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Traditional healers and community health

A review of projects in various countries suggests that traditional healers, if properly trained, can contribute significantly to the work of primary care teams. Recommendations are offered with a view to making the best possible use of this valuable resource.

In the Third World, traditional healers are a significant resource that should be fully employed in the struggle to provide adequate health care. Indeed, efforts are already being made to incorporate them into primary health care programmes. Considerable light has been thrown on the value of these endeavours by a review of the literature describing projects that have used traditional healers as community health workers *(1)*.

Information was obtained from developing countries on 17 projects in which traditional practitioners were trained to carry out one or more primary care activities in communities. Fifteen of the projects were sponsored by governments and two by nongovernmental organizations. They involved herbalists, diviners, spiritual or faith healers, traditional midwives, traditional birth attendants, *curanderos*, shamans, traditional Chinese doctors, Ayurvedic doctors, Unani practitioners and other types of traditional healer.

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Positive outcomes and changes

Training produced positive changes in healers, their clients, and modern health staff.

Traditional practitioners were available and willing to work in primary care when trained, and established good working relationships with other health staff. A great variety of healers from many different cultures were successfully trained to work in primary care projects in Afghanistan, Brazil, China, Ghana, India, Nepal, Nigeria, Philippines, Sierra Leone, Sudan, Swaziland, Thailand and Zambia. Herbalists, spiritual healers, Ayurvedic and Unani practitioners, traditional midwives, bone-setters, magico-religious practitioners and other healers enthusiastically accepted new roles in primary care. The skills taught included the following.

- Promotion of education in local health problems and methods of preventing and controlling them.
- Promotion of improved food supplies and nutrition, with information on balanced diets, breast-feeding, weaning foods, and

the growing of vegetables and fruit in kitchen gardens.

- Promotion of safe water supplies and basic sanitation, including the construction and use of latrines, personal hygiene, and the preparation and storage of food.
- Promotion of maternal and child health care, with regard to family planning, the monitoring of pregnancy and recognition of abnormalities, antenatal care, basic delivery techniques, referral for abnormal delivery, and the distribution of oral contraceptives and referral for other methods of birth control.
- Promotion of immunization against major infectious diseases, including referral of children under five to clinics for immunization against childhood diseases.
- Promotion of prevention and control of locally endemic diseases, including the recognition of symptoms of dangerous diseases such as diarrhoea, tuberculosis, leprosy, malaria and malnutrition, and the referral of affected individuals for treatment, the mixing and use of oral rehydration solution to treat dehydration and diarrhoea, the distribution of packets of oral rehydration salts, the referral of women in high-risk groups, and the use of readily available allopathic medicines (e.g., antimalarial prophylaxis).
- Provision of treatment for common diseases and injuries, as well as first aid and accident prevention.
- Provision of essential drugs, including aspirin and other first-aid medication; and the operation of basic dispensaries.

In a project in Ghana, healers were taught preventive and promotive measures, family planning, the use of allopathic medicines, and basic first aid *(2)*. A project in Swaziland focused on training healers to recognize symptoms of dangerous children's diseases and their prevention and control through oral rehydration therapy, improved nutrition, safe water and sanitation, and personal hygiene *(3)*; it also developed a referral system that enabled traditional practitioners and clinic nurses to improve communication and cooperation between the traditional and modern health sectors in the treatment of mothers and children. In Nepal, traditional practitioners learned how to recognize and manage tuberculosis, leprosy, and childhood diarrhoea and malnutrition, and how to refer patients with symptoms of tuberculosis and leprosy *(4)*. In Brazil, local healers were trained to integrate the use of oral rehydration therapy with their own indigenous practices aimed at achieving child survival. In general the healers were reliable clinical observers, knowledgeable about antidiarrhoeal plant remedies, skilled in the preparation of oral rehydration solution, and pragmatic in integrating effective modern therapies into their practices *(5)*.

In seven projects, training produced specific advances in the attitudes, knowledge and behaviour of healers, the health status of population groups, and the attitudes and behaviour of health sector staff. This indicates a need for more documented results from demonstration projects representing a diversity of circumstances throughout the world. Such data could help to answer questions on the selection, training and utilization of healers in primary care and to evaluate the cost-effectiveness of these activities.

An atmosphere of understanding, trust and respect should be created between modern health workers, traditional healers and the communities they serve.

Projects in Brazil, Ghana, Nepal, Sudan and Swaziland indicated that participants had a high degree of interest in and enthusiasm for acquiring new information and skills in primary care *(2, 3, 5–7)*. They also demonstrated the following changes in the practices of healers after they had attended training workshops:

- increased use of oral rehydration solution for children with diarrhoea;
- use of washbasins for cleaning hands in traditional healing clinics;
- decreased use of strong purges and enemas for treating diarrhoea;
- construction and use of latrines in healers' homes;
- increased referrals to clinics for patients with dangerous symptoms;
- increase in numbers of births attended by village midwives.

