dissemination of appropriate information to a wide public cannot be successfully undertaken without strong financial support from the government or outside agencies. This is a task in which nongovernmental organizations could assist.

(5.) Education and training of traditional health practitioners

The traditional practitioners and the communities they serve are very often confused about the philosophy and rationale upon which Western-based health care is delivered. Their concept of illness and disease, and its causes and symptoms, are perceived in different ways.

Effective collaboration between the practitioners of both health care systems precludes education and training of those health practices particular to each system. In Sri Lanka, for example, the Government is utilizing certain categories of traditional practitioner in local community health programmes. The traditional practitioner may also receive training in allopathic medicine and in the way the formal health system is organized and functions. At present, no measures have been taken to use traditional practitioners in the training of modern health personnel, although it has been suggested that this might be a useful strategy, given their total lack of knowledge about traditional health care and the attitudes of the community towards its practitioners. While there has not been any collaboration between the numerous associations of traditional health practitioners and the modern health personnel, the medical, nursing, and midwifery councils could initiate and organize collaborative activities, including training. The major constraint appears to be resistance to the traditional practitioner on the part of modern health care personnel, together with a lack of understanding of their role in the community and their potential value in health development. It is up to the management of a health system to encourage this exchange of learning and experience between practitioners of both systems by sponsoring, for example, joint workshops, seminars, and other activities organized for this purpose.

In Zimbabwe, the Traditional Medical Practitioner Act of 1981 provides a strong framework for training traditional health practitioners in programmes sponsored by the national health system, and the Ministry of Health has started training a small group of traditional birth attendants on an experimental basis. Courses have also begun in which medical and social science students learn some elements of traditional medicine and participate in relevant research. The Department of Education of the National Traditional Healers' Association runs two schools for traditional practitioners, and occasionally joint seminars are held for practitioners from both systems. However, a shortage of funds is the main constraint to an expansion of this activity.

Training of traditional practitioners is essential to improve their existing skills; to eliminate harmful practices; and to add, where appropriate, new functions to their present tasks. For the optimum collaboration in primary health care, traditional practitioners can be trained in detection and diagnosis of disease; prevention and public health activities; basic hygiene; family planning; immunization; diarrhoea control; and, possibly, in simple surgery.

(6.) Learning from experimental projects

Small-scale experimental projects which involve both traditional practitioners and modern health care personnel in primary health services should be developed and carried out in small administrative or geographical areas. Successful projects can later be replicated in other districts and regions in the country, or expanded under the national primary health care programme. Governments should support these projects and provide funding for their expansion. Funds not available from the national budget may need to be secured from external sources. The project experiences should be written in sufficient detail to provide guidelines for future expansion of the activity, and periodic progress reports should draw attention to those strategies which have proved successful, and explain the reasons why some have not. A team, composed of traditional practitioners and community health workers, should together work out solutions to deal with recurrent problems, relying on their own knowledge, skills, and experiences. University-affiliated hospitals could share with traditional practitioners their ideas and experience in delivering health care to underprivileged communities when it comes to designing a low-cost experimental project for implementation in their catchment/referral area.

In Brazil, the Ceará project has successfully demonstrated that spiritual healers can be effectively trained in elementary paediatrics and child care.³ Many cultures have spiritual healers specializing in child care, a traditional role which often dates from ancient times.

(7.) Research and development

Multidisciplinary action research on traditional health practitioners lays the foundation for effectively bringing them into the national health system. A proper understanding of the traditional systems of health care, through research and scientific investigation, will help to ensure the promotion of traditional medicine and facilitate the articulation of traditional practitioners with the national health system. Traditional practitioners should be fully involved in the planning of such research and in its execution and evaluation. They should be represented in all formal research bodies that are established. Adequate government funding for research must also be guaranteed.

The following guidelines are suggested when undertaking research on traditional medicine and its practitioners.

- The objective of the research activity must be very clear and directed at defined, priority health needs.
- When choosing locations for research, those geographical areas most favourable to the administration of research should be chosen.
- The criteria for evaluating the effectiveness of both modern and traditional therapies and medicaments should include the impact of treatments on both the physical and emotional well-being of the patients.

- The fundamental concepts of traditional practices must be considered when they are being evaluated, as well as the context in which they are applied. For example, if a medicinal herb is to be used as treatment in conjunction with a prescribed diet, the herb cannot be assessed in terms of its intrinsic value alone, but only in terms of its effectiveness when used with other measures.
- Research should also attempt to identify aspects of traditional practice that could be introduced into modern medicine. For example, the use of a particular herb or of a certain position for childbirth. The aim should be to systematize and standardize the traditional health practitioner's knowledge.
- Research results should be disseminated, especially to policy makers and decision makers at national level.

(8.) Financial support

Adequate financial support is a key factor in the effective implementation of policies, programmes, and projects aimed at promoting the utilization of traditional practitioners. Financial resources should be made available for public education and information and for the training of traditional health practitioners, both through their own associations and through the official health system. At the national level, funds need to be allocated for support to the working group or government unit responsible for promoting associations of practitioners and their activities.

The Chinese, Indian, and Sri Lankan experiences with traditional medicine have demonstrated that adequate financial support for the development and implementation of policy was best assured when there was a central ministry, bureau, or unit dealing with traditional medicine with its own budget. If the ministry or unit responsible for carrying out the policy had sufficient financial resources, that in itself was evidence of the commitment of the government to implement the policy.

The community will respect the sincerity of the government's commitment to traditional health care only when a substantial share of the national health budget is allocated to promote the collaboration of traditional health practitioners in community health activities destined for the health care of the vast majority of the population.

4. Conclusions

Although there is considerable literature on the training and utilization of traditional birth attendants in primary health care, documenting how many countries have been successful in improving maternal and child health^{12, 14}, the knowledge, wisdom, and capabilities of the traditional practitioner have been utilized to a much lesser extent. One reason is that, except for the herbalist, their functions are unfamiliar to most modern health care personnel. Furthermore, little research has been undertaken to discover more about the role of traditional practitioners in their communities, and the nature and efficacy of their treatments. Lack of knowledge is the greatest obstacle to the formulation of realistic and constructive policies. Action-oriented research on traditional health practitioners and their practices, therefore, has to be a priority in all countries.

The developments of a policy favourable to traditional practitioners depends upon an enlightened understanding of the nature of traditional health care, and the role and resources of its practitioners, many of whom possess a fund of wisdom, knowledge, and experience that can only serve to improve the quality of care that countries provide for their populations.

