TANZANIA MEDICAL JOURNAL SPECIAL ISSUE

Proceedings of the International Conference on Traditional Medicine Held in Arusha 6th— 8th October, 1986

Published by the Tanzania Medical Journal.

The Official Mouth Organ of Medical Association of Tanzania.

ACKNOWLEDGMENTS

We are indebted to the International Development Research Centre of Canada (IDRC) for supporting the research on which the conference was based, sponsoring the conference and eventual publication of the proceedings. Special thanks should go to the Director General of Muhimbili Medical Centre for allowing us to use the Centre's Services and Ministry of Health in Tanzania for encouragement and allowing the research to take place. We also thank Mr. E.M. Mshiu, Dr. I.A.J. Semali, Mr. D. Do Amsi and Dr. E.P. Muhondwa for their organisational and editorial services. Last but not least we are idebted to Mrs. Mugashi for her secretarial services.

Charles S. Mgone M.D.
Editor
December, 1987

TABLE OF CONTENTS

INTERNATIONAL CONFERENCE ON TRADITIONAL MEDICINE WELCOME ADDRESS

BY MSHIU, E.N.
DIRECTOR OF TRADITIONAL MEDICINE RESEARCH UNIT
MUHIMBILI MEDICAL CENTRE
6TH OCTOBER, 1986

The Honourable Dr. Aaron Chiduo, Minister for Health and Social Welfare, Distinguished Party and Government officials, our Honourable Guests and Participants, Ladies and Gentlemen.

It is a great honour and a special priviledge for me to welcome you, Sir, as our Guest of Hounour to this First International Conference on Traditional Medicine in Tanzania which I will presently request you to open officially. I am sure all participants to this conference will join me in expressing special appreciation to you for having spared the time in your extremely busy and demanding schedule to grace this occasion with your presence.

Hounourable Minister, the role of traditional medicine in the achievement of health for all by the year 2000 is currently a topic of discussion in a number of local and international forums. It is the feeling of many, that traditional medicine could be an alternative source of health care as more than 100 countries signed the Alma-Ata declaration which suggests that traditional medicine be incorporated in the delivery of primary health care, a suggestion which should now be considered seriously in Tanzania.

In some countries like China and India, traditional medicine has been institutionalized and there are formal training centres and libraries. Such institutionalization puts them in a better position to intergrate traditional medicine in the delivery of primary health care.

In Tanzania and other parts of Africa there are some limited forms of institutionalizations. These include ritual dancing groups, religious therapy groups and dian therapy groups. However these are self selective small groups, addressing themselves to particular small localities and are thus usually not uniform for the whole country.

In Tanzania, some researchers have observed the need of involving traditional healers in the delivery of health care. This need arises from the limitation of inputs required for provision of health facilities to every village in Tanzania. Thus traditional medicine is an alternative source for health care to many rural dwellers. It has for instance been observed that about 75% of all deliveries are conducted by traditional birth attendants.

It is thus obvious that traditional birth attendants (TBAs) cannot and should not be ignored. For instance in Senegal and Sudan it has been observed that training or incorporating of traditional birth attendants into the official health care system has improved the coverage and acceptance of health care services.

A survey done on some health professionals in Tanzania indicated that many of those interviewed appreciated the competence of traditional healers in some of their practices. Some indicated that these traditional healers were a potential source of health care manpower and means of educating them on some aspects of modern medicine be considered. One may argue that in the above mentioned survey the responding health workers may have not necessarily been representative of the health workers population in Tanzania, but positive developments in other countries like Sudan, Nigeria and Ghana should counter this. In these countries collaboration at small scale level has proved very fruitful. Further researches should also be done to study the attitudes of traditional healers towards modern health care, utilization of traditional medicine and attitudes of the community towards traditional medicine in Tanzania.

In Dar es Salaam, it is estimated that about 8,000 people consulted traditional healers daily for various health problems, in 1974. This implies that the presence of modern health facilities may not necessarily affect the utilization of traditional medicine. We have no doubt that the same trend may be observed in the rural sector of Tanzania.

It is because of the foregoing reasons, Traditional Medicine Research Unit in collaboration with departments of Behavioural Science, and Biostatistics and Epidemiology prepared and submitted a proposal to International Development Research Centre, Canada (D.R.C.) to fund a project which would enable us to determine the attitude and knowledge of traditional healers and birth attendants on modern health care and to determine the utilization pattern of traditional medicine by the rural population of Tanzania. This information is important in the planning of health care delivery if the goal of health for all by the year 2000 is to be met. This information would also be helpful in the intergration and institutionalization of traditional medicine in the country. Following IDRC, release of funds to the project, the collaborating institutions decided to carry the study in two regions of Tanzania Mainland namely, Iringa and Arusha regions.

In Arusha region, Hanang and Babati districts were surveyed. Fifty villages in 4 divisions were involved and 1999 people interviewed. These included 169 traditional healers and 105 traditional birth attendants. In Iringa Region, 56 villages in 9 divisions were involved and 2,617 people including 159 traditional healers and 208 traditional birth attendants interviewed. The study was carried out between March, 1985 and February, 1986 at an estimated cost of Canadian dollars 121,260 which was equivalent to Tanzania shillings 1,091,340, at that time. For this we are grateful indeed to IDRC.

Honourable Minister, before I request you to open this conference, I would like to inform you that the participants to the conference are from Canada, United Kingdom, Kenya, Italy, Zimbabwe, Uganda, Swaziland and Tanzania.

I now have the honour to call upon you, Sir, to address participants and declare the conference open.

E. N. Mshiu,
Director, Traditional Medicine Research Unit,
Muhimbili Medical Centre, P.O. Box 65000, Dar es Salaam.

OPENING ADDRESS BY THE MINISTER FOR HEALTH AND SOCIAL WELFARE HON. DR. A. D. CHIDUO (MP) TO TRADITIONAL MEDICINE SEMINAR OCTOBER 6, 1986

Mr. Chairman,
Distinguished Guests,
Ladies and Gentlemen.

May I start by expressing my sincere gratitude for the honour bestowed on me to officially open this seminar, on this wide ranging and interesting subject of Traditional Medicine.

Evidently, in recent years there has grown tremendous interest in this subject, despite enormous and almost unparalled advances in orthodox medicine. The main reason behind this overwhelming interest in traditional medicine is the failure of modern medicine to come up with sufficient answers to all health problems especially in Third World countries and the fact that traditional medicine is the only source of care for many people in the Third World. It is estimated that approximately 50% of the population receive health care from traditional sources.

Your presence in this seminar, of people of high academic and professional standing, is a vivid example of the general interest shown in traditional medicine.

Traditional medicine has been practiced for as long as we can care to remember. Through trial and error, human beings have discovered ways of relieving pain and sickness and living in harmony with nature. Many societies regard health as a state of equilibrium both internal and external to the human body. Health has been defined as a state of harmony between man and his internal and external environment; biological, physical, social, economic and cultural. Life is defined as the union of the body, senses, mind and soul. Positive health is therefore the right mix of physical, mental, social and spiritual welfare. Moral and spiritual aspects are important because they give an extremely important dimension in the resultant health sum total of all knowledge and practices (whether they can be explained or not) used in the prevention, diagnosis and elimination of physical, mental or social imbalances and relying exclusively on practical experience handed down from generation to generation whether orally or in writing.

One of the most striking features of traditional medicine is that it touches on so many other domains other than medicine proper. It takes a holistic approach; and thus fosters a broader view of the sickman as an individual with physical, social, psychological, moral and spiritual aberration or disturbance. The main problem of some of the procedures and practices in traditional medicine is that, they do not lend themselves easily to logical or scientific scrutiny. For some practices for instance acupuncture, it is hard to grasp the fact that a needle prick at some point will improve the functioning of a certain organ. To the orthodox practictioner, the argument is that it cannot happen. The main flaw in this argument is that it is immediately disproved by reality, for things do happen that cannot be easily explained.

For most common ailments herbs are usually used. The plant kingdom is a big storehouse for medicine. Many traditional healers use plant derived concoctions or a mixture of plant derived substances with animal or mineral derived articles. Because of the widespread use of plants and their local availability particularly in developing countries it is of cardinal importance that they should be scientifically assessed to exclude those that might be toxic. The therapeutic properties of several medicinal plants and popular traditional, medical practices should be investigated and validated. The scientific validation of any therapeutic result claimed in traditional medicine requires a carefully structured research design. In order to substantiate the claims of cures made by healers accurate scientific diagnosis should first be established and as many details as possible acquired from the traditional healers regarding the mode of preparation of the decoction or medicament, the specific design regimen however crude, the part or parts of plants used and any additional details pertaining to treatment. Medicinal plants of proven value cannot only meet important health needs and reduce national drugs importation bills, they can also under suitable climatic conditions be cultivated and exported so as to bring substantial foreign exchange earnings.

One area of controversy in traditional medicine is the role of the spirit healers. The attitudes towards them among orthodox medical practitioners has never been favourable. In many cultures mental or physical illness represents a disturbance of the relationship between the individual, his ancestral spirits and society. Under the circumstances human beings in their normal life activities sometimes offend their ancestral spirits unknowingly. The consequence of offending one's ancestral spirits is illness. Healing of such an illness is based on the stablishment and maintenance of satisfactory relationship between individuals, their ancestors and the spirit world. It is the spirit healer who comes into play to effect the wanted relationship and determine which laws have been transgressed. The spirit healer hands out amulets against the 'evil-eye' or prescribes induction of trances and magic dances and other rituals. The healer is at one and the same time a religious leader in touch with the ancestors and the spirit world and doctor who concerns himself whith the sick and disabled. Modern trained doctors may regard magic-eye ceremonies as charlatancy but a closer scrutiny may reveal that this may be a means of preparing the patient for real medical treatment. Short term effects are almost always striking. Acute psychoses are calmed, family disputes resolved and hysterical phenomena disappear.

Traditional Birth Attendants (Midwives) constitute a special category in the whole structure of traditional medicine. They form the main body of primary health care workers in maternal care and child delivery. With the training of a substantial number of professional midwives and scientific advances made in obstetrics, one would have simply wished traditional birth attendants away. However, we know, and it is an established fact that in most developing countries, many deliveries occur not in hospitals but in homes, and it is the traditional, midwives who deliver the babies. It is estimated that approximately 60% of the deliveries in this country are done by traditional midwives. Traditional Birth Attendants exist and they are here to stay. It is therefore, pertinent that efforts should be made to integrate them into the general system for delivery of health care. They have a very useful role to play. The psychological and physical support they give to expectant mothers throughout the maternity period and the prompt response they give to any call for assistance should be reinforced and help should

Dr. A. D. Chiduo (M.P.)
Minister of Health and Social Welfare,
Ministry of Health, P.O. Box 9083, Dar es Salaam.

be given to them to ensure that harmful practices are tactifully avoided.

