

Is Traditional Medical Practice in Africa still Community Property? - Lessons from Zimbabwe

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Abstract

In Africa and other developing countries, herbalists or traditional medical practitioners (TMPs) are the custodians of indigenous knowledge with respect to how people treat themselves. Remedies made from indigenous plants have always been a respectable substitute for conventional medicines.

However, traditional medical practice is facing a number of challenges. Trees and herbs which are the source of medicine for TMPs are disappearing at an alarming rate, especially in Zimbabwe following the land reform programme. Some TMPs are going to neighbouring countries like Mozambique to harvest trees and herbs which used to be abundant in Zimbabwe. Because trees have always been regarded as common property, there have not been enough protection measures even at policy level.

Modern medical practice is protected through patenting where those who invent new medicines and practices receive royalties and recognition for their work. On the other hand, under traditional medical practice, there are no patents because the knowledge is considered common knowledge passed orally to future generation. In response, many TMPs in Zimbabwe are resorting to secrecy as a way of protecting their knowledge.

However, there are positive developments which this paper will try to highlight. Efforts to document traditional medical practice and associated trees and herbs as a way of protecting them are gathering steam. Some TMPs who have often been unwilling to pass on their knowledge are now immersing their children in traditional medical practice. Efforts are underway to strengthen and recognise traditional spiritual healing so that it can survive globalisation.

It is becoming increasingly clear that the enhancement of knowledge of traditional herbal medicine through scientific research is greatly needed. If traditional healers are to gain the respect that, in many cases, they clearly deserve, it will be necessary for them to disclose their information. This information is their own intellectual property and can only be protected if revealed and the owner or originator is clearly named.

Key Words: *Traditional Medical Practice, Common Knowledge, Indigenous Knowledge, Zimbabwe National Traditional Healers Association, Knowledge Transfer Africa, Indigenous Knowledge Systems, HIV/AIDS, Traditional Medicinal Knowledge, Intellectual Property Rights, Anti-Retroviral Therapies.*

Traditional Medical Practice in a nutshell

In Zimbabwe, traditional medical practice is based on the indigenous knowledge of a given people, a given community, and their experiences in the context of the local culture and environment – it is dynamic and changes with time depending on the prevailing situation. TMPs comprise herbalists, bonesetters, psychic healers, traditional birth attendants, faith healers, diviners, and spiritualists who use indigenous knowledge for developing materials and procedures.

Plants and their medicinal qualities

Plants have been used as primary sources of medicine for thousands of years and were our very first medicines. Over 4000 years ago, the Red Emperor of China published a list of 4000 medicinal plants. The ancient Egyptians even placed medicinal plants in Pyramids to treat their Pharaohs after death. The mummified Pharaohs were preserved by using plants, herbs, spices, and minerals. Up until 150 years ago, the sciences of botany and medicine were the same.

Plants have medicinal qualities due to the substances they produce to protect themselves from insect pests and pathogens. We just 'borrow' these substances to treat our own viral, fungal, and bacterial infections. Many medicines are extracted from the roots, root bark, and bark of plants since these areas are the most vulnerable and provide a plant's first line of defence against an invader. Within seconds of an attack, plants begin producing and excreting a potent array of substances that are lethal or toxic to the invading virus, bacteria, fungus, insect – or even mammal. Individual plants can produce up to approximately 1000 unique chemicals. Hence a natural anti-viral produced by a plant to defend itself can also be used by human beings as an anti-viral.

Traditional healers in Zimbabwe have been identifying, experimenting, and using these substances to treat patients for millennia. By combining forces with them, we have access to thousands of years of research results. This is commonly known as indigenous knowledge (IK).