The following measures have been identified as beginning steps in the development of policy:-

(1.) Specific reference to a policy on traditional systems of health care and traditional practitioners in the national health development plan or development plan, or in the manifestos of political parties and of the government. The policy is usually reiterated in official publications and then distributed at the local level, e.g., in community health workers' manuals.

(2.) Dissemination of information to politicians, bureaucrats, administrators, opinion leaders, and communities, as well as health professionals and traditional practitioners on the benefits that can be expected from cooperation between the two systems. The means to disseminate such messages should include all available appropriate media: journals, newspapers, radio, television, etc.

(3.) The participation of representatives of traditional health practitioners on decision-making bodies dealing with the development of health policy.

(4.) The establishment of a national research programme on traditional health care within the framework of an appropriate health infrastructure that assures the programme of the necessary financial and administrative resources.

(5.) Support for multidisciplinary research on traditional health care (e.g., sponsoring postgraduate dissertations and research in faculties of medicine, midwifery, anthropology, community development, sociology, law, and psychology, etc.; funding surveys and investigations).

(6.) A review of existing legislation, and the proposal of appropriate amendments, by interdisciplinary teams of researchers from faculties of medicine, law, sociology, and anthropology. This review could extend to the identification of relevant specific and general laws and regulations concerning the practice of medicine, dentistry, nursing, and midwifery, and the control of drugs and poisons, penal laws, local laws, and public health codes.

(7.) Sufficient allocation of financial resources for the implementation of activities, programmes, and projects on traditional health care.

(8.) The creation of a special governmental office responsible for traditional health practitioners: education and training; research and information on them; registration; certification; licensing; supervision; and remuneration. This office could be within the ministry of health or a separate ministry. Alternatively, it could be a coordinating committee, council, or unit that would work with, for example, the ministries of justice, agriculture, and social welfare, and with the departments responsible for community development and women's affairs. It would also be responsible for the review of legislation affecting traditional practitioners, including traditional birth attendants, the consideration of proposals for law reform, and for drafting amendments or new statutes. Such an entity would also establish the appropriate mechanism for managing traditional practitioners;

this would normally function through organized associations of traditional healers set up for purposes of self-regulation and adherence to a code of ethics. Responsibility would also extend to ensuring a dialogue between the health professionals and the health agencies of the official health system, as well as interested nongovernmental agencies.

(9.) The study of traditional health care practices by students of Western-based medicine: nurses, midwives, physicians, etc., and training in the basic components of primary health care for the traditional practitioners, in addition to an explanation of the policy and organization of the formal health system.

(10.) Arrangements for an exchange of traditional health practitioners and modern health personnel at their places of work in hospitals, clinics, and villages.

(11.) Official government support for the formation and continued functioning of associations, guilds, organizations, federations, or unions of traditional health practitioners.

(12.) A code of ethics formulated by associations of traditional health practitioners in conjunction with the ministry of health or a specially established committee. Enforcement of the code would usually be effected through the association, but ultimate sanctions should reside in the criminal and civil laws.

5. Recommendations

The traditional health practitioners, including traditional birth attendants, constitute a major and valuable reserve of human resources that must be better utilized within every country's national health service, if the health status of populations is to be improved, and the goal of health for all by the year 2000 is to be achieved.

The participants of the Consultation unanimously agreed that primary health care programmes are central to the health development of communities, and that Member countries should take immediate action to mobilize and involve traditional practitioners in these activities. The traditional practitioners are readily accepted by the people they serve, and with support and recognition by the ministry of health and by professional health personnel, the potential they possess can add greatly to the momentum of primary health care development and accelerate the achievement of the goal of health for all.

A review of existing policies and legislation in some selected countries* revealed that in the majority of developing countries, the absence of clear and positive policies, and supportive legislation authorizing and promoting traditional health care and traditional practitioners, made progress towards full collaboration between the two systems of health care slow, and often impossible.

The broad objective of a policy on traditional practitioners is to improve the health of the population, particularly those who have no access to the official health system and who have been treated for generations by their local practitioners. The health status of these populations has now become a priority issue.

Although the formulation of relevant and realistic policy is an arduous task for governments, the Consultation recommended several approaches. However, not every proposal will be applicable to all countries. Indeed, some countries, in particular China, India, and Sri Lanka, are already well

* Case studies: India, Mexico, Sri Lanka, Sudan, Tanzania, Zimbabwe (Annex 5).

Discussed at the Consultation: Brazil, China, Japan, Philippines, Sierra Leone, Syria

advanced in their process of collaboration with traditional practitioners, and can offer useful lessons to those which are only now beginning to assume the task. The recommendations are broad in scope, and avoid detail. The formulation and implementation of policy ultimately depends upon political will, which in turn is dependent significantly on the attitudes and influence of powerful groups representing vested interests.

The recommendations place great emphasis on the need for education and information campaigns in order to instigate government action.

(1.) Formal recognition of traditional health practitioners

Governments should formally recognize and legitimize the practice of traditional health practitioners; they should declare clear policies on the utilization of traditional practitioners to improve and extend health care services. In countries where existing legislation is not supportive of traditional practitioners, supportive policies should be adopted as a temporary measure until the more time-consuming process of legal reform can be carried out.

(2.) A working group on traditional health practitioners

A working group should be established in every country where traditional practitioners provide a well-established form of health care in the community; ultimately this should become a unit within the ministry of health, or some other ministry, e.g., home affairs, community development, or it could even become a separate ministry. The group must include traditional practitioners. Its purpose is to take the lead in developing policies, programmes, and, where necessary, legislation supportive of traditional practitioners.

(3.) Legislation

Where existing legislation presents a barrier to the promotion of traditional health practice, it should be repealed, or amended, and ultimately replaced by supportive legislation. The experience of countries shows that legislation prohibiting the practice of traditional practitioners does not succeed.

Legislation that formally recognizes traditional medicine and traditional practitioners should be flexible, allowing for periodic amendment as situations change. Traditional practitioners should be consulted regarding the content of the draft. Conflicts in law should be identified and removed, deleting those sections which oppose new supportive legislation and the stated policy.

(4.) Associations of traditional health practitioners

Governments should encourage traditional practitioners to establish and maintain their own associations, and to develop their own disciplinary arrangements and training opportunities. The associations should be consulted and involved in all matters relating to policy on the practice of traditional medicine.

