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Towards professionalization of traditional medicine in Zimbabwe: A comparative analysis to the South African policy on traditional medicine and the Indian Ayurvedic system.

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Abstract
The use of Complementary and Alternative Medicine (CAM) remains prevalent in most developing countries including Zimbabwe, South Africa and India. Health care provision in these three countries continues to depend on both orthodox and traditional systems. This paper seeks to explore how the political, social and economic backgrounds have previously influenced and continue to influence CAM health policies taken by these countries. There is thus need to analyse why Zimbabwe, South Africa and India took different approaches in policy formulation and implementation as well as an analysis of the strengths and weaknesses of the different approaches taken by each country. This paper also seeks to analyse CAM evidence from the three countries as well as relating the impact of the different policies on practice. It maybe postulated that the Zimbabwean case for implementing a CAM health policy by legislating the Zimbabwe Traditional Healer's Association (ZINATHA) was mainly driven by a populist approach adopted by post-colonial politicians. On the contrary, the reverse seems true for India where there was a significant need and preference for the Ayurvedic system in comparison to orthodox medication among some sectors of the community. There are also significant similarities and differences in the road towards professionalization of traditional medicine in Zimbabwe and South Africa. It is therefore of paramount importance to compare and contrast how the different socio-economic and political dynamics yielded different end products in these countries. Analysis will also be made on how each of the country's policies impact on practice, hence enabling recommendations for improved traditional medication practices.

Keywords: Complimentary, Alternative, Allopathic, Ayurveda.

1. Introduction
Approximately eighty percent of individuals in Southern African member states (Zimbabwe and South Africa included) use traditional medicine to meet their health care needs. The two countries share a common historic perspective in which traditional medicine was marginalised during the colonial era [1, 2]. Such discrepancies in health care delivery, in particular the exclusion of traditional medicines posed a great challenge to post-colonial leaders both in Zimbabwe and South Africa, as they had to enact policies that appeased the majority of their African supporters. There was thus need to legitimise traditional medicines along with allopathic health care systems so as to assume an integrated approach.

Although Zimbabwe attained its independence earlier than South Africa, it has achieved lesser significant progress on promoting traditional medicine despite having lobbied for such policies from 1980 [3]. On the contrary, South Africa has made significant and outstanding strides in Complementary and Alternative Medicine policies as well as in implementing policies on traditional medicine. This necessitates a comparison of the different approaches taken by the two governments and their implications to health practice. India's ayurveda system with National Institute of ayurveda established in 1976 operates along allopathic western medicine. The success story of legitimizing ayurveda in India depicts its paramount importance as a reference point for developing countries that are currently on the pathway to legitimizing and professionalization of traditional medicine practice.

2.0 Background
The World Health Organisation [4] defines traditional medicine (TM) as native health practices, approaches, knowledge and beliefs that maybe applied either singular or in

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combination to treat, diagnose and maintain wellbeing. The terms complementary medicine and alternative medicine have been used interchangeably with traditional medicine. The former (complementary/alternative medicine) often refers to TM practiced in a country where it did not originate.

2.1 Policy frameworks applicable to traditional medicine legislation

Buse *et al*, [5] define a policy as a course of action and/or inaction that affect the set of institutions, organization and funding arrangements of the health care delivery system. Thus with reference to traditional medicine in Zimbabwe, reference will be made to the motivations of implementing specific legislations, the role played by the traditional healers in the policy making process, role of non-governmental organizations (NGO's) both as funding and capacity building agents, inaction by the government, actions by government which led to discourse between the allopathic medical practitioners and traditional healers as well as the pros and cons of the policy making process applied by South Africa and India compared to that of Zimbabwe.

Policy frameworks are important in correlating relationships among various elements that need to be considered for theory generation but do not themselves predict outcomes [6]. This is because policy planning and implementation are politically motivated processes that are dependent on other variables [7, 8]. Walt *et al* [7] maintain that health policy environments in middle income countries (such as South Africa and India) and high-income countries (such as Britain and USA) differ from those in low resource countries due to weaker regulations. One may also feel justified to maintain that low and medium resource countries (Zimbabwe included) are generally characterised by more patronage in political systems that in turn may deter the process of implementing important health policies.

