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# TRADITIONAL MEDICINE PROGRAMME & GLOBAL PROGRAMME ON AIDS

# REPORT OF THE CONSULTATION ON AIDS AND TRADITIONAL MEDICINE: PROSPECTS FOR INVOLVING TRADITIONAL HEALTH PRACTITIONERS

## FRANCISTOWN, BOTSWANA

23-27 July 1990



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# 1. INTRODUCTION

## 1.1 Background of the consultation

The acquired immunodeficiency syndrome (AIDS) was first identified in June 1981. By December 1990, a global total of approximately 307 000 cases of AIDS had been officially reported to the World Health Organization (WHO) by 156 Member States. Of these reported cases, about 80 000 have been in sub-Saharan Africa.

However, it is believed that these reported figures represent only a fraction of the actual number of AIDS cases. Worldwide, WHO estimates that there may have been a cumulative total of as many as 1 000 000 cases, with 700 000 of these having occurred in sub-Saharan Africa. Some 8-10 million adults throughout the world have been infected with the human immunodeficiency virus (HIV). WHO projects a total of 8-10 million cumulative AIDS cases by the year 2000.

The AIDS pandemic has had a significant impact on individuals and communities everywhere in the world, particularly in the African Region. Modern medicine has so far been unable to contain the spread of HIV infection; therefore, renewed attention has been drawn not only to the potential of traditional medicine but principally to the major role that traditional health practitioners can play in the implementation of national strategies for the prevention and the control of HIV infection and amelioration of symptoms caused by opportunistic infections and AIDS.

In 1976, the World Health Assembly acknowledged the potential value of traditional medicine in expanding health services by calling attention to the manpower reserve constituted by traditional health practitioners (resolution WHA29.72). In the following year, a Health Assembly resolution (WHA30.49) urged countries to utilize their traditional systems of medicine. Another resolution was passed in 1978, in which the Organization was called upon to develop a comprehensive approach to the subject of medicinal plants (WHA31.33). Nine years later, in 1987, the Fortieth World Health Assembly reaffirmed the main points of the earlier resolutions, as well as related recommendations made at the International Conference on Primary Health Care, held in Alma-Ata, USSR, in 1978 (WHA40.33).

The Forty-first World Health Assembly drew attention to the Chiang Mai Declaration (1988): "Save Plants that Save Lives" and endorsed the call for international cooperation and coordination to establish a basis for the conservation of medicinal plants, in order to ensure that adequate quantities be available for the use of future generations (resolution WHA41.19).

In 1989, a resolution was passed (WHA42.43) that recalled earlier resolutions on traditional medicine, traditional health practitioners, and traditional remedies and affirmed that together they constitute a comprehensive approach to the utilization of medicinal plants in the health services.

This resolution provided a fresh mandate for future action in promoting effective collaboration between the traditional and modern health care sectors in WHO's Member States. The adoption of safe and useful traditional medicine practices in the design and implementation of national health systems makes good sense in terms of economics and cultural acceptability.

Given the paucity of human and material resources available to African governments and the extremely high number of AIDS cases in the region, there is an urgent need to devise new approaches that would contain the further spread of this dread disease. These new approaches should not only be developed within the framework of national strategies for delivering primary health care, but should also take into consideration the fact that in many countries, especially those in the African Region, traditional medicine is part of the health practices of individuals and communities; a form of private practice, outside the formal health system. Governments, therefore, have a responsibility to

ensure that traditional medical practices are not harmful and to foster what is effective and beneficial, in keeping with the beliefs of the people. These positive practices can be crucial in meeting the challenge of the present crisis.

In responding to the gravity of the situation caused by AIDS, many African countries have developed national AIDS control plans. For example, Botswana, Kenya, United Republic of Tanzania, Uganda, and Zimbabwe have identified programme areas that are appropriate for involving traditional health practitioners in community health activities; these include community-based care, health education, counselling, and the relief of certain symptomatic conditions. In addition to these areas, there is also a potential for involving traditional health practitioners in providing the community with culture-specific information on sexual behaviour and in formulating and channelling specific health promotional messages. So far, these efforts have not been coordinated, and therefore there is no basis for a comparison of their effectiveness. However, there is no doubt that, properly motivated and involved, the traditional health practitioner can act as a valuable link to the majority of the population, who may be difficult if not impossible for modern health workers to reach.

