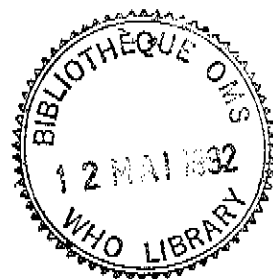


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TRADITIONAL HEALERS AS COMMUNITY HEALTH WORKERS

A review of projects
using traditional healers
as community health workers



World Health Organization

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I. INTRODUCTION

According to a 1985 report by WHO¹, conventional health systems still do not reach a vast majority of children and families in rural areas of the developing countries. Ministries of Health have inadequate resources and a major portion of their budgets are set aside for curative medicine and hospital services which primarily serve urban-based populations. There is a lack of community involvement in the planning and delivery of health services, often leading to inappropriate services being provided to rural areas. Local health staff, trained in modern allopathic models, often lack the understanding and sensitivity to the cultural beliefs and practices of rural families regarding health, illness and disease.

During the last century allopathic medicine, with its orientation toward scientific, materialistic methodology, has had a significant impact in establishing particular patterns of health care in these countries. Modern medicine has become established as the official health care delivery system in all countries. Because of the wide gap in values and ideology between the traditional and modern systems, widespread misunderstanding and prejudice have arisen between practitioners on both sides. Until recently, traditional health practitioners were legally forbidden to practice in many developing countries.

It is recognized, however, that despite its many successes and general acceptance throughout the world, the western system of healing has not replaced but has augmented indigenous healing systems. This is because traditional healing is deeply embedded in wider belief systems and remains an integral part of the lives of most people. Thus, in most developing countries of the world, the traditional medical system continues to exist side-by-side with the modern system, and the majority of the population regularly consults both types of healers. In fact, traditional practitioners far outnumber modern health professionals. For example, according to Robert H. Bannermann, "traditional midwives... form the main body of primary health care workers in maternal and child care, and in some countries they are responsible for over 90% of the births."²

During the past decade, the gulf of misunderstanding between modern and traditional practitioners has begun to narrow. There has developed a growing realization that traditional and modern medicine can work hand-in-hand to improve the health and well being of rural people, and that both traditional and modern practitioners can learn from each other.

The World Health Organization has played a lead role in proposing the use of traditional practitioners as part of the primary health care system. In 1977, a WHO meeting on Promotion and Development of Traditional Medicine³ was held in Geneva for the purpose of fostering a realistic approach to traditional medicine to improve health care. A year later, the 1978 Declaration of Alma Ata⁴ recommended the use of all resources, including traditional practitioners, where applicable, in the primary health care system. The Alma Ata Conference recommended inter-alia:

"that governments give high priority to the full utilization of human resources by defining the role, supportive skills, and attitudes required for each category of health workers according to the functions that need to be carried out to ensure effective primary health care, and by developing teams composed of community health workers, other developmental workers, intermediate personnel, nurses, midwives, physicians, and, where applicable, traditional practitioners and traditional birth attendants."

This recommendation sets forth a clear mandate for governments to define the role traditional practitioners and birth attendants can play in communities as members of the primary health care team. If we compare the needs for primary health care services in communities to the resources that are currently available, it becomes apparent that the goal of Health For All by the Year 2000 will never be

achieved unless all existing community resources, including traditional practitioners, are mobilized and used more effectively.

Because of the critical need for primary health care throughout the world, and WHO's recommendations that traditional practitioners be utilized as a component part of this primary health care team, there is a need to review studies and projects that have used traditional practitioners in some aspects of promoting community health. By evaluating the results of these studies and projects, we may be able to identify the positive outcomes and potential of using traditional practitioners in local communities, as well as to define the problems and limitations involved.

Through these results, we may better come to understand how traditional practitioners can be used more effectively in primary health care, and develop guidelines and recommendations toward that end.

II. OBJECTIVES

- (A) To Collect Information about Projects which have included Healers as Community Workers to Promote Health and Well Being.

There is a considerable body of knowledge that describes traditional medicine and the treatment and healing practices of traditional healers, but because the concept of primary health care with its focus on prevention of disease and health promotion at the community level has become formalized only within the past decade, there appears to be much less information available on the role of traditional practitioners in promoting health in the community.

- (B) To Analyze this Information with Regard to the Role of Traditional Healers in Community Health and Identify the Various Roles or Functions that these Traditional Health Practitioners have Played in Communities.

The analysis of roles and functions performed by healers was limited to primary health care activities; health education; promotion of nutrition; safe water and sanitation; maternal and child health care (including family planning) prevention and control of diseases; first aid; and provision of essential drugs.

- (C) To Make Recommendations Based on These Findings as to Future Steps which can be Taken to Involve Traditional Healers in Promoting Primary Health Care for Communities.

The aim of this review was to obtain as much information as possible on the outcome of projects where traditional practitioners were involved in an organized way to promote community health. We anticipated that the results of these projects would show positive effects as well as difficulties and problems that were encountered.

III. METHODS OF OBTAINING DATA

(A) Review of Literature

A comprehensive review was conducted of readily available published literature, (books, periodicals, reports and papers), based on studies, reviews and projects where traditional practitioners were included in community settings.

This review was conducted utilizing the following published and unpublished sources:

- a) The library computer systems of the University of California, Berkeley. This included the MELVYL and GLADYS systems, which link all University of California campus libraries as well as the MEDLINE System, which contains books and periodicals of the Schools of Public Health and Medicine.
- b) The Combined Health Information Database (CHID) of the U.S. Public Health Service, Department of Health and Human Services, Communicable Disease Center, Atlanta, Georgia.
- c) The World Health Organization's Regional Offices in Africa, Southeast Asia, Western Pacific, Americas, Eastern Mediterranean and Europe.
- d) The International Health Policy Studies Program of the University of California School of Medicine, San Francisco, California.
- e) The Network Secretariat, University of Luxembourg.
- f) The School of Public Health, University of Sao Paulo, Brazil.
- g) The Centro Internacional de Educacion y Desarrollo Humano, Colombia.
- h) The International Children's Center (CIE), Paris.
- i) The Health Education Research Centre, Perugia, Italy.
- j) Technologies for Primary Health Care (PRITECH), Arlington, Virginia.
- k) The International Child Resource Institute (ICRI) computerized resource information bank, (CRIB), containing records of information on child and family health from over one hundred countries.
- l) The Hesperian Foundation, Palo Alto, California.
- m) ICRI's field representatives in 52 countries.
- n) Dr. Wilbur Hoff's extensive personal collections of information on the use of traditional practitioners throughout the world.

Those sources which conformed to the scope of this report were abstracted, reviewed and their references were researched to obtain further appropriate sources. These were in turn obtained, reviewed and abstracted where appropriate.

Several hundred articles, books, reports and papers were reviewed for this study, covering the years 1973 to 1990.

(B) Review of Unpublished Information

ICRI contacted a wide range of organizations known or believed to have studied or worked with traditional practitioners to request unpublished information. These organizations were requested to supply any information they might have on studies or projects using traditional practitioners as community workers. We asked for any of the following information:

- reports
- evaluations
- journal and newspaper articles
- posters
- booklets
- brochures
- papers
- training materials
- any other pertinent information about traditional healers as community health workers in various countries and regions.