An understanding of frameworks and theories of policy reforms enables us to envisage how the political, social and economic dynamics inevitably interlink with each other in policy formulation and implementation. This paper will highlight the advocacy coalition framework, policy triangle framework and the networks frameworks as these reflect on traditional medicine policies taken by South Africa, Zimbabwe and India. Since health policy research and implementation may be perceived as a politically motivated process [9, 10], it is also of paramount importance to outline the correlation between policy reform and politics.

2.2 Advocacy coalition framework

This seeks to provide a causal theory of the policy process, which it divides into four, stages namely, agenda setting, policy formulation, implementation and evaluation [11]. With respect to health policy in low resource settings, agenda setting could be dictated by politicians to appease some social groups as typified by post-colonial Zimbabwe in which most policies were originally set up on socialist principles. Alternatively in democratic countries such as United Kingdom and USA there is significant consultation hence making policy formulation a democratic process. Although Harney *et al* [12] maintain that policy analysis has to be more deliberative as typified by less top to down approaches, the opposite seems true for most low resource settings. Reich [10] concurs with this as he maintains that in most instances decision makers rely on their intuition in managing the politics of reform.

2.3 Policy triangle framework

The advocacy coalition framework has been criticised for assuming linearity that does not exist in the policy-making process [10, 11]. The policy triangle framework considers how different sectors of the society, state institutions, and non-governmental institutions interact with each other to influence the context and content of health policy. Keck and Sikkink [13] agree with this when they point out that the input of the private sector including NGOs has inevitably played significant roles as policy is increasingly influenced outside state borders as a consequence of globalisation. In countries such as China where the views of participants have been explored and incorporated, this has enabled Chinese oriental medicine such as acupuncture to be recognised in diverse parts of the world.

2.4 Network frameworks

These may be viewed as clusters of actors that are capable of networking and engaging in collective action [12]. Walt *et al* [7] and Reich [10] substantiate each other that a few strategies in developing countries use network analysis during agenda setting. Harney *et al* [12] attribute such oversight to top-to-down models used as governments make uninformed decisions. Such approaches seem to be prevalent in developing countries. One may thus feel justified to assume that this is because most African governments maintain their status quo under the pretext of democracy. Such lack of political will arguably leads to isolation of important stake holders such as NGOs and church organisations that could also potentially play a significant role in research and development on medicinal herbs and traditional medicine in low resource countries.

2.5 Policy reform and politics

Reich [10] outlines five reasons that can be proposed to explain why political dimensions tend to influence policy reform. Firstly there is need to present values that represent the view of the majority of the society. Secondly health policy reform affects the distribution consequences of gains and losses. With reference to traditional medicine, for example the benefits of using some natural herbs could prove beneficial to people who believe and are content by use of these. On the other hand use of unclassified medicines such as traditional medication in Zimbabwe and South Africa could have cytotoxic consequences that are detrimental to health and wellbeing [14]. The third reason is related to interests of different groups in influencing distributional consequences. In low resource countries this may end up having negative effects on the supposed beneficiaries as policy reform could be used to manipulate the electorate. Fourthly political events have an effect on enactment and non-enactment of health policies as new governments try to appease particular groups of the society. Such is usually the case with most post-colonial governments [9, 10]. Finally, reform can influence a regime's stability or longevity.

3.0 Historical background from Zimbabwe

Zimbabwe attained its political independence from its former colonial masters in 1980. As Waite [3] puts it, health delivery in the colonial era was white run and practised apartheid. The white legislators saw it fit that they alone enjoyed Western medical services. In Southern Africa (both Zimbabwe and South Africa included), missionaries brought with them medication for their own use. The missionaries shared the medication with local communities in a bid to advance their

evangelistic work [1]. The missionaries viewed traditional medicine as witchcraft, undermined it and deemed western medication superior. According to Lange [15] and Murray &Chavunduka [16] missionaries also viewed herbal medicines as unscientific and of no physiological value. Although missionaries offered voluntarily to provide health and education services, increased incidences of TB, smallpox and other sexually transmitted infections forced the government to build hospitals and clinics for Africans who were in urban centres and also subsidised the work of missionaries [3].

