

INDIGENOUS HEALERS AND THE AFRICAN STATE:

Policy Issues Concerning African Indigenous Healers in Mozambique and Southern Africa

1996

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Some of the information contained in this monograph has been previously published in various journals and sections of a 1994 book, all listed in the bibliography of this publication.

HEALERS AND THE AFRICAN STATE:
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in Mozambique and Southern Africa

Edward C. Green

Preface

It has been a feature of post-independent African governments to attempt to exercise control in areas where regulation is neither justifiable, feasible, popular nor enforceable. Traditional medicine is such an area. In fact, independent governments have gone through some of the same processes as former colonial governments in re-discovering the power of traditional medicine and the limits of government control. The purpose of this book is to assist government officials, health planners and policy makers, public health practitioners, health educators, behavioral scientists, donor organizations, non-governmental organizations and other interested parties in their efforts to deal with the question of what, if anything, should be "done" with indigenous or "traditional" medicine and its many thousands of practitioners in Africa. The book offers assistance in the form of policy analyses and discussions that pull together experience from several African countries. It is hoped that the information presented will help promote a realistic, viable basis for collaboration between African governments and traditional healers that will serve the interests of both parties and that will benefit public health.

This book is focused primarily on Mozambique, where the author has served as an advisor to the ministry of health's program on traditional medicine since 1990 (on a part-time basis, but fulltime for one year in 1994-5). Experience is also drawn from similar experience elsewhere in southern Africa. In spite of this regional focus, the same policy-related issues invariably arise elsewhere in Africa and beyond, so that the problems and solutions discussed in Mozambique and the region should be of use elsewhere. Experience is also be drawn from relevant documentary sources, published or otherwise.

At this writing, the future of the Mozambique ministry of health's program on traditional medicine is uncertain, at least the part related to collaboration with traditional healers (the other main activity is ethnobotanical research). This points to the unfortunate fact that such programs are often controversial and therefore fragile. Many programs get started and then founder because of opposition behind the scenes. Sometimes a particular incident or action, or a series thereof, is used as a reason to suspend active support for a program, while authorities "wait and see" or reconsider the program. It is hoped that this policy-oriented monograph will help sensitize those involved in planning and implementing programs with traditional healers in a way that major mistakes are more likely to be avoided, and the programs have a better chance of continuation.

Note on "Traditional Healer"

It has been argued that "traditional healer" is a misnomer because healers are not strictly

traditional; they are adaptive and ever-changing. However I will use the term because African healers tend to prefer this term over alternatives that have been suggested. Perhaps "indigenous ethnomedical practitioners" or "autochthonous practitioners of ethnoiatrics" might be more accurate, but of course a simple, generic term is needed and "traditional healer" is already widely in use. Moreover African healers themselves favor both of the constituent words, while there are many others they do not.

TABLE OF CONTENTS	PAGE
Preface	3
POLICY ISSUE #1: THE SHIFT OF DONOR FUNDING TOWARD THE PRIVATE SECTOR	6
POLICY ISSUE #2: AN OUTLINE OF THE CONTINUING POLICY DEBATE	8
Points Against Collaboration Points in Favor of Collaboration:	
POLICY ISSUE #3: WHAT POLICY SHOULD AFRICAN GOVERNMENTS ADOPT TOWARD TRADITIONAL HEALERS?	16
Policy Options open to African Governments Regarding Traditional Healers	
Discussion of Options	
POLICY ISSUE #4: SHOULD HEALERS BE SALARIED BY AFRICAN GOVERNMENTS?	25
POLICY ISSUE #5: WHAT DO WE KNOW ABOUT TRADITIONAL HEALERS' ASSOCIATIONS?	28
The National Traditional Healers' Association of Mozambique	
The Constitution of the Namibia Eagle Traditional Healers Association (NETHA) Constitution of the North Eastern Transvaal Tinyanga and Herbalist Association Common Elements among Aims and Objectives of Healer Associations "Growing Pains" of Healers' Association: Examples from South Africa	
POLICY ISSUE #6: LEGISLATION AND TRADITIONAL HEALERS	46
Proposed legislation relating to traditional healers: Recommendations of the Department of Traditional Medicine to the Ministry of Justice, Mozambique	
POLICY ISSUE #7: GOVERNMENT AND THE MOZAMBIQUE TRADITIONAL HEALERS ASSOCIATION (AMATRAMO): A SUGGESTED POLICY.	50
The Need for a Policy	

Suggested Policy of the Ministry of Health

POLICY ISSUE #8: IS THERE AN ALTERNATIVE TO PROFESSIONAL TRADITIONAL HEALER ASSOCIATIONS?	55
---	----

The Impandes of South Africa

POLICY ISSUE #9: SHOULD HEALTH TECHNOLOGY BE "TRANSFERRED" TO TRADITIONAL HEALERS?	58
--	----

POLICY ISSUE #10: DO COMMUNITY HEALTH WORKER PROGRAMS WORK?	59
--	----

CHWs in Swaziland
CHW Evaluations Elsewhere in Africa
Solutions Attempted
Are the Problems of Community Health Workers Insoluble?

POLICY ISSUE #11: CAN HEALERS PROVIDE MENTAL HEALTH SERVICES?	69
--	----

Should the Department of Traditional Medicine (GEMT) Work in
Mental Health?
Is There a Realistic, Sustainable Approach to Mental
Health Services?

POLICY ISSUE #12: SHOULD TRADITIONAL HEALERS BECOME HEALTH PLANNERS AND MANAGERS?	73
---	----

POLICY ISSUE #13: SHOULD ETHNOBOTANY BE SUPPORTED BY MINISTRIES OF HEALTH?	76
--	----

Low-Cost Ethnobotanic Research directly related to Public Health

POLICY ISSUE #14: IS THERE A ROLE FOR CHIEFS IN COLLABORATIVE TRADITIONAL HEALER PROGRAMS?	81
--	----

REFERENCES	83
------------	----

**POLICY ISSUE #1:
THE SHIFT OF DONOR FUNDING TOWARD THE PRIVATE SECTOR**

Until the beginning of the 1980's almost all donor assistance for Africa was been channeled through the public sector, that is, through governments. By that time, there had been enough waste, inefficiency and outright misuse of development funds on the part of African governments preoccupied with staying in power that many donors (notably USAID) were prompted to re-think many basic premises and assumptions about development. Non-governmental channels for development assistance began to be seriously discussed. For some donors, the private sector seemed a logical and viable alternative to the public sector.

But what was meant by the private sector? Americans, for example, tend to think of the private sector as consisting of either "private, voluntary organizations" spawned by American private voluntary organizations, or perhaps local subsidiaries of U.S.-- or European--owned corporations. If we cannot work with African government officials, a growing cadre of whom have been educated at U.S. universities as USAID-sponsored "participant trainees," at least we can work with local employees of a U.S.- headquartered advertising and marketing firm, who may also have been educated at U.S. universities and therefore "speak our language." The problem with working with Africans whom we have trained to speak our language is that they may have forgotten how to speak the language of their own people, figuratively if not literally. As educated, urban-based elites, they may be out of touch with the culture and society of the rural peasantry.

As an alternative to speaking to ourselves we might consider those who have been in positions of leadership since pre-colonial times, namely chiefs, clan and lineage heads, princes in monarchical systems, priests or ritual specialists who headed special religious groups or "cults," and traditional healers including diviners, herbalists, and the like. This disparate group can be referred to collectively as traditional leaders, since they were leaders in traditional or pre-colonial times. In Nigeria, leaders in the political as distinct from health or spiritual spheres are often referred to as traditional rulers, although "traditional political authorities," used in Mozambique, seems preferable.

Traditional leaders are still a major social force to be reckoned with in Africa, but in recent years they have been displaced to varying degrees by modern counterparts, that is by Africans trained in Western-defined roles. Thus traditional healers have been to some degree displaced by doctors and nurses, and chiefs have been displaced by parliamentarians and cabinet members. Traditional leaders are very much aware of this. I have observed meetings of chiefs and traditional healers in Swaziland and Nigeria in which complaints have been voiced about how their roles and responsibilities have become vague and ill-defined nowadays, how chiefs and healers are being left behind and ignored as nations modernize, and how people are loosing respect for both types of leaders. Swazi chiefs in fact spend a lot of money in magical talismans and medicines alleged to make them regain the respect of their subjects.

The present monograph is part of an extended argument I have made that traditional leaders can and should be animated and re-empowered through efforts on the part of their governments as well as donors to bring these leaders into the development process. I have made the argument elsewhere--and adduced quantifiable evidence--that traditional political leaders (chiefs) can

become interested in development and can play significant roles in development after only a modest effort at "training," or exposing leaders to development in seminars or workshops (Green 1992a). I make the same argument for traditional healers here. The word training is somewhat derogatory or at least condescending because it implies that chiefs or traditional healers, for example, are somehow deficient but that once they are trained (as if remedially) by some method only we can recommend, they can become enlightened. This of course is presumptuous, paternalistic, and condescending, and it ignores the great extent to which "they" can educate "us." However the programs I and others like myself have worked in with healers and other traditional leaders often rely on monies earmarked as training funds, thus use of the term may be unavoidable with at least donor agencies.

At some point in the future, hopefully after there has been more experience in extending learning opportunities to various types of traditional leaders, it will be instructive to examine parallels between health and political leaders in more detail. From limited experience gained to date, primarily in two countries, I can already note similarities in motivation: both healers and traditional political leaders are anxious to learn more about the "modern" sphere of their respective sectors of interest. Healers want to learn about biomedicine and what it is that doctors do; traditional political authorities want to learn about what goes on in various government ministries as well as how civil servants are ranked and what it is exactly that they do. Such keen interest manifests itself in willingness to actively participate in so-called training programs designed to expose traditional leaders of both types to aspects of development. In fact training costs can be kept to a minimum because healers and political leaders are usually willing to underwrite some--or even all--of the costs of their "training." And unlike other groups of Africans not on government payrolls, traditional leaders usually have the income or wealth to absorb the per diem and transportation costs that usually figure in training sessions, especially those lasting longer than a day.

As noted, until recently, neither African governments nor assisting donor groups have looked much to the private sector for help in tackling development problems, including those relating to health. Even with the shift toward the private sector in developing countries, traditional healers are not the first group that governments or donors usually think of when considering the private sector; private nurse-midwives or pharmacists are more likely to come to mind. Yet healers (and chiefs) are part of the private sector, part of what might be termed the sub-sector of the private sector that may be characterized as traditional, or nonformal. Some might characterize these groups as non-organized but of course this is not true; healers and chiefs are organized in various ways but these are different from the way pharmacists or modern politicians are organized. The bases of organization among those in traditional roles may be difficult for outsiders to understand, as discussion of healers' impandes below might suggest. The organizational bases of these networks of diviner-mediums in parts of southern Africa are spiritual and depend ultimately on spirit possession and mediumship. African physicians and other educated ministry of health personnel may feel that inclusion of such groups is a backward step in efforts to modernize their government and their country--which modernization often parallels embracing Christianity and to some extent abandoning "pagan" or "animistic" beliefs.

This brings us consideration of other factors relevant to the continuing debate over whether or not traditional healers have a role to play in public health of African nations.

**POLICY ISSUE #2:
AN OUTLINE OF THE CONTINUING POLICY DEBATE**

It may be useful at the outset to summarize in outline form the arguments for and against collaboration between traditional healers and biomedical health practitioners. TM will stand for traditional medicine and TH for traditional healer.

Points Against Collaboration:

- * Some traditional practices appear harmful, e.g., giving enemas for child diarrhea; drinking urine or rubbing urine in eyes for conjunctivitis; douching with bleach for contraception; discarding colostrum in the belief that it is dirty; or making incisions with unsterilized razors.
- * Traditional treatment may be ineffective and even if harmless, it may prevent or delay patients from receiving effective treatment (Good 1987:305; Katz and Katz 1981; Imperato 1974).
- * Some Africans charge that outsiders advocate a "double standard of health care," with "second class medicine for the rural masses" while Western medicine is reserved for urban elite.
- * Those who favor collaboration with African healers have a pessimistic, defeatist attitude that the masses cannot be educated to change their tradition-bound thinking and behavior.¹ They are said to advocate "giving up" on the problems of modern sector health manpower and service delivery.
- * Traditional healing is a hinderance to progress, development and "enlightenment." Specifically, it impedes acceptance of scientific thinking and perpetuates magical thinking (Asuni 1979; Velimirovic 1984). Traditional medicine is the part of African culture "least worthy of protection", since it "...only prolongs a vicious circle of sickness, poverty, exploitation and lack of development." (Ventevogel 1992; Velimirovic 1984). In the recent words of one African doctor, "Most of it (traditional medicine) is based on superstition, meaningless pseudo-psychological mumbo-jumbo, which is positively harmful." (Motlana, quoted in Freeman and Motsei 1990:7). Medicine should be objective, rational, and empirically based, not superstition-based.
- * Traditional healers reinforce and perpetuate "superstitions" and belief in witchcraft, along with "irrational" and unnecessary fears and anxieties--not to mention witchcraft accusations and reprisals against innocent victims of such accusations.
- * Patients may undergo traditional and modern treatment simultaneously, posing risk of overdosing or at least of counteracting the effects of Western medicine.

¹ I have preserved the idiom in which these arguments are made. Use of "masses" reflects a Marxist or political-economic perspective

- * Traditional medical thinking and behavior holds little or no place for fallibility. Healers must project and protect their image of omnipotence, and therefore make exaggerated and unrealistic claims. Healers seldom admit failure or an inability to understand or treat any problem.
- * Dosages of herbal medicines are seldom standardized. Such medicines may be of widely varying potencies due to differences in storage and other factors.
- * Traditional psychotherapy does not increase patient's self-awareness or lead to personality maturation (cf. Asuni 1979).
- * Extending recognition to traditional healers and initiating any kind of collaboration or training raises expectations and even demands among healers. It's a kind of Pandora's box: today its oral rehydration salts, tomorrow they'll want antibiotics and a wing of the government hospital. At the very least, demand to participate in government-sponsored training sessions will outstrip government's ability or willingness to provide training. Since the government and local medical associations are not prepared to go very far, does it make sense to go down the collaboration path at all?
- * Extending recognition and initiating any sort of collaboration also extends at least tacit legitimacy and a measure of government approval to traditional healing practices and practitioners--which doctors and nurses by their training generally do not approve of and do not want to legitimize. Legitimization-by-association may also increase patient confidence in traditional healers, causing patients to make even more useless expenditure on ineffective medicines and therapies.
- * One reason modern medicine seems to be losing in its competition with traditional medicine is that patients often consult traditional healers first. By the time the healer or the patient gives up on traditional therapies, the patient may be beyond help. When such patients are finally treated at modern medical facilities, they may die--which then reflects badly on the efficacy of modern medicine.
- * Traditional healers tend to be nonliterate and therefore not to keep written patient records; this makes collaboration difficult. (But note that this is changing; healers often have young assistants or schoolchildren who read, write and even keep records for them.) THs who join professional associations may be better educated, but skeptics have argued that THs who join such associations are more likely to lack "traditional legitimacy" in their communities (Fassin and Fassin 1988). Others assert that THs' competitiveness prevents their associations from functioning effectively (le Grand and Glover 1990).
- * There are some priority areas of promotive health care that African healers, by their training, beliefs and orientation, would never promote, for example child spacing or contraception.
- * One neo-Marxist view is that Third Worlders suffer mostly from infectious diseases, which traditional healers supposedly cannot cure (even if symptoms subside). The

ultimate causes of these illnesses are said to be economic and political (mediated by environment, nutrition, etc.) Collaborative programs obscure these causes and stand in the way of the political struggle necessary to destroy the causes of disease and underdevelopment (Ventevogel 1992:15, citing Doyal 1987, Elling 1981).

* Anthropologists are biased toward things traditional. In the words of one anthropologist, "Medical anthropologists have always had a love affair with traditional 'alternative' healers in third-world countries. We have seen them as delivering some health services to the people most in need but least served by Western-trained physicians. We have also been reluctant to criticize any of these traditional healers because of our holistic approach which holds that each member of society has a role to play. (Singer 1986). Jarvis (in Wu 1995:173) likewise accuses proponents of herbal medicine as having "a love affair with nature...seeing it only as benign and benevolent without looking at the dangerous side."

Points in Favor of Collaboration:

* Many indigenous medicines are pharmacologically effective. Many rural clinics in Africa have few or no supplies of medicines on hand. Over-used antibiotics may no longer be effective due to the development of antimicrobial resistance. Or medicines may be available but unaffordable (whatever official policies might be regarding free or nearly-free medicine). Therefore indigenous medicines may be the only, or best, option available. Some argue that botanicals are in some ways superior to allopathic medicines: "...traditional medicine avoids the use of a single ingredient or extract and uses a complex mixture. The chemicals in the different plant ingredients may serve variously to offset side effects in other plants in the mixture, to increase cellular uptake of the chemicals that address the pathology, and to stimulate a generalized immune response so that it is not a single receptor site that is being targeted but rather a systemic healing response that is being activated...This pharmacological model is complex and sophisticated and calls for a synergistic approach rather than the reductionistic active ingredient approach to drug development." (Bodeker 1995:235)

* Regarding harmful practices, outsiders may not always be able to judge accurately the health consequences of indigenous practices. For example, the roots of *Mirabilis jalapa*, used in South Africa as a purgative, have been found to exhibit antibacterial activity against an impressive range of diarrhea-causing pathogens: *Staphylococcus aureus*, *Streptococcus pyogenes*, *Escherichia coli*, *Enterobacter* sp., *Vibrio cholerae*, *Shigella flexneri* and *Salmonella typhi* (Kusamba, Kizungu, Wa Mpoyi Mbuyi 1991). Further, the flowers of the plant "are reputed to emit an odor at night which stupefies or drives away mosquitoes." We should be cautious about categorical discouragement of any use of all purgatives and emetics in connection with diarrhea, at least until ethno-pharmacological or other studies have been done.

* If traditional healers are found to engage in harmful practices, there is a public health responsibility to try to change those practices and try to substitute safer practices. This can only be accomplished if there is dialogue, and some degree of cooperation, with traditional healers. There is also evidence that healers will modify or abandon practices if

they are shown that such practices are harmful.

* Whatever biomedical health professionals think of traditional healers and their belief system, it is largely to these practitioners that people turn in time of illness. THs are generally respected health care providers and opinion leaders in their communities.

* National health services in developing countries lack adequate numbers of personnel, and these are unevenly distributed, with nearly all doctors in the major cities. The resulting rural outreach is poor. THs may outnumber doctors 100 to 1 or more. THs are the de facto providers of primary health care in Africa.

* THs provide client-centered, personalized health care which is culturally appropriate, holistic and tailored to meet the needs and expectations of the patient. THs share the cognitive understandings and cultural values of those they treat.

* At the local or village level, traditional healers do not compete directly with physicians, but with village health workers or assistant nurses, whose training and competence may well amount to less than the traditional healer. Almost certainly, the TH enjoys greater prestige and credibility in health and spiritual matters.

* Traditional healers cannot be wished away or legislated out of existence. This has been tried by both colonial and post-independence governments, and all attempts have failed. THs occupy a critically important role in African societies. They perform a function broader and more complex than that of their medical counterparts in the modern sector. Traditional healers are priests, religious ritual specialists, family and community therapists, moral and social philosophers, teachers, visionaries, empirical scientists and perhaps political leaders in addition to being healers in the more restricted, Western sense. Their existence and durability stand as evidence that they meet important social needs, and these needs are in no way diminished as the clients they serve urbanize and undergo rapid sociocultural change. If anything, the needs increase. Rapid sociocultural change has been shown to lead to a variety of psychosocial problems, and healers who have experienced these problems themselves may be especially adept at helping people who are "torn by the conflicting expectations of their changing worlds."

* Surveys and limited program experience in Africa have shown that traditional healers are highly motivated to learn about Western medicine, to attend training workshops, and to cooperate with modern health sector personnel. As concluded at a conference on traditional medicine, "Traditional medical systems are open, not closed, to techniques and concepts characteristic of cosmopolitan medicine" (Rubel and Sargent 1979). There is a parallel between African healing and the broader, indigenous religious (or "magico-religious") belief systems from which it developed. Neither are rigid, orthodox, exclusive or purist; instead both are open and easily incorporate and integrate new beliefs, ideas and practices.

* Since healers have been organizing themselves in recent years, governments and donor organizations can now communicate with healer organizations through professional associations of traditional healers. Healers who belong to--and who occupy leadership

roles in--professional organizations tend to be eager to collaborate with the modern sector and to learn about Western medicine. They tend to be especially open about new ideas and practices.

* Any efforts toward cooperation seem to improve relations between the two health sectors, which results in earlier and more frequent referrals from traditional healers to clinics. The healer can perform a "triage" function by treating the less seriously ill and only sending the more serious cases on to the clinic or hospital (cf. J. Westermeyer, 1976).

* Any efforts that promote cooperation seem to improve communication between the two health sectors, allowing access to the beliefs and practices found among healers, and presumably their clients. This in turn allow for the development of creative, culturally-appropriate and effective health education strategies. It also facilitates interventions aimed at discouraging practices proved to be harmful.

* Freedom of religion and other fundamental rights are often trampled when there are attempts to directly or indirectly legislate against traditional healers. The rise of faith healers associated with Christianity or Islam only makes the problem more complex.

* An efficient, cost-effective training-of-trainers approach is possible by focusing public health training efforts on leaders of healer associations and on senior healers under whom novice healers apprentice. Members--and especially leaders--of traditional healer associations may be especially open to new ideas. In some countries (e.g. South Africa and Nigeria), the "traditional" training of healers has become more formalized, empirically-oriented, institutionalized, and influenced by rise of biomedical professionalism in Africa. A great and unprecedented opportunity now exists for adding public health ideas and methods into the "traditional curriculum" of healer training.