Many of today's modern medicines are derived from plants. Over 120 pharmaceutical products are derived from plants and 74 percent were first used by native cultures! The correlation between healer use and positive lab results is clear. Data clearly indicates that plants collected from healers provide more solid leads toward developing new drugs than random screening. Twenty-five percent of our present prescription drugs are derived from plants. The best known are quinine from the cinchona tree, morphine from the poppy, aspirin from the willow, digitalis from foxglove, vinblastine and vincristine (first choice drugs treating Hodgkin's Disease, Acute Leukemia, various lymphomas, Advanced Breast Cancer, and now HIV related Kaposi's Sarcoma) from the rosy periwinkle –

which grows in Africa – and now cotexin from *Artemisia annua* for treating malaria.

Healers in Zimbabwe are mostly herbalists, diviners, mediums, surgeons, midwives, and traditional psychiatrists. The majority use some of the many medicinal plants available in the country. Healers have specialized knowledge for treating physical, cultural, and psychological ailments. They are accessible, affordable, usually have credibility, and have a treasure trove of biological diversity from which to collect efficacious plants.

In order for public health goals to be realized in Africa, healers should be active participants in the health system. This makes good sense since each community has its very own indigenous healers. While there is growing recognition that the study of indigenous health knowledge and practices requires an essentially multidisciplinary research framework, to date, botanists, natural chemists, pharmacologists, anthropologists and health-workers have generally pursued their specific research interests in this area in relative isolation from each other. In Zimbabwe, we have been promoting cross-disciplinary linkages among the various approaches of researchers or the analysis of their findings.

The magnitude and scale of the utilization of traditional medicines in Zimbabwe has for decades been known to be quite high. With the current difficult socio-economic conditions and the problems faced by the health-delivery system, even more people are turning to herbal solutions. The popularity of, and high demand for, traditional medicines is evidenced by the mushrooming herbal clinics, 'pharmacies', and the modernization of the healing system both in the urban centres and rural areas.

Traditional medicinal plants have been harvested for centuries, but little or no documentation, development or implementation of management practices has been undertaken. In fact, it is known that some of the species have become locally extinct and others are endangered.

Sustainable supply of traditional medicinal plants depends on proper management and conservation methods. One such method is a benefit-driven approach to ensure that appropriate incentives are made available to key players. Working with the Zimbabwe National Traditional Association (ZINATHA) and rural communities, Knowledge Transfer Africa (KTA) has identified extinct or threatened species and attempts are underway to come up with sustainable management methods. According to Tapera Dzviti, a spirit medium and traditional healer, traditional practices do not normally reveal the species they use, therefore, an ecosystem approach should be adopted as a management strategy. Some of our activities include:

- Identifying and documenting sustainable harvesting techniques and levels;
- Identifying management mechanisms based on Indigenous Knowledge Systems (IKS), and their integration with modern techniques; and

- Development of ecosystem/landscape management strategies at community level.

Some of the methods we have used to gather data and knowledge on Traditional Medical Practice include:

- Household surveys to determine the status of traditional medical practice in Zimbabwe.
- Oral histories (based on open discussions with widely recognized knowledgeable elders. Opinion leaders in Mhakwe ward of Chimanimani district have been very generous with their knowledge, reinforcing the view that indigenous medical practice is common property first before it becomes individual property.
- Focused discussions with communities (men, women, traditional healers and youth) in Chimanimani, Chipinge and Masvingo.
- Local market surveys to figure out the market of TMPs..
- Structured interviews with traditional professional health practitioners and traditional leaders.

The following were some of the crucial results from this intervention:

The tacit and pervasive nature of traditional health knowledge

In general, traditional knowledge about medicinal plants and its application are very much taken for granted by both men and women in most communities. Such traditional knowledge and practices constitute routine aspects of daily life and are deeply ingrained in the socio-cultural and economic fabric of these rural societies. This clearly demonstrates the sheer scope and significance (actual and potential) of local traditional knowledge. According to village head Chaoramoyo Chikutukutu of Mhakwe ward in Chimanimani, most indigenous herbs are community property because almost every household is aware of how to use them.



Traditional leaders discuss indigenous health knowledge in Mhakwe ward of Chimanimani District. Village head Taoramoyo Chikutukutu is on the left in white clothes and blue cap.