According to World Health Organisation (WHO) recommendations in the Alma Ata Declaration of 1978, there was a need to recognise the role of Traditional Health Practitioners in providing health care. The declaration highlighted the need to research and develop appropriate policies enabling use of traditional medicine as officially recognised Complementary and Alternative Medicine [17]. This WHO proposal, coupled with domestic pressure from indigenous health practitioners necessitated the need to research, design and implement empowering policies on traditional medicine. Chavunduka [1] and Waite [3] are quick to point out that most indigenous Africans preferred traditional medicine despite its demonization and its criminalisation through the Witchcraft Suppression Act of 1889 [18].

3.1 Post-colonial Legislation on traditional medicine in Zimbabwe

In 1980, the Zimbabwe National Traditional Healer's Association (ZINATHA) was founded following a demonstration by traditional healers. The government then passed the Traditional Medical Practitioner's Act (1981) without any consultation from other stakeholders [19]. According to the International digest in health legislation (1982) the Act is among the most comprehensive legislations ever enacted on traditional medicine [20]. This Act was enacted without considering feasibility of its contents and the need to collaborate with other stakeholders as advocated by the networks framework. This was a typical top to down approach in which other valuable participants were not consulted. The Act requires that the Ministry of Health to appoint a registrar following consultation. The Ministry also sets up the Traditional Medical Practitioners Council. The Act classifies traditional medicine as every act that is to treat, identify, analyse or diagnose illnesses of the body and mind without the application of operative surgery. The Act recognises ZINATHA as the association representing traditional medical practitioners in Zimbabwe [21]. The roles of the council are to supervise, control and promote research on traditional medicine. It also holds enquiries on malpractices, maintains a register of practitioners and promotes training on traditional medicine. According to the Act, if an individual practises without registration, he/she commits offense punishable by up to two years imprisonment. Registered practitioners are to be classified as either Registered Traditional Medical Practitioner (comprising mainly of herbalists and birth attendants) or Registered Spirit Medium (to include traditional spirit mediums and faith healers). The Natural Therapists Act of 1981 was also concurrently enacted and this regulates the structure and registration of natural therapists (homeopaths, naturopaths and osteopaths). Licensing regulations are to determine the code of practice for chiropractitioners.

Five years following the enactment of the two legislations, most of the traditional healers continued to operate without ZINATHA registration and the organisation had a compromised capacity due to lack of both financial and human resources. There was increased public outcry regarding the conduct of traditional healers [3]. For example some of the so-called spirit mediums and faith healers would witch hunt individuals in public thereby causing pandemonium and fiasco. There were also reports of some herbalists using the same razor blade for a number of patients should they need to topically apply some powdered herbs on patients [1, 21, 22]. This public outcry thus compelled the government to revisit its blue print that was now gathering dust and led to the appointment of the Traditional Medical Healer's Council that was reporting to its registrar. ZINATHA continued to operate as the registering organisation for traditional medical practitioners.

A reflection on the implementation of traditional medicine could highlight the zeal of ZINATHA to set up a parallel complementary medical system. In 1981, ZINATHA opened a research centre and two training colleges that taught traditional medicine and account keeping. The college did not have any curriculum on spiritual healing [23]. The organisation also operated a total of 5 clinics in two major cities despite the fact that traditional medicine use is used more prevalently in rural areas compared to urban areas. Unfortunately as Waite[3] puts it all these projects were a flop due to lack of funding. This can also be attributed to lack of consultation with stakeholders some of whom could have voluntarily supported these noble ideas. The government itself did not have the capacity to fund many of the programmes, as it was mainly dependent on donor funds for many of its developmental project including health and education.

3.2 The role of international agents

In 2002 the United Nations issued guidelines intended to support developing countries such as Zimbabwe to develop policies on traditional medicine. The third session of the African Union Conference of Health Ministries held in April 2007 emphasised the need to accelerate the implementation of policies on traditional medicine. It also reiterated the need for significant advocacy in health policy planning [24]. This meeting resolved the need for a mid-term review on traditional medicine to be held in 2008. Following this conference, the Deputy Minister of Health organised a press conference at the University of Zimbabwe School of pharmacy in May 2007 [25]. He advocated for collaborative links between traditional medical practitioners and was quoted as saying, "We are moving, though it might be slow, in the development and use of traditional medicine." This statement clearly shows that although the Traditional Medical Practitioners Act was enacted in 1981, little progress had been attained in terms of implementation. The enactment of the law could originally have been a political rhetoric. With the new wave of dispensation from the African Union and World Health Organisation, the Zimbabwean government thus realised the need to consult and formulate the policies on traditional medicine before implementation. The advocacy coalition framework advocates for such an approach. The Minister also noted that the government had a policy draft that was now awaiting approval [25].