* The shift away from hospital-based health services to community-based primary health care and culturally-appropriate approaches brings health planners face-to-face with the contribution of THs. There must be some role for THs is this approach is to work (Ventegovel 1992).

* collaboration with THs can lead to the discovery of new phytochemical compounds, which can lead to the development of new, useful drugs. Some politicians, ethnobotanists, and others seem to feel that THs can be bypassed in this discovery. During the period prior to 1989 when the Mozambique government tried to suppress traditional healing, a unit of the Ministry of Health was still engaged in ethnobotanical research.

* The WHO, UNICEF, the Organization of African Unity, the Non-Aligned Countries and other international bodies have recommended to member states that strategies to develop traditional health manpower be developed.

Some who have joined the debate appear to have reserved their misgivings about traditional healers for Africa alone. For example, Velimirovic and Velimirovic (1978:182-3) make an

implicit distinction between African and Asian healing systems including healers. Unlike their Asian counterparts, African healers do not belong to a "formalized medical system" or a healing system based on knowledge that is shared through writing. Because of this, "The practitioners of non-formalized traditional medicine are not linked by any dogma or theory, and cooperation between them is rare--in most cases they actually compete among themselves ...Their knowledge is transmitted from person to person, not taught in special institutions." The authors go on to suggest that such healers cannot be "trained".

Of course it does not follow that because medical knowledge is not recorded in books or "taught in special institutions," indigenous practitioners do not share a common system of beliefs and practices. The evidence presented in this book refutes such a conclusion--in fact there seems to be considerable cultural continuity and homogeneity in African ethnomedical systems from geographically diverse societies, attesting to the strength, durability and viability of these systems.

Moreover there are invariably two or more sides to each of these arguments. For example, the image of traditional healer omnipotence can be beneficial since a patient's expectations can influence his recovery. Or if patients are consulting both a healer and a doctor simultaneously and are taking two types of medicines at once, does it not make more sense for the healer and doctor to be aware of this and to be talking to each other and collaborating in treating the patient, rather than pretending that the other doesn't exist?

Some of the points against collaboration are based on false suppositions. For example, while some types of illness might be characterized as "superstition-based", many or most illness biomedically classified as infectious and contagious are interpreted in essentially naturalistic ways in many societies of southern African. Regarding the narrower charge that African healers would never support something like family planning, in fact some healers have shown that they will support child spacing when programs are presented in ways that make sense in terms of mother and child health and survival.

Space does not permit point-by-point discussion of each argument. Suffice it to say that while there is merit in some of the points against collaboration, I come down on the side of attempting collaboration because I find the "pro" arguments more compelling and more realistic. In his survey of arguments for and against collaboration, Ventevogel (1992:16-18) characterizes my own work, along with that of D.M. Warren, C. Good, I. Harrison, T.C. Nchinda, T.A. Lambo and others, as representing a "pragmatist" approach that views traditional healers as a neglected public health resource. Another viewpoint, called "idealist", argues that traditional and biomedical healers have much to learn from one another, and that indigenous medicine has much that is valuable and unique and therefore should not be destroyed (Ventevogel 1992:18). In fact, I have also argued this position, although I think of it as pragmatic, rational and reflective of the actual strength of indigenous medicine rather than idealistic.

Surveys and censuses in various parts of Africa suggest there is one traditional healer for every 250-300 population, on the average (Green 1994:19). The physician-to-population ratio in a country like Mozambique is about 1:50,000, with some 52% of doctors concentrated in the capital city and most of the rest practicing in the next largest cities. The nurse-to-population ratio is 1:5,300, meaning that traditional healers easily outnumber the combined biomedically trained

health force in countries like Mozambique. Throughout Africa we see a similar pattern of inadequate numbers of doctors and concentration of these in the largest cities. Africa's high birth rates and general economic downturn--resulting in decreases in ministry of health operating budgets--mean that even greater proportions of the population remain unserved by biomedical health personnel. Traditional healers are the acknowledged *de facto* primary health care providers in rural areas, and this is not only by default. High concentrations of healers in peri-urban areas suggests that they are still frequently consulted even when hospitals and clinics are available.

Rather than disappear with modernization and urbanization, it appears that African healers are a force to be reckoned with for the foreseeable future. Many contemporary healers have developed financially-lucrative practices, some of which are located in urban areas where Western-style medicine is available. Such healers may take patients away from physicians, as can be seen in cities like Lagos where a number of healers have earned enough cash to build multi-bed hospitals with modern equipment and to own one or more expensive cars. The wealthy, successful traditional healer stands as a rebuke to the biomedically-trained physician who practices in the same neighborhood. Resentment of indigenous practitioners by African medical professionals has probably grown in recent years due to the development among African healers of what can only be called professionalization (Last 1986). In this context, the term refers to the institutionalization of more standardized, empirically-based indigenous training of healers; the (usually self-initiated) adoption of aspects of Western medicine or other non-indigenous medicine such as homeopathy; and, especially, the formation of professional associations of traditional healers (see Policy Issues #5, #7, and #8).

POLICY ISSUE #3:

WHAT POLICY SHOULD AFRICAN GOVERNMENTS ADOPT TOWARD TRADITIONAL HEALERS?

The short answer to this question, in the form of a recommendation, can be found at the end of this section. The more patient reader may wish to review the range of options that face governments and the experience in some countries in adopting one option or another.

African governments have opted to adopt several different official or unofficial policies related to traditional medicine and its practitioners. Policies have been influenced or determined by considerations other than public health, among them Western biomedicine and scientific thinking, political ideologies, and reaction to colonial policies, as well as both national pride and embarrassment regarding traditional beliefs and practices. Some countries like Mozambique have switched policies dramatically within the relatively few years since independence.

There follows an outline of the policy options that have been considered--and sometimes adopted--by governments. The outline is based on the more detailed policy discussions of Dunlop (1975) and myself (Green 1980), as well as more recent discussions by Ventevogel 1992; Freeman and Motsei (1990) and Kikhela, Bibeau, and Corin (1981). It seems useful to begin with an outline in order to compare the relative merits of various options and issues. Some of the issues and considerations associated with various options are given further discussion later in this section.

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Policy Options open to African Governments Regarding
Traditional Healers

Option 1: **Illegalize, or severely restrict, the practice of healers.**

Considerations:

- * it has proven very hard to enforce such a policy
- * colonial governments and a few post-independence governments have tried this policy. The policy always failed and had to be abandoned, officially or unofficially.
- * as a rule, people become confused and resentful when government interferes with something as important, culturally-embedded, and related to spiritual life as traditional healing. Government loses popular support through such interference.
- * the policy confronts the issue of religious freedom.

Option 2: **Ignore indigenous practitioners, at least officially.**

This may be characterized as "benign neglect." Government looks the other way while healers continue to practice; the state thereby washes its hands of responsibility. Many African nations follow this non-policy. It is an easy option because government need not take a stand in a controversial area.

Considerations:

- * Lack of government interference allows traditional healing to continue its development and adaptation to social needs naturally.
- * Some mutual referrals and informal cooperation may develop informally in local communities.
- * Some traditional practices may be harmful to health, yet with this option there would be no formal, or easily accessible, channels of communication between the biomedical and traditional health sectors. Nor could practices with beneficial effects be systematically reinforced.

Option 3: **Non-formally recognize healers.**

Co-existence or informal cooperation between the biomedical and indigenous health sectors becomes sanctioned and therefore more likely to occur. This policy option is sometimes regarded

as transitional, or appropriate until such time as biomedical health care can be extended to all population segments and all geographic areas (with negative economic growth and civil war in some countries, health coverage has actually shrunk). There may be an implicit or explicit assumption that traditional healers will disappear as modern health care expands. The anthropologist George Foster once made this general prediction but the last quarter century of experience in Africa suggests, if anything, that traditional healers are growing in numbers and popularity. Traditional medicine seems to be well-suited to the social, psychological, and other needs of its "consumers". It is a great source of comfort to Africans undergoing rapid culture change, providing security and continuity in an unpredictable, changing world. With the strife, civil war and economic downturn that has characterized most of Africa since independence, there has often been a decrease in government health services compared to previous years. This alone increases demand for traditional medicine.

Considerations:

- * This option (and option 2) does not call for changing or modifying the role of the traditional healer.
- * This option allows freedom of choice between indigenous and modern medicine on the part of the consumer.

Option 4. **Pursue active programs of collaboration or cooperation with traditional healers, with or without formal recognition.**

Examples can now be found in Nigeria, Ghana, Swaziland, Zambia, Mozambique, South Africa and elsewhere of collaborative projects in which regular dialogue is established between "modern" health workers and traditional healers. Both are exposed to some of the ideas and practices of the other. Most such efforts were considered pilot programs prior to the outbreak of AIDS. Such collaborative programs can be initiated without formal recognition of traditional healers, that is, as part of Option 3.

Considerations:

- * There are limited, yet promising, evaluation data to demonstrate that collaborative efforts can help spread public health messages and perhaps technology such as ORS, condoms and vitamins.
- * This option can be pursued with a government view toward modifying the role of traditional healer in the interest of public health, but perhaps no more than seems strictly justified.
- * Experience has shown that it is easy to interest traditional healers in collaborative programs because they are often strongly motivated to associate themselves with the modern health sector and to learn about aspects of biomedicine (see below).
- * Patient referrals between practitioners in the two sectors could occur under any of the Options 2-5, but they would seem to be more likely to occur in an atmosphere

of collaboration and formal exchange of healing knowledge.

- * In the view of many African physicians and health officials, there are a number of risks involved in even the most rudimentary "training" of healers (as exposing healers to biomedical ideas is often characterized), ranging from unrealistically raising the expectations of healers and the general public to legal suits for medical malfeasance on the part of government-trained healers.

Option 5. Formally recognize healers. Monitor healer activities and encourage healers to organize themselves into professional associations.

This usually involves government registration of healers. Registration can provide quality control on the part of both government and healer associations themselves. For example associations can administer competence tests and local reputation assessments before admitting healers to the association. Government is also able to some extent to *regulate and tax* healers. A step beyond registration can be the licensing of healers.

Considerations:

- * With this option, some modification of the healer's traditional role is implicit, if only through the requirement of minimal educational standards.
- * There is an implicit sanction and legitimization of healer's role and a recognition of the social contribution of healers.
- * In spite of some benefits that might arise from registration and licensing (see discussion below), healer associations may be "a tactic used (by African governments) to exclude traditional practitioners from primary health care training," and such associations might simply become organizations of 'junior professionals,' subordinate to the medical professions, that might be legislated against at any time (MacCormack 1986; van der Geest 1985).
- * There is often an assumption that government-healer relations are best facilitated by and through formal professional associations. However this assumption has rarely been tested through exploration of alternatives.
- * There is potential for corruption among leadership of healer associations if they have power to confer legitimacy, or to license.
- * Licensing can provide "a way of guaranteeing minimum education standards of those practicing traditional medicine..." (Dunlop, 1975). However we have no proof that formal education is associated positively with success as a traditional healer, as perceived by the "consumers" of traditional health services or by some other measure.

Option 6. Pursue a policy and program of incorporating healers into the formal health

care system. Train healers as biomedical paraprofessionals.

Incorporation, as distinct from collaboration, involves an attempt to transform the role of the traditional healer, to turn the healer into some kind of modern-sector health paraprofessional. It also provides opportunity for government control and manipulation of healers and traditional medicine.

Considerations:

- * Re-tooled healers would become government employees, probably at a level lower than registered nurses. There would be great potential here for status/role confusion and conflict. "Incorporation" would amount to subordination of traditional healers to nurses and other modern sector practitioners toward whom healers often feel superior. Healers may already be earning higher income and enjoying higher status than nurses or health assistants (Orley 1980, and see Issue #4, below)
- * This option also assumes healers would be willing to be re-tooled by the government. Governments considering this option must face questions such as: Would diviner-mediums be willing to be trained to abandon relationship with--and guidance from--their spirits? Would they be willing to work under the direction of a nurse? Which medicines would healers be allowed to administer? Would use of traditional, herbal medicines be allowed to continue?
- * This option assumes that the social costs of transforming traditional healers into something different (assuming government had such power) are outweighed by a government's gain and "provision" of a vast number of new medical paraprofessionals.

Discussion of Options

If governments choose the illegalization option, they immediately face the problem of enforcement. The financial costs alone of enforcement may be more than most African governments would be willing to pay. Experience has shown that such attempts fail, therefore there are additional costs to governments in credibility and support when this happens. Even in the event that legal suppression of traditional healing could be successful, there would be tremendous social and psychological costs. People would be confused and resentful of government interference in what would be perceived as the right to remain healthy and to be cured of illness, as well as the right to follow the spiritual and religious path of one's ancestors. Zaire is an example of a post-independence African country that attempted Option 1, and it seems to have abandoned the policy, or at least its enforcement (Dunlop 1975:585).² Mozambique under the Frelimo government also made the practice of traditional healing illegal, driving healers and their patients underground and alienating people from the government. Frelimo repudiated this policy in its 5th Party Congress in 1989.

² At present, Zaire has no real national government functioning as such.

Other countries have vacillated between restriction and benign neglect. In Senegal, a law passed in 1966 condemns all who practice health care without a license, but the law is not enforced with traditional healers. "...Official attitudes can be described as lack of acknowledgement (of healers' existence) interspersed by fits of sporadic repression..." (Fassin and Fassin 1988:354).

The second and third options are sometimes regarded by planners as transitional policies since they do not call for official recognition or incorporation, merely for coexistence or informal cooperation. For example, Harding (1975:3) notes, "although the ultimate aim is to establish comprehensive services, in the initial phases of development the structure cannot be exclusive, separate or rigid but should allow for cooperation among and exploitation of all sources of help". Yet, as already noted, there is evidence that healers are adapting to changing conditions and that they will not disappear as economic development progresses. Thus the policy of informal cooperation may have to be considered in a more permanent light.

The second and third options do not call for changing the role of the traditional healer, and this is all for the good if one believes that the healer fulfills a need that modern health personnel cannot and probably never will meet. In effect, these options would allow consumers to choose their health providers for themselves. The freedom of choice may itself be a psychological benefit to the consumer, and the existence of competition in the health sector may well be preferable to a monopoly of services on the part of one or the other group. Competition might also help keep health costs down.

On the other hand, those doctors and others who feel that at least some types of indigenous practice are dangerous to their patients' health would not be happy with option two, which in effect calls for looking the other way while healers continue to practice. Option three involves informal recognition, and perhaps seeking cooperation in referrals to modern health personnel. In such a situation there might be some opportunity to discredit the prestige and authority of irresponsible or dangerous healers, but governments would have no real mechanism for monitoring healers, nor, for that matter, authority to curtail their activities.

Most African governments seem to have taken the informal recognition option, at least for the time being. Sometimes informal recognition follows from research into traditional medicine (as in Ghana, Tanzania, Mozambique, Botswana, and several other countries), which research may be seen as a step toward more formal programs of collaboration or incorporation. On the other hand, ethnobotanical research might not lead to recognition of healers or any sort of collaborative programs involving traditional healers, evidenced by the dearth of such programs by the end of the 1980s, before concerns about AIDS spawned many new collaborative programs. Ethnobotanical research may in fact divert resources and attention away from the public health role of traditional healers. And not all ethnobotanists favor collaborative programs (e.g., le Grand and Wondergem 1990:28-9).

Option three may be the least risky and most flexible policy that governments can take (Dunlop 1975:584), even if it develops largely as a result of ambivalence towards healers and compromise with skeptics from the local medical establishment.

Option four calls for collaboration with--perhaps "training" of-- traditional healers in order to

improve their effectiveness and discourage practices deemed inimical to public health. Such programs are compatible with the policy of using all locally-available manpower resources, which the World Health Organization strongly promotes and which many African countries have already officially embraced. Some of the advantages of such collaboration are that it probably: (1) provides psychological comfort to the patient and patient's family; (2) leads to earlier and more frequent referrals to modern health personnel; (3) results in more serious cases being referred to biomedical personnel, and in screening out cases which are easier to treat; (4) enables African patients to "place one foot firmly in the familiar past while taking a risky step into the unknown future" (Ulin 1979); (5) upgrades the preventive if not curative skills of traditional healers; (6) provides modern health workers (including trainees) with the opportunity to learn local cultural/behavioral patterns; (7) increases the sensitivity, skills, and therefore the effectiveness, of modern health personnel; (8) allows for the selective and controlled introduction of modern public health concepts, techniques and technology; (9) provides an opportunity for defining and limiting traditional practices that are clearly injurious or counterproductive; (10) helps establish a foundation and precedent for cooperation between government and local healers; and (11) leads to the development of a syncretic health care system that combines the best elements of biomedical and African health care.

On one of these points, we cannot assume healer-doctor referrals will occur at all, or will develop spontaneously and naturally with urbanization and modernization, in the absence of collaborative programs. My own survey data from Nigeria showed a consistent pattern of inverse relationship between respect for modern health practitioners and frequency of patient referrals from healers, and (1) healer's level of formal education, (2) population density and (3) urbanization. In other words, healers with the greatest respect for doctors and Western medicine, and who were likeliest to refer their own patients to doctors or nurses, tended to be from remote rural areas, probably had relatively little direct contact with modern practitioners, and had relatively little formal education themselves (Green 1994:162-5). It may be that with little opportunity for intersectoral contact, there is also less opportunity for intersectoral competition and conflict. It can be assumed that these will increase in the absence of deliberate efforts to improve intersectoral communication and cooperation.

Some have wondered what might be in it for the traditional healer. Collaboration might curtail his or her professional activities and would diminish his image of omnipotence, and consequently his therapeutic efficacy (Asuni 1979:34). On the other hand, in much of Africa, the presence of biomedical personnel may diminish the image of traditional healers and collaboration is an adaptive and accommodative way to adjust to this situation. Association with modern health personnel may even enhance the status of healers. In any case, the bulk of evidence suggests that most healers are amenable to--even desirous of--collaboration. The reasons for this are worth reviewing. Traditional healers:

- tend to respect modern medicine; they recognize its efficacy--even its superiority to traditional medicine--for treating certain conditions;
- have found that the acquisition of biomedical skills--even the vocabulary or trappings of such skills--usually enhances a healer's prestige and respect in the local community. It may attract new clients to the healer's practice and enhance the healer's income (Ventevogel 1991 provides quantifiable evidence of this). In any case, it bestows added

respectability and legitimacy upon the healer;

- are often genuinely altruistic and wish to ease suffering as an end in itself, and they believe or suspect they can become more effective healers with added skills;
- may simply be curious about how allopathic medicine works.

Healers are motivated to cooperate with modern practitioners in the treatment of infectious diseases and certain other conditions because these are common diseases in Africa and healers themselves are frequently called upon to treat them. Even though healers may express great faith in their traditional remedies, the fact is they do lose child and adult clients to these diseases and so healers are open to the possibility of new and better methods of treatment. There is further discussion of healers' motivation later in this section. At this point we can note that the motivation of healers to cooperate with modern practitioners is a potentially powerful force that could be harnessed to improve public health in Africa, yet for various reasons this has scarcely begun to happen.

Returning to our policy overview, Option five calls for official recognition of healers, and Option six assumes it. Official recognition implies sanction and recognition of the contribution of healers. This recognition may be through adoption of an official policy by one or more ministries, or it may be through revision or passage of legislation (see below). Recognition may be en masse and include all self-defined traditional healers, or it may be of one or more national professional associations of healers and leave the question of defining traditional healers to the association(s).

Certainly the further step of licensing raises problems such as how to define healers, how to assess a healer's competence, how and when to revoke licenses and under what justifying circumstances. Not only how, when and what questions, but who could carry out such regulatory tasks? Civil servants trained in law and traditional medicine?

Governments may decide to limit their licensing program to herbalists, at least in the initial stages. However in practice it may be difficult or impossible to train and collaborate with one type of healer and exclude others. Who is to say whether a healer is a diviner or an herbalist? Many claim to be both, especially if recognition or other rewards are offered for identifying oneself in a particular way. In any case, it would be politically divisive and fractious to recognize only one type of indigenous healer.

Governments may see licensing as a way to "create a greater incentive for traditional healers to increase their technical knowledge". Other benefits from governments' points of view, according to Dunlop (1975:583), are that:

- (1)...licensing could provide a way of guaranteeing minimum education standards of those practicing traditional medicine;
- (2)...it may be the least costly way of opening up lines of communication between the traditional and modern health sectors...;

(3) it may be the easiest way to obtain information about the size and scope of the traditional sector.... (Dunlop 1975:583)

In fact, points (1) and (3) follow more from Option four. Licensing does not imply communication in any meaningful sense and certainly not research; these are associated with collaborative programs.

Option six, the policy of incorporating healers into the formal health care system, deserves extended treatment. This is provided in Policy Issue #4, to follow.

**POLICY ISSUE #4:
SHOULD HEALERS BE SALARIED BY AFRICAN GOVERNMENTS?**

If traditional healers are already providing most of Africa's health care, should some of the public money spent on health somehow go to healers--if not money raised by taxes, at least a proportion of the donor assistance to the health sector that is contributed annually? While this sounds reasonable, we run into a number of problems when we consider how this actually might be accomplished. For example, it has been argued that healers should be put on some sort of salary by ministries of health. If assistant nurses and even minimally-trained village health workers receive compensation, why shouldn't traditional healers? There are a number of reasons arguing for caution here.