Since traditional medicine is still widely practiced to good effect, should it not be officially recognised, encouraged improved upon, and integrated into contemporary nantional health care system? The definite answer to this question is yes. Traditional medical practices are part of our heritage. Tradition is the sum of attitudes, opinions, beliefs, habits and customs handed down from generation to generation in a given society. As such traditional medicine cannot be ignored. What is called for urgently is research into ways and means of incorporating useful traditional practices into the national health care system. We also need to intergrate traditional healers into health service. The idea of mobilizing the manpower component of traditional medicine for purpose of primary health care, particularly in rural areas has been gaining ground in many countries. However, we should not only consider the manpower component of traditional medicine. We should look at "Traditional medicine and its role in the development of health services in Africa." This calls for the promotion of traditional medicine and indigenous systems of medicine. To do this we have to foster a realistic approach to traditional medicine in order to improve health care. We have to evaluate traditional medicine in the light of modern science so as to maximize useful and effective practices and discourage harmful ones and we have to promote the integration of proven valuable knowledge and skills in traditional and modern orthodox medicine. Traditional medicine practices vary widely in different countries in keeping with their social and cultural traditions. What is needed is to promote such traditional medical practices in a self-reliant way. We have to identify ways and means in which traditional practitioners and traditional birth attendants can be trained and mobilized to play their proper role in the general health system without destroying their individuality.

On the other hand I know that there is a lot of lip-service when it comes to real action. We keep talking of our pious intention of integrating traditional medicine into modern medicine; of training and mobilizing traditional healers and Traditional Birth Attendants. But are we serious? There is the interest but it is not matched by funds for action programmes. In this country there has scarcely been any substantial budgetary provision for the promotion of traditional medicine as a system of health care in its own right. This I am sure is the position in the other countries in our region.

If indeginous practitioners are to be integrated into the countries' health services, much more need to be known about their numbers, where they are, how they practice and whom they serve. We need to establish a rapport with traditional practitioners. We must break down the barrier of communication between the traditional practitioner and the modern trained orthodox health workers. But this will require political will and the need to allocate more funds to support traditional medicine.

We have an institution in this country for carrying out research in ethnopharmacology and traditional systems of medical practice. The success of research in traditional medicine depends on how we first acquire knowledge from the traditiaonal healer himself; try out his methods clinically and subject them to scientific analysis. The aim should not be only to find cures where western medicine has failed but also to find substitutes for imported drugs and practices acceptable to the community. Research should also seek to identify potent herbal drugs for such purposes as fertility regulation and treatment of chronic non-communicable diseases especially cardiovascular diseases, diabetes, mental diseases test and the best and safe ways of using them.

In conclusion, the contribution of traditional medicine for the new universally accepted goal of health for all is potentially great. Ministries of Health, however, require guidance as well as firm political decision and direction to commit them to pursue the objective of incorporating traditional medicine into the general health system. In this national governments can cooperate by way of exchanging experience and information. Where there is the will there is a way. Seminars like this will go a long way to stimulate action. It is action that we want not words.

With these few remarks, I wish you a successful and constructive seminar. May I now take this opportunity to officially declare your seminar open.

INTERNATIONAL CONFERENCE OF TRADITIONAL MEDICINE

ROLE OF TRADITIONAL MEDICINE IN HEALTH CARE DELIVERY SYSTEMS

by
Olayiwola Akerele, M.D.
Traditional Medicine Programme
World Health Organization
Geneva

First, I wish to thank my old friend Mr. Mshiu, Director, Traditional Medicine Research Unit and the other organizers of this International Conference on Traditional Medicine, for the opportunity to speak to you today.

I thought it would be useful to utilize this occasion to cover some aspects of WHO's work in the field of traditional medicine.

The very international nature of this conference is a testimony to the success of the traditional medicine movement and a worthy measure of the work of the Traditional Medicine Research Unit of the Muhimbili Medical Centre, Dar es Salaam.

This presentation has been adapted from the texts of two addresses delivered to the "Fourth Scientific Seminar", Aligarh, India, February 1985 and to the "World Symposium on Traditional Medicine, 1985", an International Conference on World Medicine, Up-date Traditional and Indigenous Systems of Medicine, March 1985, New York, USA. And an article entitled "Best of Both Worlds: bringing traditional medicine to date" (In Press) to appear in a forthcoming issue of Social Sciences and Medicine.

Ladies and Gentlemen, I used to be a confortable WHO Doctor.

Now I am an apprentice WHICH DOCTOR.

Why am I an apprentice WHICH DOCTOR?

Partly bad luck and partly because of my previous involvements in other WHO programmes.

To those of you who think I can't spell, I went to a night school and therefore I can't spell during the day. However, my adopted spelling has the advantage of separating my apprenticeship from those practices that are based on supernatural and spiritual considerations.

Role of Traditional Medicine in Health Care Delivery Systems.

What do we consider as traditional medicine?

One definition that we like to use considers traditional medicine as comprising those practices based on beliefs that were in existence, often for hundreds of years, before the development and spread of modern scientific medicine and which are still in use today. They vary widely in different countries in keeping with their social and cultural heritage and traditions.

While no definition could be entirely satisfactory, the above has the advantage of simplicity while at the same time it excludes practices of more recent origin, thereby keeping the area of study discrete.

If there is to be any real improvement in the health of the underserved populations of the world, there will have to be a full utilization of all available resources, human and material. This is fundamental to the primary health care approach — the strategy adopted by WHO Member States for attaining the collective goal of Health for All by the Year 2000.

However, traditional medicine has been separated from the mainstream of modern medicine. A basic approach, therefore, has been to promote the bringing of modern scientific medicine with the proven, useful traditional practices within the framework of the local health system, where possible, as called for by the different resolutions of the governing bodies of WHO.

World Health Organization's Role

The last decade has seen a resurgence of interest in the study and use of traditional systems of medicine in different cultural settings. Most of the work in this domain have been done outside the aegis of WHO. While these efforts are acknowledged and encouraged, one might justifiably ask — what is the role of an international organization such as WHO has a constitutional responsibility for international health work.[1] Therefore, it should encourage countries to re-examine their traditional systems of medicine with a view to the utilization of safe and positive elements in national care delivery systems.

One of the early objectives of WHO's traditional medicine programme was to foster a realistic approach to the subject. The realism with which countries around the world, both developed and developing, are examining their own traditional practices suggests that good progress is being made towards this goal.

WHO is not a boyscout organization. It is not a charitable institution either, it is an inter-governmental organization. The countries themselves constitute the governing bodies of WHO — they decide collectively how the organization should proceed and what should be the policies that would best create a general awareness of the fact that there are useful elements of traditional medicine that could be incorporated into national health systems.

Key Features of WHO Resolutions

Being an intergovernmental organization most things begin with resolutions. Now let us examine some key resolutions in support of traditional medicine programme.

It all began in 1976 with resolution WHA 29.72 which draw attention to the manpower reserve constituted by practitioners of traditional medicine. The majority of the world's population depend on traditional medicine for their primary health care needs and therefore this resolution makes good sense. In 1977, WHA 30.49 urged Member States to utilize their traditional systems of medicine. Again, this is economically sound because traditional medicine is the people's medicine and is always readily available to them at a price that they could afford. However, recent developments if not controlled could negate this statement. In 1978, resolution WHA 31.33 highlighted the importance of medicinal plants in the health care systems of many developing countries. In addition, there are also resolutions of the Executive Board and Regional Committees of WHO, all of which called for the intensification of efforts in the development of national traditional medicine programme.

In 1978, the Alma Ata Declaration[2], that milestone in public health history, recommended to give high priority to the utilization of traditional medicine practitioners and birth attendants. It also recommended incorporating proved traditional remedies into national drug policies and regulations and called for further research, as new problems are constantly emerging. This was the first time that an international body made special mention of the potentiality of the use in the health services of traditional remedies, especially natural products derived from medicinal plants, through formulation of policies and regulations.

In spite of the universal call for traditiaonal medicine to play an important role in the development of primary health care, there are still many countries where only lip service is being paid to this principle. Other countris have initiated programmes that have had to be abandoned because they were introduced without the necessary preparatory policy formulation and implementation steps.

- Where, then, do we stand today?
- What are the main thrusts of WHO Programme in traditional medicine?
- What progress has been achieved and what are the prospects for the future?

The field is vast. The traditional medicine programme, which started some eleven years ago, has therefore focussed on three important aspects, namely:

- Evaluation
- Traditional medicine as part of national health care system
- Training

This morning, I would like to share with you some thoughts on the development and implementation of the WHO programme.

Evaluation

Evaluation is the most difficult and yet the most needed field of endevour. If a generalization may be permitted, one might say that traditional medicine has the support of the population and the opposition of the health professions.

The most important task for WHO, therefore, is to continue to promote informed opinion on the subject so that traditional medicine is neither blindly endorsed nor rejected by health authorities but is examined carefully and with an open mind.

Countries where traditional medicine is widely practiced are therefore being encouraged to re-examine their traditional medicine practices and systems by undertaking multi-disciplinary studies into the safety and efficacy of traditional remedies. Some people have drawn an erroneous analogy between multi-disciplinary research and the proverbial three blind men exposed to an elephant for the first time. It is

wrong to describe an elephant as a rope when all you can feel is a piece of its tail. Only by working together can the whole image emerge.

Such an examination, of course, is much easier in systems of medicine for which the philosophy and educational content are well documented than in the case of traditional remedies handed down from generation to generation by word of mouth.

However, in spite of the difficulties encountered, the examination of all these systems shows that they hold great promise of a rich harvest that can benefit mankind, especially in the field of ethno-pharmacology.

Medicinal plants constitute a most important element in traditional medicine. In most developing countries the flora remains virtually unexplored from the point of view of practical utilization, yet past experience shows that many valuable drugs have been derived from plants. Information that a plant is utilized in traditional medicine is often an indication that it is worth scientific study[3].

WHO will continue to play a role in sketching the main lines of action needed for the indentification and introduction of traditional medicinal plant remedies into national primary health care programmes. Further success will, of course, depend heavily on the resources channeled to these endavour by Member States. However, there is virtually no interest in exploring plants as sources of new drugs by pharmaceutical in developed countries. One wonders why?[4].

Since only a fraction of the world's plant has been studied, just think of the major changes in the practice of medicine that was brought about by examples of the discovery of only *three drugs* drom plants. Consider the impact of curare of the act of surgery. The importance of penicillin on morbidity and mortality of communicable disease. And the effect of reserpine on high blood pressure. These three drugs *alone* have dramatically altered our life expectancy and indeed the quality of life on earth[5].

Briefly, the aim of the evaluation component of WHO programme is to put traditional medicine on a scientific basis by:

(1) Critical examination of traditional Materia Medica and practices;
(2) Accurate identification of the plants and other natural products used;
(3) Identification of useful remedies and practices and suppression of those that are patently ineffective or unsafe; and
(4) Promotion of further research and exchange of information.

Fundamental approach has been to strengthen national efforts for traditional medicine research within an overall national research strategy. Through the study and research of traditional medicine, a more accurate and complete knowledge of useful and effective traditional practices, as well as potentially harmful ones, is being developed.

National research capacities are strengthened through research manpower development and institutional strengthening. In those countries where little has been done, intial efforts are being concentrated on making an inventory of traditiaonal practices.