3.3 The National Health Strategy for Zimbabwe (2009-2013)

In 2009 the Zimbabwean government of National Unity gazetted its strategy for the period 2009-2013 with the assistance of WHO Corporate Policy framework guidance. Unlike the previous strategy, this current policy framework

incorporates a comprehensive section on traditional medicine [26]. Among other issues, there is need to adopt WHO's strategy on traditional medicine. Since there are no discrete policies, the strategy proposes the formulation and implementation of national policies on complementary and alternative medicine that recognise traditional medicine. The strategy also clarifies the concerns of monitoring the safety of herbal medicines. Lack of documentation of traditional medicine and practices needs to be addressed. The strategy highlights the need to clarify and differentiate the roles of the Traditional Medical Practitioners Council, the traditional healers and the Health Professions Council. The comprehensiveness of areas that need attention clearly shows that the government is realising the need for professionalization of traditional medicine in Zimbabwe since 1980.

4.0 Analysis of findings from South Africa
Zimbabwe, South Africa and India all share a common history of emerging from former colonial rule. There are some similarities and differences in socio-political settings as well as economic positions. Keck and Sikkink [13] maintain that forces outside regional boundaries as a result of globalisation increasingly influence policy planning and implementation. Thus although different social, political and economic dynamics could have influenced the pathways taken by Zimbabwe, South Africa and India, a comparative analysis of the CAM policies adopted by the later two countries with in comparison to the Zimbabwean experience is discussed here.

4.1 South Africa
South Africa is multiple ethnic and about 80% of the population is of black origin. In 1992 a whites only referendum in South Africa approved a reform to end the apartheid system. Following multiracial elections in 1994, a government of National Unity was formed. Nelson Mandela of the African National Congress (ANC) was appointed president while FW de Klerk of the National Party and Thabo Mbeki of ANC were deputy presidents [27, 28]. Thus unlike in post-colonial Zimbabwe where ZANU-PF viewed itself as a predominant party in policy formulation and implementation, South African policies were to be enacted following a democratic process that had to encompass all other political parties and stake holders. South Africa had gained its independence from British rule in 1931 following the Anglo-Boer war. Gqola [27] purports that under the Boer dominated apartheid rule, the indigenous South Africans were relegated to a subclass that had fewer human rights. Gqola [27] and Skinner [28] concur that a number of British activists were opposed to apartheid, as they believed that educating some Africans would empower them to participate in means of production such as working in factories and mines. British missionaries in Zimbabwe that was a then a British colony fulfilled this role. Similarly the health system was discriminatory under the apartheid system.
Realising the need to empower indigenous traditional medical practitioners, traditional medicine (TM) was discussed in the National Health Plan at the annual ANC conference of 1994 where it was proposed that traditional medicine be an integral and recognised option for health care in South Africa [2, 29]. This approach may be applauded as it conforms to the first stage of the advocacy coalition framework (agenda setting). Thus like the Zimbabwean scenario, South Africa had to address the concerns of the marginalised traditional medical

practitioners. The issues raised here had a significant impact on policy as exemplified by the National Drug Policy for South Africa (1996), which took some of the concerns into consideration. Section 11 of the policy particularly focuses on issues relating to traditional medicine. Its aim is to investigate the safe and effective use of traditional medicine. According to the Act, traditional healers will be encouraged to work more closely with the orthodox health practitioners but maintaining their autonomy. Traditional medicine will also be investigated for its safety and quality. Other proponents are testing cytotoxicity of medicinal plants, compilation of a national formulary of Medicines Control Council encompassing traditional and propagation of medicinal plants [30].