First, if healers became salaried, they would have to fit in somewhere in the existing medical hierarchy. They would be assigned a civil service classification and rank. In view of biomedical attitudes toward practitioners regarded as not medically trained or medically competent, it is highly doubtful that healers would be ranked or salaried at anywhere near the level of doctors or even full nurses. Instead they probably would be ranked low on the scale, closer to village health workers. This raises the possibility that traditional healers would not be willing to work for a health ministry under such circumstances. Healers already enjoy considerable status and they tend to be at least relatively well off in their own communities. For a healer to become something like a village health worker, he or she would risk a loss of status if not substantial income. This seems to be one reason that village health worker programs have not attracted more traditional healers to their ranks. It seems safe to say that there at least would be great potential for status and role confusion and conflict if traditional healers were to be incorporated in health or other ministries.

Orley (1980:128) makes a blunt point about the question of trying to recruit healers into biomedical systems:

Before considering this further, we should perhaps ask ourselves whether it is not being presumptions to assume that traditional healers would want to be recruited into Western medical practice. They probably get more money in their practice of traditional medicine, and they might find it a much more satisfying way to practice the healing art.

Indeed he makes the point that one of the reasons for the acceptance of Western biomedicine

during the colonial period was its lesser expense "...compared with that provided by traditional healers, which often required sacrifices of several animals and fees for the healer, who was not subsidized by the Church or State" (Orley 1980: 127). There is even evidence today that clinic use can drop off measurably when low clinic fees are raised slightly (Yoder 1989), suggesting that "demand" for biomedicine is still weak, at least in the form in which it is currently offered.

There is some disagreement about the fees or in-kind compensation healers receive in contemporary Africa. Some entertain the romantic notion that in-kind fees amount to little more than token or symbolic payment. This has not been my own experience in the countries where I have worked. Payment in cows, goats, or even chickens represents a considerable sacrifice for most Africans, whether they are peasant farmers or employed townsmen. In any case, the trend is toward cash rather than in-kind payment and while more reliable data on healer fees is much needed to settle the question, my experience has been that healers often charge higher patient fees than government- or church-run hospitals or clinics. This is not surprising since most health care in Africa has been heavily subsidized by government and church up to now, and patient fees have been kept artificially and unusually low.

A more serious issue perhaps is what the effects on traditional medicine might be if its practitioners were salaried by governments. With incorporation into the civil service would come control and probably manipulation. This might appeal to some biomedical planners and administrators whose thought might be: if there are countless thousands of "untrained" healers "practicing medicine without a license," why not bring them into the ministry, train them, and control their practice? Would that not serve the public health, at least by cutting back harmful practices?

The question we must ask is what else would be changed, transformed, or distorted? Biomedicine as practiced in Africa and the United States is similar in that power is highly concentrated in the hands of doctors and administrators. U.S. physicians have spent a good deal of time and energy guarding their power prerogatives against incursions from nurses and other auxiliary health care personnel (Kotelchuck 1976). This tendency--found in Africa as well--coupled often with arrogant, disapproving physician attitudes toward traditional healers, not to mention ignorance of traditional medicine as it actually is practiced, strongly suggests that biomedically-trained ministry personnel in charge would attempt to transform healers into something they are not--and would probably not want to be.

Carl Taylor, summarizing a symposium on traditional healing, noted:

We have learned how to identify community resources from community development experts. As we found the natural leaders, the health system tended to co-opt them so that they were no longer really community representatives. This could also happen to indigenous practitioners where a process of synthesis is attempted. While this strengthens the health system at low cost--especially if sufficient seduction can be exercised to get them to work as volunteers--it may well weaken the communities' capacity to solve their own health problems (Taylor 1979:84).

It may be noted that the African National Congress is studying ways the ANC might cooperate with traditional healers under a new, majority-rule regime in South Africa. During a 1992

conference, an ANC spokesman said he "...did not think that traditional healers should become part of formal health services...(because) there was resistance to incorporation from both the formal and traditional health workers" (Wilson 1992:38).

Incorporation and government salaries could "professionalize" healers in the negative sense: governments would assume the responsibility of issuing formal credentials to healers; there might be restrictive licensing and increased costs to consumers (in the private sector); service would become increasingly impersonal; record keeping might become an end in itself; and the authority of physicians could be extended and their monopoly in health care further consolidated with a vast new "cadre" of underlings to supervise. At least one African medical professional has already suggested that traditional medicine not be legally available in Africa without a prescription from a physician--while at the same time admitting that medical professionals know nothing of the contents of traditional medicines (Adikwu 1992:122).

My feeling is that meddling with traditional medicine is fraught with unforeseen and possible negative outcomes. One does not have to be anthropologist to recognize that healers play a complex role and carry out complex, interrelated functions in their communities. We know from the written and archeological human record that healing is one of the first roles--if not the very first--to become specialized in human societies. Healers have only become scientifically-trained allopaths in the very recent historic period, and they are still out-numbered by indigenous, traditional healers in most of the world. A majority of Africans vote with their feet and their pocketbooks by choosing the services of the latter even when the former are available and perhaps cheaper. Clearly there is a need for the type of service indigenous healers provide.

I believe that the only real justification for interfering with traditional health systems at all is in the cause of improving public health. Considering that it is not always clear how best to accomplish this, as well as factors relating to African cultures and traditional healing itself, we should proceed with great caution. Given two or more alternatives involving interventions with traditional medicine, we should chose the option that is least intrusive and potentially disruptive to that system.

In any case, what is the political or economic plausibility of the incorporation option? Given present conditions, it seems extremely unlikely that health ministries would be able or willing to pay for thousands of new employees. The first argument doubtless would be that with the small allocations of public funds devoted to health services, ministries cannot presently pay for adequate numbers of existing, already-trained health care personnel. How can they then multiply personnel ranks by several hundred percent to accommodate "untrained" health staff? And if some traditional healers were invited to join government ranks, wouldn't most or all healers demand the option to join?

This last consideration would probably end the argument for a great many health planners and administrators in Africa; there would be no need to raise the other points we have been discussing. Any health-related plan seems doomed to defeat if local medical establishments oppose it. Such bodies are politically influential and persuasive in their arguments about "proper medical care" for Africans.

Some might argue that when facing a deadly epidemic such as AIDS, the above considerations

lose some of their relevance or merit. I think they do not. Africa has faced and still faces other diseases of epidemic proportion, several of which account for more morbidity and mortality than AIDS. This does not alter the problems associated with attempting to transform healers into government-salaried paraprofessionals.

There are other ways traditional healers might share or benefit from some of the financial resources for AIDS being channeled into Africa. For example, resources could be directed to national associations of traditional healers. True, there may be more than one association claiming to represent most or even all of a nation's healers. The solution would then be to find a way to fairly and equitably allocate resources among truly representative associations.

If the resources are money, we still face the problem of possible manipulation, co-optation or subordination of healer associations by governments, a point made by MacCormack (1986:153). Perhaps there would be less likelihood for this if the resources were non-monetary, for example medical supplies. Assuming government willingness to "transfer" certain "technology" to traditional healers, health care related products could then be given--or sold at discounted wholesale prices--to organizations of healers in some type of social marketing or Community-Based Distribution (CBD) program in which healers could earn a profit when they used such products in the care of their clients.

POLICY ISSUE #5:

WHAT DO WE KNOW ABOUT TRADITIONAL HEALERS' ASSOCIATIONS?

Collaborative programs between African governments and traditional healers can be facilitated if healers have organized themselves into formal organizations or associations. At the very least, communication between government and healers is greatly facilitated. However there are also a number of problems that arise with these associations that may relate to leadership, dues and money issues, expectations of government support or subsidy, and inter- or intra-group conflicts.

It is useful to summarize a forum-type discussion published some 15 years ago in response to a paper by D.D.O. Oyebola (1981), perhaps one of the first attempt to describe the aims and functions of traditional healer professional associations, in this case among the Yoruba in Nigeria. The points raised by a panel of experts responding to the paper provide a framework for understanding the findings and policy issues from South Africa.

Bannerman (Bannerman *et al* 1981:93), former head of the WHO's Department of Traditional Medicine, was upbeat on future of professional healer associations, believing that they would encourage the enactment of appropriate legislation for licensure and registration of healers, assist inter-sectoral collaboration and provide protection to the patient in the form of quality control of healers' practice.

For his part, Bibeau rejected the widely-held view that traditional healers are secretive, non-cooperating and non-communicating. "Priest-healers" and "ritualists" in particular have always been organized in formal associations characterized by regular meetings and "control over individual practice by elders in the initiation..." National associations, however, are new and Bibeau believed "they cannot exist for the time being". He advocated efforts aimed at developing

"strong local, regional, limited associations" noting that the national associations with which he was familiar were "purely legal empty forms without any power of mobilization". The "sociological traits" of "efficient healers' associations" are that: (1) they are rooted in a geographical area or in a particular form of therapy; and (2) "they are highly personalized, in the sense that leadership is assumed by a healer of great fame in the area." (Bannerman et al 1981:94).

Dunn held the notion that "some form of healers' association, however local and small in scale, can be found in any society that supports traditional healers...past or present." (Bannerman et al 1981:95) Fosu (Bannerman et al 1981:96) also finds evidence for the antiquity of associations "organized at the community level" characterized by "networks of communication channels... through which they gathered information to help them in their practice". He went on to say:

...attempts to organize them at the national level are recent. Such efforts have not always been successful for several reasons, notably internal strife for leadership positions and difficulties in legitimization and integration into the national health care system. (Bannerman et al 1981:96)

Nevertheless Fosu thought local government support could help overcome some of these problems and that "...the advantages of having accredited traditional healer associations are many."

Heggenhougan (Bannerman et al 1981:97-8) felt that collaboration with healer associations on the part of national study groups can "serve to overcome the information gap." He noted that reluctance on the part of many healers to join national associations is not necessarily due to their own competencies or wish to be secretive, rather it is because "Healers are aware that initiators of such associations are sometimes motivated by special interest, political or self-serving considerations rather than by the potential benefit to the healers and their patients."

According to a 1985 WHO report, there were healers' associations operating under official auspices, at either national or district levels, in at least 23 African countries: Ghana, Nigeria, Zimbabwe, Swaziland, Zambia, Benin, Central African Republic, Congo, Guinea, Ivory Coast, Madagascar, Niger, Rwanda, Cameroon, Togo, Senegal, Mali, Liberia, Zaire, Uganda, Kenya, Tanzania, Burkina Faso (WHO 1985). Since this survey healers' associations have sprung up in countries such as Malawi, Botswana, South Africa, Mozambique and doubtless elsewhere. National associations of traditional healers often boast memberships in the thousands and they sometimes have "modern sector" titular heads or advisors such as physicians, university professors or civil servants (cf. Chavunduka 1986:48). The inclusion of such advisors can be seen as a survival strategy: associations supported or led by a professor or doctor are harder for governments to dismiss as backward or inconsequential.

A characteristic of the healers that comprise these associations is that they are especially interested in learning more about modern/Western health care, they want to work in cooperation with the modern sector through involvement with ministries of health, they want to change the popular image of traditional healers as "primitive witch doctors," and they want to become as respectable among government officials as they typically are in their own communities.

Murray Last (1986:10-11) has discussed the rise in professionalism among African healers as a reaction to the postcolonial development of the biomedical professions. African physicians,

whose own rise of professionalism has meant to them decolonization, Africanization of jobs, and meeting the European on equal terms, have tended to regard traditional healers as something of an anachronism, as a throwback to a time when Europeans may have believed that "second-best" was good enough for Africans. In short, traditional healers have been regarded by African physicians as a threat to their own professionalism. Therefore they have often opposed initiatives that would result in official recognition of, or increased power among, indigenous healers.

As a result, what we are now seeing is a kind of "second generation" of traditional healers who have adapted their methods to meet the competition, and organized themselves to defend their right to practice against criticism from an expanding medical profession. The prize is recognition from the government, and ultimately a share in the salaries, supplies and buildings provided by government. (Last, 1986: 11).

Other observers present quite a different view of healers' associations. Wondergem and Glover (1990:110) assert that traditional healers in Ghana compete with each other for money and prestige and therefore "have little interest in becoming organized. They use their organization primarily to act against other interest groups and not to exchange views or experiences." The authors cite "serious conflicts within...various healers associations" as the major reason that "implementation of policy (of cooperation) has come to a standstill." (Wondergem and Glover 1990:21. paren. mine).

MacCormack (1986:153) also holds a distinct view of healers' associations. In fact she regards "requiring that practitioners form an association and present themselves with a well-organized hierarchy of officers where there is no cultural tradition for doing so" as one of several "tactics used to exclude traditional practitioners from primary health care training." She further observes that healers' associations might simply become a organizations of "junior professionals," subordinate to the medical professions, that might be legislated against at any time. While there may be truth in this, at least regarding the motives of some physicians and government functionaries, it has been my observation that healers who join and participate in an association tend to feel that strength in numbers offers them genuine political power and prestige in the wider society. They also tend to join these associations voluntarily, not because of government enticement or coercion. However the skeptics cited above are right in noting conflicts within healers associations, and that such associations, in their typical form, lack roots in African culture and tradition.

What is this form? Let us look at a few examples.

The National Traditional Healers' Association of Mozambique

A Maputo-based organization known as AMETRAMO aspires to be a national professional association of traditional healers that represents healers throughout the country. It was in fact one of the very first professional associations of any sort to arise after the ruling Frelimo party began to move away from Marxism and approve the formation of private associations. AMETRAMO hired a lawyer to help draft its constitution, and in mid-1990 presented a document to various

ministries including Health and Justice. It calls for:³

- o cooperation among all healers
- o the association representing all healers throughout Mozambique
- o exchange of healing and medicinal knowledge among healers
- o asking the government to recognize the "political, social and cultural legitimacy and importance" of traditional healers
- o sharing of information about the qualifications of healers throughout the association's network
- o sharing information about where medicinal plants can be found
- o structuring members according to their professional qualifications
- o exchanging experience with parallel organizations
- o offering to give the support of traditional healers to the Ministry of Health or its units
- o establishing "collaboration" with foreign health institutions
- o establishing minimal entry qualifications for the association (there is mention here of obtaining verbal and written testimony attesting to a healer's competence, plus a minimum of two years of practice)

The draft constitution also includes a section of "rights and obligations of members," among which are:

- o to "dispense care with seriousness, honesty, devotion and professional pride"
- o to keep professional secrets of patients, i.e. to maintain confidentiality
- o to avoid advertising and promoting one's healing skills in "inconvenient locations" with the object of attracting clients
- o to alert the association of individuals trying to practice without proper qualifications
- o to pay dues on time

It also calls for the establishment of sanctions against those who contravene the established rules and regulations. Sanctions consist of public reprimand, suspension of membership for one year, fines of more than Mt20,000 but less than Mt100,000 (about US\$10-50 in 1990 exchange) and expulsion from AMETRAMO. Sanctions can be carried out at the district assembly level.

In its simplest form, the structure of AMATRAMO is like a pyramid with the national conference and national executive committee at the top, followed by provincial executive committees, each of which contains several district assemblies. Actually a much more elaborate bureaucracy is envisioned. The association structure is clearly copied from the Portuguese system. At the central or national level there are six "organs." The functions of the various organs are specified, for example the national conference elects members of a central commission.

³ This document is incomplete since some minor points were not recorded at the time (1991) I had a copy of the constitution. The translation from Portuguese is my own, and should not be taken as flawless.

Duties of various leaders within the association are also specified. A "national fiscal committee" will solicit independent audits of funds raised from dues.

The association is supposed to represent the whole country and decisions are binding to all members. AMETRAMO tried to have a national conference in 1991, sending invitations to healers throughout the country. Healers from central and northern provinces seemed to have difficulty raising money to travel to the southern extreme of the country. The head of the Manica provincial branch of AMETRAMO told me he thought the association should be more centrally located, perhaps in Beira. When AMETRAMO held its first national meeting, during the last week of August 1992, attendees again seemed to be mostly from the south.

Both the Minister of Health and the Minister of Culture and Youth spoke at this conference. The press was present and gave the event full coverage (Noticias 1992). The Minister of Culture and Youth spoke of the important role traditional healers can play in the "de-traumatization" of war-ravaged Mozambican society. He emphasized their roles as community psychologists and as people "knowledgeable in the secrets of nature." The Minister of Health depicted traditional healers as knowledgeable people who combine their skills with natural substances to "eliminate social, mental and physical disequilibrium." It should be added that the Minister at that time had rare qualifications: he was a physician with a masters degree in public health who had formerly headed the ministry unit engaged in the study of traditional medicines. This meant that he was unusually sensitive to the role and value of traditional healers as well as supportive of efforts to work collaboratively with them. The Minister who replaced him in 1995 was far more typical of officials in this position: not at all sympathetic toward traditional healers.

The Constitution of the Namibia Eagle Traditional Healers Association (NETHA)

For a comparative perspective, I now present the constitution of the national traditional healers association of Namibia.⁴

1. PREAMBLE

The name of the Association shall be the NAMIBIA EAGLE TRADITIONAL HEALERS ASSOCIATION (NETHA).

2. OFFICE

The registered office and address to which all communications and notices to the Association shall be addressed, shall be KATUTURA COMMUNITY CENTRE, P O Box 24103 Windhoek, 9000 or at any other such places as

⁴ Permission to publish this was granted by Dr. Elipus Iyenda, General Secretary, and his assistant Dr. Jerry Mwene, both of NETHA of NETHA. Thanks to anthropologist Deborah leBeau of the University of Namibia for obtaining permission and providing the document. I have made no changes in the language and punctuation of the document.

determined by the Executive Committee. Any change of address shall be notified to the Ministry of Health and Social Services and other concerns and registrar of societies.

3. OBJECTIVES

The main objectives of (NETHA) shall be as follows:-

- i) To provide a therapeutic community of traditional healers offering supportive environmental health programmes to all physically, mentally, emotionally disturbed and developmentally handicapped in Namibia and elsewhere.
- ii) To act as a sole organization for all traditional healers in Namibia and to do all such things as are necessary to foster and encourage improvement by the use of indigenous trees, minerals and other resources with medicinal properties or as conducive to the attainment of that purpose.
- iii) To carry out research projects, surveys, market research on toxicology, dosage and hygiene and any such matters connected with traditional medicine.
- iv) To provide, co-ordinate training workshops for all communities engaged in traditional healing.
- v) To provide extension management and consultancy services for traditional healers.
- vi) To be a link between the government and NGO with traditional healers.

4. MEMBERSHIP

- i) The Association shall compose all types of traditional healers namely:-

herbalists, midwives, diviners, spiritualists and witchfinders;
permission to admit or not to admit rests with the national Executive Committee upon proper scrutiny.
- ii) Membership shall be open to every man and woman who has attained a required recognized standard of healing.

5. REGISTRATION FEE

Every member upon admission shall:-

- i) Pay registration fee as may be decided by the National Executive from time to time.
- ii) Pay an annual membership fee each year.
- iii) Be certified upon attaining high professional standards.
- iv) Be registered into the healers register.

6. TERMINATION

Membership shall be terminated by:-

- i) Death or insanity
- ii) Loosing an election
- iii) Expulsion
- iv) Voluntary withdrawal or resign

7. EXPULSION

A member may be expelled for:-

- i) Failure to comply with a decision made in favour of the Association requesting him or her to pay an amount due to (NETHA) as decided by the arbitrator or the national Executive Committee.
- ii) Failure to comply with the laid down regulations.
- iii) Any action detrimental or contrary to the interests of objects of the Association as laid in the regulations.
- iv) The disciplinary committee of the National Executive may charge a member a certain amount of money for small offenses as a penalty.
- v) Expulsion will only be constitutional with two thirds vote of the national executive present.
- vi) From the date of expulsion an expelled member may not be re-admitted as a member within a period of one year.

8. NATIONAL EXECUTIVE COMMITTEE

The association shall have a national executive committee of (14) fourteen of which

the following shall be members:-

- i) Chairman
- ii) Vice Chairman
- iii) Secretary General
- iv) Vice Secretary General
- v) Treasurer
- vi) Vice Treasurer
- vii) Director of Research
- viii) Vice director of Research
- ix) Publicity Secretary
- x) Vice publicity secretary
- xi) Four disciplinary committee members

The National Executive shall be elected at an Annual General Meeting and shall serve 3-5 years terms of office. The chairman of the Executive Committee shall be the ex-officio chairman of the Association.

9. TERMINATION OF BEING EXECUTIVE COMMITTEE MEMBER

Any member of the national executive committee shall cease to hold office if he/she:-

- i) Becomes insane or dies
- ii) Resigns in writing
- iii) Becomes bankrupt
- iv) Voted out at an A.G.M.
- v) Faces judgement by arbitrator or court of law in favour of NETHA.
- vi) Is convicted in a court of law of any offence involving dishonest, and imprisoned for three months or more.

10. EXECUTIVE COMMITTEE MEETING

- i) Shall be held on as decided by the members, but shall be held at least, once every month, or as the chairman may wish.
- ii) At least 5 members of the National Executive shall be necessary to make a quorum before any business shall be transacted on.
- iii) One man one vote situation will prevail, except in case of equal voting the chairman will have a final decision.
- iv) Written notice of meeting with agenda, date, time and place, this will depend on distance (written apologies should be sent to the chairman by those who fail to attend meetings).
- v) The General Secretary shall attend all meetings except where personal matters are being discussed, his vice will take minutes.

11. DUTIES OF THE EXECUTIVE COMMITTEE

- i) Shall conduct the general duties of the Association and exercise

general powers of NETHA, except those reserved for annual general meeting.