Gender and age dynamics regarding medicinal plant knowledge

Middle-aged and older women and men generally appear to have a greater breadth of medicinal plant knowledge. In addition, men often demonstrated knowledge of plants primarily procured from the wild, whereas women generally showed greater familiarity with the therapeutic uses of weedy and semi-domesticated plants found around the homestead.

Main sources of traditional knowledge

Routine observation and practice or learning by doing, was the most widely-cited method through which knowledge is acquired. A relatively larger proportion of men indicated having obtained their knowledge in this way, suggesting some notable gender differences in terms of the mechanisms by which traditional knowledge is imparted.

The medicinal plant resource base

The large majority of wild/weedy species often occur around the homestead or farm and require little management.

Knowledge in the public domain

Significant knowledge about medicinal plants resides in the 'non-professional' or public domain. In addition, local names and specific uses of most medicinal plants cited by different informants were appreciably consistent.

Role of rural professional health practitioners

In general, professional traditional health practitioners seem to play a much less pronounced role in the rural communities than has generally been presumed. It appears that most ailments are diagnosed and treated at the household level. Very few informants reported seeking professional traditional help on a regular basis. Where professionals are consulted, it is often for their specialized traditional knowledge and skills pertaining to a relatively limited range of health problems. However, communities that rely heavily on traditional plant treatments are caught in a vicious cycle, as many of the ailments that the local plant medicines are used for are linked to poor environmental sanitation. These shortcomings can be viewed as among the greatest impediments to the realization of the full potential of indigenous ingenuity and traditional approaches in meeting local health needs.

The knowledge transmission process

Exactly how is traditional health knowledge transmitted over generations? Are the traditional mechanisms that have been in place in the past still intact? It was observed that in rural areas, boys and girls as young as 8-10 years had remarkable 'botanical' knowledge, i.e. the ability to distinguish various medicinal plants growing around the homestead. But other aspects of traditional

knowledge pertaining to the preparation and administration of plant medicines and the diagnosis of diseases could be selectively threatened.

Traditional knowledge regarding the use of medicinal plants is far from being a corpus of wisdom or expertise generally presumed to be restricted to the male-dominated elite of professional traditional health practitioners. Most of the traditional treatments used in the communities are collected, prepared and administered by ordinary men and women at the household level. This implies that most rural people who rely on traditional plant-derived medicines, do not invariably consult professional practitioners.

The fact that traditional health knowledge is so pervasive and the use of local medicinal plants so widespread has paramount implications, which cannot be ignored by those concerned with health development and practitioners in the closely allied field of natural resource management. Research and development efforts must identify and address the challenges and threats faced by traditional health knowledge systems, in total. The ultimate goal is to strengthen and improve this vast knowledge base for the benefit of the great majority of the developing world who have survived on it for centuries and will continue to do so for the foreseeable future.

Traditional healers, herbalists and vendors

From our research we identified the following features of traditional medical practice in Zimbabwe's rural and urban areas:

Traditional healers:

- Use magical powers passed on to them from their ancestors.
- Their trade is protected by a system of trade secrets, magical beliefs, practices (taboos, sacredness and spiritual motivation).
- They are not usually at liberty to disclose and or reveal any of their medicinal plant products and or dosages.
- Modes of herbal practice differ amongst individuals.

Herbalists:

- Enter the profession through apprenticeship, i.e. they could be healers by association.
- Know plant species and their curative ailments; however, as information is passed on to individuals, e.g. by association, some useful information tends to be altered out as there is no documentation.
- Use common species and their mode of practice is similar.

Vendors:

- Have knowledge of one or two medicinal plants.
- Harvest and sell their medicinal plants, either raw or partially processed.
- They are motivated to collect large quantities of the resource with no consideration of impacts on resource status.