IV. REVIEW OF PROJECTS

The following represents a summary of information about projects which were identified in the review of the literature. In this section, our intent has been to review projects which have been planned or organized to use traditional healers (THs) as community workers in one or more aspects of primary health care. The following groups of "projects" include situations where THs were organized and trained to perform specific primary health care (PHC) tasks in communities and where an attempt was made to evaluate or measure the outcomes of the activities. The criteria we used to define a traditional health practitioner was a person who is recognized as practicing under various designations that included one or more of the following titles or disciplines:

- herbalist
- diviner
- spiritual or faith healer
- traditional midwife
- traditional birth attendant
- curandero
- shaman
- traditional Chinese doctor
- Ayurvedic doctor
- Unani practitioner

AFRICA

Location: Sierra Leone

Project: Traditional Birth Attendants Help Reduce Infant Mortality

Description: Traditional birth attendants (TBAs) perform approximately 70% of all deliveries in Sierra Leone. In 1974, the Ministry of Health began a programme⁵ to train TBAs to reduce the incidence of infant and child mortality. A practical 3-week training programme was conducted to teach women simple antenatal care, safety and cleanliness, how to prevent neonatal tetanus, and to recognize abnormalities during pregnancy and labor.

Results: There were no data reported on the results of the traditional birth attendants trained to practice in communities.

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Location: Sudan

Project: Village Midwives Work in the Community

Description: A WHO/UNFPA-assisted programme⁶ was begun in 1978 to train village midwives. The course was geared to teach village midwives how to perform specific tasks in the community. In addition to the standard midwifery tasks of antenatal care, delivery, newborn and postpartum care, they were also taught to give advice to mothers on family

planning, provide health education on home sanitation, immunization, prevention of accidents and, communicable diseases.

Results: Although the report indicated there were no data available to judge the tasks performed by these midwives, it stated that the proportion of births attended by village midwives increased since the inception of the programme. It was assumed that when a pregnant woman and her newborn baby were under the management of a trained midwife, they both had a far greater chance of survival than if they were under the management of an untrained midwife.

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Location: Sudan

Project: Sudan Community-Based Family Health Project

Description: The University of Khartoum, in cooperation with the Ministry of Health, conducted an operations research project to test the feasibility of involving village midwives in the delivery of maternal and child health and family planning services.⁷ The project, funded by USAID with technical assistance from Columbia University, was conducted from 1981 to 1983 in an agrarian population living in 90 villages along the banks of the Nile. The focus was to train and supervise village midwives to provide the following:

- information about contraceptives for birth spacing, distribution of oral contraceptives and referral for other methods
- information for mothers on oral rehydration therapy for children with diarrhea and distribution of oral rehydration solution packets
- nutrition education with emphasis on breast feeding and appropriate weaning foods and practices
- vaccination for children under five years of age.

Results: The project evaluation measured changes in behavior related to the four child survival interventions: oral rehydration therapy, family planning, nutrition education and vaccination. The article on this project reported data for the first two interventions only.

A post-intervention survey conducted a little more than a year after the project began, found that 87% of the mothers with children under 5 years of age had treated the most recent episode of diarrhea with oral rehydration solution. One year after the start of the project, the proportion of women ages 30-34 who had ever used contraceptives increased from 25% to 38%, and the proportion currently using them rose from 13% to 21%. The overall pattern of contraceptive use showed a considerable increase. The 1987 survey found that 27% of the women of child-bearing age were current users as compared to 10% in the pre-survey.

The authors concluded that the project proved to be so successful that it now continues to be an integral part of the health services.

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Location: Ghana

Project: DANFA - Traditional Birth Attendants Promote Health Education

Description: The Danfa Rural Health Project (DANFA)⁸, begun in 1970, was a joint effort of the University of Ghana and the University of California, Los Angeles. Project goals were to improve primary health care and family planning in rural areas. Traditional birth attendants were trained in villages to monitor pregnant women, recognize and refer high risk women to clinics, properly care for the umbilical cord, and promote improved maternal and child health practices through health education. Their participation in the community was an important aspect of the project.

Results: Data is not presented to indicate the effectiveness of TBA training or practices in the community, but it was reported that the TBA training programme had been gradually replicated throughout the country.

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Location: Ghana

Project: PRHETIH PROJECT -- Indigenous Healers Cooperate With Ministry of Health

Description: The Primary Health Training for Indigenous Healers (PRHETIH) Project⁹ began in 1979 with the aim of facilitating cooperation and coordination of Ministry of Health units with various categories of healers (TBAs; herbalists; priest/priestess healers), in the Techiman District. A 60-hour training course was designed to teach environmental health, preventive and promotive measures, family planning and simple, readily available allopathic medicines, (i.e., anti-malarial; oral rehydration and basic first aid).

Results: All types of indigenous healers, as well as their trainers, responded very positively to the programme. Follow-up surveys conducted six months after training showed the following:

- all the healers supported the training programme
- there was a high level of information retention
- all trainees stored their herbal medicines in clean, plastic bags
- care of sick children was significantly improved
- oral rehydration for children was accepted as important
- information on topics such as oral rehydration was rapidly communicated from trained healers to those not yet trained
- relationships improved between Western allopathic-trained health workers and indigenous healers
- the number of referrals between healers and other health workers increased in both directions.

A major factor which contributed to the success of the programme was the long-standing relationship of mutual trust and respect between the indigenous healers and the local hospital staff.

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Location: Ghana

Project: BARIDEP -- Traditional Birth Attendants Promote Self-Help Projects in the Community

Description: The Brong-Ahafo Rural Integrated Development Project (BARIDEP)¹⁰ was carried out from 1975-1980 by the Ghanaian Government with assistance from WHO and UNICEF. The aim was to achieve improvements in the health status of the project area population, and to promote the social well-being of the population through community self-help projects.

These projects were to be organized, implemented, financed and evaluated by the community members themselves. Over 50 TBAs were trained in 1978.

Results: Although no formal assessment was made of changes in infant mortality, or of referrals made to health centers, observations suggested that the training was well-received and had generally been put into practice.

The status of TBAs among villagers was clearly enhanced because of the training.

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Location: Swaziland

Project: Traditional Healers Cooperate With Clinic Nurses

Description: The government of Swaziland Ministry of Health and the Traditional Healers Organization conducted a one-year demonstration project¹¹ from 1984-1985. The goal was to demonstrate how specific primary health care services could be provided to mothers and children by nurses and healers cooperating.

During a one-week workshop attended by both healers and nurses, the participants developed a more trusting, cooperative relationship and agreed upon primary health goals toward which they could work.

The participant healers learned how to: recognize danger signs of common childhood diseases; refer certain patients to clinics; mix and use oral rehydration solution; to treat diarrheal dehydration; and to promote better nutrition, safe water, personal hygiene and sanitation.

Results: An evaluation was conducted two months after the workshop was completed by interviewing participant nurses and healers at their clinics, and comparing the results of those who attended the workshop with a control group. Some of the outcomes of this evaluation were:

- reduction of fears and mistrust between nurses and healers
- increased referrals (particularly for children with diarrhea and vomiting) by traditional healers to clinics
- increased understanding of the treatment and prevention of dehydration and ability to mix oral rehydration solution accurately
- decrease in the dangerous use of purges and enemas by healers

- increase in health education to patients on subjects of home sanitation, nutrition, immunizations and clinic checkups
- increased use of wash basins in healers' clinics and latrines in their homes
- healers communicated information about the content of the workshop through their own informal networks to other healers, thereby disseminating more information to others.