- ii) The chairman shall chair and control all meetings and delegate duties to the Secretary General whom the committee shall supervise and control.
- iii) To maintain or cause to be maintained true and accurate records all duties by the Executive Committee.
- iv) To register all members of the Association and keep a correct and up to date record of the register and transactions.
- v) Should negotiate for funds on behalf of the Association (NETHA), and maintain a clean record of the account, audit, budget and end of the year balance sheet.
- vi) To renew registration certificates, handle all contracts and all legal matters for and on behalf of NETHA.
- vii) To supervise, maintain clean records and recommend expulsion under these regulations.

12. ANNUAL GENERAL MEETING

The following business shall be reserved for the annual general meeting and the secretariat should table the years' report to the General Meeting:-

- i) Amendments of these regulations: by two thirds majority vote, by either acclamation or by ballot paper of one man one vote, for any amendment to take place.
- ii) Previous minutes of the meetings discussed shall be signed by the chairman and Secretary General upon adoption by the A.G.M.

13. BANK ACCOUNT

A bank account is to be maintained with one of the recognized banks, where the chairman and the Secretary General shall be signatories, and counter signed by the Treasurer, records of which shall be subjected to audit and monthly returns to the committee.

14. REGISTER

The register should show name of member, card no., date of registration, diseases specialised, house no., box no., phone, identity etc. (in case of termination date must be shown.)

15. FINANCIAL YEAR

The Association financial year shall be 31st October each calendar year. A financial report and audited balance sheet shall be tabled with the help of a professional man at every Annual General Meeting.

16. LIQUIDATION

The Association shall only be liquidated as provided for by act of parliament on societies, in consultation with the Ministry of Health and Social Services, and our Legal Advocates.

17. COMMON SEAL

NETHA shall have a common seal engraved with its name kept by the Secretary General and shall not be used unless under authority or resolution of the Executive Committee. All member of NETHA shall faithfully accept and comply with the provisions of the societies act, the rules, regulations and all amendments of such regulations, show cohesion and loyalty to the national executive committee.

ADMINISTRATION AND DIVISION OF WORK

18. CHAIRMAN

- i) Shall call for meetings, chair meetings and direct as well as control all the discussions of the house.
- ii) Shall be answerable to the Executive and Disciplinary Committee.
- iii) Shall instruct the Secretary General and consult the Committee if need be upon taking serious decisions.
- iv) His Vice takes full responsibilities during the absence of the Chairman. However the Chairman will delegate duties to both the Secretary General, Vice Chairman and the whole Executive Committee.

19. SECRETARY GENERAL

Shall take full control of the day to day administration of the association (secretariat):-

- ii) Shall report to the Executive Committee through the chairman.
- iii) Will recommend appointments, dismissals, restructuring and advisory services to the chairman and the Executive and Disciplinary

Committee.

iv) Will take minutes and keep records of the whole administration.

v) His Vice takes charge in absence of the Secretary.

20. TREASURER

i) Shall handle all monetary transactions, receipts, bank slips, bank statements, budgetary, audit and balance sheets as well as sound financial reports of NETHA.

ii) The Vice takes full control in absence of the Treasurer.

21. DIRECTOR OF RESEARCH

i) Shall co-ordinate all pilot research and project proposals in consultations with the Secretary General and the Committee.

ii) Shall collect herbs from traditional healers and take them to research institutions for scientific analysis.

iii) Shall enhance high standards of professional norms, hygiene, storage, dosage, toxicity and pharmacological exposure to traditional herbs and its practices.

iv) Shall negotiate and co-ordinate for land and research workshops and work closely with local and international research institutions, within and outside Namibia.

v) The Vice Director of research takes full charge in absence of the director.

22. PUBLICITY SECRETARY

i) Shall take full control of effective communication.

ii) In consultation with the Secretary General he will also act as a public relations officer when the chairman and General Secretary give the go ahead for press release.

ii) His Vice takes charge in absence of the Publicity Secretary.

23. DISCIPLINARY COMMITTEE MEMBERS

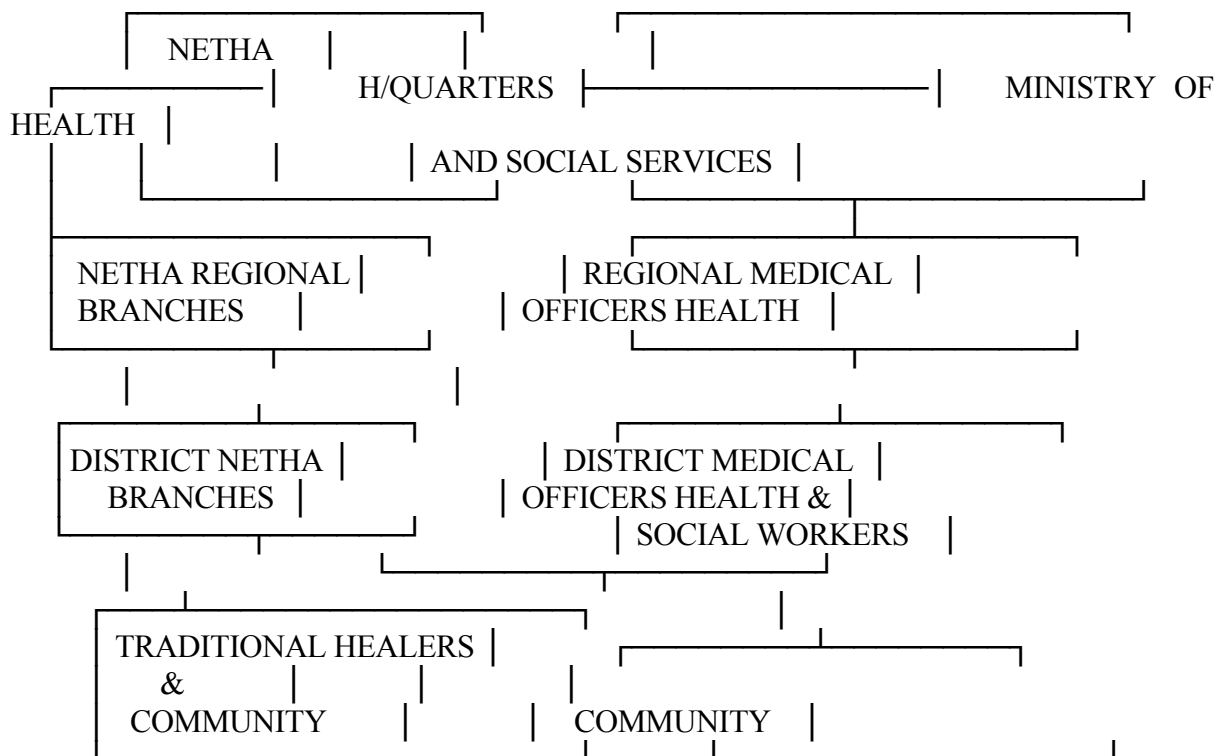
i) Shall handle all disciplinary cases of the Association.

ii) Shall elect its own chairman, and include the Secretary General, and

the chairman to resolve all disciplinary cases in the association unless otherwise, they are personally being discussed, then they have to declare interest.

- iii) When dealing with more complex disciplinary matters of the Association a full National Executive Committee will be required to sit and 2/3 (two third majority vote) for a final decision can be taken.

ORGANIZATIONAL STRUCTURE AND CHANNELS OF COMMUNICATION
OF NETHA



Note that NETHA declares its intention of acting "as a sole organization for all traditional healers in Namibia." Such is also the intent of AMETRAMO in Mozambique. Almost invariably, more than one healer association eventually arises in all but the smallest African nations. Even in tiny Swaziland, with a single language and culture, there is a second association struggling to organize itself. Countries like Nigeria and South Africa have several national and regional associations. One of the latter is the North Eastern Transvaal Tinyanga and Herbalist Association (NETTHA), the acronym of whose name happens to be almost identical to NETHA's. NETTHA participated in AIDS prevention workshops in the early 1990's, funded by USAID. The constitution of NETTHA is reproduced here.

Constitution of the North Eastern Transvaal Tinyanga and Herbalist Association⁵

1. The name of the Association shall be:

THE NORTH EASTERN TRANSVAAL TINYANGA AND HERBALIST
ASSOCIATION

⁵ This document was provided by Rexon Ndlovu and Rosina Shikwambane of NETTA. As with other association documents, no attempt has been made to edit or annotate this one.

(NETTHA)

This Association was formed in 1992.

2. AIMS AND OBJECTIVES

- 2.1 To promote better understanding and unity among traditional doctors (Inyangas).
- 2.2 To bring together traditional doctors of the area under one body.
- 2.3 To seek official registration of the Association.
- 2.4 To develop awareness and self-respect in service of the community.
- 2.6 To promote good fellowship with non-traditional doctors to combat unknown diseases like AIDS.

3. MEMBERSHIP

- 3.1 Any doctor who wants to join the association must join at his area.
- 3.2 Every area must have a Branch committee with Chairman, Secretary, Treasurer and seven members of the committee.
- 3.3 No case that can be taken through to the top executive instead of starting at his branch.
- 3.4 Any doctor must observe the art of healing as a gift from God and should not be abused.
- 3.5 Any doctor who is found to use poison or other medicine to destroy humans shall be struck off from membership of the association. This will be investigated by the top executive.
- 3.6 If a doctor treats a patient and that patient refuses to pay when healed, the association and its lawyers will take up the case to have the money paid.
- 3.8 If a doctor wants to treat a very sick patient an agreement must be signed and entered in a book; signed by the patient, the doctor and a witness.
- 3.9 Money for membership and doctor's certificate shall be decided by the top executive.
- 3.10 Membership shall be renewed annually between 1st January and 31st March.

4. MATWASANA (TRAINEE DOCTORS)

- 4.1 If a trainee doctor wrongs a doctor, will be tried by the branch executive if found guilty shall pay a fine. If the branch executive fails the case must be referred to the top

executive.

- 4.2 If a trainee doctor has a complaint with his/her doctor and they do not agree, the trainee doctor has a right to take it to the branch executive.
- 4.3 If a patient has a complaint against a doctor, she/he must report to the branch committee.
5. When doctors of one of the branches quarrel, it must be resolved by the branch executive, failing which it must be referred to the top executive committee.
- 5.1 If a doctor has work play, the branch executive committee can arrange for some money to help the member.
- 5.2 Doctors must promote good understanding amongst themselves, with chiefs and headmen of the area.
- 5.3 No doctor shall make a wife or husband of any trainee doctor.
- 5.4 The words "Toor dokter or witchdoctor" are vulgar, it is not permitted to call any traditional doctor by those names.⁶

6. ELECTION OF OFFICE BEARERS

- 6.1 Each branch executive must send three members from whom members of top executive committee can be elected.
- 6.2 The office of the top executive must remain in the office for a period of 3 years, but the office can be changed any time if the performance does not meet the required standard.
- 6.3 Branch offices will change each year.
- 6.4 The top executive shall be formed by the following officials:
 1. President
 2. Chairperson
 3. Deputy Chairperson
 4. Secretary-General
 5. Deputy Secretary General
 6. Treasurer and three Committee Members

7. BRANCH EXECUTIVE COMMITTEE

- 7.1 Each Branch will have:

⁶ The Swazi association constitution also condemns the term witch doctor (p.1).

1. Chairperson
 2. Vice-Chairperson
 3. Secretary
 4. Vice Secretary
 5. Treasurer
 6. Committee Members (7)
- 7.2 Any doctor whether male or female can be elected in as an official with equal powers.
8. DUTIES OF OFFICE BEARERS
- 8.1 Secretary-General shall keep all records of meetings of the association. Shall write all letters instructed by the chairpersons and to sign all documents required at the meetings.
- 8.2 Vice Secretary General shall do all the duties done by the Secretary General.
- 8.3 Treasurer shall keep all the monies of the association and to issue receipts for members who pay their fees and issue membership cards and also keep receipts of all transactions of the association.
- 8.4 Finance (monies) of the association will be administered by the Chairperson, Secretary General and Treasurer.
9. A member of this association is not allowed to give his card to another person to use.
- 9.1 The doctor's certificate must be signed by the President, the Chairperson and Secretary General.
- 9.2 The head office of the association shall be decided at a later stage.
- 9.3 This constitution is subject to amendment from time to time when necessary.
- 9.4 Any member of the top Executive Committee who fails to attend three consecutive meetings shall be replaced without any notification.

Common Elements among Aims and Objectives of Healer Associations

The constitution and related regulations of the Swaziland Traditional Healers Society (no date, but from 1980s) runs over 50 pages and so will not be presented here. But certain elements appear to be common to all four associations--as stated in thier official doucuments--as well as to others I am familiar with: interest in obtaining official recognition and registration of healers' names; and near-fascination with bureaucratic organization, the chain of command, and the myriad positions and statuses created within the association: Secretary General, Chairman, Secretary, Treasurer, Publicity Secretary (in charge of press releases and general public

relations),etc.⁷. Other themes include promotion of unity and communication among traditional healers; development of code of ethics; sanctions against unethical practices; provision for payment of membership fees; intention to serve as link with the government; gender equality; exchange of healing and medicinal knowledge among healers; definition of a traditional healer and/or establishment minimal entry qualifications; @

Considering the reputation of African healers's secrecy regarding medicines, it is interesting to note NETHA's intention to "collect herbs from traditional healers and take them to research institutions for scientific analysis." This conforms to my recent experience with healers associations in Zambia and Mozambique. It seems healers who join associations are eager to have the efficacy of their materia medica scientifically validated, presumably because this would confer more legitimacy and respectability in the modern, urban sphere. NETTHA's declared objective of collaboration with "non-traditional doctors to combat unknown diseases like AIDS" can be seen in the same light (unfortunately its use of the term doctor will threaten physicians and serve to strengthen their opposition to traditional healers). The Swazi association lists on p.1 of its constitution the objective "to be treated properly by our orthodox colleagues and the Western medical practitioners at large."

Some associations recognize that they qualify as a non-Governmental organizations (NGO), and as such they can establish relations with foreign donors that wish to support NGO activities (see Policy Issue #7).

"Growing Pains" of Healers' Association: Examples from South Africa

Healer associations seem to have at least the potential to reach large numbers of people at the "grassroots," especially in health and spiritual matters. In 1990, the Southern African Traditional Healers Council (SATHC) claimed over 220,000 members in South Africa and neighboring countries. It claimed 135 constituent or affiliated traditional healer organizations, and it estimated each member healer has "60-100 clients or patients". If an average client load of 80 is multiplied by 220,000, some 17,600,000 people would appear to be reachable through the SATHC. Even allowing for considerable exaggeration of numbers, it seems clear that healer associations have at least the potential to reach large numbers of people at the "grassroots," especially in health and spiritual matters. In fact the SATHC put out a bi-monthly newsletter in English and several African languages, which discusses matters relating to health and traditional healers.

It may be noted that in 1992 the SATHC was reorganized as the Traditional Healers Organization of South Africa (THOSA). It appears that the first president, a white South African, was working for the South African Defense Force and sought to co-opt traditional healers into resisting the growing power of the ANC (Cunningham, per. com, 1994).

It must be said that the experience in Africa generally has shown that healer associations do not develop without considerable growing pains. In a collaborative program involving healers in

⁷ The association president of one Swazi/South African group is called Commissioner of Oaths and Trust Nominator as well as International President.

South Africa, where there are a number of regional and national healer associations, a survey showed that a great many healers had switched association membership recently or had dropped out of associations altogether (Green and Zokwe 1996). A group of urban healers estimated that only about 20% of all healers in the Johannesburg area are currently affiliated with formal healer organizations. They believed that a greater number may have belonged to an organization at one time and then dropped out.

National and regional organizations appear to be unstable due to power struggles and politics. One widely respected healer commented, "As soon as a leader starts talking about 'my people' he or she is going to cause a lot of resentment and that leader is on the way out." Another commented, "Formal associations breed jealousy among healers. No one is treated with respect in them." In the course of group and individual discussions with healers throughout South Africa, the following charges were made against healer associations that claim national membership. Many of them have to do with the nature and behavior of association presidents.

- Association membership is not truly national. Membership lists may include false addresses for some members to make it seem membership is national;

- presidents collect money to pay for legal services, funerals and financial support upon the death of a spouse as well as other costs of interest to healers. Yet such funds are not available for members when they are in need--in fact the funds often disappear altogether;

- there are no traditional or agreed-upon mechanisms for conflict resolution within associations;

- association presidents tend to be men, and they "boss" members around, women in particular. They do not treat members with the respect they deserve;

- association presidents are "mainly interested in collecting money from healers in South Africa";

- some presidents have dubious credentials as sangomas (diviner-mediums), at least according to locally-recognized criteria such as membership in a known impande (see below). If presidents did not undergo the kutwasa process of initiation, "...their behavior is not acceptable to the traditions and cultural beliefs of sangomas;"

- many healers may be reluctant to join formal healer associations because they cannot read and write, or because they cannot speak English or African languages other than their own. Such healers may also be gullible and vulnerable and easy prey for a smooth-talking, would-be president.

- some presidents have tried to make paid membership in their associations a prerequisite for attending donor- or government-supported workshops, or specifically for receiving a training certificate. Others have tried to enlist first generation healers (those who participated in workshops initially) to recruit local second generation healers (those "trained" by the first group) for their association, collecting fees on their behalf. Loud

complaints were voiced over this at a group meeting of second generation healers.

A columnist in the (Johannesburg) Star (8/5/93) could have been speaking about national healer associations when he wrote, "Presidentialism has been the curse of Africa precisely because it concentrates so much power in one person..." Healer associations lack democratic structures for choosing--or replacing--presidents. Leaders tend to be presidents for life, like the first generation of national leaders in post-independence Africa. Indeed, why should we expect urban-based heads of traditional healer associations to use their office for nobler purpose than many African heads of state? In fact the opportunities for chicanery and corruption may be even greater for the healer-President since his constituency are rural-based healers unsophisticated in the ways of the modern world, including urban opportunities for exploitation and general corruption. Healer-Presidents are also attributed special supernatural powers--more than ordinary healers.

Healer associations seem always to be politically unstable. Traditional healers in South Africa and elsewhere appear to be strongly egalitarian; they are deeply suspicious of any peer who claims superior status and tries to exercise authority over the rank-and-file. Although there is a traditional hierarchy of statuses, status differences are either between types of healers or they relate to seniority, meaning that today's trainee will become tomorrow's senior gobela (trainer of diviner-mediums). It is also the case that formal associations are a historically recent attempt on the part of healers to exercise power in the larger state polity. As such they are still in an inchoate and unstable developmental stage; they have not yet developed structures that ensure stability and continuity. Most seem bedeviled by problems of financial management.

But is there an alternative? Can health ministries or other interested government agencies or NGOs relate to any other organized groups of traditional healers? This is dealt with in Policy Issue #8, after first examining laws and policies related to traditional healers.

POLICY ISSUE #6: LEGISLATION AND TRADITIONAL HEALERS

We now face the question of what legal reforms, revisions or modifications--if any--are needed if there are to be collaborative programs. In their paper on Zaire, Bibeau et al (1980) call legal recognition of traditional healers "an indispensable prerequisite" and a "prerequisite for cooperation" with the government. We recall that Zaire tried to illegalize traditional healers after independence (Policy Issue #3). I have worked in countries that developed collaborative programs for healers yet made no changes to their laws. True, making the practice of traditional medicine legal might stimulate cooperation, especially from the government side. On the other hand, laws require at least some knowledge base. This can mean government scrutiny of aspects of traditional medicine and its practitioners that have previously been officially ignored. The result might be government control and encroachment in areas where healers now enjoy freedom and autonomy. Results might be quite different if a scientific knowledge base can be developed by experienced medical anthropologists.

Bibeau and his colleagues make some useful recommendations relating to legislation. Government should first of all consolidate all existing laws related to traditional medicine. It should revise, expand, or delete them as necessary, then group them together in one place in the

legal code. New or revised legislation should be drafted by a commission composed of representatives from the Ministry of Health, the Ministry of Justice, the traditional healers association and other interested parties. Legislation should in general settle legal conflicts, provide guidelines for adjudication, and protect rights of both patient and healer. Government should decide on legal definition of a traditional healer.

In Zimbabwe, the government has been more ambitious in its attempt to control and regulate healers through legislation. Zimbabwe passed legislation in 1981 establishing a "Traditional Medical Practitioner's Council," with most key positions appointed by the Minister of Health who is supposed to regulate the practice of traditional medicine and the conduct of traditional healers. Membership dues for the Council are stipulated in law.

For all its provisions and legal language, it seems an untrained quack could register as a member, print up a card with R.T.M.P. (Registered Traditional Medical Practitioner) after his name, and practice a completely improvised form of healing as long as he paid his dues. The Act fails to deal with some key issues, for all its attention to peripheral details. Sect. 22(a) of the legal code comes closest to determining competence, but does not spell out competence criteria or specify requisite qualifications. Sect. 31(2) provides that any unregistered traditional healers can go to jail for two years and be fined Z\$2,000.

It seems Zimbabwe has attempted too much government control. Healers can easily become a political tool of government, yet there is no protection of their rights. I spoke about these shortcomings with the President of the Zimbabwe National Traditional Healers Association, and he confirmed that Zimbabwe's legislation has led to legal confusion and programmatic inaction--at least that was the situation a few years ago.

In 1990/91 I recommended that Mozambique try to avoid such problems by not taking on very many legal issues before an adequate knowledge base regarding traditional medicine had been established, and before government and healers had developed a working relationship for a few years. There follows the specific recommendations made through the Department of Traditional Medicine (GEMT)⁸ to the Ministries of Health and of Justice.

Proposed legislation relating to traditional healers
Recommendations of the Department of Traditional Medicine
to the Ministry of Justice, Mozambique

Considering:

- (1) that traditional healers operate in an environment which might be termed traditional legitimacy, where traditional sanctions serve to define proper behavior. Modern health practitioners operate in an environment which might be called rational-legal legitimacy, where laws and regulations define proper behavior.