Encouragement and suport are being given to local studies on traditional medicinal plants as means of reducing drug budgets and promoting self-reliance. Countries will continue to be supported in their efforts to prepare an inventory of effective traditional practices and techniques that could be utilized in national health services, especially at the primary health care level.

Other national research centres are being identified as reference centres with the view to develop collaborative activities, linking institutions with each other, as part of inter-country and inter-regional networks on the basis of culture and subject specificity.

Integration into National Health Care system

All of this is not a short-term undertaking but one that will take many years. In the meantime, we move towards the integration of traditional medicine into national health care systems, incorporating only those aspects which have been shown to be beneficial and desirable.

The first step is the formulation and implementation of relevant policies and legislation on the utilization of proven traditional medicine in national health system.

The next is to promote the incorporation of traditional medicine into general health systems through operational research, utilization of traditional medicine practitioners willing to collaborate, etc.

Where traditional medicine is well established and seen as a valuable asset for health promotion, traditional practitioners should be involved in the process which strengthens links between traditional medicine and the general health delivery system. They should help in the identification of the problems associated with the establishment of linkages at the local level. They should be involved in the planning, implementation and evaluation of community health activities so as to enhance working relationship between themselves and other members of the health team.

First and foremost, of course, the apractitioners should be involved in the evaluation of their own practices, so as to facilitate the ready acceptance by their peers of suggestions for change, including the assumption of new responsibilities in, for example, the field of health education

What this implies for WHO is:

1. Support for the elaboration and implementation of appropriate national policies and a legal framework for the practices of traditional medicine;
2. Development of a practical coordinating mechanism between health institutions, related social sectors and community agencies, including operational research into the utilization of traditional medicine practices and practitioners in health services.

A key role for WHO is therefore to disseminate widely the results of national efforts to incorporate safe and useful traditional medicine practices in their respective national health systems. Specifically, information on national policies, legislation, traditional medicine practices, research experiences and training programmes continue to be shared through various avenues including an International Traditional Medicine Newsletter published by the Collaborating Centre in Chicago, three times a year, and distributed free of charge to researchers from developing countries.

Technical cooperation among countries sharing common interests is being promoted to encourage a more rapid and effective development of the programme within countries, in areas such as provision of information on assessment of standards, toxicity/safety, stability, pharmacology and other aspects of traditional medicine remedies. An example is the Inter-Regional Seminar in China[6] that gave those responsible for health policy at the national level an opportunity of studying the utilization of traditional Chinese

medicine in primary health care and of discussing and examining the possibilities of adopting comparable approaches in the provision of health services in their own countries.

Training

The promotion of suitable policies is thus an essential first step. Once policy is established, the next step is to develop knowledge and skills and to favourably influence the attitude of both traditional practitioners and scientific health wokers.

On the one hand, specific training programmes need to be elaborated for traditional medicine practitioners. On the other hand, elements of traditional medicine need to be introduced into the already established curricula of training programmes for other health workers.

These actions should promote greater acceptance of the unsefulness of traditional medicine and lead to a wider adoption of local practices. They should also facilitate the transfer of information on foreign traditional medicine practices from other parts of the world.

All health staff, but particularly medical and nursing students, need to be made aware of the place of traditional medicine in their culture, its strengths and its weaknesses, and of the use that may be made of it.

As an example of a training activity, an Inter-Regional Workshop on the Selection and Use of Traditional Remedies in National Primary Health Care Programme was organized by DANIDA and WHO and was held in Thailand in 1985[7]. The Workshop was the first of a series intended to address some of the problems of safety and efficacy of traditional remedies used in primary health care, including related issues of standards, stability and dosage formulation. The participants comprised three from Indonesia, three from Malaysia, three from Nepal, two from the Philippines, six participants and twenty observers from Thailand. All participants are directly involved in the planning and conducting of clinical and laboratory studies of traditional remedies. In addition, there were lecturers and resource persons from the Department of Medical Sciences of the Thai Ministry of Public Health, and the collaboration of faculty members from the University of Illinois at Chicago, USA, Chulkalongkorn and Mahidol Universities, Bangkok, and the World Health Organization.
Similarly, traditional practitioners need to be approached with understanding and recognition of their skills so as to encourage them to share their knowledge and to play a part in the national health service, usually after a short period of special training.

The programme is collaborating with countries in identifying ways in which tradtional practitioners can be trained in order to ensure safety of their practices and, where possible, to mobilized them to play an effective role in the general health system without destroying their individuality. WHO will continue to collaborate with countries in upgrading the skills and knowledge of traditional practitioners.

Studies are being undertaken in a number of countries to identify those elements of traditional medicine practices that could be utilized by other health workers as well as the type of training that traditional practitioners should receive in certain aspects of modern medicine.

WHO Collaborating Centres

In getting this important programme started, WHO has felt that the first essential step was to secure the interest and involvement of those already working in traditional medicine around the world and to build up a network of specialized institutions and individuals possessing the required expertise, motivation and enthusiasm to contribute to programme development.

This has been done by establishing a number of Collaborating Centres in the different disciplines that constitute traditional medicine. At present, 21 such Centres have been designated. There are five in Africa, three in the Americas, two in Europe, one in the Eastern Mediterranean, eight in the Western Pacific and two in the South-East Asia.

This type of association between WHO and the scientific community is mutually beneficial, serving to give international recognition to the individual institutions designated and to make available to WHO their expertise, on which the organization can call on behalf of Member States. Such assistance covers a whole range of activities, for example:

(1) Situation analysis of the potential role of traditional practices and practitioners in national primary health care programmes;
(2) Development of policies and legislation for the incorporation of traditional medicine into health system;
(3) Support to multi-disciplinary investigations and surveys of local traditional medicine practices, and the use of plants of medicinal value;
(4) Collection, analysis and dissemination of information from countries and regions on successful activities, projects and programmes on traditional medicine.

The network of Collaborating Centres forms the backbone of the Organazation's programme in traditional medicine.

Guiding Pinciples

In developing the programme certain guiding principles have emerged which may be of help not only for WHO and its Member States but also to international and donor agencies working in this area. These principles are as follows:-

(1) There is no single or simple approach to the problem of how to involve traditional practitioners in national health systems, especially at the primary health care level. Dedicated and sincere action on the part of all concerned will be required to foster a collective effort to generate and implement policies best suited to any given country.
(2) The first step could be the establishment of a national council for traditional medicine, that could be charged with responsibility for preparing a national strategy and laying down a broad plan of action to be followed by government. The council should be multi-disciplinary and multi-sectoral in nature, with appropriate representation of the different types of traditional practitioner involved.
(3) Major policy issues, including as a minimum all those described in the preceding section, need to be identified, priorities determined and mechanisms established to propose the various options and courses of action open to government, with *ad-hoc* groups being formed to tackle specific issues.
(4) Adequate finance should be assured under the government's regular budget for the support and promotion of traditional medicine activities. External finance should be considered as only supplementary to the government's main effort.

(5) In parallel, it will be necessary to undertake a survey of the national situation of the practitioner, the population's preferences and needs, resources, special problems, etc.. Based on this sound national health plan reflecting the role of traditional medicine may be formulated.

Practitioners of traditional medicine should be engaged in these activities and the results should be made widely known to general public as well as to the health professions.

Concusion

There is no longer any doubt about the value of incorporating traditional medicine into modern health care. It is happening — it is part of today's reality. It is happening for manydifferent reasons but, fundamentally, because people believe that traditional practices have values that they are willing to subscribe to.

What is still unclear is how the articulation of the two systems will be brought about in different settings. Will it happen in an atmosphere of goodwill or of hostility? Will it be pursued purposefully or will it be acknowledged reluctantly? Will government and medical practitioners play a leading role or will they be mere spectators?

WHO's primary concern is to encourage countries to utilize those elements of traditional medicine which are of value in their national health services. In this modern age, the rich heritage of traditional medicine should not remain the exclusive or esoteric interest of only a few. Let me end by quoting the Dirctor-General of WHO.

> "For too long, traditional and "modern" medicine have followed their own separate paths in mutual antipathy. But their aims are surely identical: the improvement of human health and, hence, improvemnt of the quality of life."
>
> Halfdan Mahler, M.D.

References

1. World Health Organization, Basic Documents. 34th Edition, Geneva, 1984.
2. World Health Organization, Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Health for all Series No. 1, 1978, Geneva.
3. Akerele O. WHO's Traditional Medicine Programme: progress and perspective. WHO Chron. 1984; 38: 78-81.
4. Farsworth NR, Akerele, O., Bingel AS, et al, Medicinal Plants in Therapy. Bull. WHO 1985; 63: 965-81.
5. Malone MH. The Pharmacological Evaluation of Natural Products — General and Specific Approaches to Screening Ethnopharmaceuticals. Journal of Ethnopharmacology. 1983; 8: 127-47.
6. Report of the Inter-Regional Seminar on the Role of Traditional Medicine in Primary Health Care in Chine, 9-12 October, 1985. WHO Geneva (In Press).
7. The Selection and Use of Traditional Medicine in Primary Health Care, Report of an Inter-Regional Workshop Bangkok, Thailand, 25 November-4 December, 1985 WHO Document TRM/86.1.

TRADITIONAL MEDICINE PRACTICE IN TANZANIA HISTORY AND DEVELOPMENTS

Dr. J. Z. J. Kilewo [1]
I.A.J. Semali[2]., R. Msuya,[3]
E. N. Mshiu,[2] D. M. Do Amsi
C. K. Makwaya,[3] E.P.Y. Muhondwa[4]

HISTORICAL BACKGROUND

The history of traditional medicine in Tanzania goes back far beyond the establishment of Western contacts. In Northern Eastern Tanzania, the local religions and healing traditions of the well watered interior highlands were already interacting with the Afro-Islamic Coast in the period of intense slave and ivory trade which preceded the Colonial intrusion of the 1890s[1].

Before the Colonial conguest, healers and political leaders with whom they were allied had a much wide range of control over the social conditions of health than they have had ever since. In a study carried out by Fierman[2] on a Shambaa Kingdom found in the 18th Century in Tanga Region, and which survived until the German conquest of the 1890s, the Kingdom healers in cooperation with the Chiefs and local elders controlled a wide range of basic health conditions, such as, cleaning and irrigation of ditches and distribution of water. Diviners advised local people to choose villge sites in high location in order to keep them free of insect pest and diseases. Healers together with local elders and minor Chiefs insisted on isolating individuals born under an ill omen, lepers and those infected with contagious diseases, such as small pox. Some specialists such as those who could treat wide spread epidemics and those who could make war charms were required to work only at the Chief's court.

The German conquest in 1980s eliminated all forms of collective control by healers over the conditions of health except for those few weak elements of collective control which could be hidden. Healers in the country were persecuted because an African authority over collective action was taken as a threat to German sovereignity. This was partly prompted by the role of cult leadership in the Great Maji Maji rebelion of 1905, the action of Missionaries and because of cultural emperialism. After the intial period of persecution

[1] Traditional Medicine Research Unit
Muhimbili Medical Centre
P.O. Box 65001
DAR ES SALAAM.