HIV/AIDS and the demand for indigenous medicinal plants

Lack of formal health care facilities in most rural areas of Zimbabwe has seen many people resort to and depend on indigenous medicinal plant species that grow naturally in their vicinity. The demand for indigenous medicinal plants has continued to rise with the increase in HIV/AIDS pandemic cases and the costs of modern health services that are beyond the reach of many. From a survey by the author in Chipinge, Chimanimani, Matobo, Bulilima and Mangwe districts of Zimbabwe, communities have a staggering wealth of knowledge on traditional medicinal plants and the ailments they treat. This knowledge is unique to a given community and may differ from district to district due to the fact that indigenous knowledge is often localized knowledge in many parts of Zimbabwe. The knowledge has been acquired and preserved through repeated use and orally passed from generation to generation since time immemorial. Communities were able to identify many medicinal plant species that are threatened, rare or extinct from their natural habitats due to habitat loss, species-selective over-exploitation and unsustainable use. The establishment of clinics and pharmacies specializing in traditional medicines and the selling of herbal medicines in many informal markets is a huge threat to the existence of traditional medicinal plants. Realizing the high risk of invaluable indigenous knowledge being totally lost if not documented, we have started the information gathering, validation and documentation process. Various people in communities confirmed use of plant parts, fresh, dried or grinded into powders and stored for later use or given to patients in the form of infusions, powders or ointments. We are also documenting threatened medicinal plants so that policymakers can come up with sustainable conservation strategies.

The following pictures depict some of our findings:



***Annona senegalensis*, Muyembe (Shona) is threatened in some parts of Chipinge and Chimanimani districts.**



Dicoma Anomala, Chifumuro (Shona) and Ukhalimela (Ndebele). This herb is threatened in some parts of Chipinge and Chimanimani Districts.



Anselia Africana, Mugwatigwati (Shona) – threatened in Chipinge and Chimanimani Districts.



Warburgia salutaris, Muranga (Shona). This plant is believed to be critically endangered in the wild except three mature plants which are under cultivation in Chief Mapungwana's garden in Chipinge District.

Cultural features of traditional medical knowledge

In Zimbabwe, the natural substrates of Traditional Medicinal Knowledge (TMK) are conceived both as magic and as medicine (*mishonga*). These substrates manifest as magic and/or a medicine only when they are wielded by an individual possessing an entire repertoire of practices, rituals, divinations, symbols and acute timing based on a familiarity with the social, cultural, environmental and physical milieu (the concept of *hun'anga*).

In addition to the individual practitioner, the individuals who comprise the greater social field validate by their own consecration whether the magic and medicine become effective (*kushanda kwemishonga nehun'anga*).

Access to the full repertoire of ancestral TMK (*vadzimu*) begins when the juvenile kin of an elder family healer selects one among their descendants to assist them in their practice. While the apprenticeship demands hands-on practice with TMK – identifying, collecting and preparing plants; identifying, understanding and healing illnesses – it also requires lessons in the greater customary, symbolic and social milieu. The sum of the extended apprenticeship is the attainment of invaluable intuition (*mapipi*) related to the relationships and cultural codes that direct an entire TMK system. For Zimbabweans, the elders (as well as the deceased ancestors) are the key to continuing access to and inheritance of TMK through special dreaming (*kurotswa*) and ritual divinations (*kusvikirwa*) where the knowledge is revealed as a gift. A special phrase, gift of the ancestors, (*chipo chevadzimu*) indicates the special rules pertaining to a heritage and gift as opposed to a commodity. These special items do not follow economic rationale but are rather tied to social and symbolic status acquisitions.

While a general familiarity with the traditional medicinal plants is possessed by many within the local community, only selected and trained individuals gain

enough familiarity with TMK to know with certainty what combination of plants, rituals, charms, divinations and diagnoses are effective under what conditions. As a result, different lineages and bodies of TMK have evolved – some more specialized, customary, effective or powerful than others, depending on the different territories or situations.

Symbolic and social capital

While innovation in TMK is necessary to meet the changing needs of local Zimbabwean communities, it is not economic incentives that fuel this process. Traditional healers who have been specially selected to access and keep the ancestral knowledge find themselves entrusted with a duty in which they are expected to share and cure before remuneration is even considered. Often a token or a delayed reimbursement is satisfactory. Further, it is not required that the insights, intuition, and innovation of a personal practice be shared in order to gain remuneration because healers are valued first as cultural authorities, second as practitioners, and third as practicing scientists. Hence traditional healers receive a different type of payment – that of community consecration (symbolic capital). Symbolic capital is also most evident vis-à-vis ones position in a family.