(5.) Lists of traditional health practitioners

Governments should collaborate with associations of traditional practitioners to maintain a list of practitioners. The primary purpose of such a list is to document the existence of each practitioner. This is the first step towards obtaining information upon which to develop policy and legislation. Countries that have formal training programmes and licensing arrangements may need two registers: one for the formally trained practitioners, and one for the others.

(6.) Research

Multidisciplinary action research should be undertaken to promote traditional health care and the utilization of its practitioners in primary health care. They should be represented in all formal research bodies that are established, and involved in the planning and implementation of research, and in the evaluation of research findings. This involvement will later facilitate their collaboration and articulation with the national health system.

(7.) Education of health professionals and the public

Information about traditional health care and its practitioners should be introduced into the curricula of medical, nursing, and midwifery students, and in courses of social and behavioural sciences. Where possible, these students should be involved in action research.

Appropriate information about the philosophy, principles, history, and value of traditional medicine, and its practitioners, should also form part of the secondary school curricula, and be introduced in the training courses of teachers.

Joint seminars and educational workshops should be held for practitioners of both systems.

There should be information and education campaigns for the general public, and for key target groups.

(8.) Training of traditional health practitioners

Ministries of health should establish and maintain training courses covering the philosophy, principles, and essential components of primary health care for all traditional practitioners in order to improve their knowledge and skills to meet the health needs of their communities more effectively. Training can be provided through:

- a.) Associations of traditional health practitioners
- b.) Primary health care programmes

Recruitment of traditional practitioners for training should be carried out through their associations, where they exist, and the associations should participate in designing the content of the training programme, its organization, and administration.

(9.) Resources

Financial, material, and human resources should be made available for public information campaigns, education and training programmes, the establishment of clinics and pharmacies, development and organization of associations, and the maintenance of a unit or office dealing entirely with the affairs of traditional practitioners.

Recommendations to WHO for follow-up action

WHO's support to Member States in their efforts to mobilize and utilize the different categories of traditional health practitioner through adequate and appropriate education and training will help to ensure that this source of

health worker can participate more effectively in the implementation of national strategies to achieve health for all. To this end, WHO should:

- (1.) Encourage Member States (ministries of health, legislative bodies, health professional associations, planners and decision makers in health development and health manpower development) to consider the above recommendations and to select the relevant ones.
- (2.) Encourage Member States to include traditional health practitioners in national bodies to promote, support, and monitor the mobilization and utilization of traditional health practitioners in primary health care.
- (3.) Organize workshops in individual countries to study the contributions of traditional health practitioners and to examine their training programmes in order to accelerate their articulation with the official health system and to systematize their practices.
- (4.) Ensure, to the greatest extent possible, that the resources required to give effect to the mobilization, training, and utilization of traditional practitioners be made available and channelled to those countries having positively shown the will to involve traditional practitioners in primary health care.
- (5.) Support the work of collaborating centres in research on traditional medicine and its practitioners.
- (6.) Support technical cooperation between countries, through collaborating centres, in order to facilitate the sharing of knowledge and experience, and the participation in joint endeavours.
- (7.) Create a pool of experts which could be called upon to assist those countries wishing to articulate traditional health practitioners with the official health system.
- (8.) Exploit to the full public relations and channels of public information to disseminate the above recommendations to professional and public audiences nationally, regionally, and globally.
- (9.) Consider preparing some general guidelines for the development of policies to support traditional health practitioners and to promote their contribution to primary health care.

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EXPLANATORY NOTES ON TERMS USED

Ayurveda

Ayurveda means the science of life. It is a traditional Hindu system of medicine which originated mainly from Atharvaveda, one of the Vedic scriptures and is based on certain fundamental doctrines known as Darshanas.

It utilizes herbs, minerals, and dietary restrictions in the treatment of illness and advocates surgical treatment for certain diseases. By observing certain principles in its recommended way of life, Ayurveda provides for maintenance of positive health and prevention of disease.

Community health worker

A trained health worker generally coming from and selected by the community in which he/she will work, who provides on a full-time, part-time, or voluntary basis, the individual and the community with primary health care. In developed areas they may be midwives or family doctors, and in the rural areas of developing countries - where the majority of mankind lives - community health workers may be medical or veterinary assistants or auxiliary nurses, often auxiliaries with little training and frequently traditional healers or traditional birth attendants. They live within the community and work in liaison with the health and developmental services of the country.

Health system

The complex of interrelated elements that contribute to health in homes, educational institutions, places of work, and communities, as well as in the physical and psychosocial environment and the health and related sectors. The system includes services, institutions, organizations, and those operating them for the delivery of a variety of health programmes which are organized at various levels starting with the peripheral or primary level of health care (see below) and proceeding through the intermediate to the central level. It provides to individuals, families, and communities, health care that consists of a combination of promotive, preventive, curative, and rehabilitative measures. The official health system is the one operated by the government.

Herbal medicine (or phytotherapy)

Until the advent of sulfonamides in the 1930s, the vast majority of medicaments used throughout the world were of plant origin. While in industrialized countries the usage of these plants has diminished, though large quantities are still consumed, the vast majority of inhabitants of developing countries still depend on herbal remedies prescribed by their traditional health practitioners.

Licensing of traditional health practitioners

Formal, written permission from a constituted authority to give traditional health care after meeting stipulated requirements and standards of practice.

Primary health care

Essential care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. Primary health care is the central function and main focus of a country's health system, the principal vehicle for the delivery of health care, and the most peripheral level in a health system stretching from the periphery to the centre. At the very least it should include education of the community on health problems and methods of preventing them; the promotion of adequate food supplies and of proper nutrition; sufficient safe water and basic sanitation; maternal and child health care; immunization; treatment of common diseases and injuries; and the provision of essential drugs.

Primary health care approach

The establishment of a health system, as described in the Alma-Ata report,² with primary health care as the central function and main focus.

Registration of traditional health practitioners

The recording of details (age, location, training, experience, etc.) of traditional health practitioners according to their type of practice, in a register which is maintained by an official body.

Research, action-oriented

Research undertaken to acquire information that can be applied directly to the improvement of health care through the utilization of traditional health practitioners.

Siddha

A traditional system of medicine extensively practised in the southern states of India and in Sri Lanka, Malaysia, and Singapore where the Dravidian civilization was dominant. The principles and doctrines of this system have a close similarity to Ayurveda, with a specialization in iatrochemistry. It uses mainly metals and minerals (mercury, sulphur, copper, and arsenic), as well as vegetable and animal products.