[3]Department of Epidemiology
[2]Department of Epidemiology
Muhimbili Medical Centre
P.O. Box 65001
DAR ES SALAAM.

[1]Department of Biostatistics

[3]Department of Biostatistics
Muhimbili Medical Centre
P.O. Box 65001
DAR ES SALAAM.

[4]Department of Behavioural Sciences
Muhimbili Medical Centre
P.O. Box 65001
DAR ES SALAAM.

the Germans closely regulated medical treatment so as to exclude any practice capable of mobilizing people at a collective level. In 1909 the traditional healers were issued with certificates specifying illness they could treat, prices they could charge and the localities in which they could practice. Even though healers were under severe attack and although they lost much of their authority over communal affairs, the local healing traditions survived through the entire German colonial rule, for most people, local practitioners were the only healers to whom they had access. A staff surgeon in the German Protective force, Weck[3] revealed his respect for African traditional medicine when he wrote on the Wahehe traditional doctors and their science, at a time healers were hardly taken seriously. He stated that the doctors were not practicing magic but they were concerned with healing of the sick. He cited about 50 diseases and their pathological symptoms which he found correct in the majority of cases. It is worth noting that by 1910 there were only 43 German medical officers, mostly army doctors, who were stationed at various administrative centres throughout the country, and 6 private doctors. During the entire German colonial period only 12 general hospitals and 3 special hospitals were built. These had a total number of 1200 beds.

During the British Colonial rule (1919 — 1961) the authority of the pre-colonial healers was never restored, inspite of the fact that minimum funds were available for rural health service development and most of the health services were concentrated in towns and at a few mission centres. Therapeutic practice was divided between low cost treatment provided by healers for relatives and neighbours as opposed to high cost specialized practice for strangers and very distant relations.

In 1920, a series of complaints about witch doctors were noted by the British colonial government, and led to the introduction of the witchcraft ordinance in 1929. In the same year, the medical practitioners and dentist ordinance was passed which carried a provision for the practice of traditional medicine by traditional healers.

Between 1929 and 1937, one of the British Colonial Provincial Commissioner stated that only black art (Uchawi) was criminal and it must be distinguished from "uganga", the diagnosis and treatment of diseases. He was convinced that "black art" had evil intentions while "Uganga" could be described as a "Science" practice by many charlatans and not always with benign intentions.

It is to be noted that during the first to third health development plans of the Ministry of Health (1945 — 1961), there was no mention, of the role of traditional healers in health services, like wise, in the first post independence 5 year's development plan (1964 — 1969), the question of traditional medical practice was left untouched. Even after the 1967 Arusha Declaration when a lot of emphasis was put on the development of appropriate rural health facilities and rural health personnel the contributions of traditional healers and traditional birth attendants were not considered.

Although the role of healers and traditional birth attendants was not taken into account in the Ministry of Health development plans, individual researchers such as Imperato (1961/62) made observations among the Luos of North Mara on witchcraft and traditional medicine, noting that even educated persons could not disregard traditional medicine. Other investigators, such as Bura[4] wrote a paper on the Wairaq concepts of causation diagnosis and treatment of disease. Similarly Hautvast-Marters[5] while working in a Nyakyusa community identified diseases which the Nyakyusa called natural in origin, and listed diseases caused by spirits and those of magico-religious in origin and solved only by a traditional healer.

Although the practice of traditional medicine in Tanzania is legalized, the collaboration of traditional healers and modern medical practitioners has not been legalised. The relationship between the medical institutions including medicine is very different on the central and at the local level[6]. The government is well aware of the problems and benefits of traditional medicine. The policy all along has been one of encouraging concilliation and understanding between traditional doctors and modern medical practitioners, not relations between them, particularly in the rural areas are either none-existant or tense. The reason for the conflict could be that:-

(a) Medical practice introduced by the colonists in the late 19th and 20th century was the only legitimate therapeutic course in Tanzania. The European Missionary doctors in particular were not used to competing with traditional healers for clients they were treating. This attitude has not changed to date.
(b) Doctors regard the healers and their practice as unacceptable, because they have not had any formal training in the medical field and therefore, any Association with healers would be undermining their medical ethics.
(c) Tanzania does not have a separate law govening the practice of traditional medicine. There is also no Party or Government Policy on the collaboration issue. As a result there is fear among allopathic doctors of being prosecuted should a patient whose medical care was undetaken in collaboration with traditional healers die.

Inspite of the above reasons, studies carried out by Semali[7] on the opinion of allopathic health workers on traditional medicine and traditional healers on the degree of contact between the two, some of the modern health workers indicated their acceptance of traditional healers' involvement in delivery of primary health care. In another study which he carried out in 1983 involving interviews with 320 traditional healers in Kinondoni district, in Dar es Salaam Region to find out whether traditional healers would accept collaboration with modern health workers and what should be the nature of such collaboration, 28% said modern medicine was more advanced and therefore traditional healers would benefit and 29% said they were treating the same people and therefore they would be willing to join forces. 25% said that some of the diseases had no cure in modern medicine and therefore they could be cured by traditional meldicine. The rest of those interviewed had their own reservations on the issue of collaboration. The healers felt that they could collaborate on the exchange of patients and have common clinics where both practitioners could practice.

Tanzania has an estimated number of between 3,000 - 60,000 traditional healers.

DEVELOPMENTS AND ACHIEVEMENTS (1969 - 1985)

Although traditional healers in Tanzania continued to exist on their own outside government control since independence, their secrecy made the medical profession feel uneasy. In 1969 the government took new initiativs towards traditional medicine practice aimed at its planned intergration. This was largely due to the following factors:-

(a) There was an awareness of the value of traditional

medicine as noted in various regional meetings throughout African countries assisted by WHO.

(b) There was a realisation of the shortage of resources and manpower essential for the continued expansion of all types of curative and preventive services in all African states.

(c) The practice of traditional medicine was flourishing even in urban centres despite their otherwise rapid changes towards modernization.

The Chief Medical Officer in the Ministry of Health in 1969 directed the Regional Medical Officers in Tanzania mainland to collect information from healers on traditional medicine practices including drugs which were being used. These would be subjected to clinical trials and chemical analysis. The directive was however, not implemented for various reasons.

The University of Dar es Salaam was subsequently asked to carry out research into traditional medicine. The task was given to the Faculty of Medicine. In July 1974 the Traditional Medicine Research Unit was established with the following objectives:-

(a) To carry out collection of comprehensive information about traditional medical practicies including methods of treatment and drugs employed.

(b) To identify the sources of drugs and subject them to chemical analysis or other tests for the purpose of singling out the active ingredients and the analysis of which later might suggest ways in which the isolated materials could be used for the preparation of clinically useful drugs.

(c) To study the traditional practitioners practices and customs and the role they play in the Tanzania Society and work out ways of integrating the useful practices and customs with modern medicine.

(d) Finally to carry out experimented cultivation of medicinal plants which were proved to be effective and safe.

Since the Unit's establishment in 1974 the following work has been done in the implementation of the objectives, namely:-

(a) **Ethnobotanical Studies:**

The Unit has carried out a comprehensive collection of information from over 1,000 traditional healers in 5 regions of Tanzania mainland and on plants and diseases treated by the healers. 2,720 plants specimens have been collected and about 2,000 of those have been identified botanically. Ethnobotanical literature survey has been carried out on 110 popular medicinal plants of Tanzania. A book will be published on this.

Another pre-occupation of the Unit has been expemental cultivation of exotic medicinal and aromatic plants under a Joint Project, financed by the Tanzania Government and UNIDO/UNDP. This aims at producing plant based drugs which could be used instead of drugs which are imported into the country. Trial production of such drugs will be carried out before the end of this year, 1986. Some of the medicinal and aromatic plants under experimental cultivation are:- *Calendula officinaflis, Cynara scolymus, Tagetes fatula, Dracocerphalum moldarica, Thymus vulgaris, Glacium flavum, Saponaria officianalis,* and *Digitals lanata.*

(b) **Phytochemical & Pharmacological Screening:**

Although the Unit was established in 1974, phytochemical screening did not take place until 1979. The section has carried out phytochemical studies on a number of traditionally used plants including some exotic plants which have been under experimental cultivation. The results of the phytochemical screening have been published in some international journals. In addition, the section has carried out determination of total alkaloids in Cinchona barks using kerosine, and alkaloids in *Datura strammonium.* Analysis of oil content in essential oil bearing plants such as, *Eucalyptus globulus, Cinnamomum camphora* and *Elletaria cardamomum* has been undertaken.

Five hundred traditionally used plant samples have been extracted and prepared for different bioassays. 240 plants have been screened for antimicrobial activity and results have been published in international journals. Further screening has been carried out on plants claimed by healers to have antifungal and anti-gonococcal activity, and the results are promising. Other investigations have been carried out on plants claimed by healers to be useful in the treatment of malaria, sickle cell anaemia, bilharzia and trypanosomiasis. This work is still in progress.

Pharmacological studies which started in 1982, were concentrated on isolated tissues and toxicity studies. Two plants namely:- *Harrisonia abyssinica* and *Zahna africana* were studied in detail. *Harrisonal abyssinica* used traditionally for abdominal problems, skin conditions and asthma has been established to possess spasmolytic and antifungal activity. The plant is non-toxic. The plant extracts have been recommended for clinical trials in cases of various spasmogenic conditions, such as, abdominal colics and bronchial asthma.

Zahna africana (Mdaula) used traditionally as an antifungal has been found to be toxic due to the presence of saponins or tannins. Indeed the plant extracts are unsafe for use externally or internally unless detoxicated before use.

Twenty five plants traditionally claimed to be useful for the treatment of mental illness have been screened pharmacologically for anticonvulsant activity against *metrazol* induced convulsion. All of them were found to have no significant activity. However, *Hyptis sauvelonsis,* a herb used traditionally for the control of convulsions was pharmacologically screened and found to have a significant prolongation of barbiturate sleeping time in mice and further studies on isolated tissues have indicated the presence of cholinergic principles. The plant has stimulant effects as well as effects against oxytocin induced contractions on the uterine muscle. The plant has been found to be non toxic on experimental animals.

CONCLUSION:

Traditional medicine is indeed an invaluable resource that can be meaningfully and profitably harnessed in practically all African countries. In Tanzania, we require a well defined policy and appropriate legislation on traditional medicine. Although the significance of traditional medicine is acknowledged there is need for continued systematic research into various aspects of the field, such as, sociological, anthropological, historical, ethnobotanical, pharmacological, toxicological, phytochemical and clinical research.

The Traditional Medicine Research Unit is already carrying out some of this research particularly in the ethnobotanical, phytochemical and pharmacological fields. The Unit hopes to undertake anthropological and clinical research in the near future.

In Tanzania, traditional medicine is part and parcel of our culture which should be preserved and developed for the good of our people.

I am grateful to all the national and International Organizations, such as, World Health Organization for assisting in the development of traditional medicine in this country.