The highest authority and rewards are given to those healers who appropriately revere the TMK (*kuchengetera*) and demonstrate respect for the customary rituals, healing, figures, symbols, proverbs, and narratives that are used to enrich and illuminate the entire social field. This helps build status and power for that family, clan (*dunhu*) and/or totem (*mutupo*). For instance, in addition to healing, *mishonga* is used symbolically to give impetus to culturally ordained responses, rituals, and activity that may manipulate any set of factors in the environment, e.g., for success in business, politics, winning arguments, extending influence, or settling disputes. Because these practices exist in a realm where they are accepted, spoken of, and understood they become effective (*inoshandu*).

However, just because these practices are ‘cultural’ and rely on the traditional codes does not mean they are not scientific or innovative. In fact, one of the strengths of these practices lies in their flexibility in diagnosing and healing each problem or illness individually. As a result, careful customization (opposed to a standard set of diagnoses) yields many opportunities for innovation and advancement in practice.

Non-customary practices

Presently, however, several non-customary practices that appropriate the physical substrates of TMK (*mishonga*) also neglect the importance of the cultural and ritual matrix that may spark individual insights and innovation. As Zimbabwean merchants, scientists and a trade union of traditional healers have begun to remove the physical *mushonga* for product development and distribution, the entire reproduction of TMK practices (*hun'anga*) as well as the entire cultural symbolic system is threatened.

Further, when these non-customary practices are linked with foreign pharmaceutical companies, the focus on product development weakens the emphasis on ancestral gift and heritage and thereby also the expectations of duty and responsibility with respect to the local communities who rely on these practices.

Because TMK has always had a degree of collective sharing, unconsecrated and non-customary practitioners have been able to take liberties with the *mishonga* in ways that have begun to breed local misuse, misdiagnoses, and fraud. As a result of these divergent practices, an estrangement between traditional healers and their communities is settling in to such an extent that the entire reproduction of cultural practices and relationships that fuel innovation within the traditional medicinal knowledge system is threatened.

Figures from the past

Nonetheless, Zimbabwe has a changing and evolving culture. Recent years have seen specific customary figures from the distant past (*Pasichigare*) or from the “Liberation War” used to encourage the tourism industry. In theory, new local practices cannot be conceived of as not “cultural” simply because they do not flow directly from the orthodox tradition. Hence, so as to not conscript and freeze the processes that reproduce culture as a resource, both customary practices and non-customary practices must have legislation to support and protect traditional medicinal knowledge as part of the social service sector.

Symbolic engines

While industrial countries believe that Intellectual Property Rights (IPR) for intellectual resources fuels innovation through reward, the value-added to biological resources by cultural resources has symbolic engines that move it. The singular focus in development circles on protecting “plant genetic resources” overlooks the relationship between it and other resources and denies that cultural resources are crucial for the continued health, reproduction, and innovation in each type of resource.

TMK is accessed, kept, and used by individual practitioners in order to share it effectively and to attain full valuation in the surrounding community. This combats the assumption in development circles that TMK is primarily a collective resource. It is important to look past this assumption, which is married to the expansion of an intellectual property rights regime, especially since this has served to justify the alienation between individuals, families and communities and their cultural and biological heritage.

While plant genetic resources have been called a “green gold” in recent years, in reality it has been the access to territorial cultural resources (based on customary and non-customary practices with local medicinal plants) that have yielded the pharmaceutical applications receiving protection as intellectual property.

Therefore, cultural (customary and non-customary) practices related to biological heritage need a system of protection that enhance a capacity to keep relationships, social systems, social/symbolic matrices that reproduce territorially important knowledge alive.

