Traditional Healers and Formal Health Systems — Integration, Not Replacement

A study among tribal women in Odisha found that only 6% solely opted for allopathic medical treatments. The majority — 94% — use some combination of traditional and formal healthcare, approaching traditional healers first for most conditions and moving to formal facilities when t...

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This is not a failure of health education. It is a rational response to the actual healthcare landscape in tribal Odisha:

Traditional healers are present, available, and trusted. They speak the community's language. They understand the cultural framing of illness and healing. They are accessible at the time illness occurs — not after a three-hour journey to a PHC that may or may not have a doctor present.

A landscape analysis of traditional tribal healers across 43 districts in seven tribal-dominated Indian states, interviewing 1,649 healers, found three categories of traditional healers consistently present in tribal communities: herbalists (who use plant-based medicine), spiritual healers (who work with ritual and ceremony), and diviners (who identify causes of illness through spiritual means). These are not interchangeable categories — herbalists often have detailed, specific botanical knowledge of local medicinal plants that formal pharmacology has not systematically documented; spiritual healers address dimensions of illness experience that fall outside biomedical frameworks entirely.

The same study found that traditional healers maintain strong community connections while lacking systematic linkage with formal healthcare — not because they resist collaboration, but because no one has built the bridge.

What the Evidence Says Works and Doesn't Work

What works: referral relationships built on respect

The global evidence on traditional healer integration — from Africa, Southeast Asia, and India — consistently points toward referral-based collaboration as the most productive model. Healers

who understand which conditions they can effectively address and which require formal medical care, and who have established referral pathways to formal facilities they trust, produce better health outcomes for their communities than either exclusive traditional or exclusively formal care.

WHO's global experience supports this: "In regions where geographical remoteness, cultural barriers and workforce shortages limit access to formal healthcare, healers can play a crucial role in preventive care, early identification of illness, and timely referral — provided their roles are clearly defined and supported."

The 2026 Ministry of Tribal Affairs initiative specifically frames this role: traditional healers as community mobilisers and referral agents. Not as replacements for formal care. Not as subordinates of the formal system. As partners with a defined and respected complementary role.

The specific conditions where healer-to-facility referral produces the most measurable impact: sickle cell disease (where early identification and referral to haematology services matters enormously — healers who can recognise the symptoms and refer produce better long-term outcomes than communities where the condition goes unidentified until crisis); malaria and tuberculosis (where healers who know to refer fever cases that don't respond to traditional treatment can reduce the delay to treatment that is the main driver of severe outcomes); obstetric emergencies (where healers who recognise danger signs in labour and refer promptly rather than managing the emergency with ritual are the difference between survival and death); and mental health conditions (where healers who engage with psychosis or severe depression through spiritual frameworks may or may not produce harmful outcomes — understanding this case by case is essential).

What doesn't work: medicalisation of traditional practice

Top-down approaches that attempt to train traditional healers to become informal biomedical practitioners — giving them clinical protocols, drug kits, and diagnostic checklists — consistently fail. They fail because: healers understand their practice within a different epistemological framework that doesn't translate into biomedical training; the training creates confusion about scope and authority; communities lose trust in healers who appear to have abandoned their traditional role without having become actual clinical providers; and the safety risks from untrained quasi-clinical practice are real.

Equally problematic: approaches that involve traditional healers only as recruitment tools — using their community trust to mobilise community members for vaccination or malaria screening, while dismissing or ignoring their actual healing practice. Healers who feel instrumentalised and disrespected do not maintain productive relationships with formal systems.

The research is explicit: integration attempts that medicalise or decontextualise indigenous practices risk alienating communities. The WHO framework emphasises that integration must be operationalised with community leadership, not imposed from outside.

What needs honest assessment: safety

Some traditional healing practices carry specific safety risks that need honest, non-judgmental engagement. Practices that delay referral in obstetric emergencies — where a healer attempts to manage obstructed labour through ritual when referral to a facility is urgently needed — contribute to maternal mortality. Practices that involve harmful substances — preparations with toxic plants, mineral-based compounds that can cause organ damage — need to be identified and engaged with carefully. Practices that involve physical interventions — incisions, burns — that carry infection risk need similar honest engagement.

This safety assessment is not an argument for dismissing traditional healing. It is an argument for relationship-based engagement that can have honest conversations about specific practices that create harm, within a framework that respects the broader healing system and the healer's role.

What NGOs Can Do: A Practical Framework

Step 1: Map the traditional healer landscape in your operational area

Before any engagement, understand who the healers are. In most Odisha tribal communities, multiple healer categories operate simultaneously:

- The Disari or Gunia — primarily spiritual healers who identify illness causes through divination and address them through ritual
- The Vaidya or herbalist — plant medicine practitioners with botanical knowledge
- The Dai — traditional birth attendants who manage most deliveries in remote communities

Document: how many healers in each category serve communities you work in; what conditions they typically treat; whether they have existing referral practices for any conditions; and what their relationship with the local ASHA and PHC currently is.

This mapping takes two or three days of community conversations. Do it before designing any programme. The landscape varies significantly by community and district.