From 1986-1988 the Health Education Unit of the Ministry of Health continued to conduct workshops for traditional healers and nurses to expand the prevention and control of diarrheal diseases throughout the country.

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Location: Nigeria

Project: Traditional Healers Promote Primary Health Care

Description: Between 1984 and 1986, the Lagos Board of Traditional Medicine designed and coordinated a collaborative programme in Nigeria.¹² Traditional herbalists were trained in both community-based distribution of contraceptives, and in preventive/promotive aspects of primary health care.

Results: The constraints to the success of this programme included:

- inherent conflicts between the scientific and magico-religious paradigms of Western-trained versus traditional practitioners
- economic and prestige competition between the two sectors
- traditional healers feared they might become second-rate paramedical workers, and thereby cease to carry out their important function in the community (e.g., social, psychological, spiritual and health).

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Location: Zambia

Project: Traditional Healers Help To Prevent Diarrheal Disease

Description: A survey conducted in 1986 by the staff of the Diarrheal Disease Control Programme of the Ministry of Health, Department of Traditional Medicine in Zambia¹³ supports the idea that "healers constitute a valuable, virtually untapped manpower resource which could be used to promote oral rehydration therapy and therefore extend the limited resources of the Ministry of Health/Diarrheal Disease Control Programme."

Although this is only a survey of traditional healers' attitudes and practices regarding treatment of diarrhea, it does indicate that healers are already carrying out some diarrheal disease prevention and control activities in communities.

Results: The results of the study showed that many healers were aware of the signs of dehydration in children, advised mothers to give fluids, informed mothers about ways to

prevent diarrhea, and expressed a willingness to use and promote oral rehydration solution.

The study recommended that the diarrheal disease control programme produce health education materials and hold training seminars for healers on a pilot basis.

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EASTERN MEDITERRANEAN

Location: Afghanistan

Project: Traditional Birth Attendants in General Health Services

Description: The Ministry of Public Health (MOPH) trained TBAs in improved birth and delivery, care to infants and mothers, and family planning services.¹⁴ The MOPH recognized the value of indigenous practitioners with special skills, particularly in rural areas. The TBAs, usually older married women with no formal education, had several years of experience in dealing with pregnancy and childbirth, including their own personal experience. Their training included how to provide prenatal care, safeguard the fetus, and ensure easy and safe deliveries.

Results: The experience of the project indicated that the majority of TBAs had positive attitudes toward participating in the training, and in modifying their skills to provide better pre-natal, delivery and post natal care to mothers.

The project recommended that after traditional practitioners are trained, they should have a formal or informal relationship with the existing health system as part of the local health centers, provincial health facilities or as a member of the health team within the community. It was suggested that within the health centers, TBAs could provide basic information on traditional medicine as well as facilitate referrals.

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SOUTHEAST ASIA

Location: India

Project: Indigenous Healers Work in Community Health Schemes

Description: Roger Jeffrey¹⁵ reviewed government policies toward indigenous healers in India and described how indigenous healers of the Ayurveda and Unani systems have been used in the community health schemes. Both the Western allopathic doctors and the indigenous practitioners (i.e., Ayurvedic, Hakims and Vaidis) are politically strong, and have wide support in communities.

Differences between them led to disputes and interfered in the formation of a unified policy on how to involve indigenous practitioners as community health workers.

In 1977, the Janata Government called for the organization of a cadre of medical and paramedical community health workers (CHWs), among whom the trained practitioners of indigenous systems of medicine would be a part.

It was decided that the community should choose who was to be their CHW.

Results: Roger Jeffrey concluded that (as of 1982) there was no clear Government policy on the use of indigenous healers in India. The reality is that indigenous practitioners of all kinds have strong popular appeal and provide an alternative which the Government must recognize as potentially valuable in training and employing community health workers.

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Location: India

Project: INGRID PROJECT -- Traditional Midwives Provide Health Education

Description: India's New Group for Raichur's Integrated Development Project,¹⁶ (INGRID), started in 1981. The goal of the project was to improve life of the rural and uneducated population by developing leaders in selected villages who would work towards self-help community development. INGRID aimed at setting up health care within ten villages by providing low-cost health facilities and by educating people on health, hygiene and nutrition. Priorities were to establish a medical dispensary, and organize health education in all the villages.

The project used the skills of both medical doctors and traditional midwives, who were supported and trained to do ongoing preventive health education. Mobile clinics were established and a small "native-style" dispensary was set up in one of the villages with a complete selection of both modern medicine as well as local herbal medicines. The dispensary functioned on the veranda of a village healer and was run directly by local villagers.

INGRID began with very few health care resources, but they were able to draw upon assistance from traditional practitioners to help motivate villagers to take a stronger interest in creating their own preventive health schemes. The increased interaction of local villages with established health institutions led to an innovative integration of preventive, curative and traditional forms of health care.

Results: Follow-up observations indicated that health awareness increased and people were more aware of the causes of common diseases and how to control them. These observations also showed that people were making full use of the services of both the central mobile and "native" clinics.

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Location: Nepal

Project: "Dhami Jhankries" Work In Villages To Promote Health Education

Description: A two and a half year action-research project¹⁷ in Nepal, conducted in 1980, aimed to see whether "dhami jhankries" could facilitate beneficial changes among villagers.

The strategy was to enlist healers as partners by approaching them with respect, not asking them to change their beliefs and practices, and training them in basic family planning and health education skills.

Four-day workshops were conducted for 100 "dhami jhankries" in four districts. These workshops taught family planning methods, basic first aid, how to prepare oral rehydration solution and nutritious weaning foods, and when to refer patients to clinics.

Results: An evaluation was conducted by testing the healers before, and six months after, the workshops. All the participants were enthusiastic about the value of the workshops, and 98% recommended that this type of training be given to all traditional practitioners throughout the kingdom.

Results indicated that there were substantial increases in the knowledge and practices of healers. In addition, the evaluation of the project found conclusive evidence that these faith healers can play a culturally appropriate and cost-effective role in health education and family planning in Nepal.

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Location: Nepal

Project: Study of Traditional Medical Practitioners in North Eastern Nepal

Description: This project¹⁸, conducted in 1980-81, studied the attitudes and practices of Traditional Medical Practitioners (TMPs) in seven health posts in a mountainous region of northeast Nepal. The TMPs were given a two-day training with follow-up sessions over a period of eight months. The training included the purpose of primary health care and the functions of health care staff; how to recognize and manage the endemic conditions of tuberculosis (TB), leprosy, childhood diarrhea and malnutrition; and how to refer patients with symptoms of TB and leprosy.

Results: The study identified difficulties that existed in communication between health center staff and the client population. When TMPs were interviewed, they commented upon the cultural inappropriateness of the style of the health center staff, particularly their impersonal manner, lack of confidentiality, and patronizing attitudes. The TMPs were often able to bridge this gap. The data showed that the TMPs were able to refer patients with leprosy successfully and that they had an important influence in improving the general attendance at rural health facilities.

