Traditional Practitioners as Primary Health Care Workers

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A study of effectiveness of four training projects in Ghana, Mexico and Bangladesh

Division of Strengthening of Health Services and Traditional Medicine Programme
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I. EXECUTIVE SUMMARY

This study evaluated the effectiveness of four projects where traditional practitioners were being trained to provide various primary health care services to communities. The projects were based in Ghana, Mexico, and Bangladesh. The objectives were to evaluate the impact the projects had upon the communities they served, to determine which materials and training approaches were most effective, and to develop training guidelines to assist others in replicating similar projects.

A qualitative evaluation was performed of data collected from project documents and field interviews with 152 persons: 28 health agency staff (doctors, nurses, administrators, trainers), 61 traditional practitioners (herbalists, bonesetters, spiritualists, birth attendants and midwives), and 63 members of communities served by the projects.

Effectiveness of the projects was determined by criteria which included:

a) How the traditional practitioners utilized the primary health care (PHC) skills they were taught during their training.

b) How the attitudes of traditional practitioners changed after training.

c) How satisfied were community members with the services of traditional practitioners.

d) How collaboration improved between traditional practitioners and health agency staff.

e) How health behaviours of community members changed after traditional practitioners provided the new services.

f) How primary health conditions improved in the communities where trained traditional practitioners worked.

The data are reported as four case studies and the results are discussed according to various issues:

EFFECTIVENESS OF TRAINING - i.e. primary health care tasks performed by traditional practitioners, attitudes of traditional practitioners, satisfaction of community members, collaboration between traditional practitioners and health agency staff, and health behaviours of community members.

ADMINISTRATIVE ISSUES - i.e. policy issues, project planning and community involvement, training methods and materials, training of trainers, follow-up support, evaluation, costs of training, and difficulties encountered.
One general conclusion from the many specific findings indicated that trained traditional practitioners played an important role in promoting primary health care services in communities, in identifying critical cases early and referring them to clinics and hospitals, and in improving primary health conditions in communities.

The project in Ghana, the only one of the four where adequate statistical records were found, showed that during the two year period from 1990 to 1992 there was an annual decrease in the number of still births and in maternal and neonatal mortality rates in areas where trained birth attendants were working.

These records also indicated that during the 13 month period ending March, 1992, the normal nutritional status of children covered in five project communities increased from 46% to 62.3%, while the percentage of severely malnourished children decreased from 21.4% to 16.1%.

The evaluation report concludes with a section on Lessons Learned and Recommendations for Effective Planning and Implementation and Evaluation of Traditional Practitioner Training Programmes.

A summary of the Guidelines for Training Traditional Health Practitioners in Primary Health Care concludes the report with guidelines for planning the content of training, using effective methods and materials, training trainers, and evaluating training.
II. INTRODUCTION AND NEED FOR THE STUDY

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

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

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

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

This recommendation sets forth a clear mandate for governments to define the role traditional practitioners and birth attendants can play in communities as members of the primary health care team. If we compare the needs for primary health care services in communities to the resources that are currently available, it becomes apparent that the goal of *Health For All* will never be achieved unless all existing community resources, including traditional practitioners, are mobilized and used more effectively.
In places where few trained health practitioners are available, families turn to traditional practitioners to help them fight for survival. In some developing countries traditional medicine caters to most of the health needs for up to 80 percent of rural families. There has been a broad gap between the need of the family for prevention and intervention, and the view of many Western health practitioners who believe healers are charlatans and profiteers, preying on the superstitions of local families. Now, because of the aforementioned worldwide health problems combined with shrinking resources, the importance of the traditional healer is undergoing a gradual re-evaluation.

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

Few evaluations have been conducted of existing traditional practitioner primary health care training projects to provide answers to some basic questions. These include:

- What is the range of primary health care tasks which traditional practitioners can be trained to carry out effectively?
- What training methods and materials are appropriate for their cultural background and educational level?
- What kinds of follow-up services are required to insure quality of care?
- What impact will these extended services have upon reducing illness and in promoting the health and quality of life in communities?
- What would be the cost of providing such service?
- Can improved collaboration contribute toward creating a more acceptable and sustainable system of health services to communities?
- Are the differences between traditional healing and Western medicine surmountable so that the two groups can collaborate effectively?
- Would closer collaboration between the two groups foster greater understanding and trust between them and satisfy the needs of rural people for a sustainable, more culturally based health system?

In order to explore the answers to these and related questions, the World Health Organization, conducted a world wide literature review and field evaluation of four regional training projects for traditional practitioners. This report attempts to
explain the health impact of these efforts on the communities served and to evaluate how greater cooperation and collaboration between conventional and traditional practitioners may provide a more effective and efficient system of health services for communities.
III. OBJECTIVES

A. CONDUCT REVIEW OF THE LITERATURE

1. Collect information about projects which have included traditional practitioners as community workers to provide primary health care services.

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

2. Analyze this information with regard to the role of traditional practitioners in community health and identify the various roles or functions that these traditional health practitioners have played in communities.

The analysis of roles and functions performed by traditional practitioners was limited to primary health care activities which included health education; promotion of proper nutrition; provision of safe water and sanitation; maternal and child health care (including family planning; immunization against major infectious diseases; prevention and control of endemic diseases; first aid; and provision of essential drugs.

3. Make recommendations based on these findings as to future steps which can be taken to involve traditional practitioners in promoting primary health care for communities.

One objective was to make recommendations based upon the information collected that could suggest how traditional practitioners could promote community health. We anticipated that the results of these projects would show positive effects as well as difficulties and problems.

B. CONDUCT AN EVALUATION STUDY OF PROJECTS USING TRADITIONAL PRACTITIONERS

1. Investigate at least three sites which embody a range of traditional healing training modalities and conduct an evaluation to determine the effectiveness of the training programmes and the impact of the projects on the local communities served.

2. Review the methods and materials used to train the traditional practitioners in these projects and determine which materials, training approaches and strategies have been most effective.

C. DEVELOP TRAINING GUIDELINES, BASED UPON THE FINDINGS OF THE STUDY, TO ASSIST OTHER ORGANIZATIONS IN REPLICATING SIMILAR PROJECTS.
IV. METHODOLOGY

A. REVIEW OF LITERATURE

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

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

1. The library computer systems of the University of California, Berkeley. This included the MELVYL and GLADYS systems, which link all University of California campus libraries as well as the MEDLINE System, which contains books and periodicals of the Schools of Public Health and Medicine.

2. The Combined Health Information Database (CHID) of the U.S. Public Health Service, Department of Health and Human Services, Communicable Disease Center, Atlanta, Georgia.

3. The World Health Organization’s Regional Offices in Africa, Southeast Asia, Western Pacific, the Americas, Eastern Mediterranean and Europe.

4. The International Health Policy Studies Program of the University of California School of Medicine, San Francisco, California.

5. The Network Secretariat, University of Luxembourg.

6. The School of Public Health, University of Sao Paulo, Brazil.

7. The Centro Internacional de Educacion y Desarrollo Humano, Colombia.

8. The International Children’s Center (BIRD), Paris.

9. The Health Education Research Centre, Perugia, Italy.

10. Technologies for Primary Health Care (PRITECH), Arlington, Virginia.

11. The International Child Resource Institute (ICRI) computerized child resource information bank, (CRIIB), containing records of information on child and family health from over one hundred countries.

12. The Hesperian Foundation, Palo Alto, California.

13. ICRI’s field representatives in 52 countries.
Those sources which conformed to the scope of this report were abstracted, reviewed and their references were researched to obtain further appropriate sources. These were in turn obtained, reviewed and abstracted where appropriate.

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

**REVIEW OF UNPUBLISHED INFORMATION**

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

- Reports
- Evaluations
- Journal and newspaper articles
- Posters
- Booklets
- Brochures
- Papers
- Training materials
- Any other pertinent information about traditional practitioners as community health workers in various countries and regions.

**8. FIELD EVALUATION OF ONGOING TRAINING PROGRAMMES**

Using data collected from project documents along with field interviews and observations made during visits to the projects, this report presents qualitative descriptions of four case studies. Data are described and analyzed for each of the case studies, conclusions are drawn regarding the effectiveness of the projects and the lessons learned, and recommendations are made for further action.

The field work was conducted between September 1992 and August 1993. The Project Director was the principal investigator and, with the help of a counterpart who was assigned from each country, collected data during the field visits. Two weeks (10-12 working days) were allocated to collecting data at each site, with the exception of Bangladesh, where the two week period was divided between two NGO projects.
It was decided that in order to achieve the above objectives of the project, several sets of data must be collected:

1. Data to indicate how effective the training programmes were in imparting the desired knowledge and skills to the traditional practitioners.

2. Data to suggest what impact the traditional practitioner’s new services had upon the communities they served.

3. Data to recommend what types of training methods and materials are most appropriate in training traditional practitioners for PHC services.

Ideally, to measure the effectiveness of a training programme on its participants, and to determine the impact of trained traditional practitioners providing PHC services to a community, one would need to have measures of knowledge, attitudes and practices of the trainees before and after inception. In addition, a controlled experimental study should be established to eliminate other factors that might influence the relationships being studied.

This type of quantitative evaluation was not performed because the projects studied had not obtained such baseline data, nor had they established control and experimental groups from which to measure changes in peoples behaviour and health conditions as a result of the training programmes. Additionally, field conditions such as low literacy levels and limited project resources imposed constraints that made it impossible to collect quantifiable data.

In view of these circumstances, it was decided to obtain qualitative information such as beliefs, feelings, and observations from three groups of people who were vitally involved in the projects. Personal interviews were obtained from individuals of the following three groups:

1. Health agency staff members - the administrators, trainers and other related staff;

2. Traditional practitioners - the trainees and the providers of the PHC services;

3. Community members - the clients or recipients of the services.

The following four criteria were then established to measure the effectiveness of the training programmes:

1. What skills taught during training were traditional practitioners now utilizing in their communities?

2. How have the attitudes of traditional practitioners changed since training?

3. How satisfied were community members with the traditional practitioner’s services?
4. How has collaboration improved between traditional practitioners and health agency staff?

The following two criteria were established to determine the impact of the training programme on the communities:

5. How have the health behaviours of community members changed since traditional practitioners began providing these new services? (as perceived by interviewees in the three groups).

6. How have health conditions improved in the communities where trained traditional practitioners have worked? (as perceived by interviewees in the three groups and statistical data available from the health agency).

To ascertain the impact of the trained traditional practitioner on health behaviours and conditions in the community, health agency staff, traditional practitioners and community members were all interviewed regarding their perceptions and observations. High agreement among them was taken as evidence that a condition existed. For example, if responses from health agency staff and from traditional practitioners agreed that collaboration had improved between the two groups, then this was assumed to be a true outcome of the training programme. If TBAs reported that they had advised mothers to get immunized for tetanus, and mothers reported separately that they had gone to the clinic to get such immunizations, then it was assumed that these mothers' behaviours were a result of the TBAs advice, which was assumed to be the outcome of training.

These interview data were supplemented by information obtained from examining project plans for the recruitment and training of traditional practitioners, evaluation reports, and other project documents.

1. Selection of sites for case studies

Traditional practitioner training projects were selected from countries that represented three major geographic regions of the world: Africa, Latin America, and Asia. From these regions four projects were selected that met the following criteria:

- Projects should be ongoing and TPs should have been performing PHC tasks for at least six months.

- Projects should represent the training of different kinds of TPs and the performance of a variety of PHC tasks, i.e.;

  - health education;

  - maternal and child care, including family planning;

  - growth monitoring and nutrition education;

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.. diarrhea control, oral rehydration therapy;

.. hygiene, safe water, and sanitation promotion;

.. promotion of immunizations against common diseases.

(It was the intent that the projects together should represent the full range of PHC activities listed above.)

.. Projects should represent government and non-governmental sponsorship.

.. The sponsoring agency must be willing to assign a local counterpart full-time for the two week period to work with the Project Director.

To identify appropriate sites, these criteria were sent to the WHO Representatives of the above three regions as well as to selected non-governmental organizations. They were asked to recommend projects that might fulfill the criteria and whose sponsoring organizations would be willing to take on a field evaluation. Recommendations were obtained from each of the regions, and ICRI negotiated directly with the local organizations to make the final selections and arrangements.

Four projects were finally selected from the three regions for the evaluation. They included:

(1) **The Dormaa Healers Project**, in the Dormaa-Ahenkro District of Ghana, jointly sponsored by the Ministry of Health and the Presbyterian Health Services.

(2) **The Cuetzalan Traditional Practitioner Project**, in the State of Puebla, Mexico, administered by the Instituto Nacional Indigenista, a Government Institute which promotes the establishment of health services to indigenous populations of Mexico.

(3) **The Manda TBA Project**, in the Rajshahi District of Bangladesh, sponsored by the Christian Commission for Development in Bangladesh, a non-governmental organization connected to the National Council of Churches.

(4) **The Savar TBA Project**, located in the Dhaka District of Bangladesh, sponsored by The Village Education Resource Center, a non-governmental organization which provides maternal and child health services to villages.

2. Collection of data

a. Documents

A variety of documents were collected from each project. These documents included:
• Descriptions of project needs, objectives, and methods and the agency's official policy for using traditional practitioners;

• Training objectives, protocols, and methods;

• Evaluation and progress reports;

• Data on costs of training and support services;

• Training and health education materials that were developed by the project or secured from outside sources.

b. Interviews

Interviews were held with three groups: (1) key project staff and health agency personnel; (2) trained traditional practitioners; and (3) community members who received services from the project. We intended to obtain a random sample of the latter two groups, but this was not possible due to constraints of time and availability of respondents.

Standardized questionnaires were designed to obtain information about peoples’ knowledge, attitudes, and behaviour regarding the tasks traditional practitioners were performing, community members’ satisfaction with these services, and the extent and quality of collaboration between traditional practitioner and health agency staff. These questionnaires are reproduced in Appendices 1, 2, & 3.

All interviews were administered jointly by the Project Director and a counterpart from the local culture who was assigned by the local project staff. This counterpart, fluent in English and the local language, established rapport with the interviewee and asked the questions in the local language. He/she then translated the answers for the Project Director who recorded them in English. This process seemed to be effective in establishing rapport and collecting the desired information, as all respondents seemed willing and eager to provide the information requested. It should be noted, however, that it is possible in the translation of answers between the local language and English some accuracy or meanings may have been altered.

Another advantage of enlisting the participation of a local staff counterpart for the two-week period was that it provided a good opportunity for the Project Director to strengthen the counterpart's skills in interviewing and knowledge of participatory evaluation methods.

c. Training and educational materials

All available examples of training and educational materials were collected for evaluation of the effectiveness of the classes and workshops. Additionally, these materials were used to develop guidelines to assist other organizations in training traditional practitioners in PHC services.
3. Analysis of the data

The responses from the interviews were categorized separately for each of the three groups: health agency staff; traditional practitioners; and community members.

Their responses were analyzed in terms of the following categories:

- performance of traditional practitioner after training;
- attitudes of traditional practitioner after training;
- community satisfaction of services offered;
- collaboration between traditional practitioners and health agency staff;
- changes in health behaviours of community members;
- changes in health conditions of communities.
V. REVIEW OF THE LITERATURE

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

- Herbalist;
- Diviner;
- Spiritual or faith healer;
- Traditional midwife;
- Traditional birth attendant;
- Curandero;
- Shaman;
- Traditional Chinese doctor;
- Ayurvedic doctor;
- Unani practitioner.
AFRICA

Location: Sierra Leone

Project: Traditional Birth Attendants Help Reduce Infant Mortality

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

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

Location: Sudan

Project: Village Midwives Work in the Community

Description: A WHO/UNFPA-assisted programme was begun in 1978 to train village midwives. The course was geared to teach village midwives how to perform specific tasks in the community. In addition to the standard midwifery tasks of antenatal care, delivery, newborn and postpartum care, they were also taught to give advice to mothers on family planning, provide health education on home sanitation, immunization, prevention of accidents and, communicable diseases.

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

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Location: Sudan

Project: Sudan Community-Based Family Health Project

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

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

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

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

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

Project: DANFA - Traditional Birth Attendants Promote Health Education

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

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

Location: Ghana

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

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

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

- all the traditional practitioners supported the training programme;
- there was a high level of information retention;
- all trainees stored their herbal medicines in clean, plastic bags;
- care of sick children was significantly improved;
oral rehydration for children was accepted as important;

- information on topics such as oral rehydration was rapidly communicated from trained traditional practitioners to those not yet trained;

- relationships improved between Western allopathic-trained health workers and traditional practitioners;

- the number of referrals between traditional practitioners and other health workers increased in both directions.

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

**Location:** Ghana

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

**Description:** The Brong-Ahafo Rural Integrated Development Project (BARIDEP)\(^9\) was carried out from 1975-1980 by the Ghanaian Government with assistance from WHO and UNICEF. The aim was to achieve improvements in the health status of the project area population, and to promote the social well-being of the population through community self-help projects.

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

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

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

Project: Traditional practitioners Cooperate With Clinic Nurses

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

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

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

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

- reduction of fears and mistrust between nurses and traditional practitioners;
- increased referrals (particularly for children with diarrhoea and vomiting) by traditional practitioners to clinics;
- increased understanding of the treatment and prevention of dehydration and ability to mix oral rehydration solution accurately;
- decrease in the dangerous use of purges and enemas by traditional practitioners;
- increase in health education to patients on subjects of home sanitation, nutrition, immunizations and clinic checkups;
- increased use of wash basins in traditional practitioners' clinics and latrines in their homes;
traditional practitioners communicated information about the content of the workshop through their own informal networks to other traditional practitioners, thereby disseminating more information to others.

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

**Location:** Nigeria

**Project:** Traditional practitioners Promote Primary Health Care

**Description:** Between 1984 and 986, the Lagos Board of Traditional Medicine designed and coordinated a collaborative programme in Nigeria\(^\text{11}\). Traditional herbalists were trained in both community-based distribution of contraceptives, and in preventive/promotive aspects of primary health care.

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

- inherent conflicts between the scientific and magico-religious paradigms of Western-trained versus traditional practitioners;

- economic and prestige competition between the two sectors;

- traditional practitioners feared they might become second-rate paramedical workers, and thereby cease to carry out their important function in the community (e.g., social, psychological, spiritual and health).

**Location:** Zambia

**Project:** Traditional practitioners Help To Prevent Diarrhoeal Disease

**Description:** A survey conducted in 1986 by the staff of the Diarrhoeal Disease Control Programme of the Ministry of Health, Department of Traditional Medicine in Zambia\(^\text{12}\) supports the idea that "healers constitute a valuable, virtually untapped manpower resource which could be used to promote oral rehydration therapy and therefore extend
the limited resources of the Ministry of Health/Diarrhoeal Disease Control Program."

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

**Results:**

The results of the study showed that many traditional practitioners were aware of the signs of dehydration in children, advised mothers to give fluids, informed mothers about ways to prevent diarrhoea, and expressed a willingness to use and promote oral rehydration solution.

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

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**EASTERN MEDITERRANEAN**

**Location:** Afghanistan

**Project:** Traditional Birth Attendants in General Health Services

**Description:** The Ministry of Public Health (MOPH) trained TBAs in improved birth and delivery, care to infants and mothers, and family planning services.\(^{13}\) The MOPH recognized the value of indigenous practitioners with special skills, particularly in rural areas. The TBAs, usually older married women with no formal education, had several years of experience in dealing with pregnancy and childbirth, including their own personal experience. Their training included how to provide prenatal care, safeguard the fetus, and ensure easy and safe deliveries.

**Results:**

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

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

Location: India

Project: Indigenous Healers Work in Community Health Schemes

Description: Roger Jeffrey\textsuperscript{14} reviewed government policies toward traditional practitioner in India and described how traditional practitioner of the Ayurveda and Unani systems have been used in the community health schemes. Both the Western allopathic doctors and the indigenous practitioners (i.e., Ayurvedic, Hakims and Vaidys) are politically strong, and have wide support in communities.

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

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

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

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

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Location: India

Project: INGRID PROJECT -- Traditional Midwives Provide Health Education

Description: India’s New Group for Raichur’s Integrated Development Project,\textsuperscript{15} (INGRID), started in 1981. The goal of the project was to improve life of the rural and uneducated population by developing leaders in selected villages who would work towards self-help community development. INGRID aimed at setting up health care within ten villages by providing low-cost health facilities and by educating people on health, hygiene and nutrition. Priorities were to establish a medical dispensary, and organize health education in all the villages.
The project used the skills of both medical doctors and traditional midwives, who were supported and trained to do ongoing preventive health education. Mobile clinics were established and a small "native-style" dispensary was set up in one of the villages with a complete selection of both modern medicine as well as local herbal medicines. The dispensary functioned on the veranda of a village healer and was run directly by local villagers.