Significance of the African customary law system

The African customary law system only recognizes communal ownership of knowledge and apportions little reward for individual innovations. The impact of this communal ownership of knowledge has produced different reactions from innovators and indigenous knowledge bearers, in various sectors. In the high income sectors like medicine, innovators use “secrecy” to protect their knowledge. In the low income sectors such as agriculture, innovators are ‘indifferent’, in the absence of public incentive and protection to making their knowledge public. When the knowledge bearers die, the knowledge disappears with them. The result is what is called a ‘continuous but non-additive innovation’ as against ‘continuous and additive innovation’. In the absence of additivity in innovations, the knowledge remains basic and cannot produce much macroeconomic growth. The ‘static semblance’ labels and stigma are the product of the lack of incentive for individual IK innovators, in the customary law systems.

Traditional medicine is not a profession of charlatans, but rather a part of Africa’s development resource not well-studied, not adequately appreciated and developed. African traditional healers (and other practitioners of IK) are equally capable of research, innovation and healing as their ‘allopathic’ counterparts. Bone-setting, anti-snake venom production, active immunization practices or treatment of post-traumatic stress disorders are good examples of highly appreciated products of African traditional medicine. It is the secretive applications that have beclouded the true value of the activities. This secrecy however has some economic rationale.

Three factors determine the secret behaviours of African traditional healers. These are:

- The inadequacy of rents from innovation;
- Absence of public protection of intellectual property rights in the African customary law system;
- The threat of business-stealing and obsolescence by the arrival of new innovations.

Innovation, has very little predictability. This is particularly so in medicine and agriculture, where research can be costly and long-term, and where the results are uncertain. In this situation, the innovators and bearers of the unique knowledge consistently work to regulate against any threat of knowledge stealing or obsolescence. Sharing the results of the innovation in the community would deprive the healer of the income deriving from the innovation, since it could easily be copied not only by other healers but also by his/her fellow community members in a do-it-yourself application of the new treatment.

In terms of application, other disguises follow in the form of incantations, masquerading, diversionary sacrifices and scare tactics. In this way, even the patients or customers who are allowed to come in close contact with the products may not easily and freely understand which among the array of acts contributed the actual solution that they required. It thus appears magical.

African countries have to put in place the incentive policy that can help achieve a “continuous and additive innovation” in the indigenous knowledge system. The customary law system has not self-corrected for this. Therefore, the growth-enhancing effects of indigenous knowledge system will remain minimal, thus falsely supporting the misconception of the whole knowledge as static. Putting in place an incentive structure will promote indigenous knowledge innovation and development for greater benefits.

The abandonment of the associated stigma and lack of policy attention could be overcome by enabling the creation of constituencies; traditional healer associations are a first step. In Zimbabwe, working with ZINATHA, we are making great strides in formulating and promoting policies in favor of indigenous health practices. An incentive for action is the potential for growth and poverty reduction and expected contributions to the stock of knowledge for resolving several intractable global health and social problems from this locked potential.

Confessions of a traditional spiritual healer

I am Tapera Dzviti, Deputy Secretary for Administration with the Zimbabwe National Traditional Healers Association (ZINATHA). I am also the Secretary for Information and Research with ZINATHA. My career has a curious genesis.

I was born in Zaka District, Masvingo Province, Zimbabwe 37 years ago. During the time I was a toddler, our family’s spirit mediums told my parents that I would assume the name and duties of our late grandfather Taperangecho. He had been a renowned traditional healer of his generation before he died.

While playing with other young children in the bush when elders were playing drums to appease our ancestors, the spirit mediums would manifest their presence and demand that I be fetched. I would come into the house and sit on the lap of the mudzimu (spirit medium). Everyone present would be told that I was to be a great traditional healer.

When I started Grade 1 in 1977, my parents brewed beer to inform the spirit mediums and ancestors that it was time for me to go to school. The spirit mediums agreed but said when time comes for me to do their work, they would prevent me from going ahead with formal education. During Grade 5 I was shown traditional medicine for treating Dysentery and Diarrhoea through dreams. Following failure to comprehend what the teacher was saying in class, at Grade

6, my mother consulted traditional healers and spirit mediums about my problem. She was instructed to brew beer for the ancestors and spirit mediums who were interfering with my education to show a strong spiritual presence. This was done and I continued going to school, passing my Grade 7 with six units (Mathematics 6 and English 3).