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Location: Thailand

Project: Traditional Birth Attendants Promote Family Planning and Maternal and Child Care

Description: Due to the inability of the organized health system to meet basic health care needs, the Thai Government implemented a nationwide plan for the training and utilization of TBAs in community health¹⁹. The training of TBAs in Thailand dates back to 1952 when the Government embarked upon a programme to reduce maternal and infant mortality through improving rural health services. Nearly 17,000 TBAs received two weeks of training by the end of 1968. The course focused on antenatal care, delivery techniques and postnatal care. In 1970, the government decided to focus on family planning as an approach to reduce maternal and infant mortality.

Results: Findings suggested that it is feasible to train and utilize TBAs to extend maternal and child health services, including family planning services, to rural populations. It was recommended that:

- the training programme be open to all TBAs
- trainees should be grouped according to age and level of education
- the method of training should be kept as simple and as clear as possible
- each TBA should have a pre-training test on knowledge, attitudes and practices, and the results should be used as baseline data against which to measure the results of post-training tests
- a supervisory system should be set up and maintained on a continuing basis
- refresher courses should be provided periodically.

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PACIFIC

Location: China

Project: "Barefoot Doctors" Work in Community Health Programmes

Note: In 1984, the Ministry of Public Health of China declared that the title "Barefoot Doctor" would no longer be used. The existing barefoot doctors who pass an examination are authorized to have the name "Rural Doctor," which means vocational competence equivalent to that of an assistant doctor.

Description: Since 1958, the peoples' commune has been the basic unit for organization of social life in rural areas of China.²⁰ The Chinese National Health System provides a three-tiered level of services that integrates Chinese and Western medical services. The lowest level is staffed by "Barefoot Doctors" who are trained in basic concepts and skills of both Chinese and Western medicine and are capable of treating ordinary and relatively minor diseases.

Barefoot Doctors are trained to diagnose and treat without assistance the common or recurrent diseases peculiar to the region in which they work. They provide immunization services, oversee environmental sanitation, give contraceptive advice and carry out health education campaigns.

In 1985, a campaign was initiated to train traditional practitioners to become Barefoot Doctors. Traditional practitioners began to make a genuine contribution to all levels of medical care and Western trained doctors began to accept them as colleagues. The number of clinics in which both types of doctors practiced rose and were soon replaced with public rural health centers, where people could choose the type of practitioners they wanted.

New health worker roles also developed in the cities, including the "worker doctor" and the "Red Guard Doctor." Worker doctors worked mainly in health education and prevention and the treatment of simple ailments, while Red Guard Doctors worked in conjunction with health centers. These were usually housewives who were unpaid for their services and were responsible for carrying out preventive work and disseminating birth control information.

Results: Because Barefoot Doctors remained part of the peasant community, they more easily understood the medical complaints of their people, as opposed to academically trained doctors, who had difficulties in communication and lacked awareness of their patients' social conditions.

In spite of some problems with the system, Barefoot Doctors did provide medical care for peasants where none existed before. Chinese publications have chronicled the clinical successes of Barefoot Doctors and have commented on the quality of their work.

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Location: Philippines

Project: Traditional Practitioners Strengthen Community-Based Health Programmes

Description: Non-governmental organizations in the Philippines have made significant progress in rediscovering how traditional practitioners can strengthen community-based health programmes (CBHPs).

A research project²¹ was conducted in 1983 to study the entire traditional medical system in the country. A primary focus was on the extent to which CBHPs were using traditional healers to promote primary health care. Of the sixteen programmes that responded, fourteen had trained traditional medical practitioners (TMPs) as CHWs. Of the 102 traditional practitioners who became CHWs: fifty-four were midwives; twenty-nine were herbalists; fifteen were bone-setters; and four were magico-religious practitioners. All were integrated into the PHC training programmes. All the programmes which used TMPs or CHWs gave positive ratings to these retrained workers. They cited TMPs as being "more advanced," "more confident," "more interested," and "more experienced" than their co-workers.

The authors stated that:

"The traditional practitioners all retained their previous skills, integrating them with 'new knowledge' or 'with more scientific basis'. The traditional skills most frequently mentioned were empirical methods such as the use of medicinal plants, massage and 'cupping'. Magico-religious methods such as divination and prayers were also cited."

Results: In cases where TMPs did not join CBHPs, referral systems were established. This enabled the TMPs and the staff of CBHPs to make appropriate referrals to each other. Staff of the CBHPs described both negative and positive aspects of using TMPs. Magical and religious beliefs, unhygienic practices and nutritional taboos were some of the obstacles mentioned.

This study found that empirical skills such as bone setting and midwifery were helpful for PHC as well as the holistic nature of traditional medicine. But most importantly, the staff felt that "the traditional medical system's low cost is the main strength, particularly in relation to the goal of building community self-reliance."

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AMERICAS

Location: Brazil

Project: Training Healers in Oral Rehydration Therapy

Description: In 1984, The Department of Community Health at the Federal University of Ceara began a 2-year research study²² to test the theory that mobilizing and training popular healers in oral rehydration therapy (ORT) and related child survival strategies would produce significant improvement in the health knowledge, attitudes and practices of village mothers, without changing essential elements of the indigenous medical system.

The specific objectives were that the use of trained popular healers would:

- (1) increase the awareness, preparation and use of oral rehydration solution (ORS), particularly of homemade solutions
- (2) curb dangerous food withholding and promote continued feeding during diarrhea
- (3) increase vital breast-feeding during the disease episode
- (4) reduce the use of costly, commercially promoted ORS and non-indicated pharmaceuticals.

Forty-six popular healers were recruited for the project. These included twenty "prayers" (resadeciras), seven Afro-Brazilian priests (Umbandistas), four spiritualists, three popular pharmacists, one lay "doctor," one herbalist and ten visiting Protestant prayers.

The healers were taught the basic biomedical concept of dehydration, and how to prepare and use a simple homemade ORS solution. They were also taught five basic health messages:

- (1) give ORS for diarrhea and dehydration
- (2) continue feeding during diarrhea and do not withhold food
- (3) encourage breast feeding during diarrhea
- (4) eliminate drugs to treat diarrhea
- (5) ask people to seek a healer quickly at the onset of diarrhea

Healers were then taught to instruct mothers how to prepare ORS-tea using simple graphic instructions. These simple teaching materials were re-written by the healers, and a local artist illustrated them so they could be understood by illiterate mothers. In addition, healers learned five high-risk indicators so they could refer children to pediatric health services.

Results:

The staff found that in general the healers were trusted, astute clinical observers, knowledgeable about anti-diarrheal plant remedies, skilled in accurate preparation of ORS, and pragmatic in integrating modern therapies that work.

The survey data clearly demonstrated that healers had a substantial impact on vital child survival beliefs and practices of Pacatuba mothers. Specifically, over the study period, the healers significantly increased the mothers' awareness of proper preparation and use of ORS; dangers of withholding food; importance of continued feeding (including breast-feeding) during diarrhea; and reduced the use of costly commercial ORS and non-indicated drugs.