The use of networks approach in implementing the National Drug Policy for South Africa proved fruitful as some research institutes offered to participate in traditional medicine research. The conciliatory approach adopted by the multiparty political system in South Africa proved more effective than the post-independence Zimbabwe government whose ministers predominantly decided important destinies basing on their own intuition. The Medical Research Council Traditional Medicines Research Unit was founded in 1997 as collaboration between the Department of Pharmacology at the University of Cape Town, the School of Pharmacology at the University of Western Cape and the traditional healers [29, 31]. The long-term objectives include patenting entities obtained through research. The Medical Research Council (MRC) Research Unit has established collaborative links with the Universities abroad and currently seeks collaborative links with SADC universities [29]. Whereas it is appreciated that South Africa has a better capacity for self-funding, Zimbabwe also needs to forge collaborative links with Western Universities so as to benefit from the advanced pharmaceutical research units in Europe. As Reich [10] puts it, most documents drawn by international donor agents tend to be prescriptive on what countries should do and they also tend to ignore implementation problems that may result from shortage of resources. This may explain why the pharmaceutical link between traditional healers and research units in South Africa has been a success as South Africa (an upper middle-resource country) is capable to self-fund. On the contrary Zimbabwe is a low-resource country hence success of most of its health projects is donor depended. According to Reich [10] there is often what may be referred to as ignoring implementation problems by donors.

The Traditional Health Practitioner's Act of 2004 was originally declined in the constitutional court that in turn referred it to National Council of Provinces (NCOP) because the court deemed it to have been improperly processed [32]. Following further deliberations, the Traditional Practitioner's Bill (Bill 20 of 2007) was approved in 2007. The Traditional Practitioner's Act (2007) classifies traditional healers into diviners, herbalists, prophets, traditional surgeons and traditional midwives [33]. This nomenclature is congruent to Zimbabwe's Traditional Practitioner's Act (2001) mainly because both countries derive their legal framework from Roman-Dutch Law. In addition the June 2006 Lusaka summit for African heads of states adopted a 10-year plan of action (2001-2010) and the main objective was institutionalization of traditional medicine by all member states [34]. The contents of South Africa's Traditional Practitioners Act relate very closely to those of Zimbabwe with the main objective being the formation of a council that oversees the roles of traditional healers, it seeks to equally recognise traditional healers just

like allopathic practitioners and to ensure that all practitioners are registered following a minimum standard of training [35, 36]. Although the two pieces of legislations are congruent, they were drawn differently as South Africa involved different participants in agenda setting and policy formulation process as evident from the participation of pharmaceutical research centres from the incipient stages of the proposals. Among other expert committees, South Africa's Medical Control Council has an African Traditional Medicines Committee.

According to WHO [35], the pragmatic approach adopted by South Africa has enabled it to make outstanding strides in CAM and TM. Initial registration in South Africa has allowed registration of 10 treatment modalities that include Ayurveda and Traditional Chinese Medicine. The implementation of traditional medicine still faces some barriers, as there is no effective registration of practising professionals, a scenario shared with Zimbabwe. South Africa's policy of 2008 [37] is analogous to Zimbabwe's policy on traditional medicine encrypted in its National Health Strategy for the period 2009-2013. Among other issues the presidential task team appointed in 2006 co-ordinates African Traditional Medicines (ATM) issues. According to this policy, legislation should regulate ATM, protect TM knowledge and property rights, protect rights of traditional medical practitioners and monitor registration of traditional healers. Such an approach assumed by both South Africa and Zimbabwe is an important pathway to the empowerment in empowering and legitimising traditional medical practitioners.

5.0 The Indian Ayurveda system

Ayurveda refers to the science of life and it assumes that all living bodies are composed of earth, sky, water air and fire. This system of medicine was practiced since the tenth century AD. Ayurvedic philosophy assumes that there is harmony between individuals and the environment in which they live. Ayurvedic medicine consists of herbal medicines and baths. This system of medicine is practiced in Bangladesh, Nepal. Pakistan and Sri Lanka [38, 39]. The current position of Traditional and Complimentary medicine in India is well outlined in the 2002 National health policy whereby there is need to offer medical options that reflect on the diversity of the population [40].