⁸ Gabinete de Estudos de Medicina Tradicional.

As traditional healers increasingly emigrate from their home communities to towns, cities or other rural areas, and as they begin to practice health care in non-traditional ways, it becomes increasingly desirable for them to operate in a rational-legal environment. When traditional sanctions can no longer operate easily, it serves the needs of the patient, the traditional healer, and society as a whole if the rights, responsibilities and professional domain of the healer are clearly defined. However, we believe most traditional healers still operate within a framework of traditional legitimacy, subject to various traditional sanctions;

Considering also:

- (2) the lack of scientific or objective information regarding the practices of various categories of traditional medical practitioners in Mozambique and considering such a knowledge base is prerequisite for the formulation of comprehensive laws, our recommendation is to defer more comprehensive legislation until such time as the Department of Traditional Medicine, aided by other researchers, has compiled an adequate knowledge base.
- (3) that traditional medicine constitutes an alternative system of health care and therefore falls outside the rules and regulations governing health care;
- (4) that representatives of several occupational categories have recently begun to organize themselves into professional organizations;
- (5) and that at least one association of traditional medical practitioners has requested legal recognition of their association;

We recommend:

- (1) adopting the widely-accepted definition of traditional medical practitioners provided by the World Health Organization, which is:
 - a group of persons recognized by the community in which they live as being competent to provide health by using vegetable, animal and mineral substances and other methods based on the social, cultural and religious backgrounds 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 (WHO, 1978);
- (2) that properly-constituted professional associations of traditional healers be legally recognized, which implies legal recognition of all formally registered members of such associations;
- (3) that registration of traditional healers be the responsibility of the associations themselves, based on criteria of membership, including standards of conduct and professional competence, to be developed and employed by the associations

themselves;

- (4) that government is not (yet) in a position to recognize any one association of traditional healers as the sole national, provincial, etc. such association; therefore more than one traditional healer association can be legally recognized;
- (5) that recommendations (2)-(4) do not imply that traditional healers who do not belong to an association are illegal, only that such healers are not yet legally recognized;
- (6) that it is advisable to revise or repeal all existing laws regarding the practice of traditional medicine. For example Codigo Penal Art. 236, para 2, that restricts the healing practices of all those lacking a recognized diploma should be revised to specifically exempt traditional healers--provided they do not misrepresent themselves as doctors or other diploma-holding health workers. If a practitioner prescribes, dispenses or sells modern medicines, or engages in modern practices such as injections, then to this extent he is no longer a traditional healer and therefore he is subject to all laws governing the practice of formal or modern medicine;

An exception to the foregoing is when traditional healers as a matter of public policy have been trained by recognized health professionals in the use of specific modern medicines or health practices, a use of traditional health manpower resources recommended by the WHO.

Between the time of this recommendation and early 1995, there had been much discussion and many suggestions made by a variety of legal and other experts who lack understanding or traditional medicine. A number of detailed Draft Articles had been proposed, apparently inspired at least in part by a document of the Brazzaville regional WHO office called the "Brazzaville Regional WHO legal guidelines Regarding the Practice of Traditional Medicine". The WHO-proposed regulations cover registration, the definition of a traditional healer, the practice of traditional medicine, and other topics. A variety of academic-seeming definitions are offered regarding ways to classify types of traditional medicine (phytotherapy, kinaesthetic therapy, psychotherapy, etc.). It is suggested that if a healer treats more than three maladies, he should be considered a generalist, not a specialist.

I feel this effort is to little avail. We can spend years nitpicking over precise definitions, yet to what end? Most actual healers cut across several definitional categories. For example, the same person may well use divination, herbs, massage, minerals, animal parts, rituals, and mediumship. What good is it to develop a compendium of precise laws that pertain to healers representing ideal types of various arcane categories of definition? One ends up struggling for the best way to classify a healer who is a non-mediumistic, kinaesthetic, herbalist-diviner using animal parts, to borrow the language of the Brazzaville Regional WHO legal guidelines. It becomes an exercise in taxonomy and semantics.

Nevertheless a draft law with proposed articles pertaining to Mozambique circulated around official circles with requests for reactions. Article 3.2 for example, seemed to require that rural

healers be formally recognized by local authorities, presumably government authorities. Article 6.1 said that the Minister of Health should issue a formal dispatch setting the terms for the official registration of healers, and Article 6.2 said that governmental "Administrative Councils" would maintain a registry of all licensed healers. Articles 10 and 11 required traditional healers to refrain from "all publicity of a mercantile character" and disallow use a pseudonym.

The draft law further proposed that authorities of the Ministry of health be the sole determiners of who is or is not a traditional healer. This raises many potential problems, beginning with how to define part-time healers, healers who are primarily religious faith healers, or diviners who did not complete their final initiation. For any criterion we can think of to define a full-time or professional healer--for example receiving cash payment or treating people outside of the nuclear or extended family--we will find that actual healers invariably fall along continua that confound our criteria.

The laws also seemed to coerce healers into joining formal professional associations. They further specified exactly who should serve on local-level committees that regulate traditional medicine, namely local health officials; three members of the national healer's association--including a Vice-President, a representative of the State Affairs Ministry; etc. The draft law suggests establishing bureaucracies such as a (governmental) National Institute of Traditional Medicine and an inter-ministerial Administrative Council as well as various specialized, new departments within ministries. Of course each body would have its own detailed definitions and maze of regulations.

It seems far better to provide positive incentives for traditional healers to register themselves through a local authority, using the simplest definitional criteria. Incentives can also be offered for healers to join a professional association if the government thinks the advantages outweigh the disadvantages of newly-formed, healer associations. The incentives in either case might be legal recognition and therefore recourse to legal protection when, for example, a patient refuses to pay, or when a patient dies while under a healer's care. These are concerns that healers in Southern Africa frequently voice (Green 1994; Green and Makhubu 1984).

The important fact to recognize is that if government tried to control more than it is able to enforce, this would impair government credibility. It would also strain government-healer relations and raise healer's suspicions about government's motives. This is quite apart from the question of whether the government even has the right to exercise control in some of these areas. Given Mozambique's history of socialism and state control superimposed on a Portuguese-created bureaucracy, it should not be surprising that some in government would think they can and should exercise as much control as possible in the private sector. Nor should it be surprising that a national association of Mozambican traditional healers would expect control as well as support, including hand-outs, from the government (see Policy Issue #7).

It seems far more sensible to legislate as little as possible, while at the same time drawing up a lei quadro (square law), which in Mozambique's law means a series of policy guidelines-- instead of a list of regulations--along with fines and imprisonments for their transgression. The recommendations provided in Policy Issue #7 deal with the relationship between the state and organized traditional healers, but they can serve as a basis for a lei quadro relating to all traditional healers.

**POLICY ISSUE #7:
GOVERNMENT AND THE MOZAMBIQUE TRADITIONAL HEALERS
ASSOCIATION (AMETRAMO): A SUGGESTED POLICY.**

The Need for a Policy

Recent contacts between AMETRAMO and the Mozambique Ministry of Health (MOH) suggest that some misunderstandings may have developed between that organization and the Ministry of Health. For example, comments have been made such as "We were misled...", "We were promised office supplies...", "We expected support." Therefore there is a need to draft a policy that specifies the relationship between AMETRAMO and the MOH--and the Mozambique government by extension.

In order to accomplish this, AMETRAMO needs to define its own role better, including its desired relationship with government. Here the Department of Traditional Medicine (GEMT) can be of assistance because of its knowledge of experience with traditional healer associations and governments elsewhere in Africa. I and my colleagues in the GEMT proposed the following policy guidelines to the MOH.

Suggested Policy of the Ministry of Health

1. The Ministry of Health (MOH) takes a strong position that government should not alter or interfere with the role of traditional healers. Until the government knows more about the nature of Mozambican traditional medicine (through research and collaborative workshops with traditional healers), the policy is to interfere as little as possible with traditional healers, while at the same time doing whatever possible to protect the health of the people.

As the GEMT stated in 1991:

We recognize that even in a pluralistic health system, traditional healers are not and should not be part of the National Health Service. Traditional healers serve a useful, complex function in Mozambican society and it is not the Ministry's intention to transform them into ill-prepared, unpaid nurses or village health workers. Traditional healers constitute a separate, parallel and largely self-regulating health service that with the right approach can formally collaborate with the government in the realization of specific public health goals, such as lowering morbidity and mortality of major life-threatening diseases.

Because of the policy of minimal interference, the MOH does not attempt to take responsibility beyond its sphere of competence and control, such as deciding and defining who is and who is not a genuine traditional healer. Other governments in southern Africa have attempted such definitions for legal purposes, without success.

2. The MOH takes the position that Amatrano is an independent and autonomous organization representing some (but not all) of the traditional healers of Mozambique. The MOH allows for

the possibility that more than one association of traditional healers might arise and also seek recognition from the government.

The government cannot and will not have an exclusive relationship with AMETRAMO, for the following reasons:

- (1) it would be unfair to deny unaffiliated traditional healers (non-members of AmatrAMO) access to MOH-sponsored workshops on public health; it would also not serve the interests of public health to deny any traditional healers access to information that would improve the health of the people;
- (2) The MOH recognizes that traditional healers who join a formal, European-modeled, national association tend to be over-represented by urban-based, Portuguese speaking healers who are more sophisticated in the ways of cosmopolitan life. To favor such a group would be to put rural-based, more traditional indigenous healers at a disadvantage and might actually help to alter the role of traditional healers. The MOH believes that government should not alter or interfere with the role of traditional healers;
- (3) Other national or regional associations of traditional healers might develop and seek to collaborate with the MOH. The MOH encourages traditional healers to join associations, including AMETRAMO but not excluding other such organizations, particularly in urban areas, in order to promote the self-regulation of traditional healers.

3. AMETRAMO is a non-governmental organization (NGO). The government does not normally subsidize NGOs in any form, including provision of money or material, nor does it interfere in internal disputes. Accordingly, neither MOH nor other government agencies should subsidize AMETRAMO or other associations of healers in any routine way, even as far as providing such small items as pens and notebooks. Such a relationship would not be in the best interests of any association of traditional healers, because with government subsidy comes government control. The government could feel justified in asking traditional healers to adopt certain policies if it were financing the association in any form. An exception to this policy might be in the case where, in the overriding interest of the public health, the MOH decides to provide traditional healers with health-promotive items such as oral rehydration salts or condoms. Should this be the MOH's decision in the future, AMETRAMO could serve as an organizational structure through which to channel and distribute these items to a large number of healers nationwide. But again, healers belonging to another organization or to no organization at all would also be eligible to receive such commodities.

It is also not appropriate for the MOH to mediate disputes that arise within AMETRAMO, or between AMETRAMO and other organizations, even if the MOH is asked to do so. AMETRAMO is an independent NGO, not a branch of the MOH.

4. The AMETRAMO President has asked the MOH to ask permission from AMETRAMO before contacting any traditional healers for any reason. This would not be appropriate. To comply with this request, the state would have to assume the responsibility of bestowing power and exclusive rights on one particular NGO to represent all traditional healers in Mozambique. The state does not have the power, responsibility or desire to do this.

5. The MOH, through the GEMT, would like to maintain dialogue with AMETRAMO on matters of interest to both organizations, presumably those that relate to the health care of the people. It is proposed that meetings between the MOH and AMETRAMO (or any other bodies of traditional healers) be on an as-needed basis. The need can arise from either side.

The Ministry of Health recognizes that developing a collaborative program involving healers can raise the hopes, expectations, and even the perceived needs of traditional healers. The MOH must be careful not to raise unrealistic expectations and needs, that is, anything beyond the capability of government to fulfill, or anything that would alter the role of traditional healers or harm their interests in the long run.

If the government and traditional healers can agree on the above, then there is a basis of mutual agreement on fundamental policy to guide the resolution of issues when they arise. The following three issues in the form of formal requests actually arose from AMETRAMO in 1994: (1) AMETRAMO wished to have government authorization to establish a "pharmacy" where they could sell traditional medicines; (2) AMETRAMO wished to be given a room in the government hospital to treat patients who prove to be untreatable by modern medicine; (3) an international NGO wished to financially assist AMETRAMO and AMETRAMO wanted government approval or assistance to make this happen.

Our answer to (1) was: Don't invite government control where there is currently none. Healers are already allowed to sell medicinal herbs in markets and elsewhere. If they ask for formal permission to do so, it invites the government to take responsibility in a new area. Responsibility might well entail government regulation and definition of who among healers is allowed to sell which type of herbs. The government may then have to decide which herbs are safe and which are unsafe, which might involve decades of research before the herbs would be legal. In the meantime provision of herbal medicines, which accounts for most health care in Mozambique and Africa, would become technically illegal. Our suggestion was that AMETRAMO go ahead and set up a shop to sell herbs; there was no need to ask for permission. We cautioned that the shop not be called a pharmacy; this would invite professional pharmacists to complain to the government that the public was being misled. In the same vein, AMETRAMO should not use words like doctors or clinics. Traditional medicine is a separate, distinct, autonomous, parallel system of medicine. We must not blur or confuse the distinction between the two.

Our answer to (2) was: the request for a room in the hospital conflicts with the principle of fair opportunity for all traditional healers. If the MOH gave one group a room in the hospital, then any other group of healers--or even individual healers--would have a right to ask for a room for themselves. We cannot show favoritism to one group of healers. Secondly It conflicts with our policy of not blurring the distinction between the two separate health systems. If traditional healers are proud of their role in society and confident of their treatments, they shouldn't want to appear to be practitioners of Western biomedicine by operating in a "modern" facility. Healers should not want to appear to anything other than what they are. Thirdly, a room in the hospital or an office in the MOH are initiatives that have been tried elsewhere. In Swaziland, initiatives of this sort antagonized doctors and nurses unnecessarily (they didn't want the distinction between the two systems blurred). And the Swazi healers association's room in the Ministry of Health, which lasted about two years, served mostly to antagonize, and create jealousy among, other

government agencies as well as private health organizations which did not merit an office in MOH headquarters (for example the Family Life Association of Swaziland).

Finally, asking to treat "incurabales" on the same premises where Western medicine is practiced points to another experiment which has failed elsewhere. It would be competitive and confrontational and therefore does not promote the development of intersectoral harmony. It seems better to let the present *informal* system continue: health workers at the hospital, or anyone, can refer an incurable case to a traditional healer and perhaps the latter might indeed help the patient.

Regarding (3), there is no reason why government sanction or approval is needed for an international NGO to assist a national NGO, assuming the assisted activities do not contradict national laws or health policies. But should a branch of the health ministry actively assist the process by bringing such organizations together? If the resulting activities serve to improve the public health, it is probably appropriate.

But, as always, there may be a negative side. The leaders of healer organizations quickly learn that there is a great deal of money to be made as an entity known as a health-related NGO. What do NGOs do? First of all, it can be seen that they solicit funds. In recent years in Africa, international donors have been losing patience with inefficiency, and often corruption, in the public sector. Consequently a greater proportion of donor funds are now allocated to the private sector, through NGOs. As head of a local NGO, the healer-President can have direct access to foreign assistance through international NGOs, multilateral organizations like the UN or World Bank, or direct unilateral assistance from wealthy countries like the USA or France.

This may be all to the good, except that we remember that traditional healers are among the aristocrats of traditional African society. Some healers must be counted among the urban elite as well. The dues-payers of these associations have their own money; in fact they are usually considered wealthy by local standards. If healer associations claim to have no money--or truly have no money--it would seem to be because: (1) they have failed to come up with projects or programs requiring money that association members want to contribute to; or (2) association members suspect its leaders have misused--or will misuse--funds collected from the association.

The experience in Africa has been that once they join a professional association, there is a strong temptation for traditional healers to act as beggars, to present themselves to foreign donors as impoverished humanitarians who, if only they had adequate funds, could solve the country's health problems. Should Africa's traditional-sector elite choose to become beggars rather than retain their independence through reliance on their own relatively substantial resources? The agenda of the donor NGO may well be different from that of the healer association. The NGO may even be a front for some other interest with a hidden agenda. Some commercial organizations might, for example, wish to make money from import/export of medicinal plants and might see a healer association as a convenient junior partner in a money-making scheme (this is not necessarily bad).

For all the foregoing reasons, healer associations should take pains to remain independent of outside cooptation or manipulation. They should be very careful about receiving funds or non-cash contributions from either government or private organizations. This includes political

parties. A national healers association, like a church, should be above party politics. It should not be affiliated in any way with a particular political party. This would hurt the association in the long run. Traditional healers who did not favor that particular party would shun the healers association and feel the need to start a new, national association.

For understandable historical reasons, AMETRAMO began with links to the ruling Frelimo party. There is a continuing perception among many healers and other Mozambicans that the two are still linked. Therefore, whatever the political sentiments of individual members, it would be in the interest of AMETRAMO as a national association if it showed itself to be financially and otherwise independent of Frelimo.

Does this mean there should never be outside financing of AMETRAMO or any other healer association? Not necessarily. The safest "bet" would be if funds came from an established, recognized, non-profit, humanitarian organization, the type known as a private, voluntary organization (PVO) in the United States, presumably one that promotes some aspect of health. It is true that such an NGO would use its money to promote an agenda not of the healer association's choosing, but it would presumably be an agenda such as AIDS/STD prevention or child spacing or child immunizations that would benefit the Mozambican people, improve the image and indeed the effectiveness of traditional healers, and help the NGO increase its effectiveness in goal-attainment. Everyone might gain from the collaboration.

By the end of 1995, NGOs/PVOs such as Project Concern, Population Services International, CARE, Save the Children, and Doctors Without Borders were working collaboratively with Mozambican healers in health-related programs, as were international agencies such as UNICEF. Some were working directly with local healers, others were working through national or local branches of AMETRAMO.

**POLICY ISSUE #8:
IS THERE AN ALTERNATIVE TO PROFESSIONAL TRADITIONAL HEALER ASSOCIATIONS?**

The Impandes of South Africa

Given the problems of professional associations of traditional healers, whether they are temporary growing pains or something more intractable, the question must be asked, Is there any alternative?

We decided to explore this possibility in a collaborative program in South Africa funded by the USAID-funded AIDS Control and Prevention (AIDSCAP) project (Green and Zokwe 1995; Green 1994). During the second year of the program we recommended that ways be explored to not deal formally with national healer associations, but instead with impandes. This refers to indigenous, existing associations of healers that seem to have existed in South Africa (and some neighboring countries) for many generations. This term is used or at least understood by virtually all indigenous ethnolinguistic groups in South Africa, although variants of the term may be used. Ngubane (1981) describes these associations among the Zulu as networks of sangomas (diviner-mediums), yet without providing a Zulu or other Bantu name for them (cf. also Ngubane 1977).

Based on admittedly very limited research in South Africa, I provisionally offer this definition: an impande is a named network or association of diviner-mediums that trace what might be called spiritual kinship ties through association with a succession of gobelas (initiators or trainers of diviner-mediums). The term impande refers not only to people but to the medicines and distinctive rituals and ceremonies used by all who "descend" from the same gobela. Initiates (a term preferable to members) in the same impande refer to one another as sister or brother if they have been sangomas for roughly the same period of time. Those who are two or more "generations" of initiates above a sangoma are both addressed and referred to as gogo (grandmother) or koko (great-grandparent).

Like lineages of kinsmen, impandes may be subdivided or segmented into smaller groupings consisting of more restricted membership, depending on need or purpose. As impandes become too large and dispersed, new impande groupings or segments develop, yet a sense of belonging together remains between members of the larger, older impande. Members of an impande are known by special insignia, such as beads of a certain color or other decorative items that are worn.⁹ Names used to designate impandes may refer to a recent gobela, although a full name might actually consist of a succession of names of senior gobelas--one's lineage of initiators--as well as the places where initiation took place. An impande name may also refer to a class of spirits, such as emandau or emanzawe (believed to be the spirits of people from ethnic groups other than one's own who were slain during the period of tribal warfare). The insignia of diviner-mediums possessed by emandau consist of a necklace of white and red beads from which is suspended a beaded object.

No one knows the exact size of an impande since written records typically are not kept and since new impandes or impande segments develop at some perhaps indefinable point of growth. Certainly they grow exponentially: a gobela may train or initiate as many as 100-200 healers in her lifetime. Her amatwasa may in turn train 100-200 others in their lifetimes, as may their amatwasa. Even if some amatwasa, upon becoming gobelas themselves, initiate far fewer numbers, an impande of several thousand members may easily develop within a generation.

The question arises: how feasible would it be for a donor organization--or a MOH unit--to work with impandes rather than national healer associations in something like AIDS prevention? Others things being equal, it might seem preferable to build upon an existing structure rather than upon a newly-emerging, highly unstable structure, one fraught with controversy. We discovered several additional characteristics of impandes that would seem to recommend them further over national--and perhaps any formal--associations.

One is their multi-ethnic membership. It can be observed that sangomas often apprentice under a gobela from a different ethnic group. Sangomas are emphatic in insisting that it is one's ancestors

⁹ The red ocher and braided hair characteristic of many sangomas is apparently not an identifier of impande. Hairstyle is said to be something one decides on after consultation with one's ancestor spirits. The observant outsider might note that this may change within a lifetime and might relate to urbanization as well as to urban or occupational identity.

and not oneself who chooses the gobela. Still, it can be observed that ancestors often guide would-be initiates to a gobela from a different ethnic group. We might refer to the mechanism that ensures impande multi-ethnicity as ethnic discordance in the initiation process, and it would doubtless be interesting to speculate as to why this developed in Southern Africa. One result of the practice is that sangomas have some intimate familiarity with another culture. This might be a factor of how a healer practicing in a plural society can attract clients from diverse ethnic groups, although a sangoma would never explain this feature of the initiation process in such terms. Nevertheless we saw that urban-based healers attract clients from diverse groups. At a deeper functionalist analytic level, ethnic discordance in the initiation process might be seen as a mechanism that has developed to mitigate and reconcile ethnic divisiveness and strife in the broader society as it moves toward greater socio-cultural integration. In any case the structure and function of impandes seem to make it unnecessary for outside organizations to issue criteria designed to ensure equal access by "tribe" to donor resources; South African healers are already adept practitioners of cultural pluralism.

