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Indigenous Knowledge and HIV/AIDS: Ghana and Zambia

It has always been difficult to reach poor people with development aid, particularly in health where most resources benefit the middle classes in urban hospitals. For the rural poor, and increasingly also for the urban poor, often the only affordable and accessible form of health care is provided by traditional healers. Zambia with an estimated 20-25 percent of the population HIV-positive has only 900 western- educated doctors (600 of whom are foreign) but has 40,000 registered traditional healers for a population of 10 million. Ghana, with 5 percent of the population being HIV-positive, has 1,200 western educated doctors but an estimated 50,000 traditional healers for a population of 20 million. Thus, the ratio of doctor to traditional healer is 1:44 in Zambia and 1:42 in Ghana. Given the central cultural role of traditional healers in communities, they provide one of the best hopes for treating and stemming the spread of AIDS. But healers rely on medicinal plants and there has been a significant decrease in the abundance of many important medicinal plant species as their habitat are lost through deforestation, cultivation, overgrazing, burning, droughts, desertification, etc. This problem has been exacerbated by the unmanaged local and international demand for medicinal plants. Furthermore, traditional healers have identified as an important issue, the loss of indigenous knowledge regarding traditional medicine, which forms part of the cultural heritage of local communities and is usually transmitted orally. This knowledge is often undervalued by the younger generations, at least in part because traditional medicine seldom brings high economic returns to the practitioner.

In recognition of the importance to preserve and protect this ethnomedical knowledge, and the plant species on which it is based, the governments of Zambia and Ghana, with support from the World Bank, are in the process of establishing a bridge between environment and health in fighting HIV/AIDS. In Zambia the executing agency is the Traditional Health Practitioners Association of Zambia (THPAZ) through the Environmental Support Program (ESP) under the Ministry of Environment and Natural Resources. In Ghana, the effort will be part of the

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Northern Savanna Biodiversity Conservation Project (NSBCP) under the Ministry of Land, Forestry and Mines. Basically, the two projects have the same approach although they differ in design: in Zambia the initiative has been retrofitted into an already existing program while in Ghana the activities will be part of on-going project design. What follows is first a short description of the AIDS component involving traditional healers under the Zambian ESP; second, a comparison of the sociocultural findings particularly concerning gender differences related to traditional medicine in the two countries; and third, some of the difficulties experienced during the process of establishing this cross-sector initiative involving agriculture, environment, health, and rural development.

Under the Zambian initiative, "Protection and Sustainable Use of Biodiversity for Medicinal Value: An Initiative to Combat HIV/AIDS" there are three main activities. The first activity, "Conservation of Biodiversity for HIV/AIDS Prevention and Treatment" includes the establishment of botanic gardens, forest reserves for medicinal plants, and a herbarium with medicinal plants. Some of the seeds, cuttings and tubers for planting will come from Spiritual Forests, which have considerable biodiversity and contain rare species of plants and trees, which have been preserved because of the traditional rules, norms, and taboos associated with them. The second activity "Training and Capacity Building" is directed towards the traditional healers and includes a long list of topics from behavior modification in relation to HIV/AIDS, understanding ecosystems, nutrition, toxicology, basic virology, epidemics, and immunology. In addition to the environmental and medical aspects there will also be legal training so that healers do not infringe the law, such as the Witchcraft Act, and get a better understanding of human rights. The third activity "Dissemination of Information/Knowledge on Biodiversity and HIV/AIDS" will set up a communication strategy to be implemented through newsletters, radio programs, TV, drama/plays and leaflets. This activity will also include an electronic database on medicinal plants and publication of a handbook for traditional healers to be used in their practice. All training materials, programs, and publications will be in the major local languages and a basic literacy program will be added to make the (often) -illiterate healers capable of registering their patients, and documenting their indigenous knowledge.

Whereas gender analysis has been essential for project design in both Zambia and Ghana the role of women are very different in the two countries. Generally the gender division of labor has been stronger in Ghana than in Zambia. This has had an effect on the position of female traditional healers as well as their ability to participate in project activities. Some of the sociocultural differences are analyzed here. In Zambia, traditional healers have received donor help to be organized on a national basis, and 60 percent of the registered traditional healers are women. The number of women healers is even said to be growing in response to the increasing number of AIDS patients. People call HIV/AIDS "Kalaye noko," meaning "go and say goodbye to your mother," because most people die in their villages in their mothers' homes. Although women in Ghana are also the ones to care for the ill, the contrast

is striking when it comes to practicing healing. In Ghana, there is no functional national traditional healers' association, and the three northern regions have less than one-fifth of the estimated healers' registered. Of these (few) registered members, less than 10 percent are women except for one minor sub-region where an active healer has managed to raise the figure to 49 percent. However, the low figure in Ghana is more a reflection of local beliefs than of the actual number of women healers. Also, the Bank-assisted initiative might have unintentionally cemented already existing gender bias by, for example, only training the registered healers, who are overwhelmingly male. According to one female healer in Ghana, women, if they openly practice traditional medicine "are termed witches and every misfortune is blamed on them; in most cases these women are disowned and sent out of their societies. For this reason it is only the queen of witches who is known to heal, because she is so powerful that it is impossible for any member of the society to challenge her."