Introduction of allopathic medicine during the colonial era had led to Government neglecting traditional medicine in India. Post-colonial India has managed to establish an integrated healthcare delivery system encompassing ayurveda, unani, naturopathy, homeopathy, yoga and allopathic medicine [38]. South Africa and Zimbabwe are still on the path to integration of traditional medicine. The creation of the Council of Indian medicine Act of 1970 heralded the granting of legal status to complementary and traditional medicine in India. The mandates of the council include standardising training to a minimal standard for all health care professionals including traditional medical practioners [38, 39]. This consequently influenced the establishment of the National Institute of ayurveda in 1976. The Institute offers a PhD and MD in ayurveda and it is located in Jaipur. The National Academy of Ayurveda in New Delhi was established in 1988 and it offers a Degree of Membership Certificate in ayurveda. The National Institute of Postgraduate Teaching and Research in ayurveda in New Delhi offers studies for PhDs and MD degrees in Ayurveda [41]. Such a commitment to a home driven education system enables the Indian government to set up and monitor standards of practitioners of CAM and traditional medicine.

Unlike the Zimbabwean and South African policies that have been predominantly influenced by international agents such as the World Health Organisation and the African Union, India seems to have significantly sought home grown solutions that are dependent on local human resources. It is also important to note that India participates in a lot of academic exchange programmes mostly with the Western world hence enabling it benefit from technological advancement associated with the first world. This is especially important in characterisation of the components in various medicinal plants as well as the toxic and other side effects of different traditional medicines

The Central Council of Indian Medicine advises government regarding recognition and withdrawal of medical qualifications in traditional medicine. This enables systematic quality control of professionalism. It is envisaged that once South Africa and Zimbabwe manage to establish appropriate training institutes for traditional medicine then this will enable them to evaluate and control the levels of professionalism. All traditional medicine practitioners must be registered to practise. The professionalism associated with the ayurveda system has led to its recognition in various parts of the globe. According to the World Health Report [42], traditional medicine is widely used in India. India's commitment to traditional medicine is depicted in the numbers of such health services. India has 2860 hospitals providing traditional systems medicine and homeopathy and in1998, more than 75% of the beds in these hospitals were by patients receiving ayurvedic treatment. India has 221000 dispensaries of traditional medicine and has 587536-registered traditional medicine practitioners and homeopaths. The main advantage of developing such CAM programmes is its economic benefit to low-income countries as most of them struggle in enabling people to access primary health care system based on allopathic medicine. India's Health Policy Document of 2002 emphasises [38, 39] the need to continuously promote CAM and TM. It also encourages participation of the private sector as well as non-governmental and other charitable organisations.

6.0 Relating policy to practice

Despite the efforts by most African governments to professionalise traditional medicine, there continues to be problems associated with paucity of evidence-based evidence on the benefits and detriments of using various medicinal plants. For example Tagwireyi et al [43] point out that traditional medicines have been reported as major causes of hospital admissions in some African countries as a result of traditional medicine poisoning. This highlights the need for Zimbabwe to set up pragmatic research units for the investigating the side effects of traditional medicine. South Africa has already established such a centre (The Medical Research Centre) that currently seeks to forge partnerships with SADC countries, Zimbabwe included. As purported by the Deputy Minister of Health in Zimbabwe, the establishment of such research collaboration with the University of Zimbabwe's school of Pharmacy plays a significant role (http://www.allafrica.com). India has managed to circumvent such challenges by establishing a well-documented pharmacopoeia system that incorporates traditional medicines. Examples include Pharmacopoeia of India II (1966), III (1985) and Indian Pharmacopoeia (1996) with Addenda in 2000 and 2002. Such continual updating of pharmacopoeia enables traditional practitioners to either withdraw medicines with detrimental effects or to modify the dosage as recommended by research findings. South Africa published an expanded

MediCAMS index that incorporates traditional medicines that have been scientifically proven to be safe [31]. Zimbabwe still needs to establish a systematic research network both at home and internationally so as to establish the safety of traditional herbs used thus possibly leading to a pharmaceutical index that includes traditional medicines.