Traditional birth attendants

A person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other traditional birth attendants. The traditional birth attendant in many cases provides basic care to women throughout the normal maternity cycle, provides care to the normal newborn, participates in the promotion of modern methods of family planning, and participates in other primary health care activities, including the identification and referral of high-risk patients. The traditional birth attendant is also known by other names, e.g., indigenous midwife, empirical midwife, traditional midwife, etc.

Traditional Chinese Medicine

A system of health care based on the cosmological concept of Yin-Yang and Wuxing or the Five Elements, and on the accumulation of empirical observations since its earliest recorded history in 1800 B.C. and collected in a famous

medical book - the Internal Classic - around 300 B.C. It uses herbs and other natural products with over 3000 kinds of drugs for both preventive and curative purposes, and also includes treatment with acupuncture, moxibustion, and many other types of non-drug therapy. The theory and practice of traditional Chinese medicine have been adopted and extended to include local variants and pharmacopoeias in many countries including Lao People's Democratic Republic, Japan, Malaysia, Republic of Korea, and Singapore.

Traditional healer

A person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal, and mineral substances and certain other methods based on the social, cultural, and religious background as well as on the knowledge, attitudes, and beliefs that are prevalent in the community regarding physical, mental, and social well-being and the causation of disease and disability.

Unani

Unani Tibb or Graeco-Arab medicine may be traced to that system of Greek medicine that was developed during the Arab civilization. It is now practised in the Indian subcontinent. The basic framework consists of the four humour theory of Hippocrates. The pharmacopoeia consists of natural drugs, mainly herbal, but also including animal, mineral, and marine preparations.

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ANNEX 2

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AGENDA

Monday, 4 February 1985

09.30 - 10.30 hours	Registration of participants
10.30 - 11.00 hours	Inaugural session
11.00 - 11.15 hours	Group Photograph
11.15 - 12.00 hours	Adoption of Agenda
	- Introduction and objectives of the Consultation
	- HFA/2000 and Traditional Health Practitioners
12.00 - 13.00 hours	Lunch break
13.00 - 14.45 hours	Review of current situation on utilization of traditional health practitioners in primary health care.
	- Discussion
14.45 - 15.00 hours	Tea/coffee break
15.00 - 16.30 hours	Discussion continued

Tuesday, 5 February 1985

09.00 - 10.30 hours	Review of existing policies and legislation on traditional health practitioners and their implementation.
	- Discussion
10.30 - 10.45 hours	Tea/Coffee break
10.45 - 12.00 hours	Discussion continued
12.00 - 13.00 hours	Lunch break
13.00 - 14.45 hours	Discussion continued
14.45 - 15.00 hours	Tea/Coffee break
15.00 - 16.30 hours	Discussion continued

Wednesday, 6 February 1985

09.00 - 10.30 hours	Identification of policy options likely to enhance improved collaboration and involvement of traditional health practitioners in health care
10.30 - 10.45 hours	Tea/Coffee break
10.45 - 12.00 hours	Discussion continued
12.00 - 13.00 hours	Lunch break
13.00 - 14.45 hours	Discussion continued
14.45 - 15.00 hours	Tea/Coffee break
15.00 - 16.30 hours	Discussion continued

Thursday, 7 February 1985

09.00 - 10.30 hours	Approaches towards the development of effective policies on traditional health practitioners
10.30 - 10.45 hours	Tea/Coffee break
10.45 - 12.00 hours	Discussion continued
12.00 - 13.00 hours	Lunch break
13.00 - 14.45 hours	General discussion and recommendations
14.45 - 15.00 hours	Tea/Coffee break
15.00 - 16.30 hours	General discussions and recommendations (continued)

Friday, 8 February 1985

09.00 - 10.30 hours	Summary of report and recommendations
10.30 - 11.00 hours	Tea/Coffee break
11.00 - 12.00 hours	Closure of the meeting

GUIDE FOR THE PREPARATION OF COUNTRY CASE STUDIES ON POLICY DEVELOPMENT
FOR TRADITIONAL HEALTH PRACTITIONERS, INCLUDING
TRADITIONAL BIRTH ATTENDANTS

REMINDERS

1. Case study report should be limited to no more than 20 typewritten pages.
 2. If a complete description is required for any of the items, write a summary of the main points and include more detailed information in the Appendix.
 3. Report should be as concise as possible with brief descriptive statements related to, and organized in accordance with, the sub-headings. If additional sub-headings are needed, these may be added where appropriate.
 4. Deadline for submission: 30 August 1984.
- A. Identification and definition of traditional health practitioners - who are they and what do they do?
1. Categories of traditional health practitioner and the (approximate) number in each category. Traditional health practitioners may be described according to:
 - a. Uniformity and degree of training (for example, as:
 - 1) members of formal systems: Ayurveda, Unani, Chinese, or as,
 - 2) folk healers)
 - b. Healing methods - primary type of healing (for example, as
 - 1) shamans
 - 2) faith healers
 - 3) magicians
 - 4) herbalists
 - 5) bonesetters
 - 6) traditional birth attendants
 - 7) medicine sellers
 - 8) others ...)
 - c. Task

Are their tasks primarily curative or preventive or both? If curative, are the traditional health practitioners primarily concerned with somatic, psychological, psychosomatic, or social problems, or a combination of these (please include detailed information in the appendix?

2. Location of traditional health practitioners - Where do they primarily practise (for example, in urban as well as rural areas)? Does this differ for different types of healers?
3. Who are their patients?

For example, are the patients primarily unschooled and from isolated rural villages or do they represent the full spectrum of the country's population? Do particular population sub-groups make greater use of traditional health practitioners than others? Does this depend on type of traditional health practitioner and/or type of problem? If it does, please indicate accordingly. What is the approximate % of the country's population for whom traditional health practitioners are the predominant (or only) health care resource?

B. Existing national policies and legislation on traditional health practitioners

1. Policies on traditional health practitioners
 - a. Is there a general national policy for all traditional health practitioners and/or specific national policies for different categories of traditional health practitioner (for example, a positive policy relative to traditional birth attendants but less positive for other folk healers)?
 - b. If different policies exist what are the major reasons for this differentiation?
 - c. Have these policies (and reflected legislation) changed over time (what is the history of these policies)?
 - d. Are these policies popular with traditional health practitioners and local population?
2. Legislation
 - a. Is there general and/or specific national legislation concerning traditional health practitioners?
 - b. Does the national legislation differentiate according to type of traditional health practitioners and/or type of healing activity?
 - c. Is allowance made for different districts/states or political sub-groups to determine their own policy and/or form their own legislation (decentralization)?
 - d. To what extent is legislation implemented?
3. Registration and licensing
 - a. Is there a registry of traditional health practitioners? (for all or only for some? If so, for whom?)
 - b. Are traditional health practitioners licensed? (All, only some or none).