The authors concluded that healers can be effective promoters of ORT and related child survival strategies:

"No longer can we dismiss healers with their prayers, trances, and teas as curiosities unrelated to medical care; for mounting evidence has shown them capable of playing a vital role in child survival."

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V. REVIEW OF ADDITIONAL LITERATURE

This review of literature is based on general reviews of the literature on the subject of THs working in PHC, narrative descriptions of how THs have been used in specific areas of the world, and opinions and views of professionals who have studied or worked in the field. The results of this information are highlighted and summarized in this section.

Location: Canada

Topic: Traditional Healers Provide PHC Services to Indian and Inuit Communities

Summary: One of the components of PHC for Canada's Indigenous people is the utilization of traditional ethnomedicine and the recognition of the important role of traditional healers in the Indian societies. Marilyn Mardiros²³ describes how indigenous healers are being used to provide PHC services to Indian and Inuit communities. Midwives and other healers, until recently banned by the health care system, are now being actively identified and used as important members of the health care team.

Other community health representatives, such as health auxiliaries, are also being recruited and trained to provide health services and to serve as a bridge between the various health care providers within communities. Their responsibilities include education regarding child care, nutrition, oral hygiene and immunization.

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Location: Papua New Guinea

Topic: Traditional Birth Attendants Promote Community Self-Help Programmes

Summary: A successful training programme for TBAs was organized in 1981.²⁴ The programme aimed at community self-help and self-reliance.

Training took place in rural environments and encouraged beneficial traditional practices as well as introduced modern techniques which were appropriate to local conditions and could be adapted to traditional customs. Use of local materials was encouraged.

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Location: Zaire

Topic: Traditional Birth Attendants Deliver MCH Services

Summary: In Zaire,²⁵ the local hospital in the Rural Health Zone of Karawa began an extensive outreach programme to increase the access of rural women to maternity care and to expand prenatal care. Traditional birth attendants, nurses and midwives played a critical role in the programme by delivering MCH services and by providing a back-up referral system. Community participation was an important part of this programme as the

communities contributed money to pay for TBA kits and families were asked to pay a small fee for each delivery.

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Location: Vietnam

Topic: Traditional Midwives Provide Pre and Post Natal Care

Summary: The commune health stations in Vietnam²⁶ used traditional medicines and midwives in important ways. The focus of primary health care in the commune was on midwives who worked with a team to provide a variety of services. Traditional medicines, along with western medicines, were generally dispensed by the midwives, in addition to providing pre- and post-natal care and carrying out a number of other health services for families who visit the commune stations.

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Location: Sri Lanka

Topic: Ayurvedic Practitioners Assist in Family Planning and Contraceptive Distribution

Summary: In Sri Lanka,²⁷ the Community Development Services trained 1,500 Ayurvedic practitioners in family planning counseling and contraceptive distribution. Initially the project provided the Ayurvedic doctors with free contraceptives to distribute, but as the programme became more self-sufficient, the doctors began buying them at discount rates and selling them to family planning acceptors.

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Location: Ghana

Topic: Traditional Healers Perform a Variety of PHC Activities

Summary: Robert H. Bannerman²⁸ has pointed out the lack of health manpower resources in developing countries, and how primary health care is often provided by healers, herbalists, traditional midwives and other traditional practitioners. These practitioners -- experienced, intelligent and respected by the community--have an important role to play in providing PHC.

Citing the PRHETIH project in Ghana (see page 10 of this report), as an example, Bannerman describes how TBAs and other healers were trained to perform a variety of PHC activities. Although the training programme focused mainly on child care, environmental health was also given a high priority. Topics covered in the training included:

- hygienic preparation and preservation of medicinal herbs
- use of oral rehydration to treat dehydration and diarrhea
- sanitation of the environment, i.e., proper refuse disposal, use of pit latrines and food sanitation
- basic nutrition and proper foods for weaning
- family planning
- basic first aid
- recognizing dangerous signs of measles, typhoid, jaundice, leprosy and convulsions.

A major factor contributing to the success of this project was the long-standing relationship, based upon mutual trust and respect, between indigenous healers and local hospital staff.

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Location: Various

Topic: Traditional Healers Offer a Valuable Contribution to Extending Coverage of Health Systems

Summary: Olayiwola Akerele²⁹ also affirms that traditional practitioners, being both culturally acceptable and economically within reach of even the neediest people, can make a valuable contribution to extending the coverage of the health system. He emphasizes, however, the importance of evaluation to obtain safe and effective methods; integration to incorporate traditional healers into the national health care system; and training to increase beneficial health skills and practices.

In spite of the differences that exist in local cultural patterns, political systems, and national policies and practices, Akerele claims that certain common factors influence how traditional medicine can affect the health of the population. These factors include:

- strength of national commitment to support traditional practices and practitioners
- the degree to which this commitment is backed by legislation
- national research into useful traditional practices
- the extent to which primary health care plans and strategies incorporate validated traditional practices and make use of traditional practitioners.

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Location: Africa

Topic: Modern and Traditional Healers Collaborate for Improved Health Coverage

Summary: In August 1980, the WHO Regional Office for Africa held a Consultation on Traditional Medicine in Health Services Development at Accra, Ghana.³⁰ The primary aim of this meeting was to explore ways in which modern and traditional healers (THs) could harmonize for more efficacious delivery of primary health care. Nine African countries were represented at these meetings.

One of the three objectives of this conference was to formulate realistic approaches on how the modern and traditional systems could collaborate for improved health coverage of the populations. Factors which hindered and which favored such collaboration were discussed, and recommendations were made for promoting collaboration. Some of these recommendations were particularly relevant for providing better primary health care. These included:

- THs should be included in primary health care teams, especially at the village level
- THs should be given incentives and suitable training so they can report on epidemics and other health hazards
- training should also include elementary environmental sanitation, as well as simple appropriate medical technology
- practitioners of conventional medicine should learn from THs something of the physical and socio-cultural basis of the latter's practice.

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Location: Africa

Topic: Using Traditional Healers to Promote Health Education and Provide Primary Health Care Services

Summary: In a study for the Takemi Programme in International Health, Harvard School of Public Health, Charles M. Good³¹ reviews the community's role in PHC programmes in Africa and describes the potential benefits of THs in PHC. After studying several African projects, including programmes in Nigeria, Ghana and Swaziland, he concludes that intersectoral cooperation is feasible and has the potential to produce a wide variety of positive impacts, ranging from enhancement of child survival and environmental sanitation, to more effective biomedical procedures.

Since THs are already an integral part of the social fabric, and they wield great influence in matters of health and community well-being, Good asserts there is a strong argument for using THs to promote health education, and to provide better health care at the primary level. He also believes that THs should receive priority in being selected as CHWs.

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Location: Swaziland

Topic: Traditional Healers Assist in Control of Childhood Diseases

Summary: In a paper presented to the National Council for International Health in Washington, D.C., (1986), Wilbur Hoff³² describes the positive outcomes of training THs to assist in the control of childhood diseases in Swaziland. An important finding of this project was the high level of enthusiasm exhibited by the THs involved in the project. Healers who were trained went back to their own communities, and at their own initiative organized meetings with other healers in their respective areas. At these meetings they described

what they had learned, thus disseminating health knowledge to other healers who had not attended the workshops.