Following recommendations from the World Health Organisation and the Lusaka Summit on for countries to promote research on traditional medicine, the Zimbabwean government has embarked on different collaborative initiatives between traditional healers and allopathic practitioners. It is reported that Zimbabwe has launched a Registry of Practitioners Treating HIV/AIDS. According to the Zimbabwe National Traditional Healers Association's secretary, ZINATHA has reached an agreement on collaborative research in HIV/AIDS treatment. In this agreement, physicians refer people with HIV/AIDS to traditional healers who have registered with ZINATHA. The traditional healers will treat people living with HIV/AIDS who are not on antiretroviral drugs. Physicians will administer tests to determine whether patients' CD4 T cell counts are improving [44].

Whereas such an initiative appears noble, the professionalism of ZINATHA members remains highly questionable, as no significant changes have been effected in the registration process for ZINATHA members since 1981. Although the Traditional Practitioners Act of 2001 points out that the Zimbabwe Traditional Healers Council shall register and monitor traditional healers after their initial training, such is not yet the case. Lack of training for most of the training may increase the vulnerability of the HIV/AIDS patients. For example cross infection may result due to multiple use of razor blades. This thus entails the urgent need for both the South African and Zimbabwean governments to establish academies for traditional healers that offer intensive training at appreciable levels that are verified by the National Qualifications frameworks. The case scenario for India discussed earlier shows how training aids the implementation of a register of vetted practitioners who can easily be tracked and cancelled from the register in the event of malpractices. Proper training also ensures that the public is not misled by some scrupulous self proclaimed traditional and faith healers who may claim to treat some illnesses in a bit to enrich themselves.

While most of the people in Southern Africa live bellow the poverty datum line, there is need to have integrate TM/CAM into public and private health sector medical schemes reimbursement programmes. Caldis *et al* [29] maintains that urgent measures are taken to ensure that barriers to TM/CAM are removed so that trustees of medical schemes may not use these as excuses. Although this statement refers to the South African scenario, it is also relevant to the Zimbabwean setting. In India few people have medical insurance and most importantly this insurance covers traditional medicine.

Professionalization of traditional medicine entails that the health preference of the society will be fully understood hence enabling proper planning for the government. In Zimbabwe and South Africa, National health statistics have been predominantly based on allopathic medical records yet the World Health Report of 2000 postulates that about 80% of indigenous people in Southern Africa have traditional medicine at some point in their lives. Winston and Patel [14] state that in their survey, members of the Zimbabwean community appear to recognise the physical problems that may be taken to either orthodox or traditional medical

practitioners. Implementation of a TM system running as an alternative to orthodox medication will enable the government to document treatment preferences among the indigenous people thereby enabling proper planning for equitable distribution of medical resources. India has effectively implemented traditional medical clinics and has well documented statistics of such. The registration of traditional healers and the clinics they are affiliated to has been one major achievement of the Indian ayurveda system.

Traditional medicine is dependent on natural resources. If scientifically tested, this may be cost effective for low resource countries such as Zimbabwe. Instead of depending largely on imported drugs, traditional healers will have to be supported grow a vast array of medicinal herbs in state funded gardens. Those preferring allopathic medicine will still proceed as per their choice. Patenting of medicinal property rights could be valuable to countries with plants that will be scientifically proven to be effective. India and China are now enjoying the appreciation of their traditional medicine across the globe.

Most traditional healers have been known to be secretive regarding the source and identity of their herbs thereby making it difficult to effectively identify the components of the medicines. On the other hand, a number of allopathic medical practitioners shun traditional medicines as ineffective hence reneging in collaboration issues. There is thus need to set up well-defined structures and protocols for complimentary therapy collaborative consultations in South Africa and Zimbabwe.

7. Conclusion

There is an increased focus on the use of TM and CAM as exemplified by the current efforts of Southern African governments to legislate traditional medical practices. Zimbabwe, being a low resource country, faces barriers such as capacity building, financial resources and lack of political will to implement TM/CAM policies. South Africa seems to have made significant strides as a result of effective consultative processes and networking although there is still need to educate traditional medical practitioners. The South African government has managed to utilise its democratic and conciliatory approach to effectively engage various stakeholders thus making all sectors to have ownership of the policy transformation process. The success of TM and CAM in India has enabled different tribes to have access to their preferred method of treatment, be it allopathic or traditional. Zimbabwe and South Africa may need to derive lessons from India's implementation of ayurvedic system.

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