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

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

Location: Nepal

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

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

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

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

Results: An evaluation was conducted by testing the traditional practitioners before, and six months after, the workshops. All the participants were enthusiastic about the value of the workshops, and 98% recommended that this type of training be given to all traditional practitioners throughout the kingdom.
Results indicated that there were substantial increases in the knowledge and practices of traditional practitioners. In addition, the evaluation of the project found conclusive evidence that these faith healers can play a culturally appropriate and cost-effective role in health education and family planning in Nepal.

**Location:** Nepal

**Project:** Study of Traditional Medical Practitioners in North Eastern Nepal

**Description:** This project\(^{17}\), conducted in 1980-81, studied the attitudes and practices of Traditional Medical Practitioners (TMPs) in seven health posts in a mountainous region of northeast Nepal. The TMPs were given a two-day training with follow-up sessions over a period of eight months. The training included the purpose of primary health care and the functions of health care staff; how to recognize and manage the endemic conditions of tuberculosis (TB), leprosy, childhood diarrhoea and malnutrition; and how to refer patients with symptoms of TB and leprosy.

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

**Location:** Thailand

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

**Description:** Due to the inability of the organized health system to meet basic health care needs, the Thai Government implemented a nationwide plan for the training and utilization of TBAs in community health\(^{18}\). The training of TBAs in Thailand dates back to 1952 when the Government embarked upon a programme to reduce maternal and infant mortality through improving rural health services. Nearly 17 000 TBAs received two weeks of training by the end of 1968. The course focused on antenatal care, delivery techniques and postnatal care. In 1970, the
government decided to focus on family planning as an approach to reduce maternal and infant mortality.

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

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

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PACIFIC

Location: China

Project: "Barefoot Doctors" Work in Community Health Programmes

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

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

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

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

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

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

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

Location: Philippines

Project: Traditional Practitioners Strengthen Community-Based Health Programmes

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

The authors stated that:

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

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

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

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**AMERICAS**

**Location:** Brazil

**Project:** Training Healers in Oral Rehydration Therapy

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

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

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

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

The traditional practitioners were taught the basic biomedical concept of dehydration, and how to prepare and use a simple home-made ORS solution. They were also taught five basic health messages:

1. give ORS for diarrhoea and dehydration;
2. continue feeding during diarrhoea and do not withhold food;
3. encourage breast feeding during diarrhoea;
4. eliminate drugs to treat diarrhoea;
5. ask people to seek a traditional practitioner quickly at the onset of diarrhoea.

Traditional practitioners were then taught to instruct mothers how to prepare ORS-tea using simple graphic instructions. These simple teaching materials were re-written by the traditional practitioners, and a local artist illustrated them so they could be understood by illiterate mothers. In addition, traditional practitioners learned five high-risk indicators so they could refer children to paediatric health services.
Results: The staff found that in general the traditional practitioners were trusted, astute clinical observers, knowledgeable about anti-diarrhoeal plant remedies, skilled in accurate preparation of ORS, and pragmatic in integrating modern therapies that work.

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

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

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

REVIEW OF ADDITIONAL LITERATURE

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

Location: Canada

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

Summary: One of the components of PHC for Canada's Indigenous people is the utilization of traditional ethnomedicine and the recognition of the important role of traditional practitioners in the Indian societies. Marilyn Mardiros\textsuperscript{22} describes how indigenous healers are being used to provide PHC services to Indian and Inuit communities. Midwives and other traditional practitioners, until recently banned by the health care system, are now being actively identified and used as important members of the health care team.

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

**Location:** Papua New Guinea

**Topic:** Traditional Birth Attendants Promote Community Self-Help Programmes

**Summary:** A successful training programme for TBAs was organized in 1981. The programme aimed at community self-help and self-reliance.

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

**Location:** Zaire

**Topic:** Traditional Birth Attendants Deliver MCH Services

**Summary:** In Zaire, the local hospital in the Rural Health Zone of Karawa began an extensive outreach programme to increase the access of rural women to maternity care and to expand prenatal care. Traditional birth attendants, nurses and midwives played a critical role in the programme by delivering MCH services and by providing a back-up referral system. Community participation was an important part of this programme as the communities contributed money to pay for TBA kits and families were asked to pay a small fee for each delivery.

**Location:** Vietnam

**Topic:** Traditional Midwives Provide Pre and Post Natal Care

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

**Location:** Sri Lanka

**Topic:** Ayurvedic Practitioners Assist in Family Planning and Contraceptive Distribution

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

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**Location:** Ghana

**Topic:** Traditional practitioners Perform a Variety of PHC Activities

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

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

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

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

**Location:** Various  

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

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

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

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

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Location: Africa

Topic: Modern and Traditional practitioners Collaborate for Improved Health Coverage

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

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

- TPs should be included in primary health care teams, especially at the village level.

- TPs should be given incentives and suitable training so they can report on epidemics and other health hazards.

- Training should also include elementary environmental sanitation, as well as simple appropriate medical technology.

- Practitioners of conventional medicine should learn from TPs something of the physical and socio-cultural basis of the latters’ practice.


Location: Africa

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

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

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

Location: Swaziland

Topic: Traditional practitioners Assist in Control of Childhood Diseases

Summary: In a paper presented to the National Council for International Health in Washington, D.C. (1986), Wilbur Hoff describes the positive outcomes of training TPs to assist in the control of childhood diseases in Swaziland. An important finding of this project was the high level of enthusiasm exhibited by the TPs involved in the project. Traditional practitioners who were trained went back to their own communities, and at their own initiative organized meetings with other traditional practitioners in their respective areas. At these meetings they described what they had learned, thus disseminating health knowledge to other healers who had not attended the workshops.

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

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

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

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

Location: Mexico

Topic: Traditional practitioners Trained as Community Health Workers

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

- traditional practitioners continue to work longer and have a better rapport and accountability in the community than do persons selected from the outside to be trained as community health workers;

- traditional practitioners tend to integrate traditional healing and herbal medicine with modern medicine, preventive care and community health promotion;

- when health programmes collapse or fail, traditional practitioners who have received training in other aspects of health care and health promotion tend to continue with their work and retain community support.

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

A. CONCLUSIONS

An important finding that stands out among the hundreds of documents reviewed is that there are relatively few projects that reported good evaluation data. Only seven of the projects reviewed reported any evaluation findings.

While the data provides very helpful information to assess the effectiveness of projects using TPs in community PHC programmes, we need more documented results from demonstration projects that represent different conditions throughout the world. Such data is necessary to answer some of the questions about how to select, train, and utilize TPs in PHC and to evaluate the cost-effectiveness of such activities.
The information that has been reviewed in the literature is useful in arriving at the following conclusions:

1. **There are a number of positive aspects to the use of TP's in community health.**

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

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

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

   (1) **Promoting education concerning prevailing health problems and methods of preventing and controlling them, including:**

       - information about local prevailing health problems
       - methods of preventing and controlling these problems
       - use of posters and other simple health education materials.

   (2) **Promoting improved food supplies and proper nutrition, including:**

       - how to obtain a balanced diet
       - proper diet for mother and child, (i.e., breast feeding and proper weaning foods)
       - growing vegetables and fruits in kitchen gardens.
(3) Promoting adequate supply of safe water and basic sanitation, including:
   - how to obtain safe water
   - proper construction and use of latrines
   - personal hygiene and home sanitation
   - clean preparation and storage of food.

(4) Promoting maternal and child health care, including:
   - family planning
   - how to monitor pregnancy and recognize abnormalities
   - proper ante-natal care
   - basic delivery techniques
   - when to refer women for abnormal conditions of delivery
   - how to advise women for family planning
   - distribution of oral contraceptives and referral for other methods.

(5) Promoting immunization against major infectious diseases, including:
   - when and how to refer children under five to clinics for immunizations
     against childhood diseases.

(6) Promoting prevention and control of locally endemic diseases, including:
   - how to recognize symptoms of dangerous diseases such as diarrhoea,
     TB, leprosy, malaria, malnutrition and to refer for treatment
   - how to mix and use ORS to treat dehydration and diarrhoea
   - distribution of ORS packets
   - referring women in high risk groups for treatment
   - how to use readily available allopathic medicines, (i.e., anti-malarial
     prophylaxis, ORS, etc.).
(7) Providing appropriate treatment of common diseases and injuries, including:
   - giving first aid
   - preventing accidents.

(8) Providing essential drugs, including:
   - aspirin and other first aid medications
   - operating basic dispensaries.

2. Training TPs has produced several positive outcomes.

   Those projects that attempted to evaluate outcomes of training reported a number of positive outcomes.

   a. Changes in attitudes, knowledge and behaviour. Projects in Sudan\(^5\), Ghana\(^8\), Swaziland\(^{10}\), Nepal\(^{16}\), and Brazil\(^{21}\) all indicated that participants had a high degree of interest and enthusiasm in learning new information and skills in PHC.

   These same projects were able to demonstrate changes in the practices of traditional practitioners after the training workshops. These changes included the following:
   - increased use of ORS and giving fluids to children with diarrhoea
   - use of wash basins 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
   - increase referrals to clinics for patients with dangerous symptoms
   - increase in births attended by village midwives.

   b. Changes in health status of people served by TPs. While there was little data reported on changes in health status of target populations, a number of projects indicated that there was a high degree of acceptance by the communities of the traditional practitioners who had been trained. The Sudan project\(^7\) reported that the proportion of women ages 30-34 using contraceptives increased from 25% to 38% over the two-year period, and that overall use of contraceptives rose from 13% to 21%. The Nepal project\(^{16}\) reported that there was an increased attendance at rural clinics after the trained healers began working in local communities.
c. Training TPs along with health staff has produced positive changes in attitudes and behaviour of health sector staff. Many of the projects indicated that there was an increase in trust and respect between the nursing staff and TPs, and that working relationships between the two groups improved. The Swaziland project\textsuperscript{10} reported that there was an increase in referrals by traditional practitioners to rural clinics, particularly for children with diarrhoea and vomiting.

d. Training traditional practitioners has proven to be cost effective. Ramesh M. Shrestha reports\textsuperscript{16} that their evaluation of the "dhami-jhankri" training programme in Nepal found conclusive evidence that faith healers can play a culturally appropriate and cost-effective role in health education and family planning. The staff estimated that country-wide, there was a ratio of well over one hundred dhami-jhankries to each health worker, and that these traditional practitioners, as private practitioners, were paid only a modest fee by the people for their services.

In Swaziland, Wilbur Hoff\textsuperscript{20} reported that the cost to government for materials and training TPs in PHC was relatively low. "The government does not pay for services provided by TPs, since they are private practitioners and are paid by the community." The Swaziland Traditional practitioners Organization also committed a large amount of its time and resources to the project, which helped reduce the cost to government.

In the Philippines, Michael M. Tan\textsuperscript{20} reported that the project staff felt the main strength of the community-based health programme was its low cost. This was due to the project's employing traditional medical practitioners who used low cost traditional therapies. Using traditionally available remedies reduced costs of more costly commercially prepared drugs.

3. Constraints to the Use of Traditional Practitioners in Primary Health Care

The training and use of TPs in community PHC programmes can pose difficulties in some situations. Specific problems, limitations and constraints were reported from projects and in literature reviewed. These are summarized and described as follows.

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

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

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

d. There exists some conflict between traditional and modern medical practices. The paradigm conflict between the traditional holistic, spiritual healing orientation and the modern biomedical treatment-oriented approach poses a basic difference in philosophy regarding the causation of disease and the promotion of health. These differences in orientation and training can cause barriers between traditional and modern practitioners getting together and working cooperatively.

e. Some fraudulent practitioners engender prejudicial feelings against ethical and responsible traditional practitioners. Charlatans and fraudulent practitioners obscure the worthwhile contributions of the large majority of bona fide traditional practitioner. Isolated incidents of witchcraft, malpractice or unscrupulous behaviour are widely publicized by the media, which tends to reinforce the stereotypes many people have that TPs are quacks and "witch doctors". The fraudulent practice of a few inhibits the genuine movement of the majority to create better understanding and cooperation between the traditional and modern health sectors.

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

g. Many traditional practitioners lack formal education and have low levels of literacy. This can pose difficulties in the training of TPs. In both Ghana and Swaziland, it was found that low levels of literacy and education of some of the traditional practitioner participants required specially designed training methods. Conventional methods of training, such as lectures and use of written materials, were not appropriate.

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

i. **There is a lack of cooperation between TPs and health staff.** Lack of cooperation impairs coordination of services between the two groups. One example of this is the difficulty of establishing referral systems between traditional practitioners and clinic nurses. The Swaziland project discusses this issue, describing how referrals between traditional practitioners and nurses increased when the two groups began to cooperate during and after the TP training project.

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

k. **Little or no evaluation has been conducted after training TPs.** There has been little, if any, evaluation or follow-up after TP training projects have been completed. Little data is available to indicate how effective their training has been, what they are accomplishing in the community, and how satisfied community members are with TPs performance of PHC activities.
VI. DESCRIPTION OF PROJECTS

Case Study One: Dormaa Healers Project, Ghana
Sponsored by Ministry of Health & Presbyterian Health Services

A. DESCRIPTION OF PROJECT

The lives of most village families in Ghana are difficult. The majority of villagers are farmers who barely make a living growing crops such as maize, cassava, yam, and plantain. And most Ghanaians still have poor or inadequate housing, sanitation, water supply and nutrition.

The health status of Ghanaians is among the poorest in the world and the life expectancy at birth is 53 for males, 57 for females. The infant mortality rate is high, 86 per 1,000 live births, as is the incidence of diarrhoea, malaria, and respiratory infections. Hospital and clinic health services, often located far from villages, are oriented more toward the treatment of diseases than preventing illness and promoting health. These conditions represent those common to many people in other regions of Africa as well.

Recently, however, in the District of Dormaa, these poor health conditions began to improve as a result of an innovative project begun in 1985 with the cooperation of the Dormaa District Hospital, which is administered by the Ghana Presbyterian Health Services, and the Primary Health Care programme of the Ministry of Health (MOH). During that time, an anthropological study was being conducted to understand the connection between Dormaa Traditional Religion and Medicine, particularly with regard to the role traditional practitioners could play within the primary health care system. From the results of this research, the MOH Primary Health Care Project and the Ghana Presbyterian Health services obtained a grant from "Bread for the World" to conduct a pilot project to train traditional practitioners in primary health care skills.

The government health staff believed that local traditional practitioners, if well trained, could be effective in promoting health and preventing disease through health education as well as by treating traditional illnesses. When healers were asked what were the most serious health problems in the communities, they replied; marasmus, and convulsions in children, fractures, malaria, diarrhoea, guinea worm, gonorrhoea, infertility, whooping cough, stomach disorders, tuberculosis, headache, dizziness, rheumatism, yaws, osteomyelitis, measles, spiritual diseases and madness.

Because traditional practitioners recognized these diseases, it was felt that they could be taught to identify serious cases and refer patients to the hospital. They could also serve as a referral centre in the community, and learn to treat those patients unable to get to a clinic. Since smaller communities had no clinics, trained traditional
practitioners could provide services for those who were unable to obtain Western medical care.

B. OBJECTIVES

The principal aim of the Dormaa Project was to develop a non-institutionalized form of cooperation between all practitioners engaged in providing basic health care. This aim was broken down into the following specific objectives:

1. To establish and maintain relationships between all health care workers in the district, including traditional practitioners.

2. To assist TPs in improving their skills, knowledge and attitudes toward community-based PHC and other development programmes in order to contribute effectively and efficiently to a better economic and culturally acceptable health delivery system in the district.

3. To encourage a dialogue and cooperation among the traditional practitioners and biomedical workers in order to:
   a. reduce suspicion and prejudice;
   b. encourage mutual respect between TPs and biomedical workers
   c. strengthen the positive aspects of both medical systems;
   d. establish a prompt referral system between the traditional practitioner and the nearby Hospital/Health Centre;
   e. carry out preventive health and health promotive activities in their communities.

C. RECRUITMENT AND SELECTION OF TRADITIONAL PRACTITIONERS

The process for recruiting and selecting traditional practitioners for training began in the communities to be served. The project staff visited the Chief and elders of each village to obtain their recommendations of traditional practitioners whom the community respected and trusted, and to obtain information about what health problems these traditional practitioners treated.

These candidates were then interviewed separately by the project staff using a questionnaire to obtain more detailed information. This information was then compared to what the elders had said and two traditional practitioners from each village were selected. The final selection was confirmed by the village elders and ten to fifteen traditional practitioners were then chosen for each regional training programme.
D. TRAINING CONTENT

Two training programmes were developed, one for the group of herbalists, bone setters and spiritual traditional practitioners, and another for TBAs. The content of these two programmes was created after a survey was conducted with the traditional practitioners to find out what they wanted to learn. In addition to these suggestions, the Project staff added the basic elements of Primary Health Care.

The training content for the first group of healers included the following blocks of information:

Block I: Hygienic preparation and storage of herbal medicines.

Block II: Causes, diagnosis, and treatments of traditional and modern diseases.

Block III: Nutritional value of local foods and substitutes for food taboos.

Block IV: Environmental sanitation and health.

Block V: Direct and indirect prevention of diseases, ie, immunizations.

In addition to health content, a related project was started at the request of a group of traditional practitioners who wanted to learn how to keep bees. They used honey in the production of some medicines and wax to preserve them. Honey was also used for public consumption, could be sold in the market, and was useful in pollinating crops. For these reasons the project staff also agreed to teach this group of traditional practitioners beekeeping.

The training content for TBAs included the following:

- Preparation for delivery;
- Basic anatomy of the female and male reproductive organs;
- Signs and symptoms of pregnancy and common complaints;
- Care of the woman during pregnancy, ie. nutrition, rest, sanitation, relationship with husband;
- History taking and record keeping;
- High risks of pregnancy and how to refer;
- Stages of labour and care of woman during this period;
- Care of mother 6 weeks after delivery;
- Weaning and treatment of diarrhoea;
- Family planning and AIDS.

The training course was held in half-day workshop sessions two times per week for five months. This averaged eight sessions per month for a total of approximately 120 hours. These sessions were held in a village in each target zone and scheduled on non-farming days so all could attend. Before training was begun, the staff organized a two day workshop to train the trainers, ie, PHC and hospital staff.

The major content of this training included:

- Understanding of traditional practitioners and their medicines;
- Adult teaching methods, ie, the use of pictures, dialogue, and other non-formal methods;
- Communication skills and interpersonal relationships, ie, building trust and respect, use of eyes and body language, etc.

E. TRAINING METHODS

The meetings were held in a village under a tree, and participants came from the surrounding four to six communities. Ten to fifteen traditional practitioners were chosen for each training programme. One block consisted of two to four workshops, each lasting two to three hours. In every workshop one topic was covered by:

- discussing problems coming out of their work;
- exchanging experiences and ideas;
- story telling;
- role play;
- songs and dances with Nwomdoro musical instruments;
- use of audio-visual aids.

Different methods of instruction were used to make the sessions lively and keep up the interest of the group. In addition to the workshop sessions, the TBAs were given 7 days of clinical practice in the hospital and health centres near where they lived.

F. FOLLOW-UP SUPPORT

At the three regional centres, half-day refresher courses were offered every three months during which all workshop topics were reviewed. During these courses,
questions were prepared for the traditional practitioners on all the topics presented in the initial training programme. The traditional practitioners were also encouraged to ask questions and to give suggestions on how the refresher courses could be improved.

Two-day workshops were also offered for the trainers and project staff to discuss past experiences and any improvements needed. This course also served to motivate the trainers to improve their skills.

After completion of the basic course, the project staff made supportive visits at least once a month to the traditional practitioners who graduated from the project. These visits had three purposes:

- to identify problems;
- to monitor activities;
- to provide support and assistance.

During the visits, the staff found out how the traditional practitioners were doing, whether they were encountering any difficulties in their work, and if so, suggested solutions to problems. The traditional practitioners were also informed of the importance of keeping records and were taught good record-keeping methods.

G. CHARACTERISTICS OF PERSONS INTERVIEWED

1. Health Agency Staff

Eleven representatives of the health agency staff were interviewed about their relationship with and views on traditional practitioners. There were five females and six males, and the average age was 36 with a range of 24 to 45. Their occupations included: medical officer, hospital doctor, nurse midwife, nurse, medical assistant, community health worker, nutrition officer, and health educator. The average amount of time worked in their current position was 6.7 years, with a range of 1 to 12 years.

2. Traditional Practitioners

Twenty-three traditional practitioners from ten different villages were interviewed for information. These were eleven herbalists and spiritual practitioners, ten traditional midwives, and two bone-setters. Twelve were males with ages ranging from 41 to 80 and 13 were females aged 40 to 80. The average number of years the traditional practitioners had worked was 25.3, with a range of 8 to 60. Most had little or no education and few could read or write.
3. Community Members

Seventeen members of seven villages were interviewed to determine their satisfaction with the services of the traditional practitioners. Ten were men and seven were women ages 18 to 92 years and had occupations of farmer, labourer, or mother.