1.2 Purpose and objectives of the consultation

The consultation was held to consider ways and means to expand the important role of traditional health practitioners, including traditional midwives, in the delivery of health services in African communities by involving them more actively in measures to prevent and control HIV infection and AIDS.

The specific objectives of the consultation were as follows:

1. To explore and identify the best ways to involve traditional health practitioners in the prevention and control of AIDS in Africa.

2. To draft guidelines on approaches that countries could use to secure the involvement and continued participation of traditional health practitioners.

3. To examine the need for, and to define, health services operational research in traditional medicine that is relevant for developing and implementing strategies for AIDS prevention and control and for solving other public health problems.

4. To formulate recommendations to WHO and to governments in the African Region on the appropriate steps to be taken in order to facilitate the involvement of traditional health practitioners in AIDS prevention and control.

5. To produce a report that can be used as a practical instrument for Member States who wish to strengthen AIDS prevention and control activities through the involvement of their traditional health practitioners in national AIDS programmes.

1.3 Organization and proceedings of the consultation

In preparation for this consultation, the participants were asked to prepare country reports that would outline the most significant issues stemming from experiences in involving traditional health practitioners in national AIDS programmes.

Fifteen experts and members of the WHO Secretariat took part in the deliberations. The participants, representing a wide range of technical disciplines, included anthropologists, educators, health policy-makers, pharmacognocists, pharmacologists, and traditional health practitioners, as well as managers of national AIDS programmes (see Annex 1).

During the opening ceremony, the Mayor of Francistown, Mr M. I. Ebrahim, formally welcomed the participants of the consultation. Mr M. Tshipinare, the acting Minister of Health, then added his words of welcome to the participants and described Botswana's medium-term plan for the prevention and control of AIDS (see Annex 3).

The consultation was formally opened by Dr G. L. Monekosso, Regional Director for Africa. In his inaugural address, Dr Monekosso reminded the participants of the gravity of the AIDS pandemic and how it has particularly affected the African Region (see Annex 4).

Dr O. Akerele, Manager of WHO's Traditional Medicine Programme, next addressed the group and outlined to them the purpose and expected outputs of the consultation. He also described to them the objectives and activities of WHO's programme, including recent collaborative work with the Biomedical Research Unit of the WHO Global Programme on AIDS, to assess the potential anti-HIV activity of traditional remedies (see Annex 5).

Next followed the nomination of officers: Dr E. Maganu, Chairman; Dr G. L. Chavunduka, Vice-Chairman; and Dr P. Marshall and Dr Debrework Zewdie, Rapporteurs.

The participants then adopted the proposed agenda and began their deliberations (see Annex 2).

The programme began with a review by Dr B. Nkowane of the current status of the AIDS pandemic, including global preventive and control strategies (see Annex 6). This was followed by the country reports (see Annex 7) and two days of group work, during which the participants were expected to identify the most practical ways to involve traditional health practitioners in AIDS prevention and control, giving consideration to policy formulation, training, teaching/learning materials, and research priorities. Plenary sessions were held towards the end of the consultation to summarize the discussions, consider recommendations, and adopt a draft report.

## 2. APPROACHES FOR INVOLVING TRADITIONAL HEALTH PRACTITIONERS IN AIDS PREVENTION AND CONTROL

### 2.1 Guidelines for formulating policies on training, research, and ethical issues in traditional medicine and AIDS

Countries should themselves decide which types of traditional practitioners they would want to involve in their national AIDS prevention, control, and care activities. While it is important to distinguish between different types of practitioners, it is understood that all types of traditional health practitioners recognized by their communities may well have important roles to play in AIDS prevention, counselling, and care and in community leadership.