Impande membership is also geographically dispersed. As noted, healers may train and be initiated in a different area of South Africa--even a neighboring country--and then return to practice at home. Moreover healers seem to be at least as geographically mobile as the rest of South Africa. In these ways, initiates of an impande quickly spread all over the country and beyond. A sangoma can travel anywhere in the region and expect to see another sangoma wearing the beads characteristic of her impande. When this happens, the two greet each other joyfully and there is said to be an immediate sense of kinship and intimacy.

Another characteristic of impandes is that members are bound to each other by spiritual ties. They are forbidden by custom to squabble with each other, but if this occurs, mechanisms exist for conflict-resolution. A dispute is brought to the common gobela (or gogo, or koko) who with the ancestors serves as a kind of court of appeals that provides a spiritually sanctioned resolution for any conflict. Impandes are described as apolitical or above political concerns. Again the explanation lies with the ancestors: they are said to care nothing about politics. In the words of one sangoma, "The ancestors don't know who the ANC or Inkatha Freedom Party are; they have never heard of them."

Impande initiates meet on a regular basis, such as during ceremonies when newly-initiated sangomas demonstrate their spiritual qualifications. Initiates are also expected to share healing information with one another and with their gobela, and to refer clients to one another. There is said to be mutual respect.

AIDSCAP-funded collaborative workshops in the Northeast Transvaal (Gazankulu) appear to have been especially successful. Here healers were recruited and trained through the Northeast Transvaal Tinyanga and Herbalists Association (NETTHA), a local as distinct from national association. We found that about 95% of NETTHA's membership belonged to the same impande. Most members formerly belonged to a larger formal association based in the Tsonga speaking self-governing area of Gazankulu, but they became disillusioned with the association for most of the reasons already cited as problems with national organizations. At the time of the evaluation, NETTHA was trying to build upward, joining with local organizations in Venda, Lebowa, and elsewhere to form a truly regional, multi-ethnic organization for the Northeast Transvaal. The passage of time might show if it is better to build from regional associations-up

than from Johannesburg-down. In fact it may prove useful to work with or through regional as distinct from national healer associations, if that is what healers wish to do.

It should be emphasized that our research into the nature of impandes must be considered very preliminary. Certainly more time-consuming, detailed research would be desirable before reaching any policy or program decisions. However on the basis of our preliminary findings, we recommended that at the very least, AIDSCAP and other outside organizations not even give the appearance of making paid membership in national healer associations a prerequisite for benefitting from training in AIDS prevention. We recognize that outsiders might well be more comfortable dealing with formal, "national" associations than with informal networks of healers the nature of which remains obscure even to most Black South Africans. Furthermore donor organizations and the newly-elected Black-dominated South African government need to communicate with traditional healers with benefit of some organizational structure. However, coerced membership in Western-modeled organizations could undermine the functioning of indigenous networks of healers, with unforeseen consequences. For example, we have already noted that impandes are characterized by multi-ethnic membership and that this appears to have a salutary effect on one of the most dangerous and destabilizing forces in broader South African society today, namely "tribalism" or ethnic divisiveness. It should be a tenet of those promoting recognition of the value of indigenous knowledge and organizations that unless there are compelling reasons to the contrary, it is best to build on existing knowledge, beliefs, and social organization in all development or social change efforts.

POLICY ISSUE #9:

SHOULD HEALTH TECHNOLOGY BE "TRANSFERRED" TO TRADITIONAL HEALERS?

In many African countries where programs of collaboration with traditional healers are being considered, or have been started, ministries of health are unwilling to allow what might be called technology transfer to traditional healers. That is, they are unwilling to share curative medicines with healers, perhaps even including oral rehydration salts or vitamins. These ministries expect healers to simply become unpaid health educators and to advise their clients to take their problems to health posts and hospitals. Government reluctance may also be due to not wanting to transform or interfere with traditional medicine due to recognition that it is providing a valuable service. In either case, unwillingness to share technology and unrealistic expectations of what can result from "cooperation" with traditional healers are both reasons why collaborative programs have not developed very far in Africa.

Before continuing with this issue, it should be noted that most traditional healers in Africa do not use medicines produced by pharmaceutical companies, either "ethicals" or over-the-counter, in their practices. In some societies there might even be a taboo against such use or at least a loss of prestige or credibility on the part of healers using "modern" medicines. This might change to some degree in the future. In a survey I designed in Benue and Lagos states, Nigeria in 1989, 59% of a sample of 49 traditional healers were found to use some form of modern, manufactured, patent medicines. Fifty-eight percent of this group used such medicines only for themselves or their family members, while 41% used them on their patients. Analgesics such as aspirin and Panadol were the most commonly used medicines (38% of total); far less commonly

cited were malarial drugs (8%), antibiotics (3%) and "stomach medicines" (1%). A few healers commented that it might be easier to use modern than traditional medicine in some cases, such as when they are away from home and they lack the time and facilities to prepare traditional medicines. Most were referring to self-use.

I have asked this question in surveys elsewhere in Africa and always found a lower proportion of healers who report use of manufactured medicines. The practice might increase somewhat with urbanization. Lagos state, Nigeria is very urbanized by African standards.

Returning to the issue of technology transfer, if a national health program is willing to allow the transfer of some technology as well as information from the modern to the traditional health sector, then collaboration stands a good chance of succeeding in improving health care for all people of that country. Technology transfer is important because it motivates healers to participate, and it goes a long way in overcoming pan-African problems of outreach of services and distribution of medicines.

The argument that government should not try to change or interfere with traditional medicine is basically sound. However it must be recognized that traditional healers change with the times, particularly those living near urban areas or major highways. The state cannot prevent healers from adopting certain techniques or medicines available to the general public. Typically, oral rehydration salts (ORS), condoms, and bleach for sterilizing razors blades are among the first items of "technology" ministries of health share with traditional healers. These are not exactly materia medica of biomedicine, but their promotion and adoption by healers and their clients can have a profound impact on public health. They are also valuable as symbols of the state's willingness to collaborate with indigenous healers.

Chloroquine might be a next step in sharing medicines with healers. Some national AIDS/STD programs, including Mozambique's, have actually begun to consider training traditional healers--on a pilot program basis--in the administration of new, single-dose oral antibiotics to treat bacterial STDs as a way of preventing HIV transmission as well as the well-known sequelae of STDs themselves.

However technology transfer of this sort is highly controversial. Critics of collaborative programs argue that initiating any kind of collaboration or training will raise expectations and even demands among healers. It's a kind of Pandora's box, the argument runs: today we let them have oral rehydration salts, tomorrow they'll want antibiotics and a wing of the government hospital. It is true that there is great potential for misuse of medicines and related technology of biomedicine, in the hands of "untrained" healers. However it can be argued that there is even more potential for misuse if traditional healers simply begin to use modern medicines on their own, if governments turn a blind eye and ignore their activities. It may be more in the interest of public health to face the realities of what traditional healers are doing (perhaps even to anticipate them), and then try to ensure maximum safety by training healers in aspects of modern medicine that they are adopting anyway--probably in response to "demand" from their clients.

**POLICY ISSUE #10:
DO COMMUNITY HEALTH WORKER PROGRAMS WORK?**

A question that often arises in discussions about collaboration with traditional healers is why should ministries of health not simply develop a new cadre of health workers, situate them in villages and have the villages provide some sort of salary or compensation? Even minimal training in modern medicine should better equip them promote public health than traditional healers steeped in supernaturalism and inflexible traditionalism, the argument goes. The short answer is that cadres of community or village health workers (CHWs, VHWs) have been trained in a number of African countries and have been found to have serious drawbacks, not the least of which is that village health workers compete with the established person who already enjoys credibility and prestige as a health expert, the traditional healer. The WHO Global Medium-term Programme (Programme 12.4 Traditional Medicine, Mar. 1984) seemed aware of this when it noted, "Some countries tend to create new community health workers rather than incorporate practitioners of traditional medicine into their health delivery systems, especially at the primary health care level." Whatever we think of "incorporation," the implication is that upgrading traditional healers is more reasonable than creating new cadres.

What are the drawbacks of CHWs? In a recent summary article, Mburu (1994:883-4) tells us that many CHW programs have had "little or no impact...they rise only to fizzle out." Furthermore, "Beyond articulation of the concept, CHWs have repeatedly failed in their mission and seldom earn the enthusiasm of prospective beneficiaries." Reasons for CHW program weakness are that there has been insufficient: (1) empowerment of CHWs (or sharing of power between the central and "peripheral" personnel); (2) resources allocated to CHW programs; and (3) local control of programs--instead there has been outside control. In fact a number of other reasons have also been identified in the course of evaluations of CHW programs in Africa, as seen in the sections to follow.

CHWs in Swaziland

In 1992 I conducted a brief evaluation in Swaziland of Rural Health Motivators (as CHWs are known there), specifically to assess the potential of this cadre in community-based distribution (CBD) of condoms. At that time, CHWs were involved in a number of activities such as environmental sanitation, communicable diseases, general health education, home deliveries, mental health, nutrition, home economics, adult literacy, first aid and elementary curative medicine--all through home visits in a catchment area of 40 homesteads. The CHW carried a kit which included common analgesics, gentian violet and ORS. Some nurses felt that with such broad responsibilities, CHWs should not be burdened further by adding new responsibilities (condom distribution), especially since the CHW is only expected to work half-time to earn her E20 (US\$6.92) a month stipend.¹⁰

As we analyzed the situation further, the design team and I began to find a number of problems with the CHW program in general and with the prospect of CHWs serving as CBD agents specifically. The first was CHW selection. CHWs in theory are chosen by their communities, which perhaps gives the impression that the process is somehow democratic. In fact the local

¹⁰ A few RHMs were already carrying condoms for specific "clients" who requested them, but this was not widespread.

chief, aided by his council (bandlancane), seemed to usually choose CHWs without regard for even a woman's interest--let alone her objective qualifications--for the job. Nepotism and self-interest characterized the process. A more formal, survey-style CHW evaluation conducted by UNICEF in 1989, seemed to overlook many of the major problems in the program yet nevertheless found that 45% of CHWs were related to local chief or subchief. This percentage would have been higher if kinship links, including affinal connections, with members of chiefs' councils had been included.

Whatever the selection criteria, they seemed to usually be the wrong ones. Even if a degree of public consensus among the chief and his all-male council is reached, it is local women that CHWs visit and try to motivate. We found no evidence that rural women felt that they had a choice in their CHW selection, or even that existing CHWs were women they would have chosen had they had a choice. As a result, there was often a lack of support from women that seemed to undermine the efforts of CHWs in some communities even when they made sincere efforts to carry out their duties.

The UNICEF CHW survey as well as nearly 15 years of program experience has demonstrated an unwillingness on the part of local communities to support CHWs in cash or kind, even though these same communities will mobilize labor and cash to build a fixed or a mobile clinic. When women in Hhelehele were asked to support their CHWs their response was, "Why should we? We didn't hire them or even choose them." The Coordinator of the CHW program herself acknowledged a fundamental flaw in the program: it was conceived by the Ministry and more or less imposed from above. Local communities never saw a need for it and in any case have developed no sense of "ownership" of the program.

Supervision of CHWs also seemed poor or nonexistent. The UNICEF survey shows most CHWs never have any contact with a local clinic nurse; a minority have sporadic contact. Lack of supervision is said to be due to nurses being overloaded as well as a lack of transportation. Related perhaps to this is the fact that the CHW's kit often remains unrefilled, perhaps for years. This undercuts whatever value they may have developed as providers of aspirin and the like. It also bodes ill for plans to distribute condoms in these same kits. When a team member asked an CHW whether she would like to be supplied with condoms, she first said yes, "...because all I do is talk. I can't give out anything." But after a moment's reflection she observed that the local clinic has not been able to supply her with so much as an aspirin for the past 6 years. Why should she expect that the nurses would be any better in supplying her with condoms?

There was also the problem of low salary (E20/month), a salary that has remained unchanged since 1977 when the lilangeni had some 400% more buying power. This combined with the above adds the final insult to injury for many CHWs, with the result that many do little to carry out their duties. Although each CHW is expected to visit 40 homesteads a month, the UNICEF survey showed that 63% of a random sample of homesteads in areas where CHWs serve had not had a visit from an CHW in the previous month. Our own qualitative research suggested that visit rates was actually be lower by the early 1990s.

Even the training of CHWs had serious flaws. For example, in spite of training in oral rehydration therapy, only 39% of CHWs knew how to mix ORT solution properly, according to the CHW survey. A survey of traditional birth attendants conducted within a year of the CHW

survey showed that 44% of TBAs could mix ORT correctly, even though this group had no formal (government) training in ORT or indeed in anything else (Williams 1988).

In addition to the foregoing general problems with the CHW, there are additional barriers to developing the CHW as an effective CBD agent. Swazi women are often secretive about contracepting, given the attitudes of many men and elder in-laws toward contraception. Therefore trust, confidence and privacy are essential elements in the relationship between user and provider. Yet these seldom appear to characterize the CHW/client relationship. This relationship tends to be authoritarian and superordinate-subordinate. Women I interviewed described a barrier of formality between themselves and CHWs: "The CHW comes from the chief's kraal. They are like representatives of chief." With such authority, they tend to be didactic and bossy. In the words of one woman, "When they preach about health, you can't challenge them, you can't even ask them questions." No one among a cross-section of women interviewed in several rural communities in three regions thought that CHWs would make good CBD agents, once the role of CBD agents was described to them.

On the other hand it should be noted that there are some hard-working, motivated CHWs struggling to carry out their duties in spite of all odds. It has also been found, at least earlier in the program, that CHWs are knowledgeable about--and have had some effectiveness in--the area of original program focus, namely homestead sanitation (Green 1985; 1987).

In the end, we recommended that CHWs simply be encouraged to distribute condoms on a voluntary basis if they were not already doing such. We recommended that scarce project funds not be allocated to develop CHWs as commercial CBD agents. I stated my belief--and was strongly backed by the team economist--that problems with the CHW program are impervious to "quick fix" solutions, such as doubling CHW salaries or improving supervision.

CHW Evaluations Elsewhere in Africa

A far lengthier and more thorough evaluation in Tanzania showed that, "The relationship between CHWs and their communities...has often been characterized by a lack of support from the community on the one hand and by a high CHW drop out rate on the other" (Heggenhougen et al 1987:79). There were a number of reasons for this.

Both CHWs and their host villagers wanted and expected the CHWs to provide curative rather than preventive services. However, they are trained primarily in preventive services and to the extent they did any curative work, the village health posts were almost always out of drugs and other supplies. Moreover CHWs sought upward career mobility: "CHWs have expressed frustration at not being able to provide the quality of services demanded by the community and therefore want further training in curative medicine."

There was problems in initial selection of CHWs. In spite of a plan to involve all community members to participate in selection of CHWs, "it was clear that most of the respondents (in one survey) had not been involved in the selection process." Moreover, "Villagers...place a low value...on the worth of CHWs" "They 'do not know' what their CHWs do." (Heggenhougen et al 1987:95).

Typically an ideology of self-help is used to justify CHW programs. But in Tanzania self-help was "seen as a ploy by the government to abrogate its responsibility to the rural population." (Heggenhougen *et al* 1987:95). Other problems encountered include isolation, lack of supervision and financial support, lack of transportation, lack of communication, and lack of continuing education. Generalizing about Africa, Matomora (1989) has argued:

...communities should be allowed to go through the process of identifying their problems, sorting out their priorities, means of solving identified problems through the material and human resources they have at their disposal. Before communities have been allowed to go through such a process, the selection of VHWs is at best, an imposition from above. Primary health care is thus robbed of its most fundamental components, of community participation, self-determination and self-reliance. (quoted from article's abstract)

In Mozambique, the village health worker is known as the agente polivalente elementare or APE (I will continue to use CHW for simplicity). The CHW program began in 1987 and was designed along the lines of similar programs in Africa: a CHW is volunteered by his/her village (more often him), then receives a 6-month training course after which he or she is returned to the village. The village is supposed to pay a small salary or provide in-kind subsistence allowance. The CHW carries out preventive and some curative health care. For the latter, there is a basic kit with anti-malarials, analgesics, ORS packets and the like. Each CHW originally had responsibility for 250 families or about a thousand population. With health workers fleeing rural areas, each CHW soon had responsibility for a whole village, or even 2-3 villages. His functions were all health related, including the promotion of potable water and environmental sanitation.

Selection criteria for CHWs called for older, settled residents who had some sort of pre-existing economic base such as in farming. However what the Ministry often got was young people who wanted health careers, salaries, and advancement. A number of recruits thought or at least hoped they were on career tracks to become nurses.

The program was developing as well as can be expected until attacks by RENAMO¹¹ and resulting economic conditions meant that communities could no longer pay CHWs, whereupon the program began to deteriorate. Training was suspended in Maputo in 1985 and elsewhere in the country by 1989, in order to evaluate and improve the program. The main reasons for poor performance appeared to be:

- poor support by the community. Problems of who would pay for their subsistence arose immediately, even before Renamo became a factor;
- isolation, lack of supervision and support of CHWs
- lack of medicines, supplies, equipment

¹¹ The anti-Marxist guerilla group that fought the Mozambique government for many years. At this writing it is a legitimate opposition political party.

-Renamo's attack on communal villages, the base of CHWs

There have been two recent evaluations of the CHW program. Among the findings of first (Greuter 1992) are that:

-CHWs were perceived by the community as a local link with the National Health Service rather than as people who originate in or represent the local community. In other words, CHW training conferred upon them a change in status--which status seemed to be exploited by the CHW to the detriment of their perception as being a local person.

-There was confusion over the role of the CHW in curative medicine: the focus was supposed to be community-based prevention but this was not always understood.

-There was weak supervision and support of CHWs, along with a parallel problem with absenteeism;

there were doubts about the relevance of training and teaching methodologies adopted, including the question of local languages, said to be under-utilized in the process of training.

In a more quantitative evaluation study (Scuccaco *et al* 1994), 140 CHWs were interviewed in 4 provinces. National coverage of CHWs was estimated at between 5% of the population in Nampula to 11% in Inhambane. The study also found that:

-in theory, all CHWs should be chosen by the villages in which they work, yet only 75% were found to be chosen this way. (Also we don't really know what "chosen by the village" means. Was the process at all democratic?)

-91% did not receive material or financial support from the villagers;

-CHWs worked for 22 days a month and saw an average of three patients a day;

-some CHWs were urban-based commuters, leading to predictable problems in transport, local acceptance, credibility, etc.

-there were at least 12 or 13 traditional healers in each village where there was a single CHW;

-the number of government and NGO extension workers and "activists" (volunteers) found in villages was much lower than expected

-the CHW profile proved to be: young (88% under age 40), religious (Christian), married, and male (69%);

-nearly 20% of CHWs were single or childless, which the authors noted detracts from their respect and credibility in the local community;

-73% of CHWs wanted to broaden their role. The usual ambition was to become a nurse or health technician.

-there was little uniformity in the reading and related materials found in possession of CHWs. This suggests that the therapeutic (curative) activities of CHWs were not supported by instructional materials, which further explains findings elsewhere that CHWs not infrequently give curative services deemed wrong or harmful (for example giving chloroquine to babies).

-74% had bicycles, all of which were provided by the program or by local NGOs in coordination with the program. Some were inappropriate to the terrain, others were in bad maintenance.

-43% lacked latrines in their own home, although latrine promotion was central to the CHW's activities;

-70% participated actively in EPI (child immunizations) was cited as one of the few relatively successful program areas (the same was found in one Nigerian study [Iyun 1989]);

-a "lack of source of luminosity" prevented health care activities at night;

-most lacked minimal material to carry out curative services;

-50% did not sterilize their equipment;

-there were problems in supply and replenishment of medicines: 23% lacked ORS; 32% lacked chloroquine (yet malaria was reported to be the most common problem encountered). 62% had reported going for over a week with no medicines during the previous 3 months--in spite of a policy of replenishing the kit on a regular basis;

-most of CHW's time (85%) was spent in diagnostic/curative activity, not in health in preventive education;

-record-keeping was generally very poor;

-STDs were the least frequently referred cases --i.e., to health facilities. The chief investigator commented on this apparently unexpected finding. He speculated that the paucity of STD referrals might be due to lack of antibiotics in rural clinics and hospitals, or perhaps to a strong preference for traditional treatment.¹²

¹² As an alternative explanation, I have found in several African countries that STDs are thought to be treated more successfully by traditional healers than by clinics or hospitals (Green 1994, Chapter 1).

-allegiance to Renamo or other parties in the same village seemed to complicate the position of the CHW, who was associated with the Frelimo party.

-74% of CHWs were found to collaborate in some way with local TBAs e.g., assisting when there were complications in delivery. Only 4 CHWs said they would not work with TBAs. However referrals seemed limited to "recycled" TBAs, i.e. those trained and supervised by the government.

-23% of CHWs reported that traditional healers referred patients to them, but CHWs rarely reciprocated: only half of one percent of CHWs said they referred patients to traditional healers. Among the reasons given were general opposition to traditional healers; the perception that the government disapproved of healers (true until 1989); and a "lack of orientation toward collaboration". However most CHWs could give no reason for lack of collaboration with indigenous healers, although researchers reported that CHWs apparently saw themselves as higher-status than traditional healers. Researchers also observed that a structured questionnaire is not the appropriate way to get at questions of this nature. This subject proved to be very sensitive (Scuccaco *et al* 1994:62).