Case Study Two: Cuetzalan Traditional Practitioner Project, Mexico
Sponsored by Instituto Nacional Indigenista

A. DESCRIPTION OF PROJECT

High in the rugged Sierra Oriental Mountains between Mexico City and Vera Cruz lies the small town of Cuetzalan, the major centre for market activities and the source of health services for the largest group of Nahuatl and Totonac speaking peoples in Mexico. These people, descendants of the ancient Aztecs, Huastecos, Mayas, Oimecas, Teotihucans, Toltec, and Zapotecs, practice the traditions of indigenous medicine which are widely known even today for the powers of medicinal herbs and spiritual practices.

Health practitioners - midwives, herbalists, bone-setters, and prayers, passed their knowledge down from generation to generation, and these traditional beliefs and practices of healing are still rooted within the many indigenous cultures that have settled mainly in the southern and eastern parts of the country. These indigenous peoples believe disease exists not only in man's body but also in his spirit, which unites him to the earth and sky, to the wind and waters, and to the animals and minerals.

Since the conquering of Mexico by the Spaniards, the majority of the population has became a mixture of Indian-Spanish-other blood. This blending has created a tradition which leads people to use various diagnostic and treatment modalities and people do not hesitate to turn to whatever cure or medicine they feel will be effective. As of 1993, 57 Traditional Practitioner Organizations had been officially established in 20 of the 31 states in Mexico. These associations represent a very large portion of the indigenous populations throughout the country.

These people are the most vulnerable segments of the Mexican population with the least access to modern health services. They have one of the highest maternal mortality rates in the country and 70% of children under 13 years of age are malnourished. People also have high rates of fertility, tuberculosis, respiratory, and gastrointestinal illnesses. Because of increasingly difficult living conditions they are rapidly emigrating from their communities to cities and migrant labour camps in search of a better life.

In 1989 the Mexican Government, through their Instituto Nacional Indigenista (National Institute for Indigenous People), launched a demonstration project in a rural government hospital in Cuetzalan. The Cuetzalan Traditional Practitioner
Project serves 46 indigenous communities - a total population of 28,000 - and its purpose is to offer, through a decentralized health system, a combination of scientific/modern medicine, traditional healing, and folk medicine to the local village people.

B. OBJECTIVES

The objectives of the project included the following:

1. Provide specific Primary Health Care (PHC) services to the region;

2. Coordinate the activities of local institutions and resources to provide health services;

3. Develop traditional medicine and an Herbolarium as a resource for the traditional practitioner;

4. Provide medical and PHC services to treat the major health conditions, reduce the levels of malnutrition, improve sanitation, and increase immunization.

5. Promote the rural health system to local institutions and groups, international agencies and government groups.

The project is based on a primary health care strategy that was adapted to the needs of indigenous communities, promotes full community participation in decision making, recognizes the importance of traditional practitioners in serving the local communities, and involves a close working relationship with Mexico’s national council of traditional practitioners.

C. RECRUITMENT AND SELECTION OF TRADITIONAL PRACTITIONERS

The project began by enlisting the use of Health Promoters (a category of paid community health worker trained and employed by the Government Health Service), who were asked to take a census of all the traditional practitioners in their areas. The practitioners who were identified included traditional midwives (parteras), herbalists (herbalistas), bone setters (hueseros), and spiritual healers (curanderos or prayers). These traditional practitioners (approximately 120) were then all invited to a two day workshop held at the Cuetzalan Rural Hospital where the staff explained the purpose of the project, the training programme, and the plans for utilizing TP services in the communities and in hospitals.

A second workshop was held a month later with only 49 traditional practitioners attending - 24 parteras and 25 other traditional practitioners. This group continued to attend further training sessions held at the hospital. The first two workshops were intended to orient the traditional practitioners to the general nature of the training programme and how they could carry out services within their communities and the hospital.
D. TRAINING CONTENT

After the first two orientation workshops, a monthly training schedule was established. This schedule was developed around the local needs of traditional practitioners and community members who came to town during Saturday and Sunday, market days in Cuetzalan. The training staff therefore established the following schedule to hold training sessions for traditional practitioners at the Government Hospital in Cuetzalan:

Saturdays

- first and third Saturday of every month for TBAs (parteras);

Sundays

- first Sunday of the month for training herbalists and spiritual practitioners (curanderos and prayers);
- second Sunday of month for training bone setters (hueseros);
- third Sunday of month - open;
- fourth Sunday of month for all traditional practitioners to meet together and plan joint activities.

The TBAs were trained by a team of three experienced Health Promoters (auxiliary nurses) and assisted by the other staff members of the hospital. The training content for TBAs included:

- Signs and symptoms of pregnancy;
- Proper care of pregnant woman, ie personal hygiene, rest, nutrition, sanitation;
- How to identify position of fetus and what to do in difficult cases;
- How to hygienically prepare for and deliver a baby;
- How to properly cut and care for the umbilical cord;
- History taking and record keeping;
- How to identify high risks of pregnancy and refer to hospital;
- Referring women for tetanus immunizations and children for other immunizations;
- Breast feeding and weaning practices.
Three staff members trained the herbalists, hueseros and spiritual traditional practitioners. Two were trained in agronomy, specifically in the identification and growth of herbal plants and the third was an experienced herbalist practitioner who volunteered as a trainer.

The herbalist group was trained in identifying and using herbal plants in their region; collecting, drying, and preserving these herbs in a hygienic way; in growing herbal gardens to provide a ready supply of herbal medicines for their own use; and in selling herbs in the market for income. The bone setters were taught basic anatomy, hygiene, and how to collaborate with physicians in setting broken bones.

E. TRAINING METHODS

The training techniques used for all groups of traditional practitioners were generally the same. The staff used a combination of adult education methods including the presentation of information in a didactic form, using question and answer formats, demonstrating techniques and methods, illustrating points with diagrams and posters, and breaking the participants into small groups for discussion.

An important part of training sessions was having the participants share with each other their own techniques and methods of healing. This enabled the traditional practitioners to better understand what others were doing and gave the staff a chance to point out the positive or unsafe methods in their practices. The traditional practitioners were appreciative of these sharing sessions.

A review was made of the training materials which staff members used in the workshops. A manual for training indigenous doctors had been prepared jointly by UNICEF, the National Institute of Indigenous People, and the Government of the State of Oaxaca, and this was used for the training of herbalists, bonesetters, and spiritual traditional practitioners. Some visual aids were available in Spanish for training Health Promoters but contained few pictures and these were not completely appropriate for the low literacy level of the TBAs. Since few posters, flip charts and models were available, the staff improvised by creating their own visual materials. One outstanding production of the herbalist training group was the development by the traditional practitioners of a book on indigenous medicinal plants. The training staff acknowledged that the lack of suitable training materials was a serious problem for them to conduct effective training.

F. FOLLOW-UP SUPPORT

The follow up and support for the traditional practitioners was built into the continuing monthly training sessions as described in "D" above. The TBAs met twice a month to learn new information and skills and to exchange experiences with each other. The same procedure was followed with the other traditional practitioners who met once a month. At that time the training staff identified any difficulties encountered by TPs and helped resolve them.
In addition to these opportunities to provide follow up, all traditional practitioners met together once a month in a general assembly to discuss problems and plan their activities. Hospital staff provided guidance to traditional practitioners coming into the hospital on a rotating basis to offer traditional health services according to their own specialty areas.

All eight of the health agency staff members interviewed indicated they felt it was necessary to provide this type of support in order to reinforce what the traditional practitioners had learned and to insure that proper methods of treatment were used. Staff felt this type of supportive environment facilitated a positive interchange of ideas between traditional practitioners and health agency staff.

G. CHARACTERISTICS OF PERSONS INTERVIEWED

1. Health Agency Staff - Eight official health agency staff representatives were interviewed regarding their relationship with and views on traditional practitioners. There were seven females and one male, and the average age was 30.5 with a range of 24 to 38. Their occupations included: Chief of the Department of Traditional Medicine, hospital director, nutritionist, social worker, general practitioner, and nurse. The average amount of time worked in their current position was 3.8 years, with a range of 1.5 to 12.

2. Traditional Practitioners - Seventeen traditional practitioners who received training through the Cuetzalan Project were interviewed, thirteen females and four males. Of the thirteen females, twelve were TBAs (parteras) and one was a Health Promoter, while male representation consisted of two spiritual healers and two bone setters. The ages of the traditional practitioners ranged from 31 to 68 with an average age of 53.6. Eight of the seventeen interviewed were literate, although the highest level of schooling reported was six years. The average number of years in practice was 18.5, with a range of 0 to 38 years. An interesting note is that the two priest healers spoke Nahuatl, and were provided with interpreters for the training, which was conducted in Spanish.

3. Community Members - Five representatives from two communities were interviewed about their satisfaction with the traditional practitioners serving their communities and with the hospital staff services. Three men and two women aged 22 to 60 years in the occupations of farmer, mother and President of the Cooperative were asked about the health problems of their families and the services that the trained healers provided. All but one of those interviewed had at least one child under the age of six. When asked about their family's health problems over the past year, the community members listed: diarrhoea, high fever, vomiting, and coughing. Three of the five reported that they had not visited traditional practitioners but only went to the hospital for their health problems.
Case Study Three: Manda TBA Project, Bangladesh
Sponsored by Christian Commission for Development in Bangladesh

A. DESCRIPTION OF PROJECT

The Christian Commission for Development in Bangladesh (CCDB) is a non-profit, non-governmental organization and is an autonomous service organ of the National Council of Churches of Bangladesh. It is engaged in a wide variety of multi-sectoral training and other rural development programmes, all aimed at achieving sustainable development in health, literacy, agriculture, the environment, women’s advancement, and savings and credit. CCDB's approach is to involve local people in planning and implementing programmes according to their own needs.

In 1985, CCDB started a programme to train Traditional Birth Attendants (TBAs) at four rural residential training centres. Since its inception CCDB has trained approximately 5564 TBAs in 10 Districts of the country. The district chosen for this evaluation was the Manda Thana (region) of Rajshahi District, approximately 270 kilometres northwest of Dhaka.

The TBAs, when interviewed, described some of the most serious health problems of women in the communities they served: edema of feet and legs; severe anaemia; severe bleeding of haemorrhoids; difficult presentations at birth including breach, hand, cord, leg or placenta first, or transverse position of the baby; long vaginal tears or vaginal fistulae; severe bleeding before or after birth; umbilical cords wrapped around the neck of the baby; retained placenta; and the fact that many women do not get tetanus injections.

B. OBJECTIVES

The main objective of the TBA programme was to impart knowledge and enhance the skills and health care practices of TBAs by arranging periodic training courses to enable them to perform the following tasks:

- perform safe and hygienic deliveries;
- provide prenatal and postnatal care;
- select high risk pregnancies for referral;
- give nutritional advice to pregnant and lactating mothers;
- advise on immunization in pregnancy and childhood;
- advise on family planning.
C. RECRUITMENT AND SELECTION OF TRADITIONAL PRACTITIONERS

CCDB slightly modified the Government's procedure for recruiting and selecting TBAs. Their procedure was to select 5 TBAs per Ward (approximately one per village) and 15 per Union (approximately 15 villages). A letter was written to the Union Parishad requesting them to prepare, in consultation with all its members, a list of names of eligible TBAs. A CCDB Field Organizer then went to the Union and visited all eligible TBAs in their own homes to talk with them and obtain some basic information about their eligibility.

The CCDB criteria for selection of TBAs generally follows the Government of Bangladesh criteria, which are:

- between 30 and 45 years of age;
- conducts at least 5 - 10 deliveries per year;
- married, widowed or divorced;
- a resident of the area;
- well-accepted in the community;
- interested in training.

In addition, the Field Organizer consulted with formal and informal leaders in the community to get their views and to identify other TBAs who may have been missed by the Union. On the basis of these findings the final selection took place.

D. TRAINING CONTENT

The basic course consisted of 11 days of training followed 6 months later by a refresher course of four days, then followed by a second four-day refresher course after another six months. The total training time totalled 19 days, carried out over approximately a year's time.

CCDB staff believed that this pattern of training was very satisfactory and sufficient, since, being residential, it offered TBAs ample opportunity to elaborate, discuss, and repeat the learning material outside the formal sessions.

The training content covered all the MCH areas listed in the objectives in Section B.

E. TRAINING METHODS

A wide variety of training methods and materials were used in the CCDB's training programme. Many visual aids were used in presenting information. These included flip charts, anatomical models and slides. Heavy emphasis was given to
participative group discussions, demonstrations and role plays. Through past experience the CCDB found that informal settings, such as TBAs sitting on mats in a circle on the floor, encouraged group interaction and active participation.

F. FOLLOW-UP SUPPORT

After initial training, regular follow-up support was provided to the TBAs through forums organized at four month intervals. These forums were held at the Union level, and were arranged for groups of 15 trained TBAs of that Union, which was within walking distance. In between these forums, the TBAs met by themselves once a month, with one of their own group as a leader and usually at one of their homes.

G. CHARACTERISTICS OF PERSONS INTERVIEWED

1. Health Agency Staff - Five official health agency staff representatives were interviewed concerning their opinions on the effectiveness of trained TBAs in villages. Three males and two females were interviewed; their average age was 27.8 with a range of 23 to 37. Their staff positions were, TBA Programme Officer, Senior Trainer of TBAs, Assistant Trainer of TBAs, Health Organizer, and TBA Forum Organizer. They had worked in their current positions from 3 to 8.5 years, or an average of 5.1 years.

2. Traditional Practitioners - Eleven TBAs from five villages were interviewed, all were female. Their average age was 40, with a range of 30 to 55. Four of the eleven were able to read and write, and these had attended from 5 to 7 years of school. The average number of years worked was 12.7 with a range of 5 to 24.

3. Community Members - Fifteen members of four villages were interviewed to determine their views on the services provided by local TBAs. There were five males and ten females, and the average age was 31 with a range of 18 to 60. Their occupations included, farmer, labourer, student, businessman, and mother.

Case Study Four: Savar TBA Project, Bangladesh
Sponsored by Village Education Resource Center

A. DESCRIPTION OF PROJECT

The Village Education Resource Center (VERC) is a non-governmental organization which started as a collaborative project of Save the Children, USA and UNICEF in 1977. Based approximately 60 kilometres outside of Dhaka in the rural area of Savar District, it conducts a variety of integrated community development programmes in collaboration with various local, national, international NGO’s and Government Departments, all aimed at empowering the rural poor to achieve self-
reliance. The VERC places a high priority on training programmes to enable men, women and children to improve conditions of health, nutrition, family planning, water and sanitation, agriculture, education and income.

In May, 1990, with financial assistance from the Bangladesh Population and Health Consortium and the British Overseas Development Agency, and in coordination with and approval of the Government of Bangladesh, VERC began a three year project to train TBAs in specific target areas in three Districts. During the three year period, the VERC project trained 219 TBAs from selected regions in all three Districts. This resulted in approximately one trained TBA per village in the target area. The Savar region, which contains 164 villages, was selected for this evaluation.

The TBAs that were interviewed described some of the most severe health problems of the women they knew in the communities. These conditions included tetanus, haemorrhoids, early pregnancy and other pregnancy risk factors such as young age or being overweight, difficult or prolonged labour, painful urination, eclampsia and anaemia of pregnant women, abnormal presentation, infected umbilical cord, and retained placenta.

B. OBJECTIVES

The major aim of the VERC's MCH project was to reduce the neonatal and maternal mortality rates by training TBAs to provide maternal and child health services to mothers. The scope of the project was to provide MCH care not only during the labour and delivery period but additionally, pre- and post-natal care would be offered to mothers and children over the entire 320 day period, from conception until two months after birth.

The specific objectives of this project were:

- To insure safe delivery of pregnant mothers.
- To provide prenatal and postnatal mothers with care and advice and to refer risky mothers and children to health care centres or hospitals.
- To motivate eligible couples to practice family planning.
- To assist TBAs in income-generation activities.
- To increase literacy among TBAs.

C. RECRUITMENT AND SELECTION OF TRADITIONAL PRACTITIONERS

Each training group contained approximately 20 TBAs chosen from among the total 218 selected from the target areas by the selection committee. This committee consisted of representatives from the donor agency, the Upazila Health and Family
Planning authority and the VERC. The committee followed the procedure and criteria set forth by the government.

These criteria included:

- Age between 30 & 50 years and in good health;
- Experience of conducting 8-10 deliveries;
- Known as a TBA in her locality;
- Married/widow/divorced;
- Desire for training as a TBA.

D. TRAINING CONTENT

The content of the training programme followed the guidelines established by the Ministry of Health, but permission was obtained to schedule it in two sessions (a basic residential training of ten days followed later by a five day refresher course.

The curriculum included teaching the TBAs how to:

- examine pregnant women, identify high risk mothers and refer them to the nearest clinic/hospital;
- advise women to get tetanus injections and get their children immunized;
- supply iron tablets to pregnant mothers and vitamin A capsules to postnatal mothers;
- attend the delivery in a hygienic manner;
- advise mothers on family planning and proper nutrition for themselves during breast feeding and weaning of their babies;
- organize community meetings for health education;
- explain to mothers and complete the "Home Based Maternal Record" (a pictorial record card) and update it during pregnancy;
- write and read Bangla (for illiterate TBAs);
- organize and implement income generating activities.
E. TRAINING METHODS

The TBAs resided at the training centre for 10 days of basic training, after which they returned to their communities to practice for four to six months. After this period they returned for a five day refresher course to review their skills and to report any problems they had experienced in the field.

The content of the curriculum was presented according to the training manual developed by the VERC. Course content was generally presented in brief lectures followed by questions and answers, discussions, role-plays, and demonstrations. Some flip charts and models were used as well.

F. FOLLOW-UP SUPPORT

An important aspect of the training project was the weekly follow-up meetings that were scheduled for all TBAs. Fifteen field supervisors were employed by the project to organize and conduct these weekly, small group, half-day sessions in the areas where the TBAs worked. The purpose of these sessions was to review the daily progress of TBAs, to provide guidance and assistance in solving their problems, and to provide continuing field training. In addition to reviewing the TBAs’ work at these weekly sessions, the women studied their literacy materials and made plans for income generating activities.

These weekly sessions were generally held at government clinics or local hospitals in order to improve coordination and referrals between TBAs and government facilities. Additionally, this location provided the opportunity to orient government staff to what TBAs were doing.

G. CHARACTERISTICS OF PERSONS INTERVIEWED

1. Health Agency Staff - Four representative official health agency staff were interviewed concerning their views on the training of TBAs in communities and their own relationships with the TBAs. The group consisted of three women and four men (ages 21 to 33) who had worked in their present positions: Project Coordinator, Assistant Project Officer, Senior Supervisor, and TBA Supervisor.

2. Traditional Practitioners - Ten traditional birth attendants from three different villages were interviewed. All were women, who had practised as TBA's, and were 35 to 70 years of age, with an average age of 55. None of the women could read or write and none had attended school.

3. Community Members - Twenty-six members of five villages were asked their opinions about the services of the TBAs and if they had suggestions to improve their community’s health. Twenty-two mothers and four men, (a farmer and small businessman, a shopkeeper, a government worker, and a labourer) were interviewed. The group had an age range of 17 to 75.
VII. RESULTS

The results of the four case studies in Ghana, Mexico and Bangladesh will be discussed in terms of two major categories.

The first category involves the **Effectiveness of the Training Activities** and will include:

1. PHC tasks and services performed by traditional practitioners;
2. attitudes of practitioners;
3. community acceptance of these services;
4. extent of collaboration between healers and health agency staff;
5. changes in health behaviours of community members where TPs have served, and
6. changes in health conditions in these communities.

The second category pertains to **Administrative Issues** related to planning, implementation and evaluation of training activities for traditional practitioners, including the training of trainers.

A. **EFFECTIVENESS OF TRAINING**

Six criteria were used to judge the effectiveness of training programmes and the impact of these programmes on the communities. Results of interviews in the four projects are discussed under each of the following six criteria.

1. **What PHC skills that traditional practitioners were taught, are they now performing in their communities?**

Responses from interviews conducted at the four project sites are summarized, when applicable, according to services performed by TPs in maternal and child health, nutrition, personal hygiene, sanitation and health education.

a. **Maternal and child health services** - The majority of women surveyed from all four projects consulted TBAs for services for pregnancy and child health problems. TBA services included the following:

- pre and post natal checkups;
- diagnosing women for high risk pregnancies, such as anaemia, pre-eclampsia, dangerous fetal positions and referring to the hospital;
• measuring height and weight for monitoring growth of children;
• maintaining a clean environment for delivery;
• disinfecting instruments to prevent tetanus;
• delivering babies and cutting and tying the cord properly;
• performing artificial respiration on infants;
• advising mothers how to prepare and use ORS and treat diarrhoea;
• referring children for DPT, polio, and BCG immunizations and mothers for tetanus injections;
• maintaining cleanliness to prevent infections;
• counselling women about childbirth, sexuality and family planning.

d. **Nutrition services** - The following nutrition services were primarily performed by TBAs:

• assessing nutritional status of mother and child;
• advising mothers on how to get a balanced diet, and using supplemental foods during pregnancy, breast feeding, and how to wean infants;
• recommending alternative foods when taboos interfere with a balanced diet;
• supplying iron tablets and vitamin E capsules.

c. **Personal hygiene services**

• washing hands and cutting nails when treating patients and attending labours;
• cutting and binding the cord in a hygienic and sterile manner.

d. **Sanitation services** - These services were primarily performed by herbalists, spiritual traditional practitioners, and bone setters:

• cleaning, drying, and preserving herbs in a hygienic manner;
• classifying herbal plants accurately for treating patients;
• keeping flies away from herbal medicines;
• storing herbs in clean containers to make them immediately available for treatments;

• advising patients to use clean water and latrines.

e. **Health education services** - Traditional practitioners from all four projects participated in community meetings. In the Cuetzalan and Savar Projects, 100 percent of those surveyed took part in these meetings. In the Dormaa Project, 95 percent participated. TBAs in the Manda Project answered "no" to participating in meetings, however, 8 of the 15 community members indicated that TBAs did assist them in obtaining resources for getting safe water and slab latrines within the community.