Only two projects reported specific changes in the health status of target populations: in Sudan the proportion of women aged 30–34 using contraceptives increased from 25% to 38% over a two-year period and the overall use of contraceptives rose from 13% to 21%; in Nepal a project achieved an increased attendance at rural clinics after the trained healers began working in local communities. Most projects indicated a high degree of acceptance of trained healers by communities.

Healers have traditionally been private practitioners, and attempts to alter this state of affairs could create confusion or misunderstanding.

Many projects indicated that there was an increase in trust and respect between nursing staff and traditional practitioners, and that working relationships between the two groups improved. In the Swaziland project, nurses reported that there was an increase in referrals by healers to rural clinics, particularly for children with diarrhoea and vomiting. This reflected the development of a mutual referral system. In Nepal it was found that the *dhami-jhankri* or faith healers could play a culturally appropriate and cost-effective role in health education and family planning. It was estimated that the country had well over 100 such healers for every health worker, and that they were paid only modest fees by the people for their services.

In Swaziland the cost to government for training traditional practitioners was relatively low, the country's Traditional Healers' Organization having committed a large amount of time and resources to the project and the community paying for the healers' services *(8)*.

In a Philippines project the main strength of the community-based health programmes was their low cost *(9)*, achieved through the employment of traditional medical practitioners using inexpensive therapies.

Constraints

The absence of clear recognition by many governments of the potential value and role of traditional practitioners in primary care creates a poor climate for healers and health staff to work together, and tends to reinforce secretive practices. A lack of government commitment in some projects has discouraged healers from coming forward to participate in training programmes. In countries where, until recently, healers were prohibited from practising, many are

reluctant to participate in government-sponsored health programmes.

A lack of dialogue between healers and government staff has led to misunderstandings. Open discussion on common health goals has been absent and the coordination of services has been impaired. One example of this is the difficulty in establishing referral systems between healers and clinic nurses. In Swaziland such referrals increased following a training workshop during which members of the two groups agreed to cooperate.

Where the role of the healer in relation to other members of the primary care team was not clearly defined, and the tasks they were to perform were not specifically described, problems arose in both the training and work settings. For example, a weakness of many community health worker programmes was that the range of assigned duties was too broad and tasks were poorly defined. Thus in Nigeria, because the role of healers was not made clear, some feared their integration into the primary care programme might threaten their status, income and freedom of action in the community *(10)*.

The conflict between the traditional, holistic, spiritual-oriented healing and the modern, biomedical, treatment-oriented approach reflects a basic difference in philosophy on the causation of disease and the promotion of health. This difference can cause barriers between traditional and modern practitioners, not least in the planning and implementation of training projects for healers.

Some practices, such as witchcraft and sorcery, can cause dangerous psychological stress and bodily harm. Clearly in opposition to the modern biomedical approach, they are strongly rooted and often quite resistant to change, particularly where belief in the supernatural is concerned.

The activities of charlatans and fraudulent practitioners may obscure the worthwhile contributions of the large majority of bona fide healers. Isolated incidents of witchcraft, malpractice or unscrupulous behaviour are widely publicized in the media and tend to prevent understanding and cooperation between the traditional and modern health sectors.

There has been little or no evaluation or follow-up after the completion of training projects. Relatively few reported specific data indicating how effective the training had been, what the healers were accomplishing in the community, and how satisfied the community members were with the performance of primary care activities by healers.

Future involvement of traditional practitioners in primary care

The following recommendations relate to the promotion of community health by incorporating traditional practitioners into primary care teams.

- Government ministries and departments of health should take the lead in formulating policies and acting to promote the training and use of healers in primary care. They should ensure that traditional practitioners are incorporated as fully and effectively as possible into health service systems that meet the needs of communities. An atmosphere of understanding, trust and respect should be created between modern health workers, traditional healers and the communities they serve. This requires a mechanism whereby activities such as informal meetings, seminars and workshops are planned and key people representing the modern and traditional sectors come together to express their views, establish common goals and

develop ways of using traditional healers in primary care teams. Official policies should be formulated which acknowledge the value of traditional healers in this field and indicate how government intends to utilize them. A government intention to cooperate with and include healers in coordinated primary care teams might be declared. Because relatively little experience has been gained in training and using traditional practitioners, government may wish to indicate a desire to explore the roles that healers can play, and to define, through pilot or demonstration projects, appropriate functions and tasks. It may not be possible to formulate detailed policy statements and strategies until data from trial projects have indicated more specifically how traditional practitioners should be trained, their performances monitored, and their services rewarded.