One finding that surprised the investigators was the paucity of health volunteers: "activists" and NGO extension workers were very scarce in the villages, contrary to expectation. Apparently larger numbers of health workers had been trained and were being supported than actually could be found on a given day. In the 22 areas where they were found, there was said to be collaboration between them and the CHW in 59% of cases.

Researchers found that the most common problem presented to CHWs was malaria, followed by wounds or sores, and diarrhea. This was no doubt influenced by what the CHWs carried in their kits (chloroquine, antiseptics, ORS, analgesics) when they had anything at all.

Among the general conclusions of the evaluation: the CHW program is not self-sustaining. It costs a total of US\$500 a year to maintain a CHW (including the cost of medicines, bicycles, etc.). This equals about 63 cents per visit, if we assume 3 consultancies per day and 22 work days per month.

The point that must be emphasized is that *the same basic problems found in Swaziland, Tanzania and Mozambique have constrained if not crippled CHW programs throughout Africa*. True, the literature on CHWs was positive and optimistic during the first decade or so of these programs. But when the programs began to mature and be evaluated the problems outlined above were usually found to overwhelm the programs, for example in Botswana (Walt, Ross, Gilson *et al* 1989), the Gambia (Menon 1991), Niger (PRICOR 1990), Nigeria (Iyun 1989), South Africa (Mathews, van der Walt, and Barron 1994), Africa in general (Matomora 1989; Jancloes 1984) and indeed in poor countries outside of Africa (Kortmann 1994; Chevalier *et al* 1993).

Solutions Attempted

A 1989 unpublished UNICEF survey of Rural Health Motivators in Swaziland recommends

expanding the number of CHWs, paying them higher salaries, and providing more training, more vehicles for supervisors, more supervision, more medicines for CHW curative kits, etc. without exposing many of the serious problems that have undercut the CHW program. My own evaluation research in Swaziland suggests that problems with the CHW program are of the sort unresponsive to "more of everything" solutions, at least in the absence of structural and functional changes.

The Mozambique Ministry of Health recognized that traditional healers are already found in villages, and that they receive local compensation in some form for their services. The government's current policy is to promote medical pluralism. In the present context this means allowing villagers to choose between the traditional healer and the CHW. There is no policy constraint to training healers as CHWs. It is not known whether any traditional healers have been trained--or have sought training--as CHWs, but such lack of evidence may speak for itself. Elsewhere in Africa traditional healers have been thought to not seek training as village health workers because they already earn more income and enjoy higher prestige than community volunteers who receive a few weeks of training.

In fact, many or most of the problems that constrain the APE and related CHW programs (compensation, sustainability, acceptance by local community, credibility as health advisors, motivation and outreach) either vanish or are diminished greatly if, instead of creating a new health role in the village, we work with the existing traditional healer. Healers already have their own source of income, already are respected health "opinion leaders", and already have as clients most people in any village. As already noted, they are usually motivated to cooperate with anyone representing Western-style, "modern" medicine.

Having briefly reviewed the CHW program in Mozambique, it may be useful to summarize the relative advantages of the CHW and the traditional healer from both the programmatic and the local village perspective. It should be kept in mind that problems in the CHW program are common to village health worker programs throughout Africa except that the civil war and former RENAMO policy of attacking government-supported health workers exacerbated these problems.

Comparison Between the Traditional Healer
and Village Health Worker in Mozambique

COMPARISON FACTOR	TRADITIONAL HEALER	VILLAGE HEALTH WORKER
Qualifications	Years of training as well as a spiritual basis rooted in traditional religion	6 months of training. No previous health background or credibility
Age (a factor related to respect, prestige and credibility)	Tends to be older	Tends to be younger
Financial sustainability of service	Has own established income base	Has no source of income, even as a CHW. A proposed new plan would pay the VHW less than 60% of the minimum wage.
Cultural "fit"	Culturally acceptable	Seen as an agent of an alien system
Approach to Health care	Holistic, curative	Of necessity, fragmented and narrowly focused. Preventive focus initially, then curative emphasis to become accepted
Materia medica, agents of therapy	Well-supplied, medicines in stock	Health kits usually unreplenished
Practical experience in health matters	Has much experience	Has little or no previous experience
Career stability	Stable. Practitioners are content and take pride in their respected role	Unstable. CHWs want to be trained to become salaried health workers like nurses
Coverage	100% of country	Less than 30% of country
Caseload	About 1 practitioner per 250 population estimated	1 per 2-3 <u>villages</u> of population in the hundreds each.

Are the Problems of Community Health Workers Insoluble?

It is premature to conclude that the CHW model is unworkable under any circumstances. What if CHWs were selected through a popular process and were actually paid for their services? What if they were supplied on a regular basis with a few locally popular medicines, whatever their

additional role in preventive health care? What if they could work collaboratively rather than competitively with traditional healers? Some private voluntary organizations (PVOs) in Mozambique have experimented with such "radical" approaches. For example, World Vision (a large Christian-oriented PVO) has recently developed a CHW known as an adjudante (helper) in its child survival programs in Tete and Zambesia provinces. These CHWs are recruited as volunteers who are willing to serve their community in efforts to reduce disease and premature death. They are locally selected in coordination with community leaders, although they are screened for literacy and minimal educational qualifications. Unlike the government CHW (the APE), adjudantes are paid a small stipend to motivate them to work fulltime in their own communities in preventive and promotive CS activities.

By all accounts, adjudantes are appreciated by their fellow villagers and effective in their preventive work--which is always much harder to "sell" than curative services. I myself have seen them in action and was very impressed. However many in and outside of government argue that paying CHWs is unsustainable, given the severe budget limitation of the Mozambican government.

Another PVO, Save the Children, working in Gaza province, Mozambique, has tried to develop a CHW that will work for prestige and recognition rewards alone. These volunteers are called activistas. These volunteers are selected in open meetings by some sort of quasi-consensus process. They receive two weeks of initial training in promotive and preventive primary health care, after which they work on a part-time basis promoting immunization, oral rehydration therapy, infant nutrition, prenatal care, latrine construction, child spacing and other PHC type preventive health care. One activista I spoke with commented that there was some confusion over their role perception in the village: "They come to us at night for malaria pills." This preventive/curative role confusion and paradox, which expressed the difference between felt needs in the community and the priorities of public health programs, is a common problem that bedevils CHW programs.

Activistas work without pay or other direct compensation; some I talked with in 1996 had been working since 1992. One thing they had requested of Save the Children was an ID card so that people would know that they are really health workers, especially when they venture away from their immediate communities. There was also talk of special tee shirts that only activistas would wear. Tee shirts and ID cards are examples of what we might call prestige rewards; the rewards really come from the local communities but those involved in health or other programs can bestow inexpensive items symbolizing the status of those who assist the programs. It is at least equally motivating that this "cadre" of health worker is given adequate supervision by health workers and NGO staff, and their medicine kits are resupplied.¹³ These seem to be the factors that explain why CHWs are willing to work without pay.

The paid fulltime CHW of World Vision's program seems to be the more effective of these last

¹³ Curative medicine kits recently began to be provided to the activistas. The trouble is that once curative services are added--particularly if CHWs can earn some cash for sales of medicines--their preventive role often atrophies.

two models. Yet World Vision has come under considerable criticism for actually paying a CHW. This may not be fair. Cost effectiveness analysis might prove that having at least some number of paid CHWs in areas situated far from health posts yields more positive health dividends than other elements of the health care system that are accepted without question. We should not close our minds to the possibility that it might be more valuable to the nation's health to have five or ten CHWs doing effective, community based preventive health care than to support one nurse attempting curative health care in a poorly equipped clinic--which might cost the same. Indeed, World Vision's CHWs help local nurses who are typically too swamped with sick patients to engage in any of the preventive health care that the MOH increasingly expects them to do.

**POLICY ISSUE #11:
CAN HEALERS PROVIDE MENTAL HEALTH SERVICES?**

Mozambique, like many other African nations, has a national organization that coordinates mental health policy and programs. It is called the Mental Health Committee and in 1995 it was dealing with the issue of where to put resources that would best address problems such as severe mental illness, the effects of psychological trauma caused by war and the widespread disruption of families and communities, and drug and alcohol abuse.

One plan that already had been funded by some German donor organizations was for recently-trained psychologists to treat symptomatic, war-traumatized children with Western (in fact psychoanalytic) psychotherapy in a special institution called the Institute of Traumatology. Others on the Committee recognized that there has been more success with community-based, "outpatient" programs in Mozambique and countries like it. The question also arose, Who would actually provide treatment, or "deliver mental health services", at the local level in rural Mozambique? Existing government personnel such as teachers? Community health workers? Village-level workers such as APEs, activistas or Red Cross volunteers? A new cadre of CHWs trained specifically in mental health? trainers?

As good as such ideas might sound on paper or in discussion, there are some difficult questions that must be asked, based on several unavoidable considerations:

(1) teachers and other local level civil servants tend to feel overworked, underpaid, under-appreciated, under-supplied, and, as a result, often demoralized. Planners invariably think of teachers as the point men to deliver some new service at the village level in Africa. The assumption is that the teachers will think that family planning, environmental sanitation, community mental health--whatever--is such a good idea that once informed, they'll be bursting with enthusiasm to take on a new way to serve their communities. The reality is that teachers don't want to distribute condoms, motivate latrine building, or deliver mental health services unless they are paid for carrying out what they see as extra duties. Often they are demoralized because they are already owed considerable back pay for the job they are supposed to be doing.

(2) CHW programs have failed all over Africa because of: the perception on the part of intended beneficiaries that CHWs represent yet another government program thrust upon

them; initial problems in selecting the right people; CHWs do not deliver a service or a product that is sufficiently linked with perceived needs by beneficiaries; and--the perennial issue with village-level civil servants--their feeling that they are underpaid, under-supervised, under-appreciated, etc.

(3) If CHW programs have failed when trying to provide a service linked with a killer disease like cholera that traditional healers don't claim particular expertise in, why should we expect another type of CHW to succeed in providing mental health services--a domain that villagers, traditional healers, and often medical doctors alike concede is a particular strength of traditional healers? There is evidence from throughout Africa that mental illness is one of the conditions for which modern medical help is least likely to be sought (cf. Edgerton 1980; Harding 1973:200; Twumasi 1977:129).

(4) If CHW programs of any sort cannot succeed in a small, relatively wealthy African country with good physical infrastructure like Swaziland, what makes us think that mental health CHWs could possibly succeed in one of the world's poorest countries?

(5) If there is no scientific evidence that European-spawned psychoanalytic psychotherapy is particularly effective with Europeans, why should it work any better with poor, rural Africans? And if this same therapy is not particularly effective in the hands of PH.Ds and medical doctors, why should it be more effective in the hands of ill-educated village volunteers or over-worked, poorly-motivated school teachers?

It must be acknowledged that "activists", Red Cross volunteers, CHWs and others ready to contribute their services in the villages seem to exist mostly on paper and in the minds of planners in the capital city. Recent surveys have shown that few such workers can actually be found in villages on a given day (Scuccaco *et al* 1994:62). This is in part because the Frelimo party structure began to erode in by 1990 or earlier, and many of the volunteer cadres were created and sustained by Frelimo. Therefore we are left with civil servants (such as teachers), or the prospect of creating a new, CHW-like cadre to deliver mental health services in villages.

An idealist might argue that we are being too negative. After all, anything should be possible. There are always some exceptional teachers, CHWs and the like. This is true. The most recent CHW evaluation found some exceptionally effective CHWs. I certainly found some in my evaluation of CHWs in Swaziland. But we cannot run a sustainable, national program on exceptions. By definition exceptions are not the norm, not constituents of the pattern we would be able to establish nationally.

A program to "deliver" mental health services in the manner proposed is contingent upon too many improbable contingencies: if Western psychotherapy were proven effective among rural Africans who participate in a different belief system...if psychotherapy could be taught to teachers, volunteers or CHWs...if there were truly cadres of "activists" and others ready to volunteer their services in the villages...if village-level workers or volunteers could overcome all, or even some, of the perennial problems of finance, supervision, transportation, motivation, morale, logistics, sustainability that have crippled similar efforts all over Africa...then such programs might have a chance.

Should the Department of Traditional Medicine (GEMT) Work in Mental Health?

To answer this question, we must consider the following:

- 1) There are virtually no mental health services, even anti-psychotic medications, available at provincial or district level hospitals;
- 2) There seems to be little that the Ministry of Health could teach traditional healers that would make any sense in the context of prevailing "mental health" beliefs, which relate almost exclusively to the realm of spirits and sorcery (unlike STDs, diarrheal and other infectious diseases, where there is more compatibility of paradigms and therefore common ground to build upon);
- 3) With both STDs and diarrheal disease, we have a simple, safe "technology" to disseminate (condoms, ORS/ORT, bleach for sterilizing implements) as well as potentially life-saving behavior change to promote (sexual fidelity, boiling drinking water, continue breastfeeding, actually use ORT or condoms, etc.). This is not true in the area of mental health;
- 4) In the cases of STDs and diarrhea, appropriate referrals from healers to hospitals can save lives; therefore part of the communication strategy is to find ways to achieve the cooperation of healers in such referrals. Again, this makes no sense in mental health. There is nothing available at a district hospital that can save the life of a psychotic Mozambican;
- 5) Mental health is a single area of health that medical doctors are willing to concede to traditional healers. And traditional healers are unequivocal in advising against using "hospital medicine" in the treatment of what we call mental problems. So why should the GEMT work in mental health at all?

It would seem that the only justification for working in mental health is that the GEMT is in a good position to collect ethnomedical information that can inform and improve Mozambique's program and policy of mental health, in order that it develop culturally-appropriate, community-based mental health services. In fact such information is much needed and the Ministry of Health indeed wants and has asked the GEMT to conduct just such research because it is the only unit within the ministry that has an anthropologist (as well as a foreign consultant anthropologist). Because of this request, the GEMT will continue to do ethnomedical mental health research, but we must acknowledge that there is no possibility of developing an active, collaborative program in this area comparable to the collaborative programs in STDs or diarrhea. Therefore mental health research will not be given the same emphasis as STD or diarrhea research.

Is There a Realistic, Sustainable Approach to Mental Health Services?

There are approaches to assisting in the area of mental health that avoid a top-down, "high-tech", dependency-creating approach. The USAID-supported Children and War (C&W) program, administered by Save The Children (USA) in Mozambique, Malawi and Zimbabwe has assisted

children who have been adversely affected psychologically by Mozambique's protracted war by: (1) documenting "unaccompanied" children; (2) tracing surviving family members; (3) reuniting children with their own kinsmen; (4) placing children in foster families when necessary; and (5) providing for the psycho-social needs of war-affected children through various interventions (Green, Williamson and Nimpuno-Parente 1992). It arrived at this approach through a series of discussions with natural, indigenous leaders found in representative villages. These leaders proved to be chiefs, traditional healers, church leaders, successful traders, and elders serving on the chief's councils. They did not see a need for training existing or new cadres to provide any sort of direct psychological services to children; they all agreed that traditional healers were already doing this effectively.

Accordingly, the C&W program works through local and existing structures and resources to help create a stable environment for a reunified child, one in which its "basic needs" will be met. Beyond its biological needs, a child needs to be associated with other children and adults in a normal environment, and encouraged to engage in activities such as singing, play, dance, participating in story-telling, and the like. Guided activities of this sort take place in pre-schools (*escolinhas*). But it is recognized that some of this also occurs in schools. The program has also considered the basic needs of children of more advanced age and has supported some modest efforts at skill training, under apprentices who volunteer to assist needy children.

In all cases the aim is to create a stable, secure, culturally-familiar environment in which children exhibiting war-related psychological symptoms gain a sense of competence in a predictable world where they can begin to heal. The program attempts to meet the needs of war-affected or "traumatized" children in ways that are relatively inexpensive and non-dependant on manpower trained in psychology, and therefore are replicable and sustainable. The activities are culturally-appropriate; here the term is apt because none of the program activities are culturally-intrusive, let alone imposed from the outside.

The program proved popular in the villages because of these features, and because the program was jointly designed with considerable input from natural, local leaders. By mid-1992, there was a network of over 7,000 volunteers in local "community networks" assisting in the activities just outlined. In all cases, community network members present their own ideas and C&W staff try to stand on the sidelines and quietly encourage the process, providing guidance and low-cost materials when advisable. The idea is to let activities that help meet the psycho-social needs of war-affected children to emerge naturally, and to occur in open, public areas where all children can participate.

In addition to the C&W programme, a Red Cross- and UN-funded program called *Projecto Brincar Curando* follows a similar community-based approach (Cruz Vermelha 1994).

Are these achievements peculiar to Mozambique? In Angola, the Christian Childrens Fund (CCF) developed a similar program in 1994 to assist war-traumatized children in their "psychosocial" adjustment. The program discovered at the outset that--just as in Mozambique--indigenous therapy for war-affected children is provided by traditional healers in local communities. The therapy consists of ritual purification ceremonies and related practices.¹⁴

¹⁴ As in Mozambique, therapy seems to be based on beliefs that death is mystically polluting.

Although therapy of this sort has yet to be well-documented and analyzed by behavioral scientists, it seems to dramatically reduce outward symptoms of what is medically known as Post Traumatic Stress Disorder (PTSD). As in Mozambique, the CCF in Angola developed a successful program based on a kind of division of labor whereby local traditional healers took care of PTSD symptoms while CCF staff and volunteers organized "interventions" such as dances, drawing sessions, story-telling, drama and role playing, sports and games, and helped establish schools or preschools. As a result of these low-cost interventions, based on collaboration with traditional healers, a program evaluation after the first year showed:

- Improved child/child and child/adult relationships
- Decreased sleeping problems
- Diminished isolation behavior.
- Progress in psycho-motor development among younger children
- Greater participation among children in institutions
- Diminished violence between children; reduced degree of aggressive behavior
- Manifestations of greater certainty and trust in the future
- Decreased bed-wetting
- Reductions in stress reactions
- Increase in awareness, and in cognitive and affective response
- Reduction in concentration problems
- Reduction in psychosomatic illness
- Improved perspective in relation to the future (Green and Wessells 1995)

By 1996 the C&W program director in Mozambique spoke of the growing realization on the part of staff of the importance of "customary traditional practices" and traditional healers in "relieving the emotional stresses that the war had caused children and adults" (Namade 1996). Clearly this is true for Angola and elsewhere in Africa as well. And this is only one area where the mental health contribution of traditional healers is starting to be documented.

POLICY ISSUE #12:

SHOULD TRADITIONAL HEALERS BECOME HEALTH PLANNERS AND MANAGERS?

While some may feel that Mozambique's current collaborative program involving traditional healers goes too far and proceeds too quickly, there may be others who may feel it does not go far enough, or fast enough. Suggestions have been made, for example, to enlist traditional healers at a higher level and to involve them at earlier stages of the health service delivery process. It has been suggested that healers might be enlisted at the provincial level to sit down with health planners and managers from the Ministry to plan culturally-appropriate services at the district level. One or more healers might be hired by the Ministry to be placed in the Department of Traditional Medicine (GEMT) and the university to advise, plan, manage (in the GEMT) and teach ethnomedicine (in the university).

While I support in principle the idea of sharing planning and management responsibilities with

People "contaminated" by direct or indirect contact with death must be "purified".

traditional healers, I have some reservations and questions about these suggestions.

(1) Regarding the first idea, traditional healers have no experience, training or orientation in the type of planning we would expect them to participate in. At a provincial planning meeting healers might be made to feel uneducated and otherwise inadequate by confident, outspoken, formally educated health planners.

(2) Healers would be outnumbered greatly by civil servants in a regional planning meeting. Feeling outnumbered as well as out of their element, healers would probably remain quiet, or at least they would not speak openly about "traditional" illness concepts or refer in other ways to their magico-religious world view.

(3) In such a planning situation there would appear to be more opportunity for the flare-up of conflicting paradigms of health than there would be in workshops where a small number of deliberately sensitized nurses or health educators typically spend a week or two with healers in a permissive yet controlled atmosphere. In the latter situation, healers outnumber biomedical personnel and therefore they tend to feel less intimidated and would be more likely to speak openly and candidly.

In addition to conflicting health paradigms, we find different perspectives and orientations even among representatives of biomedicine. These are often evident between an M.Ph, who typically has a public health perspective and commitment, and a physician who usually has a predominantly curative perspective. Physicians who work for the government may because of the nature of their jobs develop a public health perspective, but with the (re-)introduction of private practice in Mozambique, physicians will increasingly be in business for themselves and not necessarily think about low-cost measures that would bring the greatest health improvements to the greatest number of people--especially since many of these measures fall outside of what doctors themselves do. In this regard, physicians are like traditional healers, who are also private practitioners in business for themselves.

Perhaps paradoxically, it is biomedical personnel with a public health orientation who are more likely to be sympathetic to collaborating with traditional healers. Indeed the wish of the former is to develop a sense of preventive health care responsibility among the latter--to develop a public health role for traditional healers. Yet in some important ways, healers are more like curative physicians than someone trained in public health. Given so much opportunity for misunderstanding, it might be unfair to put a few healers together with a larger group of biomedically-oriented managers and planners. And since planning meetings have been going on for some years, the agenda and operating rules for such meetings have already been established by the biomedical personnel.