I enrolled for Form 1 in 1984 and in 1985, towards Form 2 final examinations, I was injured by a big stump on the foot and failed to miss the examinations. The spirit mediums showed up and said it was now time for me to quit education and concentrate on their work— traditional healing. This marked the beginning of my career as a traditional medical practitioner. Through dreams, I started seeing various herbal medicines and methods of using them. A woman who had committed murder in the community came to confess to me, saying she had been driven by unforeseen forces to do so. I gave her guidance on appeasing those she had wronged. Using herbs revealed through dreams, I treated a man who had a stomach sore and could not urinate. Since then I have traveled throughout Zimbabwe and Southern Africa treating people with various ailments. Some of my patients are in South Africa, Botswana, Malawi, Mozambique and Zambia. Others have come from UK, Scotland, Canada, Netherlands and the USA.

As a way of documenting my knowledge, I have two plan books full of information on herbs and how to use them. Some of the diseases I treat include: Cancer, Prostate Cancer, TB, Asthma, Cardiac Arrest, Kidney Failure, Jaundice, Celibacy, Meningitis and Menstrual problems. I have been able to treat someone who had been mad for 27 years and now he is normal. A 41 year old woman who had never had a child, was able to conceive after I treated her.

From research in various districts of the country with other traditional healers, we have just discovered that Malaria can be treated. Healers in Binga district are developing treatments for influenza and malaria, among other diseases. We are also sharing trade secrets on a number of herbs.

I have discovered that most indigenous health knowledge resides in rural communities and can be considered common property. A significant number of the trees/herbs cannot be patented because they are common property used by many people in several communities. Communities may use different names to refer to the same herbs but usually there is convergence on medicinal uses. With funding and technical support the world can tap into this wealth of traditional medical knowledge in rural communities. There are particular ways of conserving different herbs which should be adopted rather than applying a one – size-fits-all approach.

Conclusion and recommendations

Herbalists or traditional medical practitioners are the custodians of indigenous knowledge with respect to how our people treat themselves. Most of the time, scientists and clinicians either ignore them at best, or treat them with contempt. Governments also tend to ignore them. People tend to think or behave as if herbal preparations that are used to manage HIV/AIDS only treat opportunistic infections; as if something as good as anti-retroviral therapies (ARTs) cannot be in herbal preparations; as if such good things must always come from the "North". With such attitudes, people will not even look for such drugs from among the armamentarium of the TMP or community knowledge. Rather they go begging for the countries, which produce the ARTs to reduce the price so that the drug will be affordable, instead of looking inside to produce something of our own that others too can use and pay for. From our experience with indigenous community knowledge, if they have the commitment, policymakers can inject innovative science and technology into our tradition to create national wealth, common wealth or wealth for all to share.

Most developing countries such as Zimbabwe have an abundance of medicinal plants which are used for their traditional forms of medicines, including their use by traditional or folk remedies, by traditional healers, the pharmaceutical industries or by food industries. Countries wishing to make full use of their heritage of traditional medicine and the wealth of medicinal plants which most of them possess, have a special interest in sponsoring ethno-medical studies, bringing together botanists, clinicians, pharmacologists and others for the purpose of making adequate resources available. A first step would be to review on a national basis the utilisation of medicinal plants in general and of medications derived from them. Such examination may reveal opportunities for making greater use and safer and more effective application of herbal remedies and preparations. This would stimulate local cultivation and production and at the same time saving scarce foreign currency. In any event, experience in the preparation and utilisation of herbal remedies is a necessary prerequisite for clinical evaluation of traditional remedies, when these have been identified as meriting further study. National inventories of medicinal plants are essential if sound programmes for their rational use are to be developed. The study of medicinal plants, together with their evaluation, utilisation and conservation form an important part of the indigenous knowledge.

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