In both countries it was extremely rare to find traditional healers who cultivated medicinal plants, and when it did happen, it was almost exclusively funded by donors. In Zambia, women healers often referred to a spirit guiding them to the medicinal plants, which they collected and prepared for medicine themselves. In Ghana, there was substantial gender bias related to the collection of plants, preparation of medicine, and even to sexuality, which had a positive influence on males but a negative influence on women. Fewer female healers in Ghana were married than were male healers, which one female healer explained by saying that she would not be able to heal if her husband was living with her. Neither would healers, who used traditional African religious rituals in the healing process, send their daughters into the bush to get the plants, because "people would think they were witches." And husbands would not let their wives help to make the medicine "because the medicine would not work" if prepared by a woman. An obvious rationale for this taboo was patrilineal location and succession which meant that a woman at marriage would move to her husband's house, and the family's secret knowledge on plants and its medical use, would thereby be in danger of being uncovered by another family. Healers in Ghana were also reluctant to teach their daughters traditional medicine, but little girls also have eyes and ears, and many women practice medicine, although not openly. That obviously had a negative influence on women's options for income generation through their practice. Only traditional birth attendants (TBA) were almost exclusively women, and most TBAs received some remuneration for their services. But most traditional healers earn their main income from farming and remuneration for healing was in farm products. In Zambia, the declining economy had forced many healers to give up payment in kind, and healers had increasingly turned to (their individual) standard payments for each disease. The highest price was always a cure for infertility, which had to be paid at the arrival of an infant son. The strong division of labor in Ghana gives a unique opportunity through the project to support women and families in HIV/AIDS prevention and poverty reduction, thereby enhancing the prospects of success for the project as a whole. The long-term goal of biodiversity conservation could seem abstract to communities suffering from food shortages and hunger; however, short-term income generation through the cultivation and selling of medicinal plants and vegetables leading to improvements in, particularly, children's health could have a catalytic effect on the success of the project.

Traditional healers, both male and female, expressed an eagerness to be trained to improve their practice. In Ghana, the mass communication program on HIV/AIDS had succeeded in disseminating information on transmission of the disease from one person to another via blood, sexual intercourse, infected needles, and so forth. But communities' knowledge on how it is transmitted was not always complete or accurate. Some communities referred to the danger of eating or bathing together with an AIDS-infected person; even shaking hands or using the same clothes was mentioned as a possible way to be infected. None of the communities admitted that there were any affected individuals in their village, and in both Zambia and Ghana, severe stigma was attached to a person with AIDS. Thus, people were less likely to admit infection and treat HIV/AIDS as a common, but serious, disease. Poverty and cultural norms also make Africa the continent with the

highest proportion of women to men infected with AIDS. In the fight against AIDS, traditional healers need training as they provide health care for about 70 percent of the population. And TBAs, according to the World Health Organization, deliver 95 percent of babies in the rural areas, which makes them particularly critical care-givers but also renders them more vulnerable to HIV/AIDS. In the long run, the health infrastructure provided by the traditional healers and their organizations could provide the distribution network for AIDS medicines when they become available at a reasonable price. Traditional healers have a unique position as educators and potential distributors of AIDS medicine—for example in handling patients' doses. No African government has the resources or health personnel in the numbers needed to fight the AIDS epidemic.

Governments in Ghana or Zambia do not support traditional healers financially as they do their (modern) medical associations, and in neither country is traditional medicine part of the curriculum at medical faculties. In this respect, African countries are far behind countries such as China and India where alternative medicine is an integrated part of modern medicine practiced at hospitals. However, Ghana and Zambia both have staff in their Ministries of Health to coordinate policies to traditional healers, and both governments want healers to be registered. Ghana has shown a positive attitude towards the conservation of medicinal plants and has acknowledged traditional healers by passing a Traditional Medicine Practice Act in 2000. In Zambia, on the other hand, it was when more than one-fifth of the population became infected with AIDS that traditional healers were invited to become part of the Technical Committee on Natural Remedies for HIV and Other Related Diseases, placed directly under the Head of State. The Ministry of Environment and Natural Resources, under which the ESP is located, was initially very reluctant to involve civil society in natural resource management, and particularly THPAZ, which is the country's largest NGO. Traditional healers were considered to be irrelevant to modernity and therefore to be excluded from development. A similar reluctance was initially found in the World Bank where traditional healers' practices were often perceived as lacking scientific validation, and hence legitimacy. This view was also widespread among western doctors, although traditional health practice predates modern medical practice just as the use of herbs and medicinal plants predates the present pharmacological practice. Gradually, however, this attitude has changed and today it is acknowledged that initiatives like the ones in Zambia and Ghana are benefiting the poor directly and have considerable potential in treating AIDS-related diseases.

This article has been written by Maja Naur, Ph.D. in sociology, consultant to the World Bank. The projects referred to are: Zambia: Environmental Support Program, report no. 16239-ZA, and Ghana: Northern Savanna Biodiversity Conservation Project, project document on a proposed grant from the Global Environmental Facility Trust Fund. The author wants to thank the concerned Task Managers, Yves Prevost and Hassan M. Hassan and not least John Lambert for his work on medicinal plants. The social studies for the projects have been undertaken by the author and funded by the Danish Trust Fund. For more information, e-mail: MAJANAUR@msn.com