With respect to methods of training THs, the paper emphasized two important points:

- the use of culturally relevant training methods
- the use of methods which were appropriate to the background and education level of participants.

Cultural beliefs about health and disease need to be carefully considered in order to present information in a context which is most easily understood and accepted. Because healers often have lower levels of education than training staff, it is important to concentrate on basic knowledge and skills, presented simply and with maximum use of informal group discussion, visual aids, demonstrations, field visits and other experiential learning methods.

The evaluation of the project found that some of the information taught in the workshops, particularly how to mix and use ORS for treating dehydration in children, how to obtain a balanced diet, and the importance of home sanitation and use of latrines, had been widely disseminated to other healers through their communication networks.

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Location: Mexico

Topic: Traditional Healers Trained as Community Health Workers

Summary: David Werner described how, for the last twenty-five years, he has worked with traditional practitioners and trained them as comprehensive community health workers in Mexico.³³

He concluded that:

- healers continue to work longer and have a better rapport and accountability in the community than do persons selected from the outside to be trained as community health workers
- traditional practitioners tend to integrate traditional healing and herbal medicine with modern medicine, preventive care and community health promotion
- when health programmes collapse or fail, traditional healers who have received training in other aspects of health care and health promotion tend to continue with their work and retain community support.

Although Werner encountered difficulties trying to teach traditional practitioners about Western approaches to medicine and the use of the scientific method, he nonetheless strongly recommended that guidelines be set up for health workers on how to evaluate the strengths and weaknesses of both traditional and Western medicine.

VI. CONCLUSIONS

(A) RESULTS OF STUDY

In this study we have reviewed 17 projects where THs were used to carry out one or more PHC activity in communities. These projects were located in Africa, Eastern Mediterranean, Southeast Asia, the Pacific and the Americas. The majority were government sponsored. Only two^{16,17} were sponsored by non-governmental organizations.

Other information from literature reviews, narrative descriptions, and views of "experts" in the field offer additional insights and suggestions about how THs can promote PHC in communities.

One important finding that stands out among the hundreds of documents reviewed is that there are relatively few projects that reported good evaluation data. Projects that reported evaluation findings are quoted in references ^{7, 9, 11, 17, 18, 21 and 22.}

While the data provides very helpful information to assess the effectiveness of projects using THs in community PHC programmes, we need more documented results from demonstration projects that represent different conditions throughout the world. Such data is necessary to answer some of the questions about how to select, train, and utilize THs in PHC and to evaluate the cost-effectiveness of such activities.

The information that is available and that has been reviewed herein is useful in arriving at the following conclusions:

(B) THERE ARE A NUMBER OF POSITIVE ASPECTS TO THE USE OF THs IN COMMUNITY HEALTH

1. THs are available and willing to work in community health.

The data supports the conclusion that THs are available and willing to take on primary health care activities when they are given training and can establish good working relationships with existing health staff. To date, a wide variety of healers from a wide array of cultures have been trained to work in PHC projects throughout the world.

Eight of the seventeen projects have trained either TBAs or village midwives. The remaining projects include the training of herbalists and spiritual healers in Africa and Latin America, Ayurvedic and Unani practitioners in India, Dhami Jhankries in Nepal, and bone setters, prayers and other magico-religious practitioners in Latin America. In each case, THs were willing and available to undergo training and were enthusiastic in accepting their new roles in PHC.

2. THs can be trained to perform a wide range of PHC tasks.

The data reviewed in this study indicate that it is possible to train THs in a wide range of PHC tasks. The projects varied with regard to the specific tasks for which healers were trained. But considering all the projects together, healers were trained in one or more tasks covering all eight categories of PHC. The following is a summary of skills taught to healers, and are based on the Alma Ata description of the eight basic PHC services:

- a) Promoting education concerning prevailing health problems and methods of preventing and controlling them, including:
 - information about local prevailing health problems
 - methods of preventing and controlling these problems
 - use of posters and other simple health education materials.
- b) Promoting improved food supplies and proper nutrition, including:
 - how to obtain a balanced diet
 - proper diet for mother and child, (i.e., breast feeding and proper weaning foods)
 - growing vegetables and fruits in kitchen gardens.
- c) Promoting adequate supply of safe water and basic sanitation, including:
 - how to obtain safe water
 - proper construction and use of latrines
 - personal hygiene and home sanitation
 - clean preparation and storage of food.
- d) Promoting maternal and child health care, including:
 - family planning
 - how to monitor pregnancy and recognize abnormalities
 - proper ante-natal care
 - basic delivery techniques
when to refer women for abnormal conditions of delivery
 - how to advise women for family planning
 - distribution of oral contraceptives and referral for other methods.
- e) Promoting immunization against major infectious diseases, including:
 - when and how to refer children under five to clinics for immunizations against childhood diseases.
- f) Promoting prevention and control of locally endemic diseases, including:
 - how to recognize symptoms of dangerous diseases such as diarrhea, TB, leprosy, malaria, malnutrition and to refer for treatment
 - how to mix and use ORS to treat dehydration and diarrhea
 - distribution of ORS packets
 - referring women in high risk groups for treatment
 - how to use readily available allopathic medicines, (i.e., anti-malarial prophylaxis, ORS, etc.).
- g) Providing appropriate treatment of common diseases and injuries, including:
 - giving first aid
 - preventing accidents.

h) Providing essential drugs, including:

- aspirin and other first aid medications
- operating basic dispensaries.

3. Training THs has produced several positive outcomes.

Those projects that attempted to evaluate outcomes of training^{9,11,17,22} reported a number of positive outcomes.

a) Changes in attitudes, knowledge and behavior.

Projects in Sudan⁶, Ghana⁹, Swaziland⁹, Nepal¹⁷, and Brazil²² all indicated that participants had a high degree of interest and enthusiasm in learning new information and skills in PHC.

These same projects were able to demonstrate changes in the practices of healers after the training workshops. These changes included the following:

- increased use of ORS and giving fluids to children with diarrhea
- use of wash basins for cleaning hands in traditional healing clinics
- decreased use of strong purges and enemas for treating diarrhea
- construction and use of latrines in healers' homes
- increase referrals to clinics for patients with dangerous symptoms
- increase in births attended by village midwives.

b) Changes in health status of people served by THs.

While there was little data reported on changes in health status of target populations, a number of projects indicated that there was a high degree of acceptance by the communities of the healers who had been trained. The Sudan project⁷ reported that the proportion of women ages 30-34 using contraceptives increased from 25% to 38% over the two-year period, and that overall use of contraceptives rose from 13% to 21%. The Nepal project¹⁸ reported that there was an increased attendance at rural clinics after the trained healers began working in local communities.

c) Training THs along with health staff has produced positive changes in attitudes and behavior of health sector staff.

Many of the projects indicated that there was an increase in trust and respect between the nursing staff and THs, and that working relationships between the two groups improved. The Swaziland project¹¹ reported that there was an increase in referrals by healers to rural clinics, particularly for children with diarrhea and vomiting.

d) Training healers has proven to be cost effective.

Ramesh M. Shrestha reports¹⁷ that their evaluation of the "dhami-jhankri" training programme in Nepal found conclusive evidence that faith healers can play a culturally appropriate and cost-effective role in health education and family planning. The staff estimated that country-wide, there was a ratio of well over one hundred dhami-jhankries to each health worker, and that these healers, as private practitioners, were paid only a modest fee by the people for their services.