REFERENCES

1. Feierman K. Alternantive medical services inrural Tanzania: A physician's view Soc. Sc. Med. 1981: 15b; 399 - 404.
2. Feierman S. The Shambaa Kingdom: A History. University of Wisconsin Press Medison, Wisconsin 1984.
3. Weck. Hehe Medicine. Tanzania Notes and Records No. 70, 1969.
4. Bura MWT. The Wairaq concepts of causation, diagnosis and treatment of disease. Dar es Salaam Medical Journal 1974; 6: 55 - 61.
5. Hautvart-Martens Analysis of Bantu Medicinal System a Nyakyusa Case Study (Tanzania). Tropical and Geographical Medicine 1972; 24: 406 - 14.
6. Feierman S. Therapy as a system in Action in Northern Eastern Tanzania. Soc. Sc. & Med. 1981; 15b: 353 - 60.
7. Semali IAJ. The opinion of Allopathic health workers on Traditional Medicine Healers and Degree of contact between the two. Thesis submitted to the University of Dar es Salaam for the partial fulfilment of the award of DPH 1982.

TRADITIONAL MEDICINE TO-MORROW

By Murray Last

INTRODUCTION

While much debate has taken place on the role of traditional medicine (indeed it represents a remarkable shift even to think of incorporating healers into a nation's health services), most of the discussion, however, has been about the short-term-treating to-day's policies as a series of stop-gap mesures. I want instead to raise here such longer-term issues as:

What sort of future (if any) is envisaged for traditional medicine — *beyond* the year 2000? What effect, for example, are to-day's policies intended to have on the next generation of traditional healers?

Or is it seriously being assumed that, once the present generation dies out and the entire population have passed through modern schools, the demand for 'traditional medicine' will have disappeared? Will there be nothing in its place but 'scientific medicine' and if so, what is the evidence for such a prediction? What developments, for example, in psychiatric provision are foreseen?

It needs to be recognised that many sectors of society *do* wish to see traditional medicine disapper, and have their own logics to back their argument. Opposition to traditional, medicine is not confined to the hospital or any other elite.

Murray Last, University College London

There *are* things wrong with traditional medicine (as there are with any system), and its future lies in part in putting some of them right. My purpose here is not to propose solutions but to draw attention, for purposes of starting the discussion off, to what is being done elsewhere in Africa, first on two aspects of policy, and then on two areas that seem to be problematic.

But, by way of introduction, a number of points need be made. 1. That "traditional" does not mean "unchanging". Although the history of traditional medical thought in any one community is extremely hard to re-construct (certain institutions or practices are of course better documented e.g. the Lemba 'drum of affliction' chronicled by Janzen, the mere fact that traditional medicine changes is more easily demonstrated. For example, in the colonial period, the years 1918 - 1925, after the first world war, appear to have been a major watershed: the older generation of healers were discredited as they proved ineffective against the new epidemics, and a new generation experimented with and elaborated new therapeutic rituals and recipes. Another persistent theme in oral traditional is how, compared with their predecessors, "to-day's healers are charlatans; they know none of the old secrets". But each generation *has* to find new ways to cure new complaints, since it is not just treatment that changes, but ideas about the ecology of illness too. "Traditional", then, can be as 'modern' as so-called "modern medicine". In recognition of this, "alternative medicine" would be a more accurate (if sometimes less persuasive) label, were it not that such "alternative" imports as chiropractice, osteopathy are already well established in parts of the continent alongside Christian faith healing. In short, one must be wary of taking the label "traditional" too literally, or of assuming that all cultures (or all people) revere "tradition" as the stereotype suggests!

2. Equally obvious is the point that in continent the size of Africa "traditional" includes a wide range of therapeutic practices, some of which conflict sharply in their logic with others. More important, however, is the fact that within any one society's medical culture there is diversity too. One 'school' may be dominant at a particular time, but the rationale for diversity is the same as in agriculture: mixed cropping gives better results than monoculture in the long run, as crises come and go; and even in monoculture, a range of seed types is a necessary reserve against new conditions in the future. In short, the diversity within traditional medicine is as crucial to traditional medicine as its ability to change.[2]

3. As part of the ability to change and diversify, many medical cultures are not highly systematised. Researchers may record a society's "common sense" and analyse it as a model. But such models are like "first aid"; they bear little relation to the complexity of a difficult case as it develops, or how it is treated over time. Far too many variables are deemed relevant for practice to be boiled down to a formula. Nor do individual healers necessarily know their medicine systematically; apparent inconsistencies of thought are problemaltic more for the academic analyst than for the successfull practitioner![3]

Traditional medicine, then, is a living style of treatment, and caplable of development. Given this record of change, diversity and relative freedom from systematisation, it is very probable that traditional medicine *will* survive in some

form. And I would suggest that it needs to survive, if only as part of people's broader resources with which to face crises. The obvious question then is, what is the best form of traditional medicine for patients? The more problematic question, however, is what is the best form, too, for the development of an effective range of alternative therapies for use in a specific community? Using the word "best" raises the problems of medical audits and tests for efficacy — all of which are hard to devise without excluding the very cultural context that helps to make any medical culture successful. Academically, proof may be impossible — in which case how should non-academics decide? But there remains the question of how to encourage (and finance?) the development of local alternative or traditional therapies; mere survival in some form or other may prove inadequate to prevent the improverishment of a traditional and its expertise. Without experiments, experience shrivels.

I. Issues of policy

A. NATIONAL OR LOCAL?

The essential fluidity of traditional medicine makes its organisation by government particularly difficult even more difficult than, say, local administration in areas where cultural differences demand recognition. Given the diversity of healing traditions within any particular state, a "national" traditional medicine necessarily is a coalition of different and possibly conflicting traditions. No state has yet attempted to 'homogenize' those traditions into a single system (it would be very disruptive and probably counter-productive to do so), not leeast because the efficacy of a given treatment lies partly in its specific cultural context. So long as communities have their distinctive cultures, it is possible to use that context to enhance the placebo effect.

Two very different models of organising traditional medicine are being tried, one in Ghana, the other in Zimbabwe. The Zimbabwean model is to emphasise intra-professional co-operation and local autonomy. Thus the Zimbabwe National Healers Association (ZINATHA), under its President Professor Chavunduka and with the backing of the Ministry of Health, has taken over the examining and certification of eventually all recognised healers. It is however still a voluntary body, financially supported only by its membership dues and not an arm of government. The idea is to enable healers develop their own systems of training and research and thus put them on a par with the hospital-based medical profession — under their own equivalent of the General Medical Council.[4] At present, however, ZINATHA is necessarily decentralised, with a small headquarters staff and much of its local control over healers execised by its branches at the local level. Given the importance of healers both historically and more recently during the war of independence, there was good reason politically to try and bring, for national unity's sake, all such locally influential leaders under a single umbrella. Not all the important spirit mediums have yet joined, apparently; the majority of the membership are primarily herbalists, as they had been in earlier healer's associations.

The Ghanaian alternative is new. A fortnight ago in Ghana, the Secretary for Health announced that a law was shortly to be promulgated decentralising the Ministry of Health. "District Health Committes would be expected to formulate and implement health policies within their areas, with Accra only giving general guidelines."[5] Furthermore, "under decentralisation, certain categories of staff could be recruited locally." This is, it seems, the culmination of a number of pilot schemes.[6] Areas elected their own district health committees on which sit a wide range of people involved in health care, including healers. Decentralisation is seen not merely as an exercise in local democracy but also as one way of overcoming the problem of formulating a nation-wide policy on how healers might be incorporated. By leaving the selection and validation of local competent healers to the various districts, the Ministry is relieved of examining and certifying an enormous range of practitioners in some standardised way. It also means that healers may find it harder to get reegistered to practise in another district or at the capital. Clearly much will depend on personalities of the committee members, in particular whether the officials and doctors posted by the Ministry will try and dominate policy; but at least they, like other members, will be accountable to the community. Co-operation from local healers has not been a problem, apparently; pilot schemes, however, with all the extra inputs they attract, may not prove so easily generalisable across the country. Another problem may be overpoliticisation if health issues becomes just another weapon in a local struggle for power.

Whereas the Zimbabwean model seeks to unite the profession across the urban-rural, herbalist-spirit medium divide, the new Ghanaian system will make the greatest use of local diversity, and of both communities' and individuals' willingness to experiment. In consequence, in some areas healers are likely to be central to the health services, in other areas marginal. It is not clear what the government proposes for Accra itself: the policy was designed overtly to meet criticisms from the countryside, and demands for more local autonomy generally. If the Accra conurbation is to be treated differently, there is a danger that traditional medicine will be ghetto-ized, equated simply with rural cultures.

B. URBAN OR RURAL?

What is to be the role of traditional medicine in the cities is government, for example, to build traditional clinics and hospitals (e.g. for bone-settlers, as in northern Nigeria), are premises to be shared by healer and doctor side-by-side (as in a Bulawayo experiment), or hospital beds allocated to healers? Or are the towns adequately served with hospitals, dispensaries, — healers being only relevant where medical manpower is short, as in the rural areas? But first, *which* "traditional medicine" does the government have in mind?

Given the importance of context to successful traditional therapy, it ought not to be surprising that there has been, in recent years, two distinct "traditional medicines" one based in rural areas, the other found in the large cities. The existing literature on traditional medicine does not always make the distinction. But very crudely speaking, rural therapy calls upon rural religious beliefs and as a conse quence has often been analysed not as medicine but as part of religion. 'Traditional medicine', then, in such analyses, is associated with herbalist traditions (and sometimes, rather quaintly, called 'leechcraft'); historically, however, the herbalist tradition was an integral part of rural religion and therapy. In towns, this herb-oriented 'traditional medicine' is usually the dominant stand — its dominance much assisted by colonial legislation, which tended to legalise herbalists

while making diviners liable to prosecution whenever a diagnosis of witchcraft was to be made.

Under colonial rule, herbalists (many of them immigrants from other countries flourished in the towns, trading in *market place* and forming associations, whereas spirit mediums and cults, though to be found in towns, were considered more efficacious if they were located in the countryside. Many of the cults' healing functions in the towns have been taken over by independent zionist churches specialising in healing and prophecy; theirs, they say, is Christian, not traditional medicine. It is in the towns, too, that a range of "alternative" therapies have become available.

Urban medicine, whether traditional or alternative, lacks the legitimacy that rural healers acquire through long, visible service in a small community. Urban healers, if newcomers, rely on certificates, on claims to foreign origin and various forms of self-advertising unnecessary in the countryside. The result is not only extravagant claims but marketing through an appeal to the unconventional and exotic. "Charlatanry" is a problem, and helps to call into disrepute traditional medicine as a whole. Thus the urban press, city gossip and the revelations of the law counts tend to focus on the bizarre goings-on of some practitioners, encouraging a popular stereotype not very different from that of the colonialist 'witchdoctor'. By contrast, established urban healers, well known in their own quarters, function more like their rural counterparts, with the minimum of publicity.