- c. Are certificates or other official documents of recognition provided to all or to some traditional health practitioners?
 - d. What is/are the process(es) of evaluation for registration and licensing and what authoritative agency(ies) implement this?
4. Regulation of fees charged to traditional health practitioners
- a. Is there any attempt to regulate fees charged by traditional health practitioners?
 - b. Is payment to traditional health practitioners reimbursable by local health insurance schemes (where they exist)?
- C. Nature of relationship between official health system and traditional health practitioners
1. Describe the predominant relationship between the official health system and traditional health practitioners. Can national policy (and legislation) on traditional health practitioners be characterized as,
- a. exclusive, prohibitive or condemning?
 - b. tolerant but not necessarily condoning?
 - c. inclusive or coexistent; condoned medical pluralism.
2. Traditional health practitioners and primary health care programmes
- a. Are (some) traditional health practitioners involved in national or local primary health care programmes?
 - b. Do traditional health practitioners function as respected partners or as dependent and controlled workers in such primary health care programmes?
 - c. How are the traditional health practitioners viewed by the majority of the official health professionals? (Does this vary according to type of traditional health practitioner?) What are the major reasons for their point of view?
 - d. What do patients want? What is the reaction of the general public to traditional health practitioners? (Does this depend on type of traditional health practitioner) Do most people use mainly one or many forms of healing resources (official and/or "traditional")? Do patients want a greater recognition of, and collaboration with, traditional health practitioners by the official health system.
3. Existence of educational exchanges
- a. Are some traditional health practitioners (e.g., traditional birth attendants) trained/educated in some form of allopathic medicine and about the official health system?
 - b. Are allopathic health workers trained/educated about different types of traditional health practitioner and their healing practices? (for example, do departments of Psychiatry, Community Medicine, etc. involve traditional health practitioners in teaching medical students or other health workers or encourage these students to carry out research regarding traditional health practitioners?)

c. What types of support are needed by traditional health practitioners?

4. Research institutions and associations for the study of traditional health practitioners and traditional medicine.

Describe existing national and/or regional research institutions, study associations, or documentation centres on traditional medicine, including the history and major focus of such institutes. Is a compilation of research literature (descriptive and evaluative) on traditional health practitioners in the country available (including "fugitive" literature, e.g., theses or dissertations)? Please include any bibliographic list in the appendix.

5. Traditional health practitioner associations

a. Briefly describe existing associations of traditional health practitioners, including their history and membership.

b. What are the major functions and/or objectives of the associations?

c. What are the qualifications for membership? How are these determined/substantiated? Does there exist a formal mechanism for evaluating qualifications of potential members?

d. Do the associations have a code of ethics?

e. What is the function of the associations relative to national policy and legislation on traditional health practitioners as well as acceptance of, and collaboration with, traditional health practitioners by allopathic practitioners.

f. What are their relationships with the medical and nursing/midwifery councils?

D. The future of traditional health practitioners and their involvement with the official health system

1. What is the writer's prognosis on the future (situation/role...) of traditional health practitioners in the country and the potential for productive coexistence, collaboration or involvement of traditional health practitioners in the country's primary health care programme(s) for the achievement of HFA/2000?

2. What are some of the major problem areas prohibiting such involvement and what are possible steps which could (need to) be taken for improved realization of positive (and prevention of negative) contributions/activities of traditional health practitioners?

3. What types of policies on traditional health practitioners could be promoted/strengthened/continued to ensure collaboration of traditional health practitioners in primary health care programmes?

4. What steps or approaches could be taken to enhance positive policy formulation?

SUMMARY OF COUNTRY CASE STUDIES

India - Professor K.N. Udupa

A. Identification of traditional health practitioners

Apart from the 400 000 registered practitioners using the Ayurveda, Unani, Siddha, naturopathy, and homeopathy systems, there are an unknown number practising yoga, and several million folk healers such as shamans, faith healers, magicians, herbalists, bone setters, and traditional birth attendants.

The traditional practitioners are primarily practising in rural areas and small towns but are estimated to provide medical and health care to some 70% of the population, combining attention to somatic, physiological, psychosomatic, and social problems.

B. Existing national policies and legislation

There is a general national health policy with regard to traditional practitioners, approved by the Indian Parliament in 1983, which fully recognizes the important role played by the indigenous systems of medicine in providing health care to the population and which lays emphasis on the phased integration of the indigenous and allopathic systems of medicine.

At the first Health Ministers' Conference in 1946, it was resolved that provision should be made for research and training in indigenous systems and that traditional practitioners should be absorbed into the state health system.

Subsequently various committees studied the question in 1948, 1955, and 1959, and most of their recommendations were accepted by the Government of India, resulting in the establishment of the Central Council of Ayurvedic Research in 1966, which later split into Central Councils for Ayurvedic and Siddha Research, for Unani Research, for Yoga and Naturopathy Research, and for Homeopathic Research.

In 1970, the Central Council of Indian Medicine Act was passed to maintain uniformity and to standardize the educational programmes of the indigenous systems of medicines and their practices. Each state also passed legislation for establishing Boards of Indian Medicine to regulate the practices of the indigenous systems, and to register all the practitioners who fulfil the qualification and experience requirements.

There are nearly 250 recognized training institutions in traditional medicine awarding bachelor degrees after 5 1/2 years of training covering anatomy, physiology, clinical biochemistry, microbiology, pathology, radiology, pharmacy, and hygiene as well as the particular system of indigenous medicine being studied. This can be followed by a three-year postgraduate programme leading to an MD degree at a number of research institutes.

There are no regulations on the fees that may be charged, but such fees may be reimbursable where provision exists.

C. Nature of the relationship between the official health system and the traditional practitioners

In general, the relationship tends to be exclusive, but tolerant and peaceful coexistence occurs in most parts of the country.

In some states, the practitioners are involved in the National Primary Health Care Programme, but work under the overall control and supervision of an allopathic health worker.

Although the practitioners now receive scientific training, the official allopathic health professionals remain utterly ignorant of the utility and efficacy of traditional medicine, having had no training or understanding of the different methods used in indigenous medicine.

Each system of traditional medicine has an association, and there is a National Integrated Medical Association, but there is no relationship with the medical, nursing, and midwifery councils.