Traditional Practitioners attended community meetings for the following purposes:

• to help plan, organize and conduct activities related to promoting health, schools, cooperatives, and political affairs;

• to promote the building and use of latrines, improved nutrition, digging of wells for safe water, reduction of accidents, reduction of mosquito breeding, preparation and use of ORS, and keeping animals in pens;

• to help dispel superstitious beliefs about foods and ghosts that are believed to cause certain diseases.

In addition to participating in community meetings, two-thirds of all TPs interviewed reported that they met with each other in small groups to conduct the following activities:

• to refresh their own minds about what they have learned during training;

• to share with each other their knowledge about treatment methods;

• to educate other non-trained traditional practitioners in what they know;

• to improve collaboration between the TBAs and other traditional practitioners.

2. How have the attitudes of traditional practitioners changed since training?

a. **As A Total Group** - When TPs were asked how the training had helped them in their practice, many responded that their own feelings had changed, e.g., feeling more competent in their work and having more popularity and status in the community. Some of their comments were as follows:

• "More people know about me now and I am getting more clients";
"More people come from the outside to visit me";

"We have more popularity and respect";

"I have achieved more status - more people come and that is a sign of great respect in our culture".

"(The training)... has opened my mind wide and increased my confidence greatly. Many people have gotten to know me";

"The training has taught me how to keep myself clean and to wash, clean and dry medicines properly";

"I believe we have reduced the number of deaths because we refer patients to the hospital on time".

b. **TPs in the Dormaa Project** - The TPs expressed that being associated with the training project has not only accorded them more respect from their communities, but improved their ability to identify serious cases, refer them to the hospital, i.e., regarding knowing when to treat certain cases and when to refer to the hospital, and to treat patients with their own herbal remedies. They responded that their judgement had improved. They felt more self-reliant, better coordinated as a group, and more united with their communities. Many TPs had been encouraged to keep records in their practices, and were doing so.

(1) **Maternal and child health** - All ten of the trained TBAs interviewed indicated that all pregnant women in their villages consulted them when they went into labour. They referred the women to the hospital only when it was necessary. They said that they had learned to identify high risk pregnancies by examining mothers for complications and then referring such patients to the hospital for delivery. Of the ten, three were currently offering prenatal care for mothers to detect complications at an early stage. They said they were able to make referrals after learning to diagnose high risk pregnancies and anaemia. Three felt that learning to detect where the baby’s head was located was one of the most helpful things about the training.

TPAs also responded that they now gave advice to women on family planning and how to prepare ORS and administer it to children with diarrhoea. Three TBAs had begun keeping records and had started monitoring growth using arm and leg beads for measurement.

(2) **Nutrition** - Sixteen of the twenty-three TPs reported learning about the importance of a balanced diet for all of their clients. They said when food taboos interfered with nutrition, they were able to recommend substitute foods in order to help patients maintain an adequate diet. Nine of the twenty-three TPs observed gradual improvement in their young clients by measuring and recording changes in height and weight with the use of strings of beads.
(3) **Sanitation** - All of the thirteen TPs who commonly used herbal medications in their practices (herbalists, spiritual traditional practitioners, and bone setters) reported learning how to clean, dry and preserve herbs with sanitary and hygienic methods was the most helpful part of the training sessions. Additionally, these TPs and herbalists said they had begun to classify herbal medications to prevent mix-ups during treatment, and were now keeping the herbs in stock so they would be available when needed.

Six TPs mentioned learning that germs were invisible and how important it was to keep flies and faeces away from medications because this could spread disease within the community.

The TPs said they were also instructed in the practice of personal hygiene when treating patients and, as a result, nine of the ten TBAs interviewed emphasized the importance of washing their hands before attending labour and of cutting the umbilical cord with a new blade to prevent infection. Six TBA's mentioned the importance of using pure oil to cover the navel of the newborn and also of covering their mouths when coughing as an important way to prevent the spread of infection. Four TBAs indicated that they were careful to sterilize the binding cord used to prevent bleeding before tying it.

(4) **Health education** - All twenty-three of the TPs interviewed indicated that they participated in community meetings and activities to plan development activities such as sanitation, construction of toilets, improvement of schools, discussion of political issues, and proper care of children in the community. After the training, nine of the twenty-three TPs said they began to give talks on nutrition, water, sanitation, and how to reduce mosquito breeding in their communities. Three TBAs began teaching mothers how to prepare ORS for their children.

All twenty-three of the TPs interviewed reported that they were now conducting meetings and activities with other practitioners in their areas. They met in order to train other TPs on what they had learned in the project, to refresh their own minds on project content, to plan other activities, to improve their work, and to exchange advice and experience on the subject of herbal medicine. One herbalist reported learning what specialties each traditional practitioner practices. For example, seven of the eleven herbalist and spiritual traditional practitioners mentioned that they cooperated with TBAs and other TPs in the area of herbal medicine. They educated one another with advice and experience in using herbal medications and exchanged supplies of medicine.

Health agency staff members noted that TPs acted as local health inspectors in some communities and promoted clean villages and good water. It is a requirement that in order to be invited to participate in the training a traditional practitioner must serve on the Health Council. The TPs interviewed said they began to organize their communities to take action about certain health problems, such as clearing weeds to prevent mosquitoes, digging wells, and keeping goats and sheep in pens. A community health worker reported that TPs were invaluable in mobilizing the community when
the health centre came to immunize the children, and that they advised mothers about growth monitoring during that time.

c. **TPs in the Cuetzalan Project** - Many of the herbalists described how they had learned to dry and store herbs in a sanitary way and to preserve them in alcohol or in a petroleum base so they could have them available when treatments are needed. TBAs reported they were able to diagnose high risk pregnancies and refer them to the hospital. They were more aware of the importance of washing hands, cleaning newborn babies and cutting the umbilical cord properly. They also began sending children to the hospital for immunizations.

Two spiritual TPs indicated they would like to strengthen the Traditional Practitioners Association and to obtain sponsorship from other organizations. All seventeen of the TPs stated that they participated in community activities either at village assemblies, schools, or cooperatives following the training sessions.

d. **TBAs in the Manda Project** - Health agency staff and community members were asked what services the TBAs performed. Five of the eleven TBAs felt that learning about the benefits of vaccinations for BCG, polio, and DPT was one of the most helpful aspects of the training sessions. They also learned how to perform pre- and post-natal checkups and care for mothers during pregnancy.

These staff members also made specific reference to TBAs being effective at encouraging community members to obtain family planning methods and immunizations. The Senior Trainer said that the TBAs essentially, "were doing the government agencies' work". The Assistant Trainer of TBAs mentioned "it was more helpful to use TBAs to educate the community because they are highly accepted by the community", and the TBA Forum Organizer stated the main strength of using TBAs in PHC services is "that communities now received better services at lower cost."

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(1) **Nutrition** - All eleven of the TBAs interviewed learned ways to dispel superstitious beliefs that people had about food and advised people how to achieve better nutrition and practice good food habits. Also, all eleven TBAs learned to advise mothers to supplement their babies' diets with additional foods between the ages of four to five months.

Four of the community members interviewed indicated that trained TBAs advised them specifically on what supplemental foods to wean their children on at the age of four to five months, and five people said the TBAs advised them on how to get a balanced diet for themselves and their children. Thirteen of the community members said the TBAs were very conscientious about advising clients to protect against vitamin A & D deficiencies and to take iron tablets during pregnancy.

(2) **Personal hygiene and sanitation** - All eleven TBAs reported they learned how to prepare themselves and their patients hygienically before attending to any clients as well as how to maintain a clean environment for a hygienic delivery. They also learned to disinfect instruments in order to prevent tetanus. The TBAs said they were
also taught to instruct mothers to wash their breasts before nursing their babies and to use only safe water for drinking and sanitary purposes.

All fifteen community members interviewed reported that trained TBAs taught them about proper personal and family hygiene. Three men said they were advised by a TBA on how to build a latrine for their community.

(3) **Health education** - Six TBAs indicated that one of the more helpful things they learned in the training sessions was how to dispel superstitions about ghosts (a prevalent cultural belief is that ghosts cause certain diseases). Five of the eleven TBAs learned the importance of keeping babies warm in the winter and cool during the hot season.

e. **TBAs in the Savar Project** - All four of the Health Agency Staff members indicated they felt the training programme was successful. They based this upon feedback they got from field representatives who reported how well the TBAs were functioning. The Assistant Project Officer stated that the TBAs were performing, "with full ability, responsibility and dedication."

Four health agency staff members said that the TBAs were most effective in advising communities about health issues and conducting health education sessions. They also indicated that the TBAs were invaluable in performing checkups, conducting normal labours, attending to pre- and post-natal care, identifying high risk mothers and making referrals to the local clinics when complications arose.

All of the 26 community members interviewed said they had received some type of service from their local trained TBA. These services included:

- measuring height and weight;
- assessing nutritional status;
- examining to determine the position of the fetus;
- advising on eating supplemental foods during pregnancy;
- giving out pictoral cards to pregnant women as a visual aid to help them monitor their pregnancy;
- supplying iron tablets and vitamin E capsules;
- advising on pregnancy precautions, breast feeding, immunizations for themselves and their babies, and on family planning methods;
- identifying delivery dates, edema, and anaemia;
- attending labour.
In addition they said the TBAs organized monthly community meetings to educate pregnant mothers and other community members about nutrition, the birth process, when and how to use ORS for diarrhoea, and other subjects.

(1) **Maternal and child health** - All of the TBAs interviewed reported learning how to determine the position of the fetus, and to correctly perform physical exams of mothers in order to identify high risk conditions such as anaemia and pre-eclampsia. Five of those interviewed advised pregnant women to not do heavy work and to rest after lunch. The TBAs also said they were instructed in the correct method of tying and cutting the umbilical cord and seven mentioned this as being particularly helpful. Five mentioned they learned the importance of checking for a complete placenta after its delivery. Three said they learned to weigh children after birth and eight reported being instructed about immunizations for both mother and child. In addition, eight indicated that the instruction on artificial respiration was one of the most helpful sections of information during the training.

Eight of the TBAs also reported that they were beginning to help families select family planning methods. And three TBAs indicated that they were discouraging breast feeding mothers from taking birth control pills.

(2) **Nutrition** - Seven of the ten TBAs reported learning the importance of a balanced diet for all their clients. They advised pregnant women to eat supplemental foods and to take more frequent, smaller meals, as well as to reduce salt intake. All indicated that they supplied Vitamin A capsules and iron tablets to their clients. All ten TBAs learned the importance of having mothers immediately feed colostrum to their newborns in order for the children to get the most nutritional benefit from breast milk. Three reported learning to advise mothers to feed their children additional nutritious foods after the age of five months in order to supplement their diets.

(3) **Personal hygiene and sanitation** - Eight of the ten TBAs interviewed reported that they learned the importance of hand washing, nail cutting and the removal of rings before examinations and deliveries, and seven mentioned learning to boil the blade and cord used in cutting the umbilical cord following delivery. Three remarked about learning to clean the child and mother in a hygienic manner after birth and the importance of maintaining hygiene during labour.

Nine of the community members interviewed indicated that formerly TBAs used bamboo and unclean blades to cut the umbilical cord following birth, but after training they were using clean blades and hygienic methods.

(4) **Health education** - TBAs indicated that they were conducting home visits in order to advise pregnant and nursing mothers to eat the right foods and rest. Eight of the ten TBAs reported using pictorial (health record) cards to help keep track of progress during pregnancy and to determine any indications of complications.

All ten of the TBAs interviewed reported that they participated in community meetings and activities. These meetings were used to bring women in the community
together to discuss health, hygiene, prenatal care, and the importance of immunizations for mother and child. These monthly meetings were also used by the TBAs to record the weights of the babies in their communities.

In addition to participating in monthly community meetings, all ten of the TBAs indicated that they also conducted meetings with other TBAs. These meetings were used to discuss problems with their practices, to conduct follow-up training, and to share knowledge and experiences. They also held discussions regarding income generation and practised their literacy lessons.

3. **How satisfied are community members with the traditional practitioners services?**

a. **As A Total Group** - In all four projects, 100 percent of community members who had visited TPs were very satisfied with the services they received from TPs. They responded that healers were friendly and accepting, careful and confident. When asked if they had any dislikes about any of the TPs' services, they all replied "nothing."

Community members responses indicated that they had more trust in the abilities of TPs after they had been trained.

b. **Dormaa Project Community Members** - Seventeen members of village communities were interviewed to determine their satisfaction with their local TPs. They were first asked what health problems their families faced. Their responses included: hernia, fever, piles, malaria, measles, coughing, yaws, abdominal pains, asthma, diarrhoea, jaundice and headache. All of the seventeen interviewed had obtained treatment from TPs, though not necessarily for all of the above conditions. Most of the treatment from TPs consisted of herbal medications. All were very satisfied with the services they obtained. All of the clients interviewed felt that the TPs were friendly in manner and most mentioned that they were "accepting" as well. One client described the TPs as being "very cordial".

Responses of community members indicated they had more confidence and trust in the abilities of their TPs after they were trained. Some community members said they preferred to go to trained TPs rather than to untrained ones for treatment.

c. **Cuetzalan Project Community Members** - Only two of the community members that were interviewed had been clients of TPs in the past year. These clients were both females, ages 22 and 36, and they were asked their opinion of the attitudes of and services offered by their local TPs. Both women were satisfied with the competence of their TPs and liked the services provided, commenting that the TPs were careful, confident, and very friendly. The services were for a birth, a diarrhoea case, and a treatment for "susto" and "mal de ojo".

These latter two conditions were traditional illnesses that are commonly treated by local TPs. "Susto" is thought to be caused by fright and is more frequent with children. The child wakes up afraid, with headache, tremors and tightness, and
often gets pale, thirsty, lazy, and lacks appetite. When this happens a curandero (TP) is called to determine the cause of susto and to provide treatment.

"Mal de ojo" (bad eye) is another common traditional illness that is thought to be caused by the "evil eye" of a person who looks at another and captures their soul. When this happens the person gets weak, loses appetite and gets sick. The cure is provided by a curandero who treats the person with herbs and prayers.

In addition to the two community members, two of the health agency staff reported that based upon their contact with patients in the hospital the community members were satisfied with the services offered by the TPs, particularly because the TPs understood the traditional diseases and knew how to treat them.

d. **Manda Project Community Members** - Fifteen members of four villages were interviewed to determine their satisfaction with the services of their local TBAs. All fifteen had received some type of service from a TBA, and all indicated they were very satisfied with the services provided. When asked about the manner in which the TBAs attended to health problems, eleven mentioned that TBAs were "friendly". Other descriptions included: "very patient, sensitive and accepting," "very good," and "tried very hard to understand." When asked if there were any problems with the services provided, all those interviewed indicated that there were "no dislikes" and two women stated: "They were available to us anytime to solve our problems - we liked them very much."

e. **Savar Project Community Members** - Twenty-six community members were interviewed to determine their satisfaction with the services provided by their local TBAs. All were very satisfied with their services. Nine of the women agreed that the trained TBAs had greatly reduced the deaths in this community. When asked about the manner of the TBAs, all of those interviewed remarked that the TBAs were friendly and three women commented that they were pleased with their visits. Community members were asked if there was anything they disliked about the services of the TBAs and all respondents replied "nothing."

4. **How has collaboration improved between traditional practitioners and health agency staff?**

Collaboration was defined as how traditional practitioners and the Western practitioners related to and worked with each other. This was expressed by how well they respected and communicated with each other and made referrals. The overall findings from responses from both TPs and health agency staff indicated that generally there was good collaboration and very positive relationships were established, although this varied with individuals from place to place.

a. **Dormaa Project** - Eleven official health agency staff representatives were interviewed about their relationship with and their views about TPs. Most felt that TPs, well trained, could be even more effective than health agency staff in providing health education and preventive work in their local communities. Some also stated that TPs were now more familiar with common rural diseases, and were able to
recognize when a patient should be referred to the nearest clinic. Those interviewed commented that trained TPs made many more referrals to the hospital for conditions of breach delivery, primipara, anaemia, retained placenta, hypertension, fits, oedema, delayed first stage, second stage delivery, and previous Caesarean Section.

The senior nurse midwife at the Dormaa Hospital mentioned that she reciprocated by referring some maternity cases to a TBA, usually when no problems were expected or when the patient lived far away from the clinic. The staff agency members also recognized the TPs as a valuable resource in rural communities where there was no clinic, or in cases when patients were unable to get to a clinic.

Effective communication between TPs and staff was encouraged by the use of coloured referral cards. Blue was for a normal referral and pink for emergencies. Seven of the community members interviewed mentioned that they noticed when TP's began to use these referral cards in their community and took the cards with them when they went to the clinic. All of them felt that this had improved the relationships between the TPs and the hospital staff and made for better care in their communities.

One problem with these referrals was that many of the TPs were not able to read or write, and thus it was difficult for them to fill out the referral slips. However, in some communities there were persons who could read and write and helped bridge this communication gap between TPs and staff. In other communities, traditional practitioners were allowed to accompany their patients to the clinic for treatment, and this enabled them to communicate with the health agency staff about the health problem verbally. Most hospital staff members felt that their relationship with the TPs was very friendly, and that they worked together for the good of the communities they served. One nurse in charge of a community clinic invited TBAs to come to the well baby clinic and help monitor growth rates and weight of local children. The senior nurse midwife at Dormaa Hospital remarked that the TPs were extremely inquisitive and eager to learn from the staff.

The majority of TPs interviewed described their relations with health agency staff as being very friendly and reported that the establishment of a mutual referral system improved communication and collaboration. When TPs were asked about which conditions they referred to the hospital, their responses included: tetanus cases, infections, meningitis, anaemia, cuts that required suturing, broken bones, polio, paralysis, neck problems, malaria, difficult labours, and bleeding during pregnancy. Fifteen of the twenty-three TPs interviewed reported that they received reciprocal referrals from clinic doctors and nurses in cases such as osteomyelitis, madness, spiritual conditions, miscarriages, vomiting and bleeding during pregnancy, difficulty breathing, boils, bedsores, abscesses in the throat, dislocations and fractures.

Two of the twenty-three TPs interviewed had reservations about their relationship to the hospital staff. They felt that the staff did not entirely trust them yet and that some looked down upon TPs’ methods as inferior to Western practices.
b. **Cuetzalan Project** - Eight official health agency staff representatives were interviewed about their relationship with TPs. The opinions of these staff members about the quality and extent of collaboration between them and the TPs were varied. Some felt that the collaboration was very good and others said it was not good at all. In one community, staff members said they collaborated more with herbalists than with TBAs simply because the herbalists referred patients to the hospital more often. The hospital director indicated that it was more common for nurses than other hospital staff to have closer relationships with TPs, because, unlike physicians, many of the nurses were native to the area and understood the concepts of traditional medicine.

All of the health agency staff interviewed felt the TPs training programme was effective. When asked about the main strengths of using TPs to provide primary health care services, three of the staff noted that TPs are usually community leaders who are well respected and able to speak directly to the local population. The same staff indicated that community members do not identify with medical health workers in the same manner as they do with the TPs. Also, one doctor indicated that TPs were able to understand primary health care and its purpose. Two nurses indicated that TPs worked to prevent illness, improve the environment, and raise the consciousness of their communities.

When staff members were asked how the TPs could be most helpful to their communities, one suggested that they work together with Western practitioners. It was felt that this collaboration not only exposed the TPs to Western practices, but also exposed staff members to alternative cures for certain diseases such as mal de ojo, susto, and moiera. "Moiera" is a traditional illness that is caused when a child's fontanelle is sunken due to dehydration from diarrhea. For example, TPs "make a spiritual cleansing to make safe the individual, family, and the community."

Two other staff members added that the participation of communities in health education and promotion efforts was very important, and if TPs were able to increase the number of participants in these programmes, it would be a useful way to integrate the TPs into the health system. Two other staff members interviewed noted that TPs were effective because they were able to recognize certain diseases and make many referrals to clinics including: second and third degree malnutrition, tuberculosis, high risk pregnancies, surgical patients, tubal ligations, irregular bleeding in the vagina (cancer), and fractures.