In Swaziland, Wilbur Hoff²² reported that the cost to government for materials and training THs in PHC was relatively low. "The government does not pay for services provided by THs, since they are private practitioners and are paid by the community." The Swaziland Traditional Healers Organization also committed a large amount of its time and resources to the project, which helped reduce the cost to government.

In the Philippines, Michael M. Tan²¹ reported that the project staff felt the main strength of the community-based health programmes was its low cost. This was due to the project's employing traditional medical practitioners who used low cost traditional therapies. Using traditionally available remedies reduced costs of more costly commercially prepared drugs.

(C) CONSTRAINTS TO THE USE OF HEALERS IN PRIMARY HEALTH CARE.

The training and use of THs in community PHC programmes can pose difficulties in some situations. Specific problems, limitations and constraints were reported from projects and in literature reviewed in references ^{7, 9, 11, 17, 18, 19, 21, 22, 30, 31, 32, 35, 36}. These are summarized and described as follows.

1. Positive government policies to promote cooperation and use of THs in PHC are lacking.

The lack of clear policy statements by government indicating the potential value and role of THs in PHC, and the conditions upon which this could take place has generated a negative climate for healers and health staff to work together. Lack of government commitment in some projects has discouraged healers from coming forward to participate in programmes designed to train them in PHC skills. In those countries which have, until recently, legally prohibited THs from practicing, many healers are reluctant and fearful of coming out to participate in government-sponsored health programmes. The absence of government policies which acknowledge the positive role THs can play in PHC tended to reinforce secretive and guarded practices which prevail in many countries.

2. There is a lack of dialogue between THs and government health staff.

A lack of dialogue between THs, nurses and other government staff, has created misunderstanding between the two groups. This has prevented open and creative discussions to identify common health goals and agree on ways to cooperate to provide better health care to communities.

3. Some traditional practices may be harmful and difficult to change.

Some practices, such as witchcraft and sorcery, can cause dangerous psychological stress and bodily harm. These and other beliefs and practices are clearly in opposition to the modern biomedical system. These beliefs are strong and often quite resistant to change, particularly those involving supernatural phenomena. They are rooted deep in the culture and are set within a spiritual, social and environmental framework.

4. There exists some conflict between traditional and modern medical practices.

The paradigm conflict between the traditional holistic, spiritual healing orientation and the modern biomedical treatment-oriented approach poses a basic difference in

philosophy regarding the causation of disease and the promotion of health. These differences in orientation and training can cause barriers between traditional and modern practitioners getting together and working cooperatively.

5. Some fraudulent practitioners engender prejudicial feelings against ethical and responsible healers.

Charlatans and fraudulent practitioners obscure the worthwhile contributions of the large majority of bona fide healers. Isolated incidents of witchcraft, malpractice or unscrupulous behavior are widely publicized by the media, which tends to reinforce the stereotypes many people have that THs are quacks and "witch-doctors". The fraudulent practice of a few inhibits the genuine movement of the majority to create better understanding and cooperation between the traditional and modern health sectors.

6. There is a general lack of community participation in the planning and implementation of primary health care programmes.

Lack of community participation in both the planning and implementation of PHC projects where THs are used have caused difficulties. Given that the ultimate purpose of PHC programmes is to improve community health, it is imperative that communities be represented in activities where THs are selected, trained and designated to work in PHC. In addition, local communities should have some say in determining the functions of community health workers and have some input into how they are trained.

7. Many healers lack formal education and have low levels of literacy.

This can pose difficulties in the training of THs. In both Ghana and Swaziland, it was found that low levels of literacy and education of some of the healer participants required specially designed training methods. Conventional methods of training, such as lectures and use of written materials, were not appropriate.

8. The roles and tasks of THs in PHC programmes are often poorly defined.

When the role of the TH in relation to other members of the PHC team is not clearly defined, and the tasks they are to perform are not specifically described, problems have been created in the training and work setting. For example, poorly defined functions were described as a weakness of many CHW programmes³⁶, and it is probably unreasonable and unrealistic to assign a broad range of PHC tasks to such a worker. This caution also applies to THs in assigning PHC tasks to them. In Nigeria¹², because the role of THs was not made clear, some healers feared their integration in the PHC programme might threaten their status, income and freedom of action in the community.

9. There is a lack of cooperation between THs and health staff.

Lack of cooperation impairs coordination of services between the two groups. One example of this is the difficulty of establishing referral systems between healers and clinic nurses. The Swaziland project³² discusses this issue, describing how referrals between healers and nurses increased when the two groups began to cooperate during and after the TH training project.

10. There are few organized TH societies.

Lack of organized traditional healer societies has been a barrier to better regulation of TH activities. In many countries, THs have organized themselves into professional societies and have set up standards for their own training and practice. Similar to Western, private physicians, many of these TH organizations are now beginning to regulate the practice of their members through their own standards and regulations. If THs are given PHC tasks to carry out as part of their regular private practice, there should be some mechanism for overseeing and regulating their performance in this area.

11. Little or no evaluation has been conducted after training THs.

There has been little, if any, evaluation or follow-up after TH training projects have been completed. Little data is available to indicate how effective their training has been, what they are accomplishing in the community, and how satisfied community members are with THs performance of PHC activities.

VII. RECOMMENDATIONS

Preface

In order to offer recommendations for the use of THs in PHC, we must first consider the important difference between the FUNCTIONAL ROLE of THs as community health workers versus the ORGANIZATIONAL ROLE of THs as community health workers.

Healers are directly responsible to the people they serve and are generally paid for their services by their clients. Functionally, THs were probably the first CHWs since all their health services were performed in a community setting. In considering whether or how to use THs as CHWs, it is important to keep in mind that they are, in fact, private practitioners who already regard themselves as community health workers in its functional meaning.

Most traditional healers no doubt already consider themselves to be CHWs in a functional sense, since they already live in communities and provide community health services to rural families. However, because THs are private practitioners, their roles are determined not by an employing organization, such as a Ministry of Health, but by their own calling, experience, training and expertise in one or more areas of healing. The status and position of a healer is also influenced by the community in which he or she works.

The definition of "community health worker", as adopted by the WHO Yaounde Conference in 1986³⁴ summarizes the characteristics of CHWs by stating that they should be: "Members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system, but not necessarily be a part of its organization, and should have a shorter training period than professional workers."

Traditional healers are almost always members of the communities in which they work. They are already health practitioners. The challenge is how to build on these positive attributes.

Recommendations

1. An essential first step is the building of trust, respect and understanding between members of the modern and traditional health sectors.

Because of the prevailing mistrust, fears and misunderstandings that often exist between THs and modern health staff, it is essential that a climate be created where they can come together in a spirit of goodwill to begin to discuss how they can work together toward common goals.

To create this climate of trust, respect and understanding, a mechanism must be established where activities such as informal meetings, seminars and workshops are planned, where key people representing both the modern and traditional sectors can come together in a supportive atmosphere to hear each others' complaints, state their own ideas and suggestions, agree on common goals and develop creative solutions for using THs as part of the PHC team.