Step 2: Build relationships before building programmes

The most common failure in healer integration programmes is treating healers as programme

targets rather than as people whose trust must be earned. Traditional healers have generally had negative experiences with formal health systems that have dismissed their knowledge, competed for their patients, and treated them as obstacles to "modern" healthcare.

The NGO's first engagement with traditional healers should not be a training workshop or an orientation session. It should be a conversation: what conditions do you treat most frequently? What do you do when a condition doesn't respond to your treatment? What do you know about the PHC — have you ever accompanied a patient there? What would make it easier for you to refer patients when you think they need facility care?

These conversations, conducted with genuine respect and without any agenda to change what healers do, produce the relationship capital that makes subsequent collaboration possible.

Step 3: Identify referral conditions and build the referral pathway

After relationship-building, facilitate a structured discussion with healers about specific conditions where referral to formal care is consistently beneficial. This is not a lecture by a health official — it is a collaborative mapping exercise where healers' own experience guides the conversation.

The questions: Are there conditions where your treatment helps most patients but some don't recover? What happens to patients who don't recover — where do they go? Is there a way to know earlier which patients need different care?

From this conversation, develop a simple referral list — typically five to eight conditions where healer-to-facility referral produces clearly better outcomes. Danger signs in pregnancy. High fever not resolving after three days. Suspected tuberculosis (persistent cough, weight loss, night sweats). Severe child malnutrition. Sickle cell crisis. Snake bite.

Then build the referral pathway: which facility? Which staff member to call? How does the patient get there? What does the ASHA do when a healer makes a referral? This is operational infrastructure, not just knowledge. A referral system where the healer knows to send a patient somewhere but the patient has no transport and the facility doesn't know to expect them is not a referral system.

Step 4: Create two-way information flow

The referral relationship works in both directions. Traditional healers need to know what happened to patients they referred — did the patient arrive? What was diagnosed? What treatment was given? This feedback loop motivates continued referral and helps healers understand which of their referrals produced good outcomes.

ASHA workers, who are the node between community and facility in the NHM system, can function as the feedback channel: when a patient referred by a healer presents at the PHC, the

ASHA notes this and subsequently informs the healer of the outcome. This simple mechanism — which costs nothing — builds the healer's trust in the formal system and reinforces appropriate referral behaviour.

Step 5: Knowledge documentation — with community ownership

Traditional healers hold detailed botanical and ecological knowledge — of medicinal plant species, preparation methods, seasonal availability, specific conditions for which specific preparations are used — that is disappearing with elder generations and has not been systematically documented anywhere.

This knowledge is both culturally significant and potentially scientifically valuable. ICMR-RMRC Bhubaneswar's mandate under the Bharat Tribal Health Observatory specifically includes documentation of traditional healing knowledge.

NGOs can support documentation — through video recording, written registers, botanical mapping — but the documentation must be community-owned, not extracted. The healer and their community must understand what is being documented, why, who will have access to it, and what protections exist against commercial exploitation of their knowledge. This requires explicit community consent, clear agreements about knowledge ownership, and protection against bio-piracy — the use of traditional knowledge for commercial product development without community benefit.

Do not document traditional healing knowledge without these protections in place.

What the B-THO Initiative Means for Odisha NGOs

The establishment of the Bharat Tribal Health Observatory at ICMR-RMRC Bhubaneswar in January 2026 is directly relevant to Odisha NGOs working on tribal health. The B-THO's mandate includes:

- Generating tribe-specific health data
- Supporting implementation research on traditional healer integration
- Guiding evidence-based interventions in tribal districts for malaria, tuberculosis, and sickle cell disease

NGOs working in tribal health should establish contact with ICMR-RMRC Bhubaneswar to understand how their field experience and community relationships can contribute to the B-THO's research agenda — and how the observatory's emerging evidence can inform their programme design. This is a new collaboration opportunity that did not exist before 2026.

What Success Looks Like

A productive traditional healer integration programme at 18 months should show:

- A documented map of traditional healers in the operational area, with their healer category and primary practice areas
- A referral list and referral pathway agreed with at least five healers per operational block
- Evidence of healer-initiated referrals to PHC — documented through ASHA referral records
- A feedback mechanism functioning: healers informed of outcomes for referred patients
- No evidence of healers being instrumentalised for programme recruitment without reciprocal respect for their practice

What it should not show: healers trained to deliver biomedical services; healer practices dismissed or suppressed; community trust in traditional healing undermined; or knowledge documentation without community consent and ownership.

Related Knowledge Commons content: Health & Nutrition Sector Primer (Sector 08) · Practice Note: ASHA Programme — How NGOs Can Strengthen the Last Mile · Practice Note: Mobile Health Clinics — Design for Remote Tribal Contexts

Evidence Grade: B — Multi-study. This Practice Note draws on the Biores Scientia landscape analysis of tribal healers in India (2023), Outlook India reporting on the B-THO launch (January 2026), the ResearchGate analysis of modern healthcare and indigenous healing (2025), WHO traditional medicine framework, and ICMR-RMRC Bhubaneswar programme documentation. Last reviewed: April 2026.

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