D. The future of traditional practitioners and their involvement with the official health system

The practitioners should be given orientation and training in various public health and family planning programmes and trained to carry out specified activities within those programmes. They should be utilized to delivery primary health care as part of national strategies to achieve health for all by the year 2000.

They should be given an independent status to work in the rural health centres, to provide curative as well as preventive and promotive aspects of health care, working under the overall supervision of primary health centres with a suitable referral system.

The major problem is the attitude of the allopathic health professionals towards traditional practitioners. Frequent discussions among all the experts of both the traditional and allopathic systems could help to create a climate for promoting a synthesis of the best of all the systems.

Mexico - Dr X. Lozoya

A. Identification of traditional health practitioners

During a survey performed in 1983 of the 3 500 rural communities, 9 482 traditional practitioners were registered. It was estimated that these communities accounted for 70% of the total number of practitioners throughout the country, hence a countrywide figure of over 13 000 may be estimated. Four established categories were recognized (though there are 150 different types of practitioners subdivided according to specialty) with the extrapolated countrywide figures in brackets).

- i) Traditional birth attendants - during the period 1974-1984 more than 15 000 traditional birth attendants have been trained for rural and urban areas; they cover more than two-thirds of the total number of childbirths in the country.
- ii) Healers (3 250) - with 24 subcategories
- iii) Bone-setters (2 340) - with 10 subcategories using massage and ritual manipulations.
- iv) Herbalists (720) - a highly qualified specialist in the knowledge of plants, using them for curative purposes, though this form of therapy is also used by other traditional practitioners.

The work of the practitioners is primarily curative and concerned with somatic, psychological, and social problems.

Sixty-one percent are women; nearly 90% are over 40 years of age, and 25% of them are over 60 years. Their highest concentration is in rural areas, but with a geographical concentration among the Mexican-Indian populations in the southwest of the country.

With the recent increase in financial resources due to oil export, over 3 000 new rural allopathic medical units have been opened, covering 60% of the population. However, traditional practitioners have continued to be the first choice of the rural population.

B. Existing national policies and legislation

There is no general positive national policy for traditional practitioners, nor specific national legislation or regulation of fees.

Some of the training programmes for traditional birth attendants are controversial, resulting in their being referred to by such terms as "pill TBAs" or "empiric TBA".

C. Nature of the relationship between official health system and traditional health practitioners

The relationship may be characterized as co-existence. The dominant culture looks at traditional medicine as a manifestation of underdevelopment.

In 1980, the Mexican Institute of Social Security created a unit to study medicinal plants and other aspects of traditional medicine. Later it introduced a programme for the interrelation of both systems of medicine. This programme was designed to involve traditional practitioners in the health activities of 3,500 rural medical units of the Social Security system.

The objectives of this activity were to: introduce the allopathic medical staff to traditional health practices; identify the practitioners in the community and invite their collaboration; create a botanical garden at the unit and collect the most important medicinal plants in the area; detect the ailments specially treated by the practitioners; and to offer training courses for practitioners on basic medical procedures.

The reaction of the allopathic medical group was mainly positive, and it was even suggested that traditional birth attendants should be appointed to community health committees.

D. The future of traditional practitioners and their involvement with the official health system

The health care of traditional practitioners will probably be influenced by their collaborative work with the official health services and this will, in turn, undoubtedly modify to some extent the way they carry out their health activities. This could lead in future to a disappearance of Mexican traditional medicine, as such, and the official health system would absorb its approved practices, making its practitioners another category of modern health worker.

Sri Lanka - Prof. N. Ratnapala

A. Identification of traditional health practitioners

There are two categories:

- i) The Ayurvedic, Siddha, and Unani practitioners, trained at formal institutions, such as the Ayurveda College attached to the University of Colombo, the Siddhayurveda College, and several private colleges. These practitioners are awarded diplomas, or recognized, by the Department of Ayurveda and the Hospital Board.
- ii) Traditional healers registered by the government who have been engaged in the practice of traditional medicine for a number of years. They specialize in treating snake bite, hydrophobia, fractures and dislocations, eye, mental and skin diseases, boils, cancer, burns, and acupuncture.

Graduates tend to practise in urban areas; registered traditional practitioners usually practise in rural areas where allopathic medicine is not readily available and where they represent primary health care. There were about 12,000 registered traditional practitioners by February 1984.

B. Existing national policies and legislation on traditional health practitioners

The Government health policy is to recognize and encourage traditional forms of medicine and this is formalized under the Ayurveda Act No. 31 of 1961 as amended by the Ayurveda (amendment) Law No. 7 of 1977.

This Act resulted in the establishment of the Ministry of Ayurveda, the Bandaranaike Ayurvedic Research Institute, the Ayurvedic Drug Corporation and of Boards for compiling the Ayurvedic pharmacopoeia; the expansion or setting up of Ayurvedic hospitals and dispensaries receiving financial grants; the affiliation of the Ayurveda College to the University of Colombo; and the training of traditional Ayurvedic physicians, including the publication of books on this form of practice of medicine. This legislation provided also for the Siddha and Unani systems.

The Government has no policy with respect to traditional birth attendants being replaced by public health midwives.

Registration and licencing of all traditional practitioners is carried out by the Ayurvedic Medical Council, either accepting the certificates of satisfactory passing out of the various Ayurvedic institutions or after carrying out examinations.

Traditional practitioners who previously considered it their duty as members of society to assist their fellows now tend to charge fees which, however, are not reimbursable under health insurance schemes.

C. Nature of the relationship between official health system and traditional health practitioners

While the Government's policy is to treat both the traditional and allopathic systems on an identical basis, in reality the relationship is more one of tolerance and accomodation. However, administrators and practitioners within the allopathic system do not welcome traditional medical practice. Nevertheless, the rural populations generally have greater confidence in the traditional practitioners.

The Government is involving certain traditional practitioners in local primary health care programmes; 300 Ayurvedic physicians are being trained in family health in a pilot project sponsored by WHO and financed by the United Nations Fund for Population Activities.

Although traditional practitioners trained at the Institute of Indigenous Medicine acquire substantial knowledge about allopathic medicine and the official health system, the allopathic health workers do not have any knowledge or training in the traditional systems of medicine. However, more traditional practitioners could be introduced to modern scientific achievements through short training courses, seminars, etc.