Traditional healers would need to be trained or otherwise developed as planners, managers, or university lecturers before the ministry put them in situations where they would be expected to function as such. In fact it has been recent ministry policy to not interfere with, or attempt to alter the role of, traditional healers--at least until a great deal more is known about both their role and the potential ramifications of changing this role. In any case it would be easier to attempt any such training after a few years of successful collaboration and diminished suspicion on both sides. In this regard, the GEMT in 1991 proposed introducing medical anthropology into the

training of health workers at all levels; this is now part of the in-service training of many categories of health workers. It makes sense to allow a few years for ministry personnel to become sensitized to the importance of culture and traditions, and to become more understanding about the role of traditional healers in Mozambique and more comfortable relating to them.

If we did decide to develop healers as planners or managers, we must admit we are sailing in uncharted waters; at least I know of no experience elsewhere in Africa to guide us. How long would such training take? Could it be accomplished through workshops or would something more formal be required? Would we want to inaugurate Mozambique's program by training healers in planning, rather than by upgrading their curative/preventive skills?

(4) Instead of trying to develop healers as civil servants or planners at this time it seems preferable to the GEMT to assist national and regional healer associations become organized and effective. Until there are functioning healer associations, the ministry would not know which healers to train or even invite to a health planning meeting--and neither would healers know who should participate if they were not organized and communicating among themselves beyond the level of local village or neighborhood. If we treated as a spokesman of traditional healers anyone who ingratiated himself to the Ministry, this could sow discord among healers and set back relations between healers and the ministry.

A related point is that a healer drawing salary from the ministry would likely be suspected by other healers--sooner or later--as putting ministry interests before those of healers. African healers tend to be suspicious of one another to begin with, and this would be intensified if a healer spent much time with politicians and civil servants in non-traditional pursuits. We do not find in Africa the Asian tradition of indigenous healers sharing healing knowledge with one another. Major Asian indigenous health systems, like the newer allopathic medicine, spring from literate traditions. A salaried traditional healer at a ministry or university who was regarded with suspicion by his fellow healers would scarcely be an asset.

Experience elsewhere in Africa has shown that the presence of traditional healers in health ministries or hospitals (I am unaware of such precedent in universities) is threatening to many biomedical personnel with the result that the latter become alienated from the overall collaborative effort. This is a risk that conceivably might be worth taking if hiring healers "paid off" in furthering this effort, but such initiatives would more likely serve to unnecessarily antagonize biomedical health personnel.

The GEMT stated its position at the beginning of its program proposal that it does want to "allopathize" traditional healers, that is transform them into a species of minimally-trained government health worker at the periphery of the formal health care system. It seems to us that enlisting a healer as a civil servant in a health ministry would do more to allopathize (or re-tool biomedically) the healer than to accept him or her as a separate, alternative health care provider whom we might persuade to adopt oral rehydration salts, vitamins, condoms, spermicides or some other specific, limited "health technology" in his/her practice. It would also have a more predictable health impact, since there is documented experience in the latter case. My concern is that we interfere with the (admittedly changing) role of the traditional healer only at our own peril: his or her role is so integrated in such functionally complex ways that a little social engineering with one part might reverberate in unforeseen ways.

(5) It is possible to plan ways to improve public health in Mozambique without necessarily attempting to turn traditional healers into planners or managers themselves, at least at this time. This can best be done--given the present circumstances--by actively seeking and making use of the advice of healers chosen by formal associations or other representative groups of healers to act in such capacity. This would be not only for matters affecting healers directly--such as the present 3-year program of traditional medicine, but for all important decisions involving especially the rural population.

POLICY ISSUE #13:

SHOULD ETHNOBOTANY BE SUPPORTED BY MINISTRIES OF HEALTH?

Traditional African medicine consists of materia medica as well as practitioners. There is little emphasis in this book on the former because I believe research or policy development relating to medicinal plants and other natural materials may hold comparatively little potential for public health impact, at least in the short term. Research related to the medicinal value of plants may be justified in several ways: (1) achieving community or national self-reliance in health by promoting locally-available and already-accepted herbal medicines; (2) developing an indigenous pharmacological industry, based on local plants, that reduces national dependence on expensive, imported drugs; (3) promoting natural health care and reducing the iatrogenic effects of modern medicine; (4) finding out what traditional healers are using and if medicines are found to be dangerous and highly toxic, trying to persuade healers to substitute safer plants or at least reduce dosages; or (5) finding an effective-seeming indigenous medicine for the symptoms of a high-priority illness such as child diarrhea, then finding ways to promote more widespread use of the medicine.

All of these ideas sound promising at first glance and all have been tried in Africa, yet there has been little progress toward the realization of these goals, plus there are serious problems of economic justification in every case. For example, research aimed at the pharmaceutical industry as the target--with the idea of earning money or at least being able to promote an indigenous herbal medicine--seems seldom if ever to fulfill its promise. My colleagues in the Department of Traditional Medicine, in the Mozambique Ministry of Health had direct experience in this. For some time they had investigated popular medicines used to treat malarial symptoms. Through discussions with traditional healers in a community near Maputo, as well as monitoring progress of their malarial clients, they narrowed their interest to two plants that seemed to reduce malarial symptoms. One in particular, known as munangati in the Tsonga language (ngati means blood in Nguni languages), was laboratory tested with blood culture, and it indeed reduced parasitic load in the blood (Jurg, Tomas, and Pividal 1991).

The problem was what to do with findings of this sort. My colleagues soon came up against a harsh reality: the large pharmaceutical companies have hundreds of such "promising" plants lined up to be tested, including many with demonstrable antiparasitic action against P. falciparum. However testing is slow, expensive and laborious. The cost of testing in fact averages about \$231 million per plant and take about 12 years to develop a new drug (WRI 1993:16). Companies need to get a return on their investment, yet the people who suffer from tropical diseases tend to be poor. In the case of munangati, the international pharmaceutical

industry was not interested in analyzing the Mozambican plant, even though malaria is the most endemic, prevalent disease of the tropics. Minor irritations of the wealthy nations such as post-nasal drip may actually have more potential for profit than tropical diseases such as oncho- or schisto- or trypanosomiasis.

Farnsworth (quoted in Bailey 1986) observed that in the early 1980s, there were only two U.S. pharmaceutical companies supporting research to investigate new drugs from plant sources.¹ This research cost about \$200,000 and represents a negligible part of a prescription drug industry which was over \$8 billion annually. In addition to the costs of developing drugs from plant sources, Bailey (1986) suggests additional reasons for corporate reluctance to support applied phytochemistry. One is a bias against traditional and natural substances in favor of synthetic chemicals. Another is a desire to maintain control over the production and sale of medically-useful compounds. It appears to be easier to control synthetic compounds; anyone might pick up and use organic compounds, whereas herbs cannot be patented. However this fear may be unjustified since natural compounds rarely occur in optimal form for medicinal use; they usually must be modified synthetically or related compounds must be synthetically manufactured. (For opposing considerations, see Bodeker 1995; Duke 1995)¹⁵

Even if the industry had been interested in exploring a potential antimalarial, any resulting manufactured medicine would be largely out of physical and financial reach of the mass of Mozambicans. If our target is the rural "masses," we always run up against the problem of expensive testing before a government is willing to risk formally promoting an herbal medicine. If we talk about reinforcing community self-reliance on things people are already relying on, why then would we need to do it? If we talk about warning traditional healers about toxicity of plants they are using, they probably know more about such properties than ministry personnel who in any case have little credibility in this area in the eyes of either healers or their clients using the traditional medicines. Moreover experience has shown that it is difficult under the best circumstances to change traditional health practices.

Another problem is that many of the more-or-less established properties of medicinal plants relate primarily to the amelioration of common symptoms such as pain, cramps, fever or chills; or to general conditions such as weakness, fatigue or shortness of breath (high blood pressure). For example, Oku Ampofo, in his practical guide for health workers, First Aid in Plant Medicine (1983: viii), lists remedies for the following conditions: cough, asthma, burns, skin rashes, snake bite, jaundice, cuts, wounds, diarrhea, and convulsions. (Even with these, Ampofo--a medical doctor--suggests that the health worker might want to use an allopathic medicine along with the traditional plant remedy!). Virtually none of these conditions except diarrhea are high priority concerns among African health ministries.

¹⁵ Bodeker notes, "...traditional medicine avoids the use of a single ingredient or extract and uses a complex mixture. The chemicals in the different plant ingredients may serve variously to offset side effects in other plants in the mixture, to increase cellular uptake of the chemicals that address the pathology, and to stimulate a generalized immune response so that it is not a single receptor site that is being targeted but rather a systemic healing response that is being activated. In addition, extra herbs are added to the mixture to address the specific imbalances and medical needs of the patient. This pharmacological model is complex and sophisticated and calls for a synergistic approach rather than the reductionistic active ingredient approach to drug development" (1995:235).

Other ethnobotanical and pharmacological analyses have shown that a number of phytomedicines (medicines of botanical origin) do in fact have antibacterial, antiviral, and fungal properties, at least in vitro. I have already referred to the roots of *Mirabilis jalapa*, used in South Africa as a purgative, that exhibit antibacterial activity against a broad range of diarrhea-causing pathogens (Kusamba, Kizungu, Wa Mpoyi Mbuyi 1991).

Yet even when plants are found to be effective in symptom reduction or elimination of the causative pathogen we again run up against the problems of (1) the plants could not be officially promoted without a great deal of "high-tech," expensive testing; (2) if a large pharmaceutical firm were to develop a drug from one of the promising plants, the Africans who were using the drug in its natural form could not afford it nor would they receive royalties from sale of the new drug; and--the ultimate nagging question--why has there apparently not been a single plant drug promoted officially elsewhere in Africa, for example in a country like Ghana where there has been years of ethnopharmacological research and where there is more money and better infrastructure than in Mozambique. On this point, even le Grand and Wondergem (1990:36) make this comment about the much-cited Traditional Medicine Institute in Ghana: "...after more than 10 years of research, no plants are presently recommended for use" (there has now actually been more than 15 years of research). More than 10 years of research at the Department of Traditional Medicine, Muhimbili Medical Center in Dar es Salaam has likewise not resulted in official promotion of any herbal medicines in Tanzania (Mshiu 1993).

What if we used different, more relaxed standards for promotion of herbal medicines, arguably appropriate for the poor countries of Africa? Suppose we found a plant whose medicinal use is well-established in southern Mozambique, we establish that it seems to work quite well, we know from the literature that the same plant seems to work quite well elsewhere, and it does not appear toxic. Could this indigenous medicine be promoted? Again there are various problems: (1) the health ministry, as the promoter, could be accused of lowering public health standards for the poor and non-white, compared to the standards maintained in the rest of the world; and (2) the ministry would be reluctant to promote a medicine about which not enough has been established regarding toxicity, dosage, side-effects, storage, etc. And a country like Mozambique cannot afford the requisite tests.

In sum, any possibility that involves the medicinal properties of plants seems to run up against a variety of insurmountable problems. On the other hand, possibilities involving the nutritional value of plants circumvent many of these problems, especially when considering known edible plants. If a plant is edible and its nutritional value is known--which is usually true even for tropical plants--then there is no need to investigate toxicity, optimal dosages, side-effects, etc.

One idea that seems viable is to look at high-priority, endemic diseases or conditions for which there are nutritional treatments. If it can be determined that there is an indigenous plant high in iron, for example, its use could be promoted in the treatment of child anemia, which is a major complicating factor in many infant and child deaths from infectious diseases such as malaria, according to a recent World Bank Health sector report for Mozambique. True, it is very difficult to get tradition-bound people to adopt new foods, especially indigenous plants not locally regarded as edible. However the approach could be to promote the plant through traditional healers as a medicine which can ameliorate the symptoms of anemia. Perhaps the healer could be

encouraged to make a tea from the iron-rich plant. Traditional healers are open to adopting new medicines, they have a preference for indigenous plant medicines, and they have the influence and credibility to persuade their patients to adopt a new medicine. The plant with nutritional rather than medicinal value has several advantages starting with the fact that expensive, lengthy research to determine the active chemical compounds of plants as well as their toxicity would be unnecessary.

One of the staff members of the GEMT followed this advice and conducted research on the anti-asthmatic and other health-related properties of garlic, which is probably the most-studied and therefore best-documented natural product in the world. He is now pursuing graduate studies in ethnobotany at a Portuguese university. Neither the research nor the further education is paid by the MOH.

Another possible justification for ethnobotanical research might be in researching the toxicity of plant medicines in current use, then warning traditional healers and laymen about poisonous plants and toxic dosages of useful plants. This in fact is a responsibility of the Branch of Botany of the National Herbarium in Zimbabwe (under the Ministry of Agriculture). Although healers may already know a lot about plant toxicity, there nevertheless seem to be more poisonings and overdosings with traditional medicine than with biomedicine, even if most cases go unreported, according to a government botanist (Mavi 1991). It appears that urban healers nowadays buy herbs increasingly from retailers, and they often find themselves in areas with different vegetation from the area where they learned to practice, the result of both being that they may not be sure what they are mixing and prescribing. They may confuse unfamiliar with familiar plants. Therefore there may be a need to provide healers and the public with certain information on medicinal plants.

Other than approaches such as these, I have been unable to find any real public health justification for allocating scarce funds of African ministries of health to research the medicinal properties of indigenous plants. Moreover I am not certain WHO's role as a sponsor is justified (nor is it likely, considering how little is allocated to its Programme on Traditional Medicines).¹⁶ As a confidential memorandum circulated by a private, voluntary organization recently noted, even the WHO-supported ethno-pharmacological database at the University of Illinois, Chicago (NAPRALERT, or Natural Products Alert), at least partially "serves the interest of the pharmaceutical companies who use WHO support to scour the world for plants which can be useful for pharmaceutical production." Ethnopharmacological and ethnobotanical research of course deserve support, however this probably should come from private industry and foundations rather than public funds. It can also come from private investors. Shaman Pharmaceuticals, a U.S. company established to develop new drugs based on traditional medicines in use, raised \$42 million when it went public in early 1993 (WRI 1993:120).

Low-Cost Ethnobotanic Research directly related to Public Health

Yet there are certain ethnopharmacological research questions that should be pursued because of

¹⁶ At this writing, this unit consists of one professional and one secretary.

their direct link to public health. I take some examples from AIDS and sexually transmitted disease (STD) crisis in Africa. Two questions relating to collaborative programs involving healers are: (1) can at least some indigenous medicines be effective against any of the common STDs? and (2) can at least some indigenous medicines be effective against any of the opportunistic infections that characterize AIDS in Africa? A quick although preliminary answer to the first question could be provided by clinically testing clients under the care of a traditional healer before administration of any treatment. If the clients are clinically found to have an STD prior to treatment, and they are shown to be free of their STD after treatment, and it can be shown that they received no biomedical treatment from any source while under a traditional healer's care, the next research phase should be pharmacological analysis of indigenous medicines used in STD treatment. Such a study might violate codes of medical ethics if the STD sufferer were thought of as being denied treatment of known efficacy. However if the patient prefers to use traditional medicine instead of an antibiotic anyway, the study ought to be ethical--especially if the patient were eventually treated with an antibiotic in case the indigenous treatment failed.

Regarding the second question, a WHO Expert Committee Meeting recently in Botswana concluded that it is appropriate for traditional healers to treat some of the opportunistic infections of AIDS, suggesting that the Committee sees potential in their medicines (Staugaard 1991). Indeed there are some tantalizing, preliminary findings from a small study in Pangani District, Tanga region, Tanzania, an area reputed to have powerful traditional practitioners and medicines (Mbura, Mgaya, and Heggenhougen 1985). Here, an experimental group was treated with a combination of herbs administered by a traditional healer and "modern drugs." The latter consisted of antibiotics, antifungals and other commonly available medicines, but not AZT or other expensive anti-virals. A control group was treated only with modern drugs. Of the 21 in the experimental group, 4 died within nine months and 17 "improved." Among the 27 in the control group, 14 died within nine months. "Improvement" in the experimental group meant living longer, gaining weight, and scoring better in three clinical tests: hemoglobin, erythrolyte sedimentation rate, and white blood cell counts (although the last tests were not done with all patients.) The authors conclude, "Preliminary results indicate that taking the herbal regimen has a positive effect on people suffering from HIV disease" (Ulrich, Waziri, Nesje, and Scheinman 1991:8. Cf. also Scheinman *et al* 1992; Scheinman, Nesje, Ulrich, and Malangalia 1992; Mshana and Scheinman 1991). The herbal medicines are currently being tested in Norway with AIDS patients, and in vitro at the National Cancer Institute in the United States, both with promising results (Scheinman 1993.) It should be noted that these herbs (Steganotaenia araliacea, Harrisonia abyssinica Oliv., Aspilia mossambicensis, Steganotaenia araliacea, Acalypha fruticosa) came to the attention of scientists as a result of a collaborative workshop during which an elderly healer--who possessed little or no formal knowledge about AIDS--nevertheless recognized some of the opportunistic infections of the disease and offered to treat some AIDS patients provided by the European doctor who had initiated the workshop.

If the answer to either or both of our ethnopharmacological research questions is yes, then clearly the nature of collaborative programs in AIDS/STDs is different than if they were no. Instead of simply promoting Western-style contraceptives and looking for ways to reach healers' clients with antibiotics, we would also want to reinforce the use of certain indigenous medicines--even in the absence of millions of dollars of pharmacological research for each medicinal plant--in the context in which they are currently being used.

The GEMT is currently investigating question (1). Such a study was also approved in principle by the Morehouse/Tulane AIDS Prevention Project in Zambia, but it has not yet been implemented.

**POLICY ISSUE #14:
IS THERE A ROLE FOR CHIEFS IN COLLABORATIVE
TRADITIONAL HEALER PROGRAMS?**

When I first began to work in Mozambique in 1990, there was a great deal of official denial that there were anything resembling traditional chiefs in the country. This "cadre" was overthrown at independence, the story went, because many chiefs cooperated with the colonial authorities. In fact the official abolishment of traditional political authorities (TPAs) was part of a radical program to transform the country's economy and society as quickly as possible. Its motives were good but its anthropological sophistication--its recognition of the power and tenacity of culture--was poor.¹⁷ The "traditionalism" of the various ethnolinguistic groups seemed to stand in the way of "scientific socialism," and so there was an attempt to abolish traditional practices such as bride-price (lobolo), polygamy, initiation rites, land tenure, and indigenous healing practices and practitioners, as well as TPAs. The rural masses were obliged to re-group into communal villages in order to engage in new forms of collective agriculture. These and similar edicts from the capital city were not popular with the rural masses in whose name the proclamations were made.

With the end of Frelimo-Renamo hostilities in Mozambique in late 1992, government and NGO programs began to reach with rural populations for the first time. It soon became clear that the authority of TPAs was never really challenged for most of the country. In areas beyond Frelimo control--most of the country--TPAs probably grew stronger since there was no central, national government. In the areas close to cities and towns which were under Frelimo control, TPAs often operated informally or underground. Soon the government as well as NGOs and donors were anxious to learn about the current influence and prestige of ex-regulos, ndunas, fumos, cabos de terra, mwenes (moenyés) and the like.

In 1992 USAID and other donors developed a Democratic Initiatives Project, one component of which was for the Ministry of State Affairs to work with TPAs in the massive-scale rural reconstruction effort that followed signing of the Peace Accord. This effort involved infrastructural rehabilitation; emergency food-aid distribution; resettlement of 5 million refugees, dislocated people, and demobilized soldiers; reconciliation of opposing combatants at the local level; reunification of separated family members and villagers; and allocation of land and the peaceful resolution of land disputes. TPAs seemed to have the best chance of encouraging, organizing and directing such an effort at the local level.

TPAs and healers typically work in coordination with one another in Africa. Sometimes the roles

¹⁷ It is an irony of Mozambique's history that the founding father of Frelimo, Eduardo Mondlane, was a U.S.-trained sociologist who used to teach anthropology. He was assassinated early in the independence movement.

can be combined, as among the Yoruba of Nigeria. In South Africa, we note that NETTHA formally states its objective of promote "good understanding" between healers, chiefs and headmen of the area. It has been my experience that government interventions involving traditional healers--or involving rural Africans in general--can be assisted if not cooperation of TPAs at the local level. For example as part of a traditional healer program in family planning in Nigeria, "awareness seminars" were held for local chiefs, district and clan heads, and other traditional political authorities. This effort was undertaken to preempt possible opposition from traditional authorities and to try to gain some measure of their support. TPAs were also enlisted to preside at workshop opening or closing ceremonies, where they gave speeches and handed out training certificates to healers. Over 500 such leaders attended awareness seminars and/or participated in workshop opening or closing ceremonies in the first year of the healer program (Green 1994:174). These modest efforts to involve TPAs almost certainly helped sanction program efforts, facilitate the recruitment of healers (and avoid major squabbles over who was left out), and ensure implementation of the program without major problems.

There was initial discussion in Mozambique on selecting healers as workshop participants through consultation with local traditional chiefs. Yet this was a time (just prior to the 1992 cease-fire) when there was still much denial that TPAs existed. Nevertheless the arguments in favor of including TPAs were that this would:

- (1) Help repair relations between government and chiefs, which by the early 1990's had become severely strained. Asking for the chiefs' help would show respect for their continuing influence in rural areas;
- (2) help provide traditional sanction for efforts to develop traditional healers in ways that assist government health programs. Many healers themselves were and are suspicious about government motives, and the involvement of traditional chiefs in selection would help demonstrate FRELIMO's current policy of reconciliation and pluralism.

It conforms to current government policy to use all locally-influential human resources including traditional leaders as agents in health campaigns. The GEMT should therefore investigate the value of designing "awareness seminars" for traditional leaders in order to support proposed efforts to train traditional healers, and for community-based health efforts in general. The GEMT would need a mandate from the government before proceeding with such a plan.

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1. The number of U.S. and multinational companies had grown to at least 20 by 1993 (WRI 1993:8-13).