Three of the eight staff respondents indicated that some staff members had trouble accepting the new roles of the TPs. TBAs seem to be accepted without reservation, however, spiritual TPs and bone setters were not as confidently accepted in all cases.

TPs described collaboration from their perspective in a variety of ways. Thirteen of the seventeen TPs interviewed described their relationships with health agency staff as being very good. Six of the TBAs reported receiving referrals from doctors "when a child was not properly placed and needs turning." Six of the TBAs mentioned "nurses can help explain when we do not understand the doctors."
bone setters indicated that they referred patients to the hospital when it was necessary. The priest TPs reported that they did not collaborate much with doctors and nurses, but would like to improve relations. Most of the TPs received help and referrals from health staff. Eight of those interviewed reported receiving referrals. The spiritual TPs had treated some cases that were referred by doctors "when Western treatment did not seem to help."

e. **Manda Project** - Five official health agency staff representatives were interviewed about their relationships with the trained TBAs. They reported that health agency staff generally accepted the new roles of the trained TBAs. (Health agency staff here included both staff of the NGO Project and the doctors and nurses in the government clinics and hospitals where the TBAs make referrals.)

All of the TBAs interviewed described relations with health agency staff members as being good. TBAs reported making referrals of patients for family planning, immunizations, and in cases of high risk pregnancy. Six TBAs also indicated doctors and nurses sometimes refer normal patients to trained TBAs. Five of the TBAs said they receive support and assistance from the hospital/clinic staff at any time.

d. **Savar Project** - Three of the four staff members interviewed indicated that collaboration between TBAs and staff had not always been good, but more recently had become very effective. The TBA Supervisor stated, "The clinic staff benefit because when our TBAs refer cases and advise mothers about family planning and immunizations, more people go to the clinic/hospital and their statistics go up." The Project Coordinator stated that the degree of collaboration can also depend on the geographical area in which they work.

Ten TBAs were asked about their relationship with health agency staff and they reported that collaboration was for the most part good. However, three of the TBAs indicated that they were accepted by some doctors and nurses, but not by others. Five of those interviewed reported that doctors and nurses accepted their referrals "courteously." These TBAs indicated that they personally took patients to the clinic and received good cooperation when staff members were able to identify them as trained TBAs from their badges and special sharees (dresses).

All ten of the TBAs interviewed indicated that they made referrals to their local clinics or hospitals. The conditions for which they made referrals included: tetanus injections, haemorrhoids, retained placenta, incomplete delivery, and prolonged labour.

5. **How have community members behaviours changed after traditional practitioners provided new services?**

a. **As A Total Group** - Health agency staff and TPs reported they had observed certain health behaviours of community members after the trained TPs began working in the communities. These behaviours are summarized under their major content areas.
(1) Maternal and child health behaviours:

- mothers changed from consulting untrained TBAs to trained ones;
- more pregnant women consulted TBAs for pre and postnatal care and labour; (hospital staff in Dormaa estimated up to 70% of women were delivered by TBAs)
- more mothers were taking iron pills during pregnancy;
- mothers went to clinics for immunizations and brought their children to be immunized;
- mothers prepared and fed ORS to children with diarrhoea;
- more mothers were practising family planning and breast feeding.

(2) Nutrition behaviours:

- more people were choosing to eat foods to obtain a more balanced diet;
- more children were eating vegetables and eggs;
- more mothers were feeding children supplemental foods for weaning;
- some families were beginning to raise chickens for food.

(3) Sanitation behaviours:

- some villages had organized to build latrines and were using them;
- mothers taught their children to defecate in pans instead of around the homes;
- mothers were bathing their children more frequently;
- some villages were digging wells to obtain safe drinking water;
- clients of traditional practitioners were keeping their homes cleaner;
- more mothers were boiling water for drinking;
- more individuals practised personal hygiene, such as washing hands, cleaning dishes, cutting nails, wearing shoes.
(4) **Environmental health behaviours:**

- some villages had cleared brush and weeds from around their houses to eliminate mosquito breeding places;
- some villages had cleared wastes and trash to reduce the spread of diseases;
- some families were keeping their sheep and goats in pens to prevent the spread of diseases.

(5) **Health education behaviours:**

- community members sought traditional practitioners' advice on personal hygiene, nutrition, and family planning;
- people were dropping common superstitious beliefs about eating certain foods;
- community members assisted traditional practitioners with their farming to reward the traditional practitioners for their services.

b. **Health Behaviours in the Dormaa Project Community**

(1) **Maternal and child health** - All 10 of the trained TBAs who were interviewed mentioned that following training, all pregnant women in their villages consulted them when they went into labour and nearly all chose to remain in the villages to deliver their children. They referred mothers to the hospital only when necessary, in cases of high risk pregnancies or previous Caesarean Section.

According to the hospital staff, up to 70% of pregnant women now delivered their babies in the community because it was less expensive than the hospital and it also alleviated the need for the difficult and sometimes lengthy trip to the hospital. After the training programme, the community seemed to have more faith in the abilities of the TBAs. According to one hospital nurse, "The pillar of primary health care lies in the hands of traditional practitioners".

When asked what they had learned from the TBAs to prevent illness and to keep their families healthy, eight community members mentioned the importance of visiting clinics for services such as immunizations. And the Nurse-in-Charge at one community clinic reported that TBAs in her area were teaching mothers how to prepare ORS for their children, and that this was very helpful for early treatment of dehydration.

(2) **Nutrition** - According to the Project Coordinator, "people are now much more conscious of trying to eat a balanced diet, they now understand that filling the belly alone does not make good nutrition." This belief was borne out when eight
community members identified the importance of a balanced diet as one of the important things they learned from the TPs since the training took place.

(3) **Sanitation** - Five of the twenty-three TPs interviewed reported that they had organized people in village communities to build latrines since the training, and these communities were now more conscious of using them instead of defecating around the village. Additionally, one TP noted that children were now being taught to defecate in pans or to use the latrines built by the community. One mother reported that she learned from a TP about the importance of bathing her children every day. One village chief stated that he helped his community organize itself to dig wells for the village drinking water supply, and two others reported that communities were now more careful to drink only protected or safe water.

Two villagers reported learning the importance of hygienic practices such as cutting their children's fingernails in order not to spread any germs that might be collected under uncut ones, and not spreading their clothes on the ground to dry.

(4) **Environment** - Eight of the seventeen community members interviewed reported that under the direction of trained TPs, they were clearing brush and weeds from around the outside of the villages in order to minimize mosquito breeding areas. These eight community members also indicated that the TPs had started to emphasize the importance of keeping the village and surrounding areas clear of any waste materials and trash where insects or scavengers might feed and thus become transmitters of disease. The importance of confining sheep and goats to pens in certain sections of the village was also emphasized by these TPs to prevent the spread of disease.

(5) **Health education** - Seven traditional practitioners reported that when the TPs spoke to the community or visited homes to talk about health, personal hygiene, nutrition, and family planning, their advice was now much more accepted by family members, and sometimes the community even solicited their advice on these matters. These TPs also reported that since the training, the community has helped them more on their farms as payment for treatment.

Seven villagers reported that following the training, TPs made periodic visits to their community to educate them about the importance of a balanced diet, environmental sanitation, and personal sanitation practices. A bone-setter exercised his role as health educator by advising people to be careful to reduce fractures.

One traditional practitioner spoke about the importance of the counselling role with patients. These changes seemed to show a broader role for the TP not only as someone to go to when ill, but as an educator and health promoter - someone from whom to seek advice about not becoming ill in the beginning.
c. **Health Behaviours in the Cuetzalan Project Communities**

(1) **Maternal and child health** - Six TPs reported their clients lacked trust in the TBAs that had not participated in the training project and therefore went to the ones that were trained.

(2) **Nutrition** - Seven TPs said they had observed that children in their communities had received better nutrition following the training, that is, the children were eating more vegetables and eggs compared to the period prior to the training.

(3) **Sanitation** - Thirteen TBAs responded to the question about the observation of changes in community behaviours following their training. Seven of these noticed that the homes of their clients were cleaner and that mothers in their communities began to pay more attention to the cleanliness of their children. In addition, these same TBAs noted an increase in the practice of boiling drinking water before consumption. One TBA interviewed in a small group stated that in one community where she spoke to people about the importance of sanitation, the community built 50 latrines in 2 1/2 years.

(4) **Health Education** - The Chief of the Department of Traditional Medicine in the Project reported that she noticed after the TPs were trained and began working in the communities, the families tended to follow the TPs suggestions for health promotion. She said that TPs were spiritual leaders and if they recommended hygiene, nutrition and immunization, community members tended to follow these recommendations.

d. **Health Behaviours in the Manda Project Communities** - Six of the eleven TBAs reported that since the training they noticed more interest in the use of family planning methods. These same six TBAs also indicated there was an increase in mothers feeding colostrum immediately to their newborns. Pregnant women began to obtain tetanus shots and mothers received post and antenatal checkups. They also reported a decrease in the number of maternal deaths since the implementation of the training and five TBAs reported that mothers brought their babies to get medication for worms.

According to one health agency staff member:

"Family values are changing in rural areas. families now want no more than two children. They take their children to TBAs to get immunized and they consult trained TBAs for advice with family planning methods."

And two other staff members similarly indicated that children are being inoculated in the communities for childhood diseases and mothers for tetanus because of the TBAs efforts to educate people about immunizations. These statements were borne out by fourteen of the fifteen community members who were interviewed and who reported that TBAs had advised them on the importance of getting tetanus injections and other immunizations.
(1) **Nutrition** - All eleven TBAs interviewed noticed a change in the behaviour of community members with regard to food habits. Some people were more conscious of eating a balanced diet and others began to feed their children supplemental foods in addition to breast milk at the age of four to five months. Eight reported that mothers had learned to feed their babies colostrum immediately after birth to begin the breast feeding cycle. Some families began to raise chickens for food in order to round out their diets. Additionally, five TBAs reported an increase in the number of mothers taking iron pills during their pregnancies.

(2) **Sanitation** - Six of the eleven TPs interviewed reported noticing changed behaviour in their communities regarding the use of safe water for drinking, cleaning dishes, and washing hands. Five TPs noted community members were cleaning their homes on a more regular basis.

One community member reported that trained TBAs educated the community about personal and environmental hygiene such as food, water, and sanitation.

One staff member noted that communities were becoming very conscious of using safe water for their needs. And two other staff members noted there were slab latrines being built in some communities and people were using them to improve environmental sanitation. The Assistant TBA Trainer reported that community members began to keep the areas around their homes cleared for the same reason.

(3) **Health education** - The TBA Programme Officer remarked that due to efforts in community education by trained TBAs, common food superstitions were being abolished, such as not eating eggs or fish during pregnancy, eating small amounts during pregnancy to have a small baby, and eating only dried foods after delivery.

e. **Health Behaviours in the Savar Project Communities** - A farmer and small businessman, said: "I am more confident about the TBAs - now we send mothers to the TBA instead of the hospital." Three of the four health agency staff members reported that since the training of the TBAs, they have noticed that the community members have started to change their superstitions regarding food practices and other health related topics. "They can now accept looking at pictures of a birth, while before this was not accepted because of the inhibitions associated with sexuality in their Muslim culture. Their TBA training has made them much more accepting and at ease about discussing childbirth, sexuality, and family planning with women."

(1) **Maternal and child health** - When asked about what new things the TBAs had taught them to do in order to prevent illness, five of the community members indicated they now got immunizations, accept family planning methods, and if pregnant, do not work too hard and rested after work. Twelve of the 26 community members interviewed reported learning that they could identify anaemia by looking at the lower eyelid.

(2) **Nutrition** - Seventeen community members reported that under the direction of the trained TBAs, they have learned the importance of maintaining a balanced and nutritious diet. They now tended to eat smaller meals on a more frequent basis and
concentrated on nutritious foods. One client of the TBAs reported, "I did not know vegetables could provide vitamins or that we should eat a variety of foods to get a balance."

Two women noted that it was important to feed babies colostrum immediately after birth and to add other foods with breast feeding after the age of five months. Nine women said that measuring the height and nutrition status of children was important. Also, five TBAs said that their clients were now giving ORS to their children for diarrhoea after being educated in how to do it.

(3) **Personal hygiene and sanitation** - Five of the ten trained TBAs reported that their clients now practised general cleanliness. Thirteen of the twenty-six community members interviewed specifically indicated that they are following the good hygiene practices advocated by the trained TBAs. These practices included hand-washing before meals and after using the toilet, cutting fingernails, wearing shoes, and bathing their children every day.

(4) **Health education** - Nine women from communities indicated that their TBAs made monthly visits to the village to hold discussions about various topics. These visits were used as educational forums to inform community members about issues such as the importance of good nutrition and personal hygiene, the benefits of family planning, and the warning signs of possible pregnancy complications.

Eight of the community members reported that their TBAs gave them a pictorial card (health record card) to use during pregnancy to keep track of progress and to mark off milestones such as tetanus immunization. They also used these cards as educational tools to help pregnant women recognize some warning signs of possible complications with their pregnancy, and also as guides to show what constitutes a balanced diet.

6. **How have health conditions improved in communities where trained traditional practitioners have worked?**

a. **Summary of Advantages to the Community, Traditional Practitioners, and Health Agencies.**

The data indicate that trained TPs play an important role in promoting primary health care services in communities, identifying critical cases early, and referring them to clinics and hospitals.

(1) **Advantages to the community:**

* increased treatment for certain Western diseases;

* referrals increase immunization coverage for tetanus and childhood diseases;
• hygienic use of herbal medicines and convenience of these medicines being preserved and stored;
• increased village sanitation - use of latrines and disposal of trash;
• faster referral of serious cases to hospital;
• more deliveries are performed safely in villages;
• improved nutrition among children and adults;
• increased availability of safe water;
• people practice more personal hygiene;
• mosquito breeding is reduced;
• saves money and time for community members.

(2) **Advantages to the traditional practitioners:**

• more status and acceptance by the community;
• increase in private practice;
• more united among their own groups;
• enhanced leadership in the community;
• better able to mobilize communities for health promotion, i.e. for immunizations, to obtain better nutrition, better sanitation and safe water;
• better reputation in the area;
• greater confidence in own skills;
• less fear to practise openly.

(3) **Advantages to the health agencies:**

• decrease in work load in hospital maternity wards;
• decrease in maternal and infant mortality, and in anaemia and tetanus cases through prompt referrals;
- traditional practitioners can mobilize communities quickly for staff programmes in nutrition and immunizations;
- costs to hospital are reduced.

b. **Improved Conditions in the Dormaa Project** - In the Dormaa Project the Ministry of Health Department of Statistical Records had data recorded from the last three years which documented the changes in still births and maternal and neonatal deaths in regions where the trained TBAs had worked. These data are shown in Table 1.

<table>
<thead>
<tr>
<th>Year</th>
<th>TBA Coverage</th>
<th>Still Births</th>
<th>Maternal Deaths</th>
<th>Neonatal Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>11%</td>
<td>7.40%</td>
<td>0.20%</td>
<td>2.20%</td>
</tr>
<tr>
<td>1991</td>
<td>25%</td>
<td>5.70%</td>
<td>0.60%</td>
<td>0.50%</td>
</tr>
<tr>
<td>1992</td>
<td>31%</td>
<td>2.1%</td>
<td>0.09%</td>
<td>0.60%</td>
</tr>
</tbody>
</table>

* Mothers delivered by trained TBAs

Source: Statistical Records, Ministry of Health Dormaa District

As noted in Table 1, the increase in the number of deliveries by trained TBA's has increased from 11% in 1990 to 31% in 1992. This is related to a corresponding decrease in the number of still births (from 7.4% to 2.10%), maternal deaths (from 0.20% to 0.09%), and neonatal deaths (from 2.20% to 0.60%) over the two year period.

The statistical records also recorded data for status of malnutrition in children 0-6 years in 5 communities served by trained TBAs. Table 2 indicates that over the 13 month period for which data was recorded, normal nutrition status in children increased from 46% to 62.3%; the percentage of mildly malnourished decreased from 32.4% to 26.7%; and the severely malnourished children decreased from 21.4% to 16.1%.
Table 2

Change in Malnutrition Status of Children 0-6 Years in five communities served by trained TBA’s (As measured by weight/age)

<table>
<thead>
<tr>
<th></th>
<th>September 1990</th>
<th>December 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>46.0%</td>
<td>62.3%</td>
</tr>
<tr>
<td>B</td>
<td>32.4%</td>
<td>26.7%</td>
</tr>
<tr>
<td>C&amp;D</td>
<td>21.4%</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

A = normal nutritional status  
B = mildly malnourished  
C&D = moderately to severely malnourished

Source: Statistical records of the Ministry of Health, PHC Nutrition Project

c. **Improved Health Conditions in the Cuetzalan Project** - An attempt was made to obtain data that would indicate changes in rates of maternal and infant mortality, malnutrition, or other health conditions as a result of trained healers working in communities. Such data were not available. The medical director of the Cuetzalan hospital indicated that their statistical records were not in a condition that they could compare health statistics in regions where trained healers were working with regions where they were not.

However, health agency staff members did report their observations about health improvements. When asked about the benefits of the training programme to the community and hospital, they reported that delivery complications had decreased over one year, that deaths from childbirth had diminished, as well as the number of patients they had seen at the hospital with advanced conditions of disease.

d. **Improved Health Conditions in the Manda Project** - An attempt was made to obtain statistical data which would show improvements in maternal, perinatal or neonatal mortality rates in areas where the trained TBAs were working. The Medical Director of the Manda District Hospital, where such data was kept, was interviewed, and he said that they had not been able to collect reliable data on registration of births and deaths. It was therefore not possible to draw any conclusions regarding changes in maternal and infant morbidity or mortality since these data were not available for those areas where TBAs were working.

e. **Improved Health Conditions in the Savar Project** - The Medical Director of the Hospital in Savar Thana was interviewed to find out what records they kept to determine morbidity and mortality rates of mothers and infants. He indicated that they had no reliable data available to make these determinations. It was therefore not possible to document any changes in health conditions as a result of trained TBAs working in the communities.
B. ADMINISTRATIVE ISSUES

1. Policies

In order to successfully design and implement the training and utilization of traditional practitioner programmes, government policies should be established to address major issues and to regulate the activities of TPs.

Such policies could include the scope and nature of tasks for which TPs should be trained; the content of the training and selection of participants; the extent of accountability for performance; rewards given for service; the types of records and reporting procedures required; and systems for monitoring performance.

In the context of developing policies for the training and utilization of TPs in community primary health care programmes, it is important to emphasize that in the four training projects studied, none of the TBAs, herbalists and other TPs were employed by the sponsoring government or non-government agency. Thus there was no formal employment contract between the agency and the individual practitioners. Generally, TPs function as private practitioners and they depend upon their clients for remuneration.

Because of the nature of this relationship, health agencies should consider that any regulations governing their performance should be used as guidelines only. The conventional meaning of supervision of an employee by a nurse, doctor, or other agency staff member does not apply in cases where TPs have been trained to perform primary health care services for which they have made a voluntary commitment to work.

For this reason the words 'supervisor' or 'supervision' have not been used in this report, even though the documents and staff comments from the case studies have described 'supervision' activities that they carried out with TPs. In this report, instead of using the word 'supervision', it has seemed more accurate to use terms such as 'support' or 'guidance', since these more accurately reflect the true nature of the professional relationship which exists between the agencies and TPs.

There was one exception to this voluntary work situation in the Cuetzalan project where the hospital paid a fixed daily fee to the TBAs and the other TPs who practised on a rotating part time basis in consulting rooms set aside for their practice of traditional medicine within the hospital facilities.

a. GHANA - The Ghana Ministry of Health has within the last few years established a Minister of Traditional Medicine. As of 1992 the MOH was in process of establishing an official government policy on the use of traditional practitioners for the country as a whole. The following is an excerpt taken from the government's policy statement:

"Hence government policy is to enable Ghanaians to use whatever form of health care they desire. M.O.H. collaborates with TBAs and the"
Centre for Scientific Research into plant medicine. M.O.H. is therefore, training TBAs to improve quality and scope of their practice. Through this, the TBAs will be able to manage diarrhoea and motivate couples to accept Family Planning services.

"Among traditional practitioners M.O.H. acknowledges that there are some who have treatment for diabetes, fractures, etc. all of which are valuable resources which should be used. However, there are "quacks" but M.O.H. lacks the expertise and competence to identify such people. It is only the communities who know the good ones. Hence M.O.H. is advocating the setting up of Regional Traditional Practitioners Association for accreditation of members."

b. MEXICO - The Government of Mexico has a very strong policy toward the support and promotion of traditional medicine which is spelled out in detail in a 44 page document. This document begins with a statement of basic principles:

"The right of indigenous people that live in the Mexican Republic to conserve, practice, develop and transmit our traditional medicine and to defend the medical beliefs, concepts and practices inherited from our ancestors, practised and renovated by present day indigenous traditional practitioners.