D. The future of traditional health practitioners and their involvement with the official health system.

The traditional practitioners have a vital role to play in the country's programmes to extend primary health care. However, the official health system has failed to recognize, employ, and remunerate practitioners, probably because they lack modern scientific knowledge. On the other hand, practitioners of the allopathic system do not appreciate the value of traditional practitioners in the villages and rural communities. Information about traditional health care should be incorporated in the education programmes for nurses, midwives, and other modern health care personnel. The role the traditional practitioner can play in the preventive aspects of primary health care should be recognized in the wider social context, and the practitioner should be brought together with other public health workers in the rural areas.

Sudan - Dr A. El Safi

A. Identification of traditional health practitioners

The main types of traditional practitioners may be categorized as follows:

- i) Faith healers - religious healers of the Moslem areas. Their medical knowledge is derived from Islamic sources: Tibb an Nabawi (medicine of the Prophet) and medieval Moslem physicians. The faki is generally an itinerant cleric with healing ability and who can practise black magic.

The faqir is usually the head of a religious brotherhood. Exclusively male, their practice is based on a blend of astrology, numerology, divination, and herbalism.
- ii) Zar practitioners occur throughout Moslem areas and are more commonly found in urban areas. Predominantly women, their clientele are exclusively women suffering from social, psychological, and psychosomatic illness. Zar is considered curative and corrective and may be practised periodically as a preventive measure.
- iii) Traditional birth attendants or daya were illiterate women with no knowledge of asepsis, hygiene, or anatomy. Since 1920, however, they have been encouraged to attend practical training courses.
- iv) Bone-setters are generally skilled men. They also compound drugs and use poultices, dietary regimes, and massage. They are, however, ignorant of anatomy and physiology, so their results are frequently unsatisfactory. They are found in both urban and rural areas.
- v) The Shamans of the Nuba mountains are those in whom a powerful spirit is incarnated. They mainly deal with mental illnesses, and are called upon to bring rain, a good harvest, or to alleviate illness and epidemics.
- vi) Herbalists are not generally specialist healers. The market peddlers of herbs are usually Moslem Nigerians who are famous for their skill in black magic. They deal in snake bites, scorpion stings, stab wounds, etc.
- vii) There are many other healers, e.g., witchdoctors, but not all lend themselves to categorization.

B. Existing national policies and legislation on traditional health practitioners

There are no clauses in the Sudan Medical Council Act 1973 or in the Public Health Act 1975, amended 1980, that identify or recognize traditional medicine or that refer to any other alternative system of health care. Traditional medicine has never been prohibited or condemned by law. In spite of more attention to traditional health care over the past 15 years in official policies, in general the attitude is still benign indifference. An exception is the training of midwives. They are also certified, licensed to practise, and issued midwifery kits.

C. Nature of the relationship between official health system and traditional health practitioners

Traditional health care and its practitioners co-exist peacefully with allopathic medicine, but they have remained obscurely on the sidelines. However, the government has founded three institutes related to traditional medicine in an attempt to explore the potential of traditional health care to community health development.

- i) The Medicinal and Aromatic Herbs Research Unit of the Medical Research Council, founded in 1970.
- ii) The Traditional Medicine Research Institute was founded in 1980 to draw up a national policy on research in traditional medicine, to evaluate it in the light of modern science, and to promote the integration of valuable knowledge and skills of traditional medicine into the health care practices of the official health system.
- iii) The Medicinal and Aromatic Herbs Research Institute, which has been carrying out research on herbs and plants for over a decade. Traditional practitioners are not yet involved in primary health care and there is no exchange of instruction on allopathic or traditional medicine with practitioners of the two systems, except for the training of traditional birth attendants that began in the 1920s. The Sudan, however, no longer has any training programme for traditional birth attendants.

D. The future of traditional health practitioners and their involvement with the official health system

Traditional practitioners are community health workers in the broadest sense, and they should be utilized in primary health care. Religious healers are men of great power and authority and they could be useful if they were involved in the planning, implementation, and evaluation of primary health care programmes.

The President of the Republic announced in June 1981 a General National Programme for Building of the Modern Science-Based State. Its philosophy rests on scientific research, transfer of modern and appropriate technology, and development of indigenous technologies, of which traditional medicine is a priority. The Programme emphasizes the development of community resources and participation.

Thailand - Dr P. Desawadi

A. Identification of traditional health practitioner

The traditional health practitioners may be classified in three categories:

- i) Traditional medicine practitioners (about 13 000); often priests or old men of the village using holy water and spiritualism.
- ii) Traditional birth attendants (about 17 000); almost all of them are old because, as there is an increase of governmental health services, the traditional birth attendants are being utilized less and less. Nevertheless, in rural areas up to 40% of deliveries were attended by traditional birth attendants.
- iii) Herbalists (about 13 000) treat with herbal remedies. The results of treatment are rarely harmful and may even be very satisfactory.

Traditional practitioners usually practise in rural areas and they tackle curative problems rather than preventive measures. Some are concerned with psychosomatic problems. Training is usually practical, and through some have passed an examination of the Ministry of Public Health, there is no degree or diploma.

B. Existing national policies and legislation on traditional health practitioners

There is no overall written national policy on traditional practitioners but in the Fifth Five-Year Development Plan an attempt is being made to use herbal medicine in the health system.

Training programmes have been arranged by the Ministry of Public Health and a school for traditional health practitioners has been set up.

Legislation was enacted in 1936 giving traditional health practitioners permission to practise traditional medicine, midwifery, or herbalism after passing an examination held by the Ministry of Public Health.

The three categories of practitioner may be registered and licensed. A certificate is provided for herbalists and traditional practitioners, but not for traditional birth attendants.

There are no regulations in respect of fees and these are not reimbursed to patients through any health insurance plan.

C. Nature of the relationship between the official health system and traditional health practitioners

There is no serious or organized relationship between the two systems, but traditional practitioners are now involved in primary health care programmes at both national and local level and work closely with local health officers. Some herbalists and practitioners have been trained to work in specific health programmes, such as immunization and family planning.

The allopathic health workers receive no training in traditional medicine, but some joint seminars and workshops on the role and practice of traditional medicine have been held.

For the most part the population consider traditional medicine as an alternative choice or option, after having tried modern medicine.

There are a number of associations of traditional practitioners. Several institutions are conducting research on traditional medicine.

D. The future of traditional health practitioners and their involvement with the official health system

There is research being carried out and ongoing activities for integrating traditional practitioners in the primary health care programme. To achieve this end, it is essential to change the attitude of health officers and the community. The plan to effectively involve the traditional practitioner in official health services should begin with small activities in primary health care. The success of this collaboration would enable the Ministry of Public Health to extend the involvement of traditional practitioners in other health programmes, thereby forming a basis upon which to develop a national policy.