- The role that traditional practitioners should play in providing primary care ought to be carefully defined. Healers have traditionally been private practitioners, and attempts to alter this state of affairs by employing them or enlisting their cooperation as community health workers could create confusion or misunderstanding. The views of people in the modern and traditional health sectors, as well as those of the community in general, should be considered when defining the roles to be filled by traditional practitioners in a particular region or country. The roles may vary in accordance with the levels of responsibility, traditional status, and cultural practices of the healers, the priorities, goals and resources of the ministries of health, and the wishes of the communities.

- The planning, implementation and evaluation of programmes for the training and use of traditional practitioners in primary care should be done jointly by representatives from health and other related sectors of government, nongovernmental organizations, traditional healers, and the communities served. A system of primary care requires cooperation between modern and traditional health practitioners. The two sectors should establish a partnership in which all members are part of a team serving the community. Some projects have established mutual referral systems, whereby healers refer patients with certain conditions to Western medical clinics and hospitals, and Western-trained nurses and doctors refer certain patients to healers, an arrangement that can lead to an overall improvement of health services. Increased communication enables both modern and traditional health workers to learn from each other.

- Training programmes should be designed which meet the special needs of traditional practitioners. Many healers lack formal education and have low levels of literacy, and this can pose difficulties in training. In some projects it was found that these circumstances required specially designed training methods and materials. Conventional methods, involving lectures and written materials, were not appropriate. Because traditional practitioners have cultural and health orientations differing from the Western ones, and because many of them have a lower level of education and training than modern health staff, it is important to design training programmes that meet their special needs.

- In order to develop effective strategies and methods for the incorporation of traditional practitioners into national primary care programmes, it is desirable to conduct demonstration, evaluation and

research projects. Because of the scarcity of data on training and using traditional practitioners in primary care, carefully designed pilot projects should be conducted to demonstrate and test methods before they are widely employed. Good evaluation components should be incorporated so that progress can be measured. It is important to collect information about the impact that training programmes have on the attitudes, knowledge and practices of healers and on the health status of communities.

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The present review suggests that traditional practitioners are a valuable resource for providing primary care to communities. Services can be strengthened so as to promote health and prevent illness if traditional practitioners are properly trained and utilized.

Recommendations are offered in this article with a view to making the best possible use of traditional practitioners in the provision of primary care in community settings, and to limiting problems and difficulties. They are intended as guidelines for government and nongovernmental organizations wishing to give improved primary care to communities and ultimately to improve people's quality of life.

Health workers should look carefully at the resources in the traditional health sector. Given the major status and influence of most traditional practitioners among their own people, their role in providing sound and culturally appropriate primary health care should not be underestimated. In countries where needs are great and resources scarce, traditional practitioners can play a significant role in helping people in rural communities to improve their quality of life. □

References

1. **Hoff, W. & Shapiro, G.** *Traditional healers and community health, a review of the literature describing projects using traditional healers as community health workers.* Berkeley, International Child Resource Institute, 1990 (unpublished document).

2. **Warren, D. et al.** *Ghanaian national policy towards indigenous healers: the case of the primary health training for indigenous healers programme.* (Paper presented to the annual meeting of the Society for Applied Anthropology, Edinburgh, 1981).

3. **Hoff, W. & Maseko, N.** Nurses and traditional healers join hands. *World health forum,* **7**: 412–416 (1986).

4. **Oswald, I.H.** Are traditional healers the solution to the failures of primary health care in rural Nepal? *Social science & medicine,* **17**: 255–257 (1983).

5. **Nations, M. K. et al.** Brazilian popular healers as effective promoters of oral rehydration therapy (ORT) and related child survival strategies. *PAHO Bulletin,* **22**: 335–354 (1988).

6. **El Tom, A.R. et al.** Family planning in the Sudan: a pilot project success story. *World health forum,* **10**: 333–343 (1989).

7. **Shrestha, M. & Lediard, M.** *Faith healers: a force for change.* Kathmandu, UNICEF, 1980 (Preliminary report of an Action Research Project).

8. **Hoff, W.** *Training traditional healers to assist in the control of childhood diseases in Swaziland.* (Unpublished paper presented to the National Council for International Health, Washington DC, 1986).

9. **Tan, M. M. et al.** The integration of traditional medicine among community-based health programmes in the Philippines. *Journal of tropical pediatrics,* **34**: 71–74 (1988).

10. **Green, C.** Collaborative programmes for traditional healers in primary health care and family planning, In: Fyfe, C. & Maclean, U., ed. *African medicine in the modern world.* (Proceedings of a seminar, Centre of African Studies, University of Edinburgh, 1986, pp. 115–144.).