"The right of all Mexicans to protection of their health in accordance with the 4th Art. of the Political Constitution of the United States of Mexico and to free access to services that provide traditional medicine.

"That the recognition of traditional medicine by the indigenous communities should constitute the basis for institutional recognition.

"The need to reaffirm the existence of a valid system of health care in the country which has the following essential elements: academic medicine, traditional medicine and domestic or home medicine. In consequence, this implies the need to establish laws and national programmes to protect and develop all these useful manners of healing.

"That traditional medicine forms part of the historic inheritance of the indigenous people as do 'their languages, cultures, practices, customs, resources and specific forms of social organization', and that, along with these, it should be protected and promoted in its development by law, in accordance with the 4th Art. of the Constitution.

"The right of indigenous traditional practitioners to form organizations that contribute to the consolidation and development of their knowledge base and practice.

"The right of the traditional practitioners to participate in the development of policies and programmes destined to improve the health status and living conditions of the indigenous communities."
The document continues with a description of objectives, and a plan for recognition and support, organization, assessment and training, creation and development of projects, follow-up and evaluation, legalization, and communication and diffusion. Because of this official government support, as of August, 1992, fifty-two independent Organizations of Traditional Practitioners had been established throughout the country.

c. BANGLADESH - The Ministry of Health of the People’s Republic of Bangladesh has established a policy for the selection, training, and use of traditional birth attendants. This policy is practised by the government training centres for TBAs as well as all NGOs and other organizations who desire to train TBAs. The VERC and the CCDB have followed these regulations in selecting and training TBAs in these two case studies.

2. Involvement of Community Members in Project Planning and Implementation

Issues related to planning and implementing projects for training TPs in primary health care will be discussed primarily in terms of the extent that community members were involved in the planning and implementing stages. All four projects studied had clearly written project plans which incorporated the involvement of local communities in their design and implementation.

Duties and roles in community involvement varied, i.e., TBAs became more involved with women’s groups and meetings, whereas male herbalists and spiritual healers participated in general community meetings.

a. GHANA - Dormaa Traditional Practitioners Project - The Dormaa Project grew out of an anthropological study of traditional healing practices and was a pilot project based upon traditional beliefs of healing and how the practices of TPs could be strengthened. From the very beginning, staff realized that community members must be involved in the planning and implementing of the project. For example, the stated aim of the project was to promote cooperation and collaboration between all practitioners engaged in providing basic health care. This aim was spelled out more clearly in two of the three project objectives: “to establish and maintain relationships... between health care workers in the district, including TPs”; and, "To encourage a dialogue and cooperation among TPs and bio-medical workers..."

The process for recruiting and selecting TPs began in the communities where staff visited the Chiefs and elders to obtain their recommendations for TPs that were respected and trusted by the community. After review by the staff, the elders were again consulted to obtain their confirmation on candidates for training.

When the staff were developing training programmes for TBAs and for other TPs, they went to the communities to survey the TPs to find out what things they wanted to learn. Using these inputs as a base, project staff then integrated basic elements of primary health care into the training content.
In the Dormaa Project, 22 of 23 healers reported participating in community activities. There were no differences reported in the types of community work done by different types of healers. All were very interested in community development, sanitation and communal labour.

In addition, eight of the eleven health agency staff commented specifically on how effective healers and TBAs were in communities for providing health education, disease prevention, hygiene, nutrition, sanitation and community organization.

b. MEXICO - Cuetzalan Traditional Practitioners Project - The planning of the Cuetzalan Project was based upon providing primary health care services according to the needs of the indigenous communities. The development of objectives and training involved the participation of surrounding communities. Project planners also had a close working relationship with Mexico's National Council of Traditional Practitioners.

To recruit and select TPs, the project enlisted the Community Health Promoters to conduct a census of all TPs in their areas. These TPs were then invited to an orientation workshop. TPs were selected to participate in one of two training programmes, one for TBAs and the other for herbalists, bonesetters, and spiritual TPs. Each group was consulted as to what subjects they desired to learn.

The scheduling of training sessions in Cuetzalan on weekends was chosen to accommodate the needs of TPs, who generally came into town to market on Saturdays or Sundays.

All seventeen healers indicated they participated in village assemblies. Two of the male spiritual healers also participated in schools and cooperatives. Two of the five farmers interviewed specifically indicated they worked with their communities to improve the road and suggested working with healers to improve the water system and the school.

c. BANGLADESH - Manda TBA Traditional Practitioners Project - The Manda Project, sponsored by CCDB was based in an NGO which has, since 1992, reoriented its entire development approach towards people participating in planning programmes according to community needs and visions. The aim of this approach was to empower people with knowledge and skills to build sustainable levels of development. This approach was followed in the TBA training project. Although CCDB followed the official government guidelines for selecting and training TBAs, with government's permission, they modified the procedure for recruiting TBAs by asking the leaders of the villages to prepare a list of names of eligible TBAs. After each eligible TBA was interviewed by a staff member, the formal and informal community leaders were then consulted before a final selection was made.

In Bangladesh, only female TBAs were trained as TPs. Their response regarding participation in community meetings was varied. In Manda, none of the eleven TBAs said they participated in community meetings. However, eight of the
fifteen community women said TBAs helped them to obtain resources for safe water and slab latrines.

d. **BANGLADESH - Savar TBA Traditional Practitioners Project -** The SAVAR Project, sponsored by VERC, also involved community members in selecting TBAs by forming a committee consisting of representatives from the donor agency, the Upazila Health and Family Planning authority and the VERC. It then made a final selection of candidates using government criteria.

The objectives and curriculum for training TBAs in the SAVAR Project differed significantly from the other four projects in three ways:

1. The scope for providing MCH services was broadened to cover MCH care for mothers and children over a 320 day period from conception until two months after birth;

2. TBAs were taught how to create income-generating activities for their own families and how to organize and show women in their communities how to do the same;

3. TBAs were provided literacy materials to improve their reading and writing skills and to promote these skills among women in their own communities. These additional activities were based upon the needs of women in the project area.

All ten TBAs indicated they participated in community meetings. They reported getting together with groups of women to discuss health, hygiene, prenatal care and to monitor growth of babies.

3. **Training Content**

The content of the training programmes in each of the four projects was a result of the policies of the Government's Ministry of Health, the health problems within the country, and the priorities of the sponsoring government or non-government organization.

The **Ghana Project**, begun as an outgrowth of an anthropological study on traditional healers, was designed from suggestions from TPs in the district and interests of the Presbyterian Health Services and the Ministry of Health. The training was designed to cover all types of healers in the district - TBAs, herbalists, bonesetters, and spiritualists.

The **Mexico Project** was a direct result of a strong policy of the Government of Mexico to provide a dual system of health services to indigenous population groups. The content of this training project was similar to the Ghana Project in that it covered all the major types of TPs that practised in the region. These included TBAs (parteras), herbalists, bonesetters and spiritualists (curanderos).
Both projects in Bangladesh focused only on training TBAs, however the scope of the Savar TBA Project, which prepared the TBAs to provide pre and post natal care to mothers for almost an 11 month period, was much broader than that of the Manda TBA Project. The Ministry of Health in Bangladesh had placed a high priority on the training of TBAs due to the high incidence of maternal and child mortality and high birth rates in the country.

4. Training Methods and Materials

The discussion of issues related to methods and materials of training TPs will focus on two areas: (A) scheduling of training; and (B) appropriateness of training methods and materials.

5. Scheduling of training

The four projects varied in the way they scheduled training activities over time.

a. GHANA - Dormaa Traditional Practitioners Project - The Dormaa Project, for example, held separate training courses for TBAs and other TPs because the content was different. Sessions were held in half-day workshops twice a week for five months. This pattern was established to accommodate the needs of local TPs as each session was held in a village in the target area on days when TPs did not have to work on their farms. This periodic scheduling offered several advantages:

- It enabled the TPs to assimilate the information more easily than if the training had been presented in a large continuous block of time;
- It avoided the costs of housing and feeding TPs at a residential site for days at a time;
- It enabled the TPs to try out things they had learned in between sessions and return to discuss them.

b. MEXICO - Cuetzalan Traditional Practitioners Project - The Cuetzalan Project adopted a similar periodic schedule for training. Half-day training sessions were held for the TBAs on the first and third Saturday of every month. And the other TPs came on different Sundays of the month. The herbalists and spiritualists came on the first Sunday and the bone setters on the second Sunday. This schedule accommodated the TPs as many of them already had other reasons to come to town on the weekends. This periodic monthly scheduling had similar advantages to those in the Dormaa Project, except in Cuetzalan the TPs came to the hospital for training, whereas in Dormaa, the staff went to the villages to conduct sessions.

c. BANGLADESH - Manda TBA Traditional Practitioners Project - In Bangladesh, both the MANDA and the SAVAR Projects established a residential training system for the TBAs. The MANDA Project conducted a basic course of 11 days with a four-day refresher course which followed after six months. This was then followed six months later by a second four-day refresher course. The staff reported that this training pattern was satisfactory for three reasons:
The residential conditions enabled the women to get away from family
duties and distractions;

The environment of the women living together allowed them to form
close friendships, bond together, and feel more confident and united in
their work as trained TBAs;

The alternating between periods of training and work offered the
women a chance to learn, practice, and then come together to discuss
their learning, their problems and how to overcome them.

d. BANGLADESH - Savar TBA Traditional Practitioners Project - Staff in the
SAVAR Project had a slightly different pattern of periodic training. They held a basic
residential training for 10 days after which they returned to their communities to
practice for four to six months. They then returned for a five day refresher course to
review their learning and the difficulties they experienced in the field.

B. APPROPRIATENESS OF TRAINING METHODS AND MATERIALS

In order to determine the effectiveness of projects that are training TPs in
primary health care, key questions must be answered. For example, what kind of
training methods are being used? Are these methods appropriate to the education
level of the participants? Do the methods fit the cultural backgrounds of the
participants?

These questions are particularly relevant for the training of TPs because they
come from cultures with long traditions of passing knowledge along orally and of
learning skills through apprenticeships and hands-on methods.

Two criteria were used to determine the appropriateness of training:

1. Was the literacy level appropriate for the education level of TPs?

2. Did the training projects employ methods and materials that followed the
principles of non-formal adult education?

1. Literacy Level of Material

The first criterion is extremely important for training TPs. Within the four
projects studied, a total of 61 traditional practitioners were interviewed. Of this group,
42 or 69% were illiterate (could not read or write). The remaining 19 TPs had an
average of only five years of school.

There was considerable variation in literacy rates between the four projects. In
Dormaa, 70% of the TPs were illiterate and the others had an average education
level of 5.6 years. In Cuetzalan, 53% of the TPs were illiterate and the others had an
average education level of 3.6 years. In Bangladesh, the illiteracy rates were higher. In
the SAVAR Project, all 10 TBAs were illiterate, while in the MANDA Project, 64 %
were illiterate and the rest had an average education level of 5.8 years. The Bangladesh illiteracy rates tended to be higher because the TBAs were all women, and illiteracy is usually higher among women than among men in these countries.

The high percentage of illiteracy rates and the generally low levels of education among TPs indicates the importance of using training methods that are educationally and culturally appropriate.

2. Participatory Methods

a. GHANA - Dormaa Traditional Practitioners Project - Dormaa Project staff reported that each training session focused on one topic, lasted from two to three hours and was held under a tree in a village. During these sessions they used the following methods:

- presented information on the topic;
- used AV aids (many were locally produced);
- encouraged TPs to exchange their ideas & experiences;
- related topic information to the TPs work;
- made field trips;
- told stories to illustrate ideas;
- used local songs & dances;
- TBAs were given 7 days of clinical practice in the hospital or clinic.

The training staff used three different TBA training manuals to present information in the curriculum. Two of these were prepared in Ghana and the third was published in London. There were no manuals available to teach the herbalists, spiritualists and bonesetters.

Staff prepared sets of 35 mm slides, which were produced locally, and used with small portable projectors. Flip charts and diagrams were prepared locally to illustrate different topics. Models showing the birth of an infant were also available.

The TPs responses to questions about the training were generally very favourable. Most had no complaints and said they understood the topics. They commented that the dialogue was good and they liked the visual aids.

The TPs made several suggestions for improving the training. Some wanted to learn about more diseases and protective measures against infections. They wanted to continue the use of dialogue and more visual aids such as slides and videos. Some
TBAs suggested they be allowed to accompany their maternity patients into the hospital delivery room to observe and learn from the nurse more about deliveries.

b. MEXICO - Cuetzalan Traditional Practitioners Project - The training methods used in the Cuetzalan Project were more or less similar for the three groups of TPs. The training was conducted in half-day workshops in classroom type settings at the hospital. Staff used a combination of didactic presentations followed by questions and answers. Emphasis was placed upon using small discussion groups where TPs could share with each other their techniques and methods of healing. There was a lot of "hands on" teaching with demonstrations, particularly with the TPs who were learning how to identify and preserve herbs for traditional medicines.

The staff made the best use of the few training materials that were available. There were a few manuals and visual aids available for training Health Promoters, but these were not generally suitable for indigenous TBAs. The manuals were written in Spanish and had many words and few pictures. The staff adapted what they could and created most of their own diagrams and posters.

For the other TPs, there were no manuals and few visual aids. Since a large part of their training covered the identification, preservation and use of herbs, the staff and participants created their own book on indigenous medicinal plants. This book was part of a larger project which the TPs took on as part of their training.

This project was the creation of a large botanic herbal garden on the outskirts of Cuetzalan. A large piece of land was donated to the local TPs association and the TPs as a group grew 315 different species of medicinal plants. They volunteered their time on a rotating basis to water and care for the plants and used the garden as a learning experience and as an income generating activity. The TPs learned how to identify and grow their own herbs and they sold the surplus for cash.

This project stimulated herbalists in the surrounding areas to grow their own community herbal gardens and to recover some income for their efforts. In one community an herbalist cultivated three hectares of ginger root as a cash crop as an alternative to growing coffee.

Health agency staff commented about how to improve the training programme. An administrator said he thought the training was too vertical - that it was too much of a top down approach coming from doctors and nurses down to the TPs. He thought there should be more interchange between hospital staff and the TPs. Another person wanted more meetings between TPs so they could exchange knowledge they had learned and have more opportunities to discuss how to apply these learning in practice. Another said the training staff lacked skills in how to teach adults and that they should teach TPs more methods of health education. Other comments were that the trainers needed more and better visual aids and they badly needed an up-to-date training manual.

The TPs who were interviewed also had comments on their training. Some had difficulty with the Spanish language. (Their native tongue was either Nahuatl or
They found some of the vocabulary difficult to understand. Only a few of the training staff understood Nahuatl and they frequently needed translators. TBAs wanted more observation and practical experience in the hospital. Other suggestions were to have more videos about the birth process and treatment procedures, and to learn additional items such as how to build latrines, how to control mosquitoes and disinfect water, how to teach others how to read, and additional information about how to use medicines to treat wounds, diarrhoea and dehydration, vomiting, and TB.

c. **BANGLADESH - MANDA TBA Traditional Practitioners Project** - The Manda Project trained TBAs in a residential site using a wide variety of training methods and materials and in informal learning settings. Many participative methods were used such as group discussions, demonstrations, and role plays. The staff prepared guidelines and daily lesson plans using a 128 page TBA training manual which was developed and printed in Bangladesh.

This project contained the greatest number and widest variety of training materials of the four projects studied. Among the visual aids were four model sets showing pelvis, fetus and infant; a large set of 35 mm colour slides filmed in Bangladesh; nine different sets of colour flip charts produced in Dhaka; a flannelgraph and a large flip chart on MCH/FP. The project presented each trainee with a 30-page colour picture book/flip chart to use in their work with mothers.

In addition to these visual aids, the training centre had a VCR, TV monitor, and a radio. The CCDB staff used the half hour health messages which the Bangladesh government radio station regularly broadcast for educational purposes as part of the training for the TBAs.

The MANDA Project staff offered some suggestions for improving the training programme. One was to have a well designed flip chart which they could give to each TBA for use in the communities. Another was to produce some good training videos that could illustrate the processes of examining a pregnant woman and the birth of a child.

The TBAs also requested some good videos that would show them how to deal with normal and abnormal procedures in birth. They also wanted more time during the training programme and to meet together as a group every month instead of every four months.

d. **BANGLADESH - SAVAR TBA Traditional Practitioners Project** - The training methods used to conduct the SAVAR project were similar to those used in the MANDA project. The curriculum followed the Bangladesh Government training manual and was presented using group discussions, role-plays, demonstrations, and brief lectures followed by questions and answers.

The materials used for training included a large coloured flip chart, a smaller flip chart, and a set of small flip charts for each TBA. Other materials included a model of a doll mother with placenta, a 35 mm slide set, and a UNICEF TBA kit. They also used a 35 mm slide set to teach income-generating activities.
An outstanding item which the project developed was a pictorial Home Based Maternal Record Card, used both for teaching and for use by the TBAs with mothers. This record card was unique in that it was almost completely pictorial and was designed to be understood by TBAs with little or no ability to read. It was still being field tested at the time of this study. When completed, it will serve as a home based record with which low literate TBAs can effectively chart the progress of a woman through pregnancy and delivery.

A unique feature in the SAVAR TBA training programme were the weekly follow-up meetings held for small groups of TBAs in their work areas. These meetings were organized and conducted by staff Field Supervisors and had a dual purpose - continued training and follow-up support.

The TBAs who were interviewed gave some suggestions for improving the training programme. One said it would be very helpful to have some videos on how to examine a pregnant woman and identify the position of the fetus in utero. Several said that at the beginning they had difficulty understanding some of the content but after the reviews and discussion they had no trouble.

3. Training of Trainers

Training trainers is an important issue in programmes that train TPs. Trainers must possess knowledge in their specialty area, as well as effective skills in teaching adults with less ability to read or write and little or no experience with a classroom style of education. The trainer must also be able to communicate well and have a sensitivity to and understanding of cultural beliefs and practices of TPs. Most doctors, nurses, educators, and other health professionals therefore need some preparation to participate effectively in such training programmes.

Three of the four projects conducted special training workshops and activities for their trainers. The Dormaa Project staff organized a two day workshop to train their PHC and hospital staff. This workshop included an understanding of traditional healing and its medicines, adult teaching methods, communication skills, and interpersonal relations.

The Cuetzalan Project had no organized plan to train their staff. While the staff appeared to be technically competent, they had no preparation in non-formal adult education or health education methods. This may account for the fact that their training workshops were somewhat more formally presented and had fewer training and health education materials.

The Manda Project held a five day course on training content and methods, plus once or twice a year they held a 3/4 day workshop on a current topic. They also encouraged staff to attend continuing education and short courses on training TBAs.

The Savar Project sent their TBA trainers to a special one month training workshop before they began the programme, and the Coordinator of Training took a course that included curriculum design, preparation of materials, and logistics.
4. Follow-up Support

After training, TPs must be given ongoing support in the field if they are expected to effectively carry out their new tasks and responsibilities. Regular guidance must be provided to help TPs solve problems, improve their practice, and facilitate good collaboration between them and Western health workers so that appropriate referrals of high-risk and complicated cases can be made. Such support could include periodic visits and meetings with TPs in the field to review skills and solve problems, continuing education programmes and/or follow-up workshops to upgrade skills and practice.

All four projects studied had excellent periodic follow-up support built into their programmes. Details of this support are summarized as follows:

The Dormaa Project staff made support visits to all trained TPs at least once per month and organized half day refresher courses every three months to review topics covered in the training. Two day workshops were periodically presented to trainers and project staff so they could review project activities and make improvements needed.

In the Cuetzalan Project, follow-up support was built into the monthly training sessions for all TPs. The TBAs met twice a month, and the others once a month. In addition, all TPs met together monthly in a general assembly to review their work and make plans for other activities. And TPs who worked in the hospital on a rotating basis received guidance from members of the hospital staff.

The Manda Project devised a system where trained TBAs met in groups of 15 in regular forums every four months. Project staff met with them to review progress, help solve problems, and give them up to date information.

In the Savar Project, Field Supervisor staff organized weekly half day meetings for all TBAs. They usually held these meetings at government clinics or local hospitals to improve the coordination and referrals between the TBAs and the government nurses and doctors.

5. Evaluation

An important part of a training project is the evaluation of results. Unless steps are taken to determine what specific knowledge and skills the participants have learned and how effectively they are performing services in the community, the organization will not be able to determine how successful the programme has been. It is also useful to identify any difficulties that have occurred and what follow-up actions or other changes may be needed to improve the programme.

No data could be found to indicate that formal evaluations were performed in the Dormaa and Cuetzalan Projects. Staff members did report that they held information evaluations during training sessions and workshops.
The Manda Project had carried out three evaluation studies within the last seven years. In 1986, the CCDB commissioned a survey of the knowledge, attitudes, and practices of TBAs. A major objective of this survey was to obtain information on which to develop a course curriculum and course contents for the TBAs based on the above experiences and traditional system. Two years later, in 1988, the Health Programme Coordinator of CCDB performed an evaluation of the ongoing training programme for TBAs. The 54 page evaluation report described a quasi experimental control study comparing trained TBAs to a group of untrained TBAs from adjacent areas. In this study, technical inputs from course curriculum, criteria of trainee selection, training methodology, and learning materials were reviewed. Pre- and post-progamme comparisons of KAP changes showed statistically significant differences.