United Republic of Tanzania - E.H. Mshiu

A. Identification of traditional health practitioners

There is only one category of traditional health practitioner, known as folk healers. These may be subdivided into groups according to their method of healing, namely: herbalists, herbalist/spiritualists, spiritualists/herbalists, spiritualists, traditional birth attendants, bone setters, medicine sellers, and Moslem religious faith healers. Compared with the 15 000 health personnel in the official system, it is estimated that there are more than 30 000 traditional practitioners, including traditional birth attendants.

The practitioners generally carry out curative practices rather than preventive work and those in urban areas deal mainly with psychological and psychosomatic problems. In rural areas, however, where the coverage of allopathic personnel is inadequate, the practitioners deal mainly with somatic problems within their own communities. Some 80% of the population in these areas utilize traditional practitioners, and 60% of the deliveries in the country are carried out by traditional birth attendants.

The Government defines folk healers as "persons recognized by the community to which they belong, to be duly trained in the practice of systems of therapeutics according to native methods".

B. Existing national policies and legislation on traditional health practitioners

The practice of traditional health care is tolerated by the Government, but there is no national policy on traditional practitioners.

There are sections under the Medical Practitioners and Dentists Ordinance of 1920, the Pharmaceutical and Poisons Act of 1978, and the most recent Medical Practitioners and Dentists Ordinance, Cap 92 of 1 August 1984, that permit traditional practitioners to practise in their own communities provided such practices are not injurious to life. The Witchcraft Ordinance of 1928/9 declared witchcraft a crime and differentiated it from Uganga, the traditional way of diagnosing and treating illness.

There is no registration or licencing of traditional practitioners but District Cultural Officers issue letters to some healers recognizing their existence and their right to practise in a community as a way to protect them from police harrassment.

C. Nature of the relationship between official health system and traditional health practitioners

In a study of the attitude of allopathic health personnel towards traditional practitioners in 1982, the former considered that modern and traditional systems of medicine were incompatible, since the traditional practitioners are illiterate and have no knowledge of disease. The allopathic health workers were not interested in the knowledge or methods of traditional practitioners. Some field studies are being carried out on traditional birth attendants and traditional practitioners by medical students and nurses.

Plant materials used by traditional practitioners had been investigated by the Government chemist from 1936 to 1970, and then different university institutions continued the work.

Following a directive from the Ministry of Health in 1969, the Faculty of Medicine of the University of Dar es Salaam formed, in July 1974, a Traditional Medicine Research Unit with the objective of collecting comprehensive information about traditional medical practice and the drugs used, so that the methods and medicaments could be tested.

D. The future of traditional health practitioners and their involvement with the official health system

The Government now fully supports the practice of traditional health care, and a law is being formulated for the registration and licensing of traditional practitioners. To date there are no national associations of practitioners. The Ministry of Health is also planning to train traditional practitioners, including traditional birth attendants.

The main obstacle to achieving some sort of collaboration with traditional practitioners is the attitude of the allopathic health worker. The majority consider the practice of traditional health care dangerous and harmful to the people, and feel that it would be unethical to associate with them. In addition, the traditional practitioners are suspicious of allopathic health workers. Nevertheless, during workshops held between the two groups in 1980, there were indications of a willingness to co-operate in the exchange of patients. Many allopathic health workers recognize the importance of traditional practitioners, particularly in rural areas, as a means to extend primary health care to the rural populations.

In order to realize a collaborative effort between these two groups of health care providers, consideration should be given to courses in traditional medicine during the training of allopathic health workers.

Zimbabwe - Prof. G.L. Chavunduka

A. Identification of traditional health practitioners

The nearly 60 000 traditional practitioners may be placed in six main categories:

- i) Spirit-diviners (6 000) claim to have inherited a healing spirit. They are experts in diagnosis and are only concerned with the cause of illness or other social problems. They do not normally handle medicines.
- ii) General diviners (18 000) claim spirit possession, but do not use it, preferring other methods such as throwing of bones to make diagnoses, at which they are expert. They usually inherit their knowledge from an older family of healers.
- iii) Herbalists (12 000) are apprenticed to another healer or attend a school of traditional medicine. Apart from herbs they use portions of animals, insects, and birds to treat their patients.
- iv) Diviner-herbalists (18 000) are experts at carrying out diagnosis and handling traditional medicines; they also use psychological methods.
- v) Traditional birth attendants (3 600) have received some form of medical instruction; they may also be herbalists.
- vi) Faith healers (1 200) are members of certain religious sects who rely mainly on prayer, receiving their skill from their gods or ancestor spirits.

Traditional practitioners are involved in both curative and preventive medicine; they also deal with social problems and often act as legal and political adviser and marriage counsellor. They are spread more or less evenly between rural and urban populations except the traditional birth attendants, who work mainly in rural areas.

The full spectrum of the population consult traditional health practitioners except in the case of traditional birth attendants, who are more often consulted by uneducated families in rural areas.

B. Existing national policies and legislation on traditional health practitioners

There is no clear-cut policy at present. However, the Traditional Medical Practitioners Act No. 38 of 1981 established the Traditional Medical Practitioners Council which supervises and controls the traditional health practitioners, promotes their practice and promotes research into such practice. The Council consists of twelve members; seven are appointed by the Ministry of Health and five are elected by registered traditional practitioners.

The register of traditional medical practitioners is maintained by the Registrar of the Council. Those registered may designate themselves as Registered Traditional Medical Practitioner or Registered Spirit Medium.

There is no attempt to regulate the fees charged by traditional practitioners, but these are not refunded by local health insurance schemes.

C. Nature of the relationship between the official health system and traditional health practitioners

This relationship could be described as medical pluralism. Many medical practitioners are qualified to practise in both allopathic and traditional medicine, and in many districts of the country modern health personnel work very closely with local traditional practitioners. However traditional practitioners are still viewed with suspicion by many official health professionals.

Probably for this reason they have not yet been brought into the national or local primary health care programmes.

The National Traditional Healers Association has, since 1981, run two medical schools and a research department. Joint seminars for traditional and allopathic practitioners have been held to exchange information on medical issues.

D. The future of traditional health practitioners and their involvement in the official health system

It is anticipated that traditional practitioners will be called on to play a more effective role in health care in the future; however, there are major problems in respect of such involvement:

- the lack of a clear government policy;
- hostility between members of the two systems; and
- the lack of government financial support.