A long established, urban tradition of medicine is practised by Muslims. The identity of Islam with traditional, precolonial values has meant that Muslim healers, unlike their Christian counterparts, come under the rubric of traditional medicine, at least in a country like Nigeria. But the attitude of Muslim institutions towards medicine has always been more secular than has traditional Christianity's (since according to tradition the Prophet Muhammad was less engaged in performing medical miracles than was Jesus Christ), and as a consequence the rural religious elements in traditional medicine were traditionalism's "unacceptable face". In towns, such rural beliefs and practices were deemed inappropriate, improper; they were associated more with harming than with healing, with providing power and protection for the ambitious or vengeful. The new influx of migrants into the towns and the competition of contemporary urban life may have made such practices (if not beliefs) more commonplace, but for many urban-dwellers such therapies are not the respectable form of traditional medicine. Fears of such practices are further accentuated by the very invisibility of life in towns, in contrast to the social transparency of the country life.

Urban traditional medicine, then, has two major problems: 1. "charlatanry", and a lack of 'qualifications'; 2. misuse in the form of sorcery. Rural medicine's problems are different: the rejection, for example, of its religious premisses outside the immediate local context with people gradually losing faith (or fear) in its sanctions; the acceptance, instead, of zionist churches or of reformist interpretations of Islam; finally, the relegation of rural medicine as the preserve of a few specialists to whom the urban healers can refer only the hardest of their cases — in short, the townsmen's notion of the deep countryside, the "bush", as a kind of natural asylum. In this process, urban traditional medicine eventually replaces rural medicine even in the countryside. In which case, rural medicine's problems become the same as the town's: "charlatanry" and misuse.

II. Problematic areas

A. EDUCATION

"Charlatanry" is central to the issue of medical education. Traditionally in rural areas the would-be healer received training either by apprenticeships under recognised healers or through the guiding "spirit" who initially called the healer. In the latter case (as Dr Reynolds has shown) the trainee has been taught his (or her) herbal expertise as a child and will have participated (along with many others) at sessions of therapy; what is unique to him (his "gift") is his personal style which potentiates, for him and his patient, an otherwise standard format of medical treatment locally.[7] The training and subsequent validation of the healer's skill comes through time, as the healer practises under the scrutiny of the community. For the community contains many who know enough to be healers, should they ever receive the "call". There may even be, as Dr. Ngubane has shown, a network of healers meeting regularly to discuss cases and "examine" new healers.[7] Under such conditions "charlatanry" cannot last long.

None of this is new, though how long the system will continue may depend on the stability of rural communities. What is new is the attempt formally to teach trainee healers and have the training officially recognised. Again, this seems to be a consequence of the growth of urban traditional medicine, with its need for qualifications and its opportunities for young people to embark on the sale of medicine. Schools have been started in Zimbabwe: the one organised by ZINATHA has been temporarily closed — it was perhaps too ambitious intellectually and financially; the other has been founded by the Ford Foundation and is herbalist in orientation. The major obstacle in theory is how to systematise the skills and expertise of traditional medicine to fit a school model. In the Zimbabwe case, where plants prescribed for specific ailments may depend not on the plant's pharmacology but on which clan the patient belongs, the teaching appears to be deliberately "un-traditional" in the local context.

A further development is the exposure of hospital medical students to courses on traditional medicine given by local healers. The results are, not surprisingly, reported as being good. What is not clear, however, is what exactly is taught and, more importantly, how far the teaching has been modified to match medical students' (and teachers') expectations. A "package" of traditional medicine is being created and "sold" to medical schools, a package that had not existed before the demand created it, and as such, it is an indirect product of the medical school system.

Such foreign influence is not new, of course. There is, for example, inthe curriculum of old-established schools of herbal medicine such as exist in South Africa considerabfle borrowing from traditions of herbalism developed abroad; and these schools have trained many traditional herbalists in southern Africa. Similarly, textbooks of Indian or British pharmacognosy are widely available in the continent, as are Muslim texts (in Arabic). Given that these texts are available, and nothing comparable has so far been produced from within the African tradition, it is perhaps invevitable that they are in use. Lists of medicinal plants are being published state by state, but their classifications not just of plants but of disease terms (in translation) as well tend to follow international conventions. The dominance of academic medicine is further evident whenever new schools of traditional

medicine are being planned; offers of help are not easily refused, locally respected healers shy away and in the process 'traditional medicine' (as taught) is transformed.

The 'colonisation' (or 'modernisation', as some call it) of traditional medicine has its own logic: therapies are linked up to the legitmacy of internationalism herbalism, its funds and its research. The pattern is widesprad: for years now, for example, the London covens of witches have exported material to Lagos, just as Rosicrucian and other mystical traditions from Europe have their adherents at all levels of society. Nor is the trade confined to Europe. Indian and Chinese techniques and material medical find a ready market. The internationalisation of magic (good and bad) is ancient, and two-way: West African scholars were noted pre-colonially for their learning in the occult sciences and settled in Egypt and elsewhere. And it is through this internationalisation that many changes in traditional medicine have apparently come about.

Training, however, is perhaps less problematic than establishing an examination system with uniform standards. Again, the solution adopted has usually been to leave it to a committee of other local healers who would be responsive to wider opinion in the community. In rural areas that would not pose problems, but in the towns an equialent community opinion is more elusive. The churches solve the problem by creating their own community, institutionally within the church hierarchy, and congragationally through its members. Associations of healers have tried to fill this institutional role, as have cults which involve both healers and healed (like the Lemba 'drum of affliction' described by Janzen).

If licensing solves the problem of protecting the consumer from "charlatans", it also creates the problem of examinations, and from examinations arise such problems as an agreed syllabus, which in turn requires formalising a particular tradition of medical expertise. No government, as far as I know, has tried to confront these problems; at best, they have been left to the profession itself to resolve.

B. LEGAL RESPONSIBILITY

Licensing requires legal powes to make it effective. An alternantive solution to "charlatanry" and misuse of medicine has been through criminal law. While the various witchcraft ordinances and their successor statutes are well known, much less known (and much more difficult to research) is the attitude of the police and local courts towards healers' malpractice. The most gross cases may go to court as manslaughter, but the majority of instances involving negligence, malpractice or simple errors of judgment (as in paediatric dosage) seldom result in litigation — at least, as yet. Consumers' rights and the responsibility of a healer in his capacity as a trader in particular services are, apparently, rarely tested in traditional medicine — sometimes, presumably, out of fear of retaliation from the healer.

Once again, the use of the law to "clear up" traditional medicine is above all an urban problem. In the countryside communities could act against a healer who was thought to have been negligent or had poisoned a patient. This requires a delegation of powers few nation-states easily permit; but few states too can prevent "self-help" by a community intent on ridding itself of a social outcast, whatever the claims of formal justice. In the towns such actions constitute a riot. Yet unless some formal channels, of the kind the legal system normally provides, are available, riots are simply seen as themselves a necessary kind of judicial process.

If the courts are to be the way of obtaining redress against a healer's malpractice, then once again standards of reasonable practice have first to be established. As expert witnesses on matters of health healers' evidence would have to be admissible in court, just as healers' signatures might have to be as valid as doctors' certificates, or adequate for medical insurance documents. The legal recognition of healers' expertise would presumably require some form of licensing of healers generally, and with it appropriate criteria for assessing that expertise. In the multiplicity of traditional practice, that my not be easy, but it is probably inevitable.

IN CONCLUSION

In this brief essay I have tried to focus attention on more general points of policy, and on problems which will require considerably more research to resolve. I have stressed the impotance of traditional medicine in the major cities of Africa as the arena in which I suspect the greatest difficulties will be encountered. My own experience of traditional medicine has been predominantly rural; this essay is therefore for me exploratory, yet presented to colleagues who have undoubtedly considered these kinds of issues before. I look forward to their comments!

REFERENCES

1. J. Janzen, *Lemba, 1650 - 1930*, New York, 1982.
2. On local agricultural expertise, see P. Richards, *Indigenous Agricultural Revolution*, London, 1985; *Coping with Hunger* London, 1986.
3. M. Last, "The importance of knowing about not knowing", *Social Science & Medicine*, 1981.
4. G. L. Chavunduka, in M. Last, G. L. Chavunduka, *The Professionalisation of African Medicine*, Manchester, 1986, ch. 1.
5. *West Africa*, 22 September 1986, p. 1999.
6. Cf. the work of D.M. Warren and colleagues in P. Yoder (ed.), *African Healing Systems*, Los Angeles, 1982.
7. P. Reynolds, in M. Last, G. L. Chavunduka, *op. cit.*, ch. 8.
8. H. Ngubane (Sibisi), "Aspects of clinical practice & traditional organisation of indigenous healers in South Africa," *Social Science & Medicine*, 1981.

USE OF NON-FACTUAL QUESTIONS IN A SURVEY: RESPONDENT'S OR INTERVIEWERS' OPINION?

C. K. Makwaya[1], J. Z. J. Killewo[2], I. A. J. Semali[3], R. Msuya[1], E. N. Mshiu[3], D. M. Do Amsi[1], E. P. Y. Muhondwa[4].

ABSTRACT

It is quite common in survey practice to use non-factual sometimes also called opinion questions in seeking for some useful information. Unlike the case with factual questions, it is somewhat difficult to examine the reliability of responses fron non-factual questions.

Imprecision in question wording may lead the individual respondent or sometimes the interviewer to make personal interpretations. One typical non-factual question expressed in a rather unbalanced form of "do you think traditional medicine practice should be banned?" is being used to assess the interviewer's influence on the respondent's reply. This paper highlights some problems in a form of observer bias, with non-factual questions particularly when different interviewers are used in survey questioning.

INTRODUCTION

The type of questions widely used in survey practice may broadly be classified as being factual or non-factual. An important difference between them is that with factual questions there are individual true values for the information sought which, in principle, can be determined from some external independent source other than the respondents' report, whereas with non-factual question this does not apply.

Literature survey abounds with examples demonstrating that survey responses apart from being sensitive to the precise wording, format and placement of the questions asked may also be biased by the interviewer. While validity studies may be conducted to examine how successful factual questions are in obtaining respondents individual true value, with non-factual questions validation is much more difficult and less certain. One way of examining the reliability of responses from non-factual questions is to determine whether the relationships of the responses with other variable conform to those predicted by a theory.

This paper assesses the contribution of the interviewers' bias in relation to responses from particular non-factual question.

[1] Department of Biostatistics
Muhimbili Medical Centre
P.O. Box 65001
DAR ES SALAAM.

[2]Department of Epidemiology
Muhimbili Medical Centre
P.O. Box 65001
DAR ES SALAAM.

[3]Traditional Medicine Research Unit
Muhimbili Medical Centre
P.O. Box 65001
DAR ES SALAAM.

[4]Department of Behavioural Sciences
Muhimbili Medical Centre
DAR ES SALAAM.

METHODS

In this survey of "The Practice and Use of Traditional Medicine" upon which this paper is based, three different questionnaires were used: One was directed to the traditional healer the other was specific for the traditional birth attendant and a general questionnaire that was meant for heads of households as representatives of the general community presumably the recipient of the traditional mejdicine practice. Eleven interviewers were trained together to participate in the survey by making home visits and actually asking the questions and recording the answers following a structured questionnaire. The study areas selected for the survey were Iringa, and Hanang, both rural districts. Prior to the actual field work a pilot study, clearly meant among other things, to check against any effect of the precise wording of the questions on the responses was conducted.