The most recent evaluation of the Manda Project was conducted in October-November, 1992 at the request of the Ministry of Foreign Affairs of the Dutch Government, which provided funds for CCDB's Rural Development Programme. A comprehensive evaluation of the TBAs training programme was undertaken at this time. Results of this comprehensive evaluation study were reported in a 67 page document. A unique feature of this evaluation was that it combined the expertise of a five member Dutch/Bangladesh team who used a participatory approach in obtaining information from trained and untrained TBAs.

In 1991 the Savar Project undertook a comprehensive evaluation after the first year of its TBA training programme. A five member team consisting of the Training Project Director, the Executive Director of VERC, a representative from the ODA-NGO project, one Upazila Family Planning officer, and the Assistant Coordinator of VERC's Research, Evaluation and Documentation unit conducted the evaluation using non VERC staff women to collect data from pregnant and delivered mothers and TBAs. Overall, the findings were positive and demonstrated that the trained TBAs were performing effectively. The study also pointed out some weaknesses and problem areas in the programme. Results of the study were described in Evaluation Report on VERC-MCH Project.

6. Costs of Training

The costs of training traditional practitioners were described for each case study, where such data were available. A summary of these cost data is presented here.

In the Ghana Project the average direct cost for training an herbalist, spiritual healer or bone setter was approximately US$98. The average cost for training a TBA was about US$40. No administrative costs were included in these figures.

The average cost for training a TP in the Cuetzalan Project was approximately US$110. This applied only to the initial training period because data were not available to calculate the costs for the periodic follow-up training.
In the Manda Project the average cost of training a TBA was approximately US$30. These costs included selection, training and follow up. When administrative costs were included, it doubled the average cost to about US$60.

The average cost for training a TBA in the Savar Project was estimated at US$95. This included all direct expenses for the basic 10 day course plus the five day refresher course.

These cost figures should be considered as general guidelines only, as in some cases data were not available to accurately figure all costs. Also, while these figures include direct costs for basic training, in some cases additional follow-up training was also provided. These costs do not include expenses for providing continued support in the field, which in some cases was extensive.

In spite of the tenuous nature of these cost figures, they do give an indication of the range of costs for training TBAs and other TPs. Direct costs for training a TBA in the projects ranged from US$30 to $110. Similar costs for training other TPs ranged from US$98 to $110.

7. Project Difficulties

Project staff reported a number of difficulties they experienced in different stages of planning and implementation. These difficulties did not necessarily occur in all projects, but are reported here in summary:

1. A few hospital physicians did not respect or trust the TPs, which led to fewer referrals between some of the TPs and these physicians. One staff member said this tended to happen more often with new young doctors who had to serve their required residence in a rural hospital upon graduation from medical school.

2. One project reported that at the beginning some of the older TPs were suspicious of the new training project and hospital staff and were reluctant to share their ideas in the training sessions. It was reported that they felt they were being spied upon, but these feelings disappeared after they gained confidence in the training staff.

3. Another project reported that they had difficulty in scheduling training sessions at times when all TPs were available. These were sessions held in the community and many TPs spent time cultivating their own farms.

4. A problem common to all the projects was that the low level of literacy among TPs made it difficult and sometimes impossible for them to keep good health records of their clients. One solution was to have these TPs enlist the help of a literate villager to help record information. A related problem occurred in projects where some TPs spoke only an indigenous language and the staff had to use an interpreter to communicate information.

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5. Several projects indicated lack of adequate training materials such as slides, flip charts, models, and videos. And several staff said they would like to have more skills on how to teach adults, as they believed they put too much emphasis upon lecture and information giving and not enough on participation methods.

6. Both staff and TPs emphasized that not enough rewards were given to TPs for all their additional time and effort providing primary care services to communities. All agreed that more rewards should be given, but most staff said their lack of organizational resources made it impossible for them to provide anything more.

7. TBAs and other TPs stated they wanted to provide better facilities in their own communities for treating their patients. TBAs requested a room which they could keep clean, where they could store their own birthing supplies and deliver babies in private. Due to limited space, herbalists and bone setters also requested more room for their patients since sometimes they had to keep them for up to several weeks for extended treatments and recuperation.

8. In one of the Christian homes sponsored projects, the training staff encountered resistance and conflicts over differences between Christian doctrines of spirituality and traditional views of spirituality. Some Christian leaders thought the spiritual TPs were practising Paganism and using other ceremonies that Christianity forbid, and thus did not want to recruit such TPs into the programme.
VIII. LESSONS LEARNED AND RECOMMENDATIONS

Lesson 1: Traditional practitioners as a group were willing and able to learn how to perform PHC services and were dedicated and effective in carrying out these services when appropriately trained and supported.

Evidence obtained from interviews with health agency staff, TPs, and community members in these four training projects indicated that generally the training programmes had been effective in teaching TPs how to perform primary care services in communities. These services were appreciated by community members, and the provision of these services had measurably improved health behaviours and health conditions of the communities served.

Direct costs of training TPs to perform these services in these projects was relatively low; from a low of US$30 to $40 for TBAs to a high of US$98 to $110 for other TPs. Although these figures did not include costs for administration or follow-up support, they indicated that training TPs might be a cost effective means of providing increased primary health care to communities. Incorporating the use of TPs into the primary health care system appeared to be an effective and sustainable measure to improve health care to these communities. This seems particularly relevant in view of the fact that TPs already live and practice in rural communities and the day to day services they provide to families cost the official health agencies practically nothing, outside of the costs of initial training and follow-up support. Furthermore, TPs, being an integral part of the culture and life of the communities, are highly respected by community members and thus can be very influential in promoting healthy lifestyles.

Recommendation 1:

It is recommended that government and nongovernment health agencies encourage and support the training of TPs to provide more cost effective primary health care in communities.

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Lesson 2: Official government policies can effectively promote and guide the scope and nature of how TPs are utilized to provide primary health care services to communities.

The government policies related to the training and utilization of TPs in the three countries varied widely in scope and detail, but all served to guide the direction of the training programmes. In Ghana, the MOH viewed the Dormaa Project as a demonstration to provide information to expand the training in other regions. The Ministry of Health had already begun to formulate general guidelines, but had not yet established specific policies for the training and utilization of TPs for the country as a whole.
The Mexican Government has given strong support to the development of services provided by TPs, and this policy has contributed to the growth of the many traditional practitioner associations that exist in the country and the government's programme to train TPs in primary health care.

The high priority placed by the Government of Bangladesh on training TBAs to cover all villages in the country and their policy to encourage NGOs to participate in this training has led a number of NGOs as well as government centres to train TBAs. These policies have had a positive effect on encouraging NGOs to implement effective training programmes.

Recommendation 2:

It is recommended that governments establish official policies or guidelines for the utilization of TPs in PHC programmes and that these policies and guidelines be based upon knowledge gained from existing studies and on-going training projects and that they be in line with the governments' aim to provide PHC services to all communities. These guidelines should cover specific issues such as:

- how traditional knowledge, values and practices about health can strengthen PHC services to communities;
- the nature and scope of PHC services that TPs can perform;
- selection criteria and the content and methods of training programmes for TPs;
- a process for certification of trained TPs;
- procedures for follow-up, evaluation and regulating the quality of TPs services to communities;
- degree of responsibility by government, NGOs, and communities for providing support to TPs for their services;
- how the involvement of NGOs, indigenous groups, TPs and members of communities can strengthen the planning and implementation of PHC programmes with trained TPs;
- how the traditional and modern health sectors can collaborate effectively together;
- guidelines and/or support for the formation of professional organizations of TPs;
- the use of innovative projects to demonstrate cost effective ways to utilize trained TPs in PHC programmes.
Lesson 3: Non governmental organizations played an important role in innovating training methods and the provision of support services for TPs.

The private sector can assume a very important role in demonstrating new training methods and alternate ways to provide support services to TPs in primary health care programmes. Non-governmental organizations generally have more flexibility to innovate and try out different programmes than does government. Of the four projects studied, two were sponsored by NGOs and one was co-sponsored by a Church organization. The two NGO sponsored projects were the only ones who conducted formal evaluations and that involved TBAs in the process. All three utilized somewhat different methods of training and systems for providing follow-up support, and each was successful in providing PHC services that were appropriate to their respective communities.

Recommendation 3:
Encourage NGOs to share in the responsibility for training of TPs by providing technical assistance and grant monies to them for training programmes.

Lesson 4: Projects which involved the communities in the planning and the decision making achieved a high level of interest and commitment on the part of the TPs and community members.

All four projects sought the involvement of communities at different stages. For example, all projects consulted TPs as to what knowledge and skills they wanted to learn, and these desires were programmed into the workshops. This involvement generated a high level of interest among the TPs as they felt the training would enable them to practise more effectively. And because these projects consulted community leaders in recruiting and selecting TPs, they were able to identify the most respected TPs in the community and the ones which the community believed were most competent. And one project involved an experienced herbalist as part of the training staff.

Based on the responses of participants in the study, it appears that project staff might have done more to obtain community commitments for remunerating or rewarding TPs before the training programmes began. Many of the TPs complained that their communities did not support them enough for the extra time they spent after training to provide health services to families. The TPs wanted clinic rooms where they could practice, help in their farming to raise more income, and help pay for their supplies.
Recommendation 4:
Involve communities (including the TPs) in the planning and decision making to insure that the recipients and TPs are committed to the programme. Community involvement could be encouraged by incorporating specific suggestions in policies and guidelines for recruitment, selection and training of TPs.

Lesson 5: Training programmes for TPs are most effective when they are planned to meet local needs.

The importance of this principle was evident in how all four projects considered the special needs of the TPs and the communities in their regions when planning their training programmes and support systems.

Health and social conditions vary from place to place. Cultural values, beliefs, and lifestyles are unique in every region. And resources of governments and local institutions differ according to economic conditions. These different needs should be carefully considered when utilizing TPs in PHC programmes.

Recommendation 5:
Plan training programmes for TPs according to specific community, regional, and country needs.

Lesson 6: Training programmes that adopted non-formal adult education methods and materials and that were designed for low literate groups were most effective in increasing knowledge and skills.

A key finding of the study was that methods and materials for training TPs must fit the learning styles of the participants. Projects which used more participative and small group methods in classes and had the most variety of diagrams, posters, flip-charts and models to aid in the presentation of information, had fewer complaints from staff and TPs about the ease of understanding the training content. This reinforced a basic principle of adult education - that people learn by doing.

Regular training staff should have a thorough knowledge of how to use participative and experiential teaching methods and how to select and use a wide variety of supplementary teaching aids.

Recommendation 6:
Use participative non-formal learning methods and visual aids that are appropriate for training TPs in PHC skills.
Lesson 7: Programmes that integrated services other than PHC skills into the training measurably contributed to the quality of life of TPs and community members.

Three of the projects incorporated the teaching of income generation and literacy improvement, which gave support to TBAs in their personal lives as well as their professional role as PHC providers.

Two of the projects taught herbalists how to cultivate and preserve herbs and how to keep bees and sell the honey in the markets. Another project taught TBAs how to generate income from small business projects, using loans from savings banks and from other community activities and how to increase their reading and writing skills. In addition to improving their personal lives, these skills enabled the TPs to keep more accurate patient records and communicate more effectively.

Recommendation 7:
PHC training projects should include activities that meet literacy and economic needs of TPs.

Lesson 8: Staff who understood the cultural background and values of TPs were effective in training TPs and more effective in establishing collaboration between TPs and bio-medical health staff than medical staff who had less accepting or negative attitudes toward the TPs.

The Project Director in Ghana had previously participated in an anthropological study of traditional medicine in the same region and had a thorough knowledge of the traditional attitudes and beliefs of TPs. The staff used this prior experience to integrate some of the traditional wisdom into the training programme and to orient the doctors and nurses in the hospital in how to understand and collaborate more effectively with TPs.

To be most effective, staff who participate in training and provide support to TPs should have a respect for and sensitivity to TPs and have a basic understanding of traditional medicine and healing practices. Doctors, nurses, and other professionals should be able to communicate effectively with TPs and to integrate, where possible, the teaching of PHC knowledge and skills with basic beliefs of traditional healing. These attitudes and skills are particularly essential for establishing good collaboration and referrals between modern health staff and the TPs.

Recommendation 8:
Prepare trainers with skills in effective communication and methods of informal adult education and orient all bio-medical staff who work with TPs with a basic understanding of traditional medicine and healing practices.

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Lesson 9: Good collaboration between TPs and modern health staff depended upon mutual respect, good communication, and an established referral system.

For the most part, collaboration between TPs and modern health staff was good in the projects. Factors that contributed to this were:

- where TPs were taught how to identify life-threatening and serious health conditions and how to refer these cases to clinics and hospitals;
- where TPs and bio-medical staff understood and respected each other and there was good communication between agency staff and the TPs;
- where projects had developed a formal referral card system that TPs could use to refer patients to clinics and hospitals;
- where nursing staff allowed TBAs to accompany their patients into the delivery room or a learning experience.
- where periodic meetings were held between TPs and clinic/nursing staff to discuss referrals, problem cases and other matters.

Recommendation 9:
Establish an effective referral system for TPs and promote good communication and a professional collegial relationship between TPs and modern health staff.

Lesson 10: Periodic follow-up support was essential to insure that TPs were providing quality PHC services.

All projects provided TPs with follow-up support, primarily through small group sessions in the field, though they differed in the amount of staff time allocated and the scheduling of these sessions. Both TPs and staff regarded these sessions as very important for solving problems and providing continuing education.

Recommendation 10:
Provide continued follow-up support to TPs in their communities.

Lesson 11: Traditional practitioners who were compensated in some way for their PHC services were more committed to providing lasting service to their communities.

Traditional practitioners in these projects were not paid by their sponsoring agencies. They provided PHC services to individual families as part of their
commitment to their communities and the sponsoring projects. And they received very little rewards from their clients for these services. As a result, many had a difficult struggle to survive economically and depended upon other sources of income, such as farming and small businesses.

Projects tried to compensate trainees for their time and services in different ways such as by presenting certificates for completion of training; giving a birthing kit or an umbrella or dress with badge to TBAs; giving first aid supplies; reimbursing for transportation costs. These were very much appreciated, but not all felt they were enough. Since community members were the beneficiaries of the TPs' services, both TPs and agency staff members suggested that these communities should commit more of their own resources to compensate the TPs for their services. Suggestions included payments of money, help in working the farms of TPs, building community clinics for TBAs, herbalists and other TPs to practice in.

Recommendation 11:
Project staff should involve communities early in the planning stages to obtain local commitments to provide compensation to TPs for the services they provide to the communities.

Lesson 12: Projects which periodically evaluated their training programmes obtained valuable data from which they could make better decisions for modifying existing programmes and planning future ones.

Two of the projects studied had conducted formal evaluations using outside contractors. These evaluations were quite comprehensive and provided useful recommendations to the staff for improving the curriculum to identify the benefits to community members of the training project.

The most recent evaluation performed by one of these projects used a participatory approach with a team composed of outside members together with TBAs to collect the data. Participatory evaluations have many advantages such as educating local people in the importance of evaluation as a process to aid in decision-making and future planning, and stimulating local evaluators (such as TBAs) to utilize the evaluation process in improving their own practice.

Recommendation 12:
Conduct periodic evaluation of training programmes and involve local staff in the evaluation process.
Lesson 13: Good communication and an exchange of information and experiences between planners of traditional practitioner training projects and other health agencies, (i.e. government, non-government, and international health and health related organizations) regarding resources that are available for the training and utilization of TPs could contribute to more successfully planned and conducted programmes in PHC programmes.

In each project studied, the administrative and training staff were not aware of many outside resources that were available to them. Some of these resources existed within their own city or country in offices of the Ministries of Health, WHO Regional Offices, or NGOs conducting similar projects nearby. Project staff seemed to be working in isolation from other projects or organizations from which they could draw upon for technical assistance in the design and evaluation of training projects, obtaining materials on health education, or for other support.

Worldwide there exists a large body of information that, if it could be made available to these and other similar projects, could be of great value in planning and conducting effective projects that utilize TPs in PHC programmes. For example, the four projects in the field study had a great wealth of information which could be shared with each other and with others who desire to achieve similar goals.

Recommendation 13:

   Establish a central data base to collect information about existing studies, training programmes, audio-visual materials, and other relevant data and provide this information through a communication network to assist organizations and individuals in formulating policies and strategies for utilizing TPs in PHC, for conducting evaluation and research in this area, and for developing programmes to train TPs to provide PHC services for communities.

Collective recommendations made by health agency staff and their visions for the future. Health agency staff were asked to state their future visions of how Western and traditional practitioners might collaborate to provide a better health service. The following are some of their verbatim responses:

- "Western and traditional practitioners should come together, dialogue, and work hand in hand. Each should treat what they do best and refer to each other what they cannot do."

- "I see traditional practitioners in an equal partnership with Western medicine. I think we need to document what they are doing and perform more research on traditional medicine."

- "Both should be recognized and supported for the best of the community."
- "Traditional practitioners are emphasizing the curative aspects - we should help them strengthen the preventive side."

- "We should support and develop their own model of healing and get more agreements between health agencies and traditional practitioner organizations."

- "We need to continue the programme but improve it. Have the TBAs come to the hospital to learn more. Improve the teaching aids and training methods. Doctors need more training in how to teach adults."

- "The traditional practitioners and hospital doctors should work together in the community. Medical doctors need to know how the community lives."

- "If doctors could share friendship and work as a team with the TBAs it would be much better."

- "Train the TBAs to organize village women into groups or forums where doctors, family planning officers, and others could come to share ideas."

- "We need to teach TBAs how to organize community groups to conduct health education - they could be doing more with the older mother-in-laws and father-in-laws."

- "Because the traditional practitioners are older and more influential, they are able to promote nutrition, sanitation and family planning more effectively than the young nurses assigned to the community clinics."
IX. SUMMARY OF GUIDELINES FOR TRAINING

A final objective of the evaluation study was to develop training guidelines which could be used by other organizations to prepare Traditional Health Practitioners (THPs) to provide PHC services to communities. These guidelines were prepared from data collected from interviews with training staff and healer participants in the four projects in Ghana, Mexico, and Bangladesh; from observations of actual training sessions in these projects; and from other publications (handbooks and training manuals) dealing with the preparation and training of community health workers and traditional health practitioners.

An attempt was made to identify lessons learned from previous training projects and to select specific methods and materials that have worked successfully in these projects. This information was then compiled and put into practical guidelines which hopefully can be used by local health agencies for training THPs in their own countries and regions.

This summary is a condensed version of the complete guidelines and is included here to give the reader a general idea of the contents of the complete edition. A few examples of the visual aids from the complete edition are included in the Appendices.

The complete version of these training guidelines is available as a separate publication, entitled GUIDELINES FOR TRAINING TRADITIONAL HEALTH PRACTITIONERS IN PRIMARY HEALTH CARE. (In process of publication by WHO, Geneva, 1995).³⁹

STEP I: Planning for the Training

An effective training programme requires careful planning which begins by collecting information from health organizations, indigenous groups, communities and traditional practitioners.

Review existing policies and regulations

Government Ministries of Health, NGOs, and other health agencies may have already established policies for how THPs should be trained and utilized in their jurisdictions. Carefully review these policies and regulations to determine any limitations for training and incorporating THPs into PHC programmes.

Involve THPs and community members in the planning

Involving community members and THPs in the planning and implementation of the programme is essential for success. Community leaders, teachers, and healers can be extremely helpful in identifying needs, recruiting and selecting participants,
making the training content relevant, evaluating progress, and in providing other kinds of support for the project.

It is particularly important to ask healers what they want to learn so their needs can be incorporated into the training content. Equally important is to ask community leaders to participate in the selection of healers to be trained. Without this involvement there is a high risk that the most respected and dedicated healers in the community will not be chosen and that healers may not be committed to the project.

It is also essential that good collaboration exist between members of the community, the staff of the training project and appropriate health and medical units involved.

**Identify the health conditions of communities**

Training objectives should be aimed at promoting good health and reducing or eliminating illness and disease. It is important, therefore, to identify the significant health problems that exist in the target communities. These can be determined by examining the health agency's priorities and goals and from talking with community leaders.

A good way to identify the health needs of a community is to perform a simple community survey by talking with community members and THPs. Information about a community's health and social needs and the resources that exist for health improvements is very valuable for planning a successful PHC programme.

**Identify the types of health practitioners available**

In the sample projects studied there were two general categories of traditional healers: Traditional birth attendants, or midwives; and another group which included herbalists, bonesetters, and spiritualists. Experience has shown that training for TBAs and training for "other" types of healers can be separated into at least two different curricula. The scope of duties and training for TBAs has been more uniform, whereas the training for other types of healers has varied depending upon the types of health services they perform in communities. One common denominator with healers in this latter group is that most use herbal remedies in their treatments.