2. Governments (i.e. ministries and departments of health), should formulate policies that acknowledge the value of THs in PHC, and which indicate how the government intends to utilize them to promote better health for communities.

Little progress will be made toward utilizing THs as health resources unless government authorities have the political will to do so. This should be stated in an official policy to make clear to the public, THs and NGOs, the government's willingness and strategy to progress in this direction.

Such a policy statement might include the government's intent to cooperate with and include THs as part of a coordinated PHC team. Because there is still relatively little national experience with training and using THs, the government may wish to indicate its desire to carefully document the role that THs can play, and to define, through model projects, appropriate roles and managerial processes. These experiences, preferably in district health systems, will inform national policy and strategy at the same time as they are the basis for expanding to the rest of the country.

3. In the context of a national policy and strategy, projects or programmes using THs should be planned according to the specific needs and conditions that exist in each district (or local) health system.

The selection, training and use of THs in PHC should be based upon careful consideration of: a) the needs and wishes of local communities; b) the desires and capabilities of the THs; c) the goals, priorities and resources of the health system (ministries of health, non-governmental organizations, etc.); d) the cultural, economic, environmental and social conditions that exist in the area. The planning, implementation and evaluation of programmes to train and use THs must be acceptable to all parties involved, and be appropriate to their needs and living conditions.

Each country has health, social and economic conditions that are unique to its own people and geographic location. The role of THs in African countries, for example, is different from the way healers practice in Latin America or in Southeast Asia. Cultural traditions and the needs of communities vary from one region to another. Programmes that use THs must, therefore, be carefully planned to meet specific needs of local communities and areas.

4. Communities should be involved in the training and utilization of THs.

Since the intent of PHC is to develop better health of communities, its planning and implementation should involve representatives of these communities. Community members should have some say in defining the roles and tasks of THs in PHC and how their services should be monitored, evaluated and remunerated.

A useful way to assist in the planning, implementation and monitoring of PHC programmes using THs would be to establish an advisory or coordinating body which could meet periodically and oversee the progress of the programme. Representatives from the communities served, traditional healers, the Ministry of Health, and other appropriate groups could be members of such an advisory body.

5. Define carefully the role of THs in PHC and in the local health team.

The role that THs should play in providing PHC to communities should be carefully defined. It is important to keep in mind that healers have traditionally been private practitioners, and any attempt to alter this role by employing them or enlisting their cooperation as CHWs may create confusion or misunderstanding in the minds of THs, health staff and the community. It is

suggested that inputs be obtained from the modern and traditional health sectors, as well as the community, in defining what role a TH should play in a particular region or country. This role may vary, depending upon the types of THs that exist, (i.e., their level of responsibility, traditional status, and cultural practices), the priorities, goals and resources of the health system (i.e., ministry of health), and what the community wants.

A main consideration is how to integrate the traditional private practitioner's role of healer into the established health system so that they can become an integral part of the PHC team and strengthen health services provided to communities. In addition to providing PHC duties, THs and (CHWs) can be a valuable resource in community leadership to facilitate other community development activities which will promote self-reliance.

It is necessary to think of expanding their present "professional" role as healers by training them to perform additional PHC tasks and incorporating them as "team members" of the local PHC system.

Within the many categories of THs, there is a wide range of duties and levels of responsibility. A traditional birth attendant (TBA), for example, performs a more limited role in community health than a traditional midwife. TBAs are usually untrained lay people who use their life experience to assist mothers with childbirth, while traditional midwives have more training and are skilled in treating problems with pregnancies, birth and post-natal conditions. Admittedly, their distinction is not usually made, or even recognized, by the health sector.

Herbalists may specialize in using herbal medicines alone or combine these skills with spiritual or faith healing. And the Ayurvedic doctor uses a highly organized system of medicine which has evolved over several thousand years.

6. Define specific PHC tasks for THs

After the general role and responsibilities of THs have been agreed upon, it is important to define specific PHC tasks that THs will be trained for and assigned to perform. Some projects have experienced difficulties in training and in monitoring performance of THs when their duties were broadly defined and/or vague. A similar difficulty occurred when CHW job descriptions were too inclusive and generally stated. Experience has shown that it is better to begin using THs by training them to perform a few specific PHC tasks. After achieving success in training and performance of a limited number of tasks, additional training and responsibilities can be added as deemed appropriate.

The number of PHC tasks that THs can be trained to perform depends upon several factors: (1) their willingness and ability to learn and perform them; (2) the willingness of government to incorporate and utilize this new role and function of THs into the health system; (3) the resources available to train healers and to monitor their tasks; and (4) the desires of the communities to be served.

The potential range of tasks for which THs can be trained is broad. Projects have shown that healers can effectively carry out tasks in health education and promotion, prevention of illness and disease, and in the treatment of certain diseases. In addition, they can carry out leadership roles in communities by facilitating community development activities in other health-related areas.

7. THs require special training for PHC duties

Because THs come from a cultural and health orientation that is different from the conventional point of view, and because many THs have a lower level of education and training than conventional health staff, it is important to design training programmes that meet these special needs.

Several factors are important: (1) the objectives for training should be agreed upon by both the THs and the health staff; (2) the team approach should be used to enable selected health staff (i.e., nurses, CHWs) to be participants along with THs; (3) methods of training should be experiential (i.e., informal discussion, demonstrations, use of community-based experiences); (4) content and materials for training should be developed according to the educational and cultural beliefs of the participants; and (5) trainers should be carefully selected and prepared so they are sensitive to the special needs of participants and can use training methods that are appropriate to the group.

Upgrading the training of THs makes PHC more accessible to communities. THs live among the people with whom they work. In many isolated rural areas, THs may be the only health workers available to serve local communities. Being a part of the indigenous culture, they often provide a variety of functions which meet the physical, psychological, social and spiritual needs of their patients.

8. The ultimate goal (of PHC projects using THs) should focus on integral human development and self-reliance

One of the most important underlying beliefs that is common to both primary health care and traditional healing is the holistic and integral nature of life. This is evident in WHO's affirmation of health as being "a state of complete physical, mental and social well-being", and that PHC involves "all related sectors and aspects of national and community development."⁴ The idea of the holistic nature of life runs through most traditional healing practices and can serve as a common ground upon which training and use of THs can be based.

Primary health care has been defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families 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". Health programmes based on CHWs can help communities become more self-reliant by using their own indigenous resources more effectively. THs are a particular kind of indigenous health resource.

9. Conduct model projects to document experiences and to develop methods on which to base country-wide expansion.

Model programmes are a practical way of "learning by doing". Because of the scarcity of experiences in many countries, it would be worthwhile to have more carefully designed projects to demonstrate and test appropriate methods so that they can be replicated on a wider scale. Such projects should have good evaluation components built in to measure the progress and outcome of their activities. They are best conducted in the context of district (or local) health systems based on primary health care.

10. Provide rewards to THs who perform PHC tasks

Rewarding CHWs is important in order to encourage the continuation of their service³⁶. Rewards should be appropriate to the nature of the role performed. Rewarding THs who become CHWs is particularly important because in most cases THs earn all or part of their income by providing health care. In some projects, healers received increased status in the community as a result of their participating in government training workshops. This was an important non-monetary reward.

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