Responses to an important question seeking for an opinion about the future of traditional medicine practice have been used to assess the relibility of responses to a non-factual question with reference to the interviewer. In particular the question was an open ended one reading "Do you think the practice of traditional medicine should be banned?" and thereby leaving the interviewer to "judge" whether a given response amounted to saying either "Yes" should be banned" or "no, should not be banned", or "don'tknow". More to the point is that as Kalton and Schuman put it, the question was expressed in an unbalanced form simply as "Do you favour X?", with the contrary opinion left entirely unmentioned.

A chi-square test for independence was used to test the null-hypothesis of non-dependence of the respondents' opinion on the interviewer.

RESULTS

There were in total 3988 members of different households interviewed and their responses to the question at hand, recorded. Of these, about 90% expressed some opinion, with 81.5% of them saying that traditional medicine practice should not be banned.

We note from the table below that the type of opinion depends on the interviewer, that is the distribution of the type of response is not stable across the interviewers. At one extreme interviewer 9 for instance, recorded 3.6% of the responses as suggesting banning of the traditional medicine practice while at the other extreme interviewer 1 indicated that as much as 25.0% of the study population would favour banning of the traditional medicine practice. A similar and indeed equivalent argument can be built by looking at the proportions in the other categories of opinion including the "Don't know".

A statistical signifance test on the null hypothesis that the proportion observed in the various categories of opinion are indepent of the interviewers give (20) — 240.03, p 0.001. Thus we can't reasonably estimate the proportion of a kind of opinion regarding the banning of traditional medicine services as this would significantly depend on the interviewer.

Table 1

RESPONSE TO THE QUESTION: "DO YOU THINK TRADITIONAL MEDICINE PRACTICE SHOULD BE BANNED?"

Interviewer No.	Yes	No.	Don' Know	Total
	n%	n%	n%	
1	152(25.0)	394)64.7)	63(10.3)	609
2	114(20.5)	361(64.9)	81(14.6)	556
3	63(12.7)	346(69.9)	86(17.4)	495
4	111(20.1)	425(77.0)	16(2.9)	552
5	112(20.1)	383(68.6)	63(11.3)	558
6	24(11.9)	168(83.6)	9(4.5)	201
7	33(14.9)	157(71.0)	31(14.0)	221
8	13(5.6)	214(91.4)	7(3.0)	234
9	9(3.6)	206(81.4)	38(15.0)	253
10	17(10.1)	146(86.9)	5(3.0)	168
11	14(9.9)	120(85.1)	7(5.0)	141
TOTAL	662(16.6)	2920(73.2)	406(10.2	3988

DISCUSSION

The question considered in this paper is a typical non — factual one. The results suggests an interviewer bias on the kind of opinion to be given in non-factual questions. With non — factual questions two apparently closely similar forms of questioning may yield remarkable effects onthe responses obtained. In particular when people offer opinion when invited to do so on issues with which they are not sure about their implications and are only doing their best to cooperate in response to the urgent prompting of interviewers to do so.

It is not unexpected that when given the opportunity to opt out by an offer of "no opinion" or "don't know" status, respondent will in fact opt out. If it seems important to give all subjects equal opportunities of responding out of their true opinion or knowledge the working of questions would have to be more generalized accordingly. With a factual question a response of "don't know" does not do much harm; for there is an answer to the question but the respondent cannot provide it. With opinion questions, however, a "don't know" has a different interpretation for respondents may truly have no opinion on the issue under study. The form of the question being referred to in this discussion and the categories of the response obtained clearly indicate that the option to answer "don't know" was not explicitly included and that interviewers would use the "don't know" response category only when the respondent offered it spontaneously. This procedure may explain the relatively small overall proportion of 10.2% of the "don't know" response. The danger with this procedure is that some respondents may feel pressurized to give a specific answer such as yes, shold be banned, or no, should not be hanned in this particular case even though "don't know" is their proper response. If an interviewer happens to be an anti-traditional medicine practice or equivalently a pro-the traditional medicine practice respondent is likely to be pressurized to give a "suitable" answer.

The general conclusion from the above discussion can be put that survey questioning is not a precision tool. In constructing a non-factual question the questionnaire designer has to consider the different forms of questioning.

There is enough evidence to indicate that the responses to opinion questions can sometimes be substantially affected by apparently insignificant variations in the question form. Morover, in designing questions we have to be willing to recognize the possible interviewer's bias as a result of probably different questioning forms. This points to saying that the relationship between interviewer and respondent is one of the most important variables influencing the outcome of interviews.

Imprecision if framing a question may lead individual respondents, or sometimes interviewers to apply their own interpretations. We need to develop questions that minimize this variability, acknowledging that they may not be the questions that come closest to the truth. Otherwise we may not justifiably assess the respondent's opinion if it is significantly influenced by the interviewer.

Reference

1 Kalton G. and Schulman, H. Effect of the question on Survey Responses.3. Royal Stat, Society, 1982; 145; 42—73.

ATTENDANT AT BIRTH AS A RISK FACTOR IN CHILD SURVIVAL

Introduction

Maternal and child health (MCH services have been established in Tanzania with one of the goals of the program being to reduce child mortality and morbidity. The measurement of child morbidity requires periodic assessment which the country cannot afford. It is easier to measure child deaths and to investigate the risk factors associated with these deaths. In a paper presented in the Association of Obstetricians and Gynaecologists of Tanzania it was shown that some maternal characteristics like maternal age, birth interval, previous pregnancy loss and parity were important determinents of neonatal deaths[1]. It is the intention of this paper to look into the contribution of these risk factors in child survival in the light of the birth attendant.

Materials and Methods

The detail methodology used has been described in Do Amsi and Mwaikambo[1]. The risk factors observed in the previous study were cross tabulated against the birth attendant and the resulting death rate was compared against the overall death rate.

Dr. E.D. Mwaikambo, M.D.; M.Med
Lecturer in Paediatrics and Child Health.

Mr. D.M. Do Amsi,
Lecturer in Biostatistics,
Muhimbili Medical Centre, P.O. Box 65000, Dar es Salaam

Table 5

Distribution of the Sick Household Members by Region and Service Utilized

REGION	HEALTH SERVICE									
	Modern		Traditional		Both		None		Total	
	n	%	n	%	n	%	n	%	n	%
Iringa	1729	69.9	341	13.8	333	13.5	71	2.9	2474	100.1
Arusha	1532	78.1	174	8.9	54	2.8	202	10.3	1962	100.1
TOTAL	3261	73.5	515	11.6	387	8.7	273	6.2	4436	100.0

THE PATTERN OF ILLNESS

Table 6

Distribution of the Sick Household Members in Iringa by Education Status of the head of household and Service Utilized

Health Service	Education Status of Household Head					
	None		Low		Medium	
Modern	281	73.4	210	71.9	99	72.8
Traditional	55	14.4	48	16.4	20	14.7
Both	47	12.3	34	11.6	17	12.5
Total	383	100.1	292	99.9	136	100.0

Table 7

Distribution of the Sick Household Members in Arusha by Educational Status of the Head of Household and Service Utilized

Health Service	Education Status of Household Head					
	None		Low		Medium	
Modern	585	86.8	225	85.9	120	89.6
Traditional	69	10.2	33	12.6	11	8.2
Both	20	3.0	4	1.5	3	2.2
Total	674	100.0	262	100.0	134	100.0

RESULTS

Table 1

Crude Survival Rates in Percent

Outcome	Attendant at Birth							
	hospital personnel		traditional birth att.		self delivery		total	
	n	%	n	%	n	%	n	%
Number of births	708		1420		1120		3248	
Number of deaths	107	15.1	238	16.8	219	19.6	564	17.4

Table 2

Parity 1 as a risk factor in child survival

Outcome	Attendant at Birth					
	hospital personnel		traditional birth att.		self delivery	
	n	%	n	%	n	%
Number of births	156		257		184	
Number of deaths	20	12.8	47	18.3	43	23.4

Table 3

Birth Interval as a Risk Factor in Child Survival

Outcome	Attendant at Birth					
	hospital personnel		T.B.A.		Self delivery interval of 1 yr.	interval of 1-2 yr.
	interval of 1 yr.	interval of 1-2 yers.	interval of 1 yr.	interval of 1-2 yrs.		
Number of births	21	70	27	120	23	79
Number of deaths	6	23	7	51	13	40
% of deaths	28.6	32.9	25.9	42.9	56.5	50.6

Table 4

Maternal Age as a Risk Factor in Child Survival

Outcome when maternal Age is ≤ 20 years.	Attendant at Birth					
	hospital personnel		tradition-al birth att.		self delivery	
Number of births	n	%	n	%	n	%
Number of births	119		298		159	
Number of deaths	18	15.1	48	16.1	49	30.8

Discussion

The proportion of births carried outside the health system has remained at more than 50 percent[2, 3]. In Tanzania, this setup will prevail for a long time to come. The risks of deaths associated with known risk factors are lowest for the deliveries carried out by the orthodox health workers, followed by the births carried out by the traditional birth attendants and lastly the worst outcome are from unattended deliveries. The risk factors of child survival identified are not peculiar to Tanzania. Training and encouragement of traditional birth attendants should decrease child deaths, wherelse self deliveries when coupled with other known risk factors increase risk of child survival. In the meantime the traditional birth attendants and the women should be educateu on the risk factors of child survival so that the high risk groups are referred for the required care.

REFERENCES

1. Mwaikambo ED, Do Amsi DM. Maternal Relative and Attributable Risks of Neonatal mortality. Paper presented in 11th Annual Scientific Meeting of Association of Obstetricians and Gynaecologists of Tanzania, 1986.
2. The United Republic of Tanzania Inventory of Health Facilities, Dar es Salaam, 1979 p. 135.
3. National Demographic Survey of Tanzania, Dar es Salaam 1973; 1: 325.

TRADITIONAL MEDICINE IN THARAKA, KENYA

INTRODUCTION

I wish to contribute to the discussion on Traditional Medicine issue by presenting a short report about the research project we are conducting among the Tharaka people of Meru District in Kenya.

I shall brleifly illustrate the basic theoretical principles of the Participatory Action Research approach used in the project; showing, afterwares, how such an approach can work in practice in a field research project on traditional medicine.

Finally, since this is a work in progress, instead of presenting final results I shall state some tentative findings only; I shall conclude by adding two recommendations.

Participatory Action Research (PAR) is a new methodology which has emerged from the work of social scientists in the Developing Countries of Asia, Latin America and Africa[1] to effectively assist rural communities in such countries in their efforts to gain more control over their lives. This method involves a fundamental change from the conventional role played by development professionals to a role in which the people are no longer seen as "objects" of development but as "subjects".[2]

According to PAR methodology, professional researchers should attempt to help local communities to understand their situation better and work out solutions together using local resources and initiative. The aim is to stimulate grass-roots self-reliance, seeking to generate processes of the people's own consciousness and action according to their own priorities.

The role played by the researcher consists of catalyzing, supporting, co-ordinating and synthesizing tasks. As time goes on the dependence of the people on the initial catalysts is supposed cease, through the generation and development of internal leadership and skills. The people should within a reasonable time be able to carry on with their collective activities on their own[3].