**Identify important characteristics of health practitioners**

It is very important to identify characteristics such as age and sex; level of education; language; economic status; and traditional beliefs about healing. These characteristics are important to know when planning training because they can help in how you structure the curricula, at what grade level to write lesson plans, what kind of translation is required for different languages, the types of visual aids and learning experiences you need to create, and so forth.
STEP II: Determining Content for Training

Three factors should determine the content of training programmes: what the community wants and needs to improve their health; what THPs want to learn; and what the health agency’s policies and priorities are for training THPs.

Information from the informal survey described in the last section can be used to identify key areas of knowledge and skills that THPs will need to provide PHC services. Using THP input increases their level of commitment to the programme. In the same way, agency policies must be taken into account to ensure that training is consistent with them.

Identify what trainees need to know

Be sure to prioritize skills and information into what must be taught and what might be useful. Consult existing training manuals published by WHO and other agencies to identify specific functions and responsibilities that TBAs, herbalists, and other types of traditional practitioners have already been taught.

Train to alleviate social and economic need

Improved literacy is a social skill often requested by THPs who may have had little formal schooling. As most health practitioners are not paid by health agencies who provide their training, it is helpful to teach income-producing skills as part of the programme.

Write specific training objectives

Clear objectives detailing skills, behaviours, and attitudes to be taught are a must to any successful training programme. When this is done, the programme runs more smoothly because both trainers and trainees know what results are expected. When staff have agreed on programme content, written performance objectives can act as a way to measure progress.

STEP III: Determining the Training Methods

Develop a training plan

A training plan is another key element of a successful programme. The plan is like a blueprint for building a house: the training plan identifies the behaviours to be taught to THPs and lists the activities and educational materials that will be needed to achieve these results. The plan should also include a timetable and a chronological order to the skills to be learned.

A training plan is a curriculum divided into sessions with a lesson plan for each session. Each lesson plan consists of one or more objectives, materials and methods needed, and a description of exactly how each session will be conducted.
Group the knowledge and skills to be taught in a logical pattern

For TBAs, this might include birthing skills, prenatal care, etc. For herbalists, it might include the collection, preservation, and use of medicinal plants, organizing communities toward better sanitation, etc.

Integrate the teaching of new ideas about health with indigenous beliefs about health and illness

A number of indigenous concepts about healing can be used to explain some modern principles about the promotion of health and the treatment of illness. This makes it easier for THPs to understand and embrace the concepts being taught.

Choose appropriate training methods

Be sure to consider the educational and cultural backgrounds and the learning styles of adults. Do not let the lack of formal education be a barrier to learning. Use a variety of methods and make the learning process as active and participative as possible.

Use some of the following methods: Give a talk. Use discussion, taking care to draw people out and facilitate group participation. Role play with students. Give a demonstration, being sure to encourage discussion afterward. And use summary and review to reinforce skills learned in the day’s session.

STEP IV: Selecting Training Materials

"A picture is worth a thousand words." Visual aids, such as posters, flash cards, videos, and films can enhance the learning process many times. Be sure to select them with an eye to the background of the students.

Review the needs for audio-visual materials in the curriculum

Audio visual materials are very useful, both for classroom training, and for use by THPs when educating community groups. Classroom materials may include training manuals, diagrams and posters, flip charts, films, slides and videos. Health education materials for community use may include posters, flip charts, and flannelgraphs.

Select AV materials that already exist locally

This may reduce costs. You can also adapt existing materials to the culture, environment and specific needs of the training group. Be sure to take into account education level, language issues, suitability of drawings, relevance of material, and religious and cultural beliefs and values.
Prepare your own materials

Use low-cost local materials and use pictures as often as possible. Keep words and numbers at a minimum. Use colours and graphs and keep the display easy to understand. Be sure that any human figures reflect the dress of the community and look friendly and approachable. Take care to illustrate technical points accurately.

Pretest materials before using

This will give you a chance to adapt materials to a local audience to avoid misinterpretation by a target group. Be sure that the language is clear, the material interesting, the message comes across, and the drawings are understood.

Use AV materials effectively

Use a variety of AV materials to illustrate main points. Processes like delivering a baby may be better shown by using a film or video. When possible, make visual aids interactive by asking the trainees to explain or discuss what they see.

For examples of visual materials used in THP training programmes see Appendices 4, 5, 6, and 7.

STEP V: Training the Trainers

All staff members who train or work closely with THPs should have respect for THPs as dedicated health professionals; be sensitive to the different beliefs that healers have about traditional medicine and healing; and have appropriate skills to teach the PHC knowledge and skills required in the programme. Another essential is that all staff be able to communicate in a manner that facilitates good collaboration between THPs and the health professionals in clinics and hospitals.

THP training projects usually require three types of staff: primary training staff, who teach the major part of the curriculum; professional health staff, who lead sessions according to their specialty area (i.e., nutrition, childbirth); and THPs, as assistant trainers.

Primary training staff design, implement and evaluate the training programme. They should have a complete understanding of the training content as well as being competent in the use of non-formal, participative, adult education methods. Trainers must also possess good communication skills and have sensitivity to traditional healer attitudes and beliefs.

Other professional health staff include doctors, nurses, health educators, nutritionists and sanitation workers. They should lead sessions according to their area of expertise and be oriented toward adult teaching methods and sensitivity to traditional beliefs.
THP trainees are a crucial element of the training process. More experienced THPs may already act as mentors to other healers and are already skilled at communicating indigenous concepts to their junior peers. Trainees who assist in the training programme can translate information into the local language and help to present concepts in a manner that is more easily understood by their peers.

STEP VI: Evaluating the Training

The evaluation process can be very rewarding to all who participate in it. One might regard it as an opportunity to gauge progress in meeting the goals of your programme.

Purpose of evaluation in training programmes

Evaluation is intended as a way to assess success in achieving training programme goals. As health professionals, it is our mission to provide the best service possible. Evaluation also allows us to see where we can improve our efforts.

Who benefits from evaluation?

Evaluation is most often performed for the benefit of trainees and training staff. But other groups benefit as well.

Trainers and programme staff need to know how effective their training methods are and how effectively the THPs are performing the skills they were taught. Doctors, nurses and others who collaborate on referrals can identify problems in the system from evaluations. Feedback from the THP trainees can provide valuable information for the trainers and programme staff to assess the effectiveness of the training.

Administrators need adequate data to determine programme effectiveness and to justify continued use of public monies to keep their programmes going. They are more likely to continue supporting training activities if they have adequate data to show how effectively the programme is actually working.

THP trainees benefit greatly from knowing how well they are doing. Evaluation data can help them to correct mistakes and improve performance during the training. Evaluations can help staff to identify the most competent THPs to help supervise and train others.

Community members can provide very useful information about the nature and quality of health services they are receiving. By asking them to participate in evaluation, you will increase community awareness and understanding of the project and facilitate their accepting more responsibility for health promotion and disease prevention activities.
Funding agencies always need positive evidence that a programme is worth their money. Having good evaluation data fulfils a major requirement for being accountable for spending project monies and greatly enhances one's chances for continued funding.

TYPES OF EVALUATIONS:

Progress evaluations

Progress evaluations can take place at many different stages during training on a daily or weekly basis by assessing performance of trainees and staff.

Assessment is accomplished by conducting exams or observing students at work. It also enables trainers to evaluate their programmes.

A good assessment must be practical, economical, accurate, easily understood by trainees and give feedback on the success of your teaching methods.

METHODS TO ASSESS PROGRESS OF TRAINEES:

Informal testing can be done inside or outside the classroom. Remember to make questions clear, precise, easily understandable, easy to answer in brief. Encourage students to participate in the process, taking care not to embarrass any student.

Formal testing or examination can be accomplished by having a trainee demonstrate his or her ability at a certain task; or through oral tests by probing a trainee’s knowledge through questions and answers.

Continuous observation is more effective than a final exam. Staff members can routinely observe the performance of trainees and identify their strengths and weaknesses. This type of assessment is more reliable because it enables a trainer to keep a continuous check on the trainees performance and can correct errors as they occur.

Self assessment is when a student evaluates his or her own performance. You must set clear standards and make sure the trainee understands how to assess their own progress. One advantage of this is that it gives the THP experience in evaluating his or her self and they can continue this evaluation process independently after the programme is ended.

Peer assessment means that students assess each other. It is a good learning tool but not a final evaluative method. Again, you must give good instructions and set clear standards. Peer assessment can give greater meaning to field experience and have more relevance than more formal tests.

Assessing the performance of trainers is important too. Trainers can obtain information about their effectiveness in the following ways: Self-evaluation; peer
evaluation; and evaluation by the trainees themselves. Trainer evaluations should take place daily or weekly, as well as at the end of the course. Trainers should develop a set of standards by which these evaluations should be performed.

OUTCOME EVALUATIONS:

These are usually performed at the end of a project cycle, such as after one, two or three years. These evaluations attempt to measure outcomes of the training programme, such as the knowledge, attitudes and skills gained by the trainees, the types of health services delivered by the healers, the type and frequency of referrals made between healers and health agency staff, and changes in health behaviours and health conditions of community members.

Outcome evaluations can be performed internally by the agency's own staff members; externally, by hiring outside consultants; or a combination of the two methods. An advantage of the combined internal and external method is that it lends itself to a participatory type of evaluation that includes all groups involved.

The value of a participatory evaluation allows those who participate in a project to play an active role in evaluating themselves and the results of their project. This type of evaluation shifts the control of project knowledge back to the participants and the community. This process enables local communities and organizations to assess information, make decisions, and take responsibility for improving their own health programmes, thereby promoting greater self-reliance among the participants.

Various levels of project staff, government personnel, THPs, and male and female community groups can be involved. Programme elements which have been evaluated this way have included: the process for selecting THPs; training content and methods; trainers; referral systems; collaboration with other agencies; health impact on the community; and cost effectiveness.
REFERENCES


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31. Werner, David, Hesperian Foundation, Palo Alto, California, a personal communication received July 1990.


APPENDICES

Appendix 1  Questionnaire for Health Agency Staff
Appendix 2  Questionnaire for Traditional Practitioners
Appendix 3  Questionnaire for Clients and Community
Appendix 4  
A. Different Positions of the Baby in the Womb
B. Eating More During Pregnancy
C. Educating the Community
Appendix 5  Birth Checklist
Appendix 6  How to Grow an Herb Garden
Appendix 7  Pregnancy Progress Chart
QUESTIONNAIRE FOR HEALTH AGENCY STAFF

Name of Health Organization_________________________ Date____

Location_________________________

Name of Interviewer_________________________

Introduction

The (Health Agency) wants to find out how effective its services are to the communities. You can help improve these services by giving us some information about your work in this programme. This information will also be used to help other countries develop better health programmes for their communities.

1. What is your name?

2. Age _____

3. Note sex: M  F

4. Title of position_________________________

5. How long have you worked in this position?

6. What is (has been) your responsibility or function in this job (project)?

7. How do you think traditional practitioners can be most useful to help communities prevent illness and promote health?

8. Do you think the training programme for traditional practitioners was effective in increasing their health knowledge and skills? Yes  No

9. If yes, how?

10. How well do you think the traditional practitioners are performing the duties for which they were trained? Probe for specifics, such as, their ability, responsibility, dedication.

11. Do you believe the traditional practitioners need any support in their day-to-day work? Yes  No

12. If yes, what do you suggest?

13. How has the community benefitted from the traditional practitioners who were trained?

14. After the traditional practitioners started working have you noticed any changes in people's behaviour, such as specific actions they do to prevent illness or promote their health? Yes  No

15. If yes, what specific activities are they doing differently?

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16. What kind of collaboration exists between the traditional practitioner and the health agency staff?

17. How has the health agency benefitted from the project?

18. Have the health agency staff accepted the new roles of the traditional practitioner? Yes No
   In what ways?

19. Have there been difficulties in planning or implementing this project? Yes No

20. If so, what were they
   - regarding the training programme?
   - regarding the services to the community?

21. What could be done to correct these difficulties?

22. What do you think are the main strengths or advantages of using traditional practitioners to provide primary health services to communities?

(If you are interviewing a health agency staff member who does not work directly with traditional practitioners in a clinic, hospital or community, omit questions 23 through 31 and go to question 32.)

23. During the last 6 months have any traditional practitioners referred cases to you for treatment or other health service? Yes No

24. If so, how many cases?

25. What kind of referrals were they?

26. Do you refer any cases to traditional practitioners? Yes No

27. If so, what kind of referrals do you make?

28. Have you been able to communicate effectively with traditional practitioners? Yes No

29. If no, how could that be improved?

30. Have you encountered any other difficulties working with traditional practitioners? Yes No

31. If yes, what were they?

32. What is your vision in the future for how Western and traditional practitioners might collaborate to provide a better health system for improving the quality of life in communities?

33. Do you have any other suggestions about how to use traditional practitioners in providing health services to communities?

Thank you very much. This is the end of the interview.
QUESTIONNAIRE FOR TRADITIONAL PRACTITIONERS

Name of Health Organization_________________________ Date _____

Location_________________________

Name of Interviewer_________________________

Introduction

The (Health Agency) wants to find out how effective its services are to communities. You can help improve these services by giving some information about your work in this programme. This information will also be used to help other countries develop better community health programmes.

Do you mind if I ask you some questions? Please give us your honest opinions and views. This information is confidential and your name will not be used.

1. What is your name?

2. Age____

3. Note sex: M F

4. How many years did you go to school?
   If no school can he/she read & write? Yes  No

5. What kind of healer do you call yourself, ie.:
   herbalist
   spiritual healer
   TBA/midwife
   bone setter
   other

6. How many years have you worked as a traditional practitioner?

7. What do you consider to be the most serious health problems of the people you serve?

8. What did you learn from the training programme for traditional practitioners?

9. Which things were most helpful to you?

10. Did you have any difficulties understanding the training?

   Probe about: understanding the information presented;
                 the methods used.

11. Can you suggest any ways to improve the training?

12. How are you using the things you learned in training? Probe for specific tasks.
13. After training and you started working in the communities, did you notice any changes in people's behaviour? Probe for things that they did differently to promote their health.

14. What kind of collaboration do you have with nurses and doctors that work in the clinics or hospital? Probe for specifics.

15. Do you refer any patients to the clinic or hospital? Yes  No

16. If yes, what kind of patients?

17. Do the nurses or doctors refer any patients to you? Yes  No

18. What kind of patients?

19. Do you get enough assistance from health workers in the clinic or other health staff? Yes  No

20. If not, what kind of assistance would you like to get?

21. Can you suggest any ways to improve cooperation between traditional practitioner and other health staff?

22. Do you conduct meetings or do other activities with traditional practitioners in your area? Yes  No

23. If yes, what kind of activities?

24. Do you participate in any community meetings or community activities? Yes  No

25. What kind of meetings or activities?

26. If you could have more training, what would you like to learn to help communities improve their quality of life?

27. How has this training helped you as a traditional practitioner in your own practice?

28. Do you have any other comments or suggestions about how to improve the training of traditional practitioners to improve the health of communities?

Thank you very much. This is the end of the interview.
Appendix 3

QUESTIONNAIRE FOR CLIENTS AND COMMUNITY

Name of Health Organization________________________ Date______

Location__________________

Name of Interviewer________________________

Introduction

The (Health Agency) wants to find out how effective its services are to your community. You can help improve these services by telling us how you like or do not like these services. This information will also be used to help provide better services to other communities.

Do you mind if I ask you some questions? Please give your honest opinions and views. This information is confidential and your name(s) will not be used.

If individual:                            If group:

1. What is your name?                    Number of adults
2. Age                                  Estimate age range
3. Note sex  M  F                        # of M  # of F
4. What is your occupation? ie, mother, farmer, shop keeper, etc.
5. Have you or your family obtained health services from a traditional practitioner within the last year?
   Yes  No
6. If yes, what services did the traditional practitioner provide?
7. How satisfied were you with these services? Probe for details
8. How was the attitude or manner of the traditional practitioner when he/she provided the service? ie, friendly, unfriendly, etc.
9. Did you dislike anything about the service? Probe for details
10. Can you suggest any ways the traditional practitioner can improve services?
11. Have you learned anything new from the traditional practitioner about how to prevent illness or to keep you and your family healthy? Probe for details.
12. Can you suggest any ways your community could work together to improve the quality of life?

Thank you very much. This is the end of the interview.
THIS ILLUSTRATION SHOWS

- A baby in the womb with head downwards.
- A baby in the womb with buttocks downwards.
- A baby in the womb placed sideways.

POINTS FOR DISCUSSION

- How can the position of the baby in the womb be recognized?
- At which stage should this be checked?
- What are the different positions a baby may take in the womb?
- When should a TBA refer the pregnant woman for management of abnormal position of the baby?

POINTS TO REMEMBER

- By feeling the abdomen for the position of foetal parts and locating the place of foetal heart sound, the TBA can have a rough idea of the position of the baby in the womb. This can also be done by checking where the head of the baby is located.

- Checking for the position of the baby should be done only during the last two weeks of pregnancy since the baby can change positions before this.

- A baby may be born head first (which is normal) or buttocks first or may be placed in the womb sideways.

- Always refer a woman who has her baby sideways in the womb since this baby cannot be delivered at home. It will require an operation. If the TBA suspects that the baby will be born with buttocks first she must consult a midwife or doctor to confirm and to decide about the place of delivery.
POINT TO REMEMBER

- A pregnant woman must eat extra food every day to meet the needs of the rapidly growing baby in the womb.
- A pregnant woman should eat more of the foods that she normally eats at home. If she cannot eat large amounts of food at one time, she should eat several times during the day.
- No special foods are required.
- A pregnant woman should not restrict foods since any restrictions may reduce her total food intake. This will affect the growth of the baby adversely.
EDUCATING THE COMMUNITY
Flip chart for TBAs and Mothers
**THIS ILLUSTRATION SHOWS**
- A TBA discussing the importance of women's nutrition in her community.

**POINTS FOR DISCUSSION**
- What role can a TBA play to increase community involvement in improving MCH and family planning services?
- Whose assistance should the TBA seek for the success of her work?

**POINTS TO REMEMBER**
- In addition to providing nutrition education during pregnancy, TBAs must help families to obtain appropriate services. This will help in pregnancy spacing, immunizations, treatment of illnesses and promote safe motherhood and child survival.

- TBAs should utilise all resources available in the community such as community leaders, women's groups and other agencies concerned with community development. This can be done by interacting with people and groups frequently.

- TBAs should interact with people and educate them about the essentials of health care.
BIRTH CHECKLIST
A Visual Aid for TBAs

1. Prepare a clean bed.

2. Wash your hands well with soap.

3. Use the delivery kit.

4. Tie the umbilical cord.

5. Immediately after birth, encourage the mother to nurse the baby.
HOW TO GROW AN HERB GARDEN
Visual Aids for Herbalists

A COMMUNITY PHARMACY OF MEDICINAL PLANTS

(Knowing and practising that which you have learned, look around for a place that will serve to protect our plants and arrange them in order for when you need them.)

FARMACIA COMUNITARIA DE PLANTAS MEDICINALES.

CONOCIENDO Y PRACTICANDO LO QUE SE HA Dicho, PODEMOS BUSCAR ENTRE TODOS UN LUGAR QUE SERA PARA GUARDAR NUESTRAS PLANTAS Y TENERLAS ORDENA DAS Y A MANO PARA CUANDO SE NECESITEN.
### Appendix 7

**Pregnancy Progress Chart**

A Graphic Record Card for TBAs

<table>
<thead>
<tr>
<th>গণ্য ধারণের অন্ত্যগতির তালিকা</th>
<th>Data last menstruation</th>
<th>নারীর ক্রিয়ার জারিক</th>
<th>Expected birth date</th>
</tr>
</thead>
<tbody>
<tr>
<td>গণ্য ধারণের অন্ত্যগতির তালিকা</td>
<td>Date last menstruation</td>
<td>নারীর ক্রিয়ার জারিক</td>
<td>Expected birth date</td>
</tr>
<tr>
<td>Date last menstruation</td>
<td>নারীর ক্রিয়ার জারিক</td>
<td>Expected birth date</td>
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</tr>
<tr>
<td>গণ্য ধারণের অন্ত্যগতির তালিকা</td>
<td>Data last menstruation</td>
<td>নারীর ক্রিয়ার জারিক</td>
<td>Expected birth date</td>
</tr>
<tr>
<td>Date last menstruation</td>
<td>নারীর ক্রিয়ার জারিক</td>
<td>Expected birth date</td>
<td></td>
</tr>
<tr>
<td>Check under the eyelids</td>
<td>Take iron tablets</td>
<td>Take 2 R/1 booster shots</td>
<td>Take good care of breasts</td>
</tr>
<tr>
<td>Examine the body</td>
<td>Abnormal positions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladdinq</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swelling of feet and headaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constitutions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery kit!</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Appendix 7*