2.1.1 The purposes of a policy on traditional medicine are:

(a) to protect the patient from substandard care;

(b) to recognize the role of traditional health practitioners and define their rights, privileges, and responsibilities as health care providers;

(c) to educate and guide the practitioners and the community;

(d) to correct the serious neglect in the education and training (including continuing education) of traditional practitioners and in research on the effectiveness of their practices;

(e) to protect the traditional health practitioner from malpractice suits and prosecution under existing and proposed penal laws;

(f) to protect individuals and the community from charlatans.

2.1.2 The goals of policy formulation include:

(a) the improvement of the health and welfare of the population;

(b) elaboration of a framework enabling the formulation of appropriate legislation and regulations for operational traditional medicine programmes;

(c) the provision of a basis for the consideration of key ethical issues:

- respect for the person as an individual and respect for the community as a whole;

- promotion of the beneficial effects of traditional medical care and elimination of the harmful ones;

- promotion of social justice through ensuring safe, culturally acceptable, and cost-effective traditional medical care to individuals and communities.

2.1.3 A policy on traditional medicine should provide guidelines for the following major areas: legislation and regulation; education and training; research and development; ethical issues; and allocation of financial and other resources.

(a) Legislation in traditional medicine should: enable the recognition of traditional health practitioners; define and standardize basic concepts of traditional medicine; define areas of practice; state the rights, privileges, and responsibilities of traditional health practitioners; provide a basis for their recruitment and registration, as well as the modalities for their utilization in health systems. Legislation drawn up by peers should provide the basis for ordinances and standards of reference to determine malpractice. Provision should be made for enactment of laws to protect the practice of the profession, as well as to stipulate the appropriate materia medica upon which traditional medicine should depend for its growth and survival.

(b) Education and training in traditional medicine should promote its acceptance and recognition as an integral part of the cultural heritage of the people, and it should facilitate collaboration between the modern and traditional systems. Information about traditional health care and its practitioners should be introduced into medical, nursing, and other health sciences curricula, as well as in social and behavioural sciences. Students of both systems should be involved in multidisciplinary action research in traditional and modern medicine. Appropriate information about the philosophy, principles, history, and cultural value of traditional medicine (merits and limitations) and the role of its practitioners should be included in secondary school curricula and introduced in the training courses for teachers. Prominent traditional health practitioners should be invited to explain and discuss their work. The complementary aspects of the modern and traditional health systems within a community must be emphasized to the practitioners of both systems in order to promote mutual professional respect. The following are educational activities that might promote the involvement of traditional practitioners in community health care:

- joint seminars and workshops should be organized for practitioners of modern and traditional medicine as well as for scientists of relevant disciplines;

- special courses of various grades and duration should be organized for traditional health practitioners, and, eventually, schools of traditional medicine should be developed, as was done in China and India.

Special training of traditional health practitioners for their participation in certain primary health care programmes must be emphasized. Appropriate entry points for their involvement in primary health care activities could be:

- oral rehydration therapy;

- traditional midwives for primary health care centres;

- family planning programmes;

- control of sexually transmitted diseases and AIDS;

- integrated AIDS and family planning programmes;

- endemic disease control such as of leprosy and tuberculosis;

- expanded programme on immunization;

- nutritional education;

- breast-feeding;

- elaboration of national traditional medicine pharmacopoeia;

- needs assessment through KABP surveys on AIDS (knowledge, attitudes, beliefs and practices);

- collection and dissemination of information and simple statistics on health care.

(c) The importance of research as the source of new information for establishing community diagnosis, determining needs, and resolving community health problems must be emphasized in the development of a policy for the promotion of traditional medicine. Multidisciplinary action research should be recommended as the best means to promote traditional health care and the utilization of traditional health practitioners in primary health care at the district level. Traditional health practitioners should be represented in all formal national research bodies for traditional medicine. They should also be involved in the planning and implementation of research and in the discussion and evaluation of results for feedback. In all of this they should be treated with respect, adequately compensated for their participation, and duly acknowledged. University faculties and research institutions should be encouraged and funded to take an initiative in these efforts. Various kinds of research are necessary for a full and balanced development of traditional medicine. The following are some examples:

(i) operational or applied research that seeks to discover the strengths and weaknesses of traditional medicine practices in order to propose and offer solutions for improvement;

(ii) research to explore new remedies for health problems and diseases such as AIDS;