External resources and expertise are not considered to be primary in solving local communities problems, but are offered only as supplements when needed and available to the mobilization of the people's own resources and skills.

A development process can be really effective only if is self-reliant. Passive acceptance of inputs supplied by external professionals or agencies in a more or less paternalistic manner can only produce cultural parasitism and economical dependence. The failure of thousands of non-participatory cooperation programmes in the Third World confirms this statement.

THE PROJECT

(a) *Personnel and Institutions involved*

There is a pre-existing Rural Health Care (RHC) Co-operation Program being carried out in Tharaka by Nkubu Hospital, where some voluntary doctors belonging to the Italian NGO; CUAMM; are woking. The Department of Sociology of the University of Bologna particularly the Social and Cultural Anthropology Section has started a PAR Project within the framework of such pre-existing RHC Co-operation Program. It is a Joint Research Project, with the membership of CUAMM (which is sponsoring the project through the Italian Ministry of Foreign Affairs) and of the University of Nairobi, particularly the Institute of African Studies and the Department of Community Health Moreover, there is in Italy a theoretical-methodological elaboration team, composed of many sociologists, anthropologists, medical doctors and public health spelcialists, which plays a role of supervision ofthe work and its reults.

Furthermore, for the specific purpose of a phytochemical and pharmacological evaluation of Tharaka hebalistic practices, collaboration with the Kenya Medical Research Institute (KEMRI) as a member in the Joint Research Project has been established. In fact, the Institute has been charged by Kenya Government with the responsibility of evaluating traditional medicines and herbs.

(b) *Objectives of the Research*

The objective of the research in the Social and Cultural Dynamics of Health Development among Tharaka people and in particular, the relations between internal (endogenus) dynamisms coming from cultural heritage and creative present inventiveness of the local community and external (exogenus) dynamisms — coming from multiple contacts of Tharaka culture with foreign cultures are considered.

The aims of this research are mainly two:-

(i) to stimulate a self-development process in the health field of Tharaka people through the methodology of anthropological PAR involving in particular actively the Tharaka traditional health practitioners,

(ii) to foster the integration of their precious traditional

Dr. Guido Giarelli,
University of Bologna, Italy
Department of Sociology.

knowledge about health care with elements of modern western medicine, starting a constructive co-operation between traditional and modern health practitioner so as to achieve a creative interchange between Tharaka traditional medicine and western medicine.

We are trying, by pursuing these aims, to experiment and formulate a new theoretical and practical approach to co-operation programmes, especially in health care development.

(c) *Research Plan*

The research project is to last three years (extendable for other two years if necessary). Such a three year period is subdivided into five stages: a preliminary one and four consecutive ones, each stage lasting about six months, apart from the second one which lasts twelve months.

Every stage follows detailed objectives and, according to PAR methdology, terminates in Tharaka by a series of meetings attended by the research workers, voluntary doctors, traditional health practitioners and local people and authorities involved. The practice of classical applied research resulted in a complete and exclusive control of the process and outcome of research by professional researchers. Professional control over the generation, utilization and elaboration of knowledge was not questioned:

> "The researcher develops knowledge based on data collected from invidivuals, groups and organisation in a social setting. Those individuals, groups and organisations do not have any control over the knoledge generated from the data obtained from them. They are only the "objects" of research"[4].

Particularly Research considers the actors in the situation as not merely objects or someone else's study, but are actively influencing the process of knowledge generation and elaboration. In our project, the emerging data and results archived by the researchers are communicated to Tharaka people during these meetings. Their consideration and criticism are valued and they are requested to give their opinions on how to improve research methods by adapting them to the concept of reality of local culture.

At the end of these meetings in Tharaka, theoretical and methodological seminars are held in Italy by the collaborating team, with the possible participaltion of experts on purpose invited from Kenya. The seminars examine throughly the data and results achieved and discuss the basic theories, methodologies and technics to be applied during the following stage.

PRELIMINARY RESULTS

A three months field survey was carried out in Tharaka two years ago during the preliminary stage of research. The pre-existing Rural Health Care Program was examined. Limitations and lack of the conventional approach used in such Program were pointed out.

Special attention was also paid to information on Kenya health development policy, particularly towards traditional medicine, operating at microsocial level although PAR should also take into account the general situation at the macrosocial structure.

The first stage of research started in July 1985: a screening was conducted to single out different types of Tharaka traditional health practitioners. An approach was made to contact, censor and classify them according to Tharaka proper categories. In the area of research (South Tharaka Location, 12, 863 inhabitants according to Census 1979) five years of traditional health practitioners were sorted out as shown in table 1.

Table 1:

DISTRIBUTION OF VARIOUS TYPES OF TRADITIONAL PRACTITIONERS IN THARAKA LOCATION

Tharaka Health Practitioner		Sex		Total number
Tharaka name	Translation	M	F	
mugao	herbalist-magician	39	6	45
muringia	diviner		4	4
kiroria	prophet		1	1
mutani	circumcision expert	2	1	3
mujukia	birth-attendant		50	50
		41	62	103

For each type of a practitioner an athnographic interview was conducted using a check-list which included questions about personal data (age, age-group, age-set, clan), when and why he became a practitioner, type of apprentiship, therapeutic specialty (kinds of diseases he can treat), possible teaching, work relationship (with other practitioners), number of patients and their provenance, possession of a licence and willingness to collaborate with modern health workers.

In the case of Traditional Birth Attendants (TBAs) the approach was done by involving local community through village health committees. Reasons and aims of the work were explained to the members of the committees who were requested to choose themselves the best known TBAs to be interviewed.

This work enabled the researchers to have a clearer idea of which kind of health practitioners are tradtionally operating in the area considered and which kind of medical practices they do perform. It also helped the Tharaka health practitioners to come out in the sun-light after a long period of dread and harassment.

Furthermore, a survey was carried out by medical doctors of Nkulu hospital to evaluate opportunity and shortcomings of Tharaka modern health facilities government and missionary dispensaries' and health centres. A statistical inquiry was conducted by a sociologist to enumerate how many Tharaka people frequent modern health facilities, how often and for which diseases[5]

The first stage of research has been aimed to obtain at the cognitive level a quite complete and realistic picture of the situation of both traditional and modern institutions and practitioners operating in Tharaka.

Moreover, at the behavioural level some initial interesting collateral effects has been stimulated by the research:-

(i) some traditional practitioners (herbalist-magicians) have started joining in small professional groups taking an oath of collaboration among themselves;

(ii) modern health practitioners both doctors and nurses have started taking an interest in different aspects of

traditional medical practices and believes, previously ignored or opposed;

(iii) it has been possible to arrange some meetings at the local dispensaries between doctors and traditional health practitioners, so as they have started knowing one another, exchanging ideas and information.

The second stage of research, which is still going on, is aimed at a fuller understanding of the main concepts of health, disease, healing, death, and birth which belong to medical field of Tharaka culture. This is probably more important for an applied research project aiming at a fuller understanding of the related behaviour of Tharaka people in the so-called "health-seeking process".

We are particularly interested to sort out changes and persistences in the cultural choices of Tharaka people regarding both traditional and modern medicine.

Methodologically we are using two types of approach:

(a) Through participant observation and by collection of certain number of "stories of patients" we are trying to understand the relevance of different choices and constraints in the health-seeking behaviour of common people of Tharaka.

(b) With traditional health practitioners, using ethnographic interview and participant observation during the healing rituals we are trying to understand the therapeutic value of such rituals.

Medical practitioners of Nkubu hospital are, in the meanwhile, trying to carry out a scientific evaluation of healing treatments from the bio-medical point of view with the assistance of KEMRI researchers from Nairobi.

Afterwards, they will try to compare the two different medical approaches namely the western and Tharaka traditional healing inquired through some particular clinical cases followed up during this stage so as to formulate, practical proposals of integrating the two systems.

If the main outcome of the participatory approach is increased knowledge about the social setting that is available to both the researcher and actors in the situation[6], then the second stage of research is readly the greatest effort will be placed on sharing the acquired knowledge about Tharaka health situation with local people particularly traditional health practitioners and birth-attendants. A series of grassroots work-shops will probably be arranged with them during the third stage of research, so as to assist them to improve their knowledge in a changing situation as an effective participatory process must increase the capacity of the actors involved to inquire into and change their situation.

RECOMMENDATIONS

I would like to conclude by adding two recommendations with some relevance for health policies related to traditional medicine:-

1. It is important, before starting any kind of integration programme between traditional and modern medicines to undertake a field research to know exactly what traditional medicine means in that area. "Traditional Medicine" is a very general terminology for many different things; and "Traditional Health Practitioners" is just a cover term. Each local culture has got its own traditional medical practices and its own practitioners, classified according to different categories by indigenous terminology. It is important to carry out a long-term, face-to-face approach with the people in the field; and the research should continue even after the integration process has started, so as to survey which social and cultural dynamics will spring from such process.
2. PAR approach seems to be the best one to be used to involve local people particularly local traditional health practitioners since the beginning; stimulating their creativity, their local cultural resources and leaving them to decide which sort of integration to operate between traditional and modern medicine, which selected elements to borrow from western medicine to incorporate into their traditional one. Theoretically, we distinguish in PAR approach between an "action level" and an "intervention level": where the former relates to self-reliant actions carried out by local community, stimulated by inputs coming from collateral effects provoked by the latter level, by the external agents of acculturation on the whole (doctors, researchers, central authorities, etc).

A correct PAR approach should give so much inputs by intervention level that action level of local community will be stimulated without beinf stifled, in a symetric process of common struggle where people and researchers become partners and each side has to learn qually from the other one.

REFERENCES

1. Callaway, H (ed). Participation in Research, Case Studies of Participatory Research in Adult Education. Amersfoort, 1980; Fals Borda, O.; "Investigating Reality in Order to Transform it", Dialectical Anthropology, 4, (1), 1979: 33-56; Mustafa K., "Participatory Research amongst Pastroralist Peasants in Tanzania", International Labour Office, Geneva, 1981; TANDON, R. Participatory Research in Asia, New Delhi, 1980.
2. Fals Borda, O., "The Challnge of Action Research", Development: Seeds of Change, 1, 1981: 55-61; Moser, H., "Action Research as a New Research Paradigm in the Social Sciences", Symposium on Action Research, Cartagena, Colombia, April 1977; Moser, H., "Participatory Action Research: The Aspect of Research", Internantional Seminar on Participatory Research, Lepolampi, Finland, September 1981; Oquist, P., "The Epistemology of Action Research," Symposium on Action Research, Cartagena, Colombia, April, 1977.
3. Rahman MA, "The Theory and Practice of Participatory Action Research", in Fals Borda (ed) The Challenge of Social Change, SAGE studies, 1985:116.
4. Tandon, R. Participatory Evaluation and Research: Main Conceptls and Issues", in Fernandes Tandon, R. Participatory Research and Evaluation, New Delhi, 1981.
5. Data elaboration is still in progress at the Computer laboratory of the Department of Sociology in Bologna.
6. Tandon, R., cit., p. 32.