

Beyond Biomedical Hegemony: Towards an Integrated Framework for Traditional and Allopathic Medicine in Zambia's Quest for Universal Health Coverage

Ackim Lungu, Phanny Lungu, Zacks Yuma, Monford Chishimba

Mulungushi University, Kabwe, Central, Zambia

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ABSTRACT

Healthcare systems globally encompass diverse paradigms of healing and wellness. In Zambia, the prevailing biomedical model operates under a framework that implicitly delegitimizes traditional medical practices, reinforced by religious discourses that conflate indigenous healing with sorcery (Sugishita, 2009). However, empirical evidence challenges this exclusionary approach. The World Health Organization (WHO) estimates that over 80% of Zambia's population, consistent with broader African trends, relies on traditional medicine for primary healthcare needs (WHO, 2003). Traditional medicine offers distinct advantages: geographical accessibility, cultural congruence, economic affordability, and holistic approaches to wellbeing that address physical, social, mental, and spiritual dimensions simultaneously. Despite systematic denigration rooted in colonial legacies and religious proselytization, traditional medicine remains inextricably woven into the fabric of Zambian society. Preliminary scientific investigations increasingly validate the therapeutic efficacy of numerous indigenous pharmacopoeias. Concurrently, Zambia grapples with severe healthcare access disparities, with rural communities often situated beyond 50 kilometers from the nearest biomedical facility, coupled with a critical shortage of medical practitioners (Ministry of Health Zambia, 2021). This paper argues that recognizing the complementarity between traditional and allopathic medicine within a robust regulatory framework represents not merely a pragmatic necessity but an imperative for achieving universal health coverage. It examines the historical trajectory, contemporary utilization patterns, legal lacunae, and impediments to integration, proposing a comprehensive framework for harmonizing these parallel healthcare streams to optimize population health outcomes.

Keywords: Traditional medicine, allopathic medicine, complementarity, healthcare integration, regulatory framework, Zambia, health policy, universal health coverage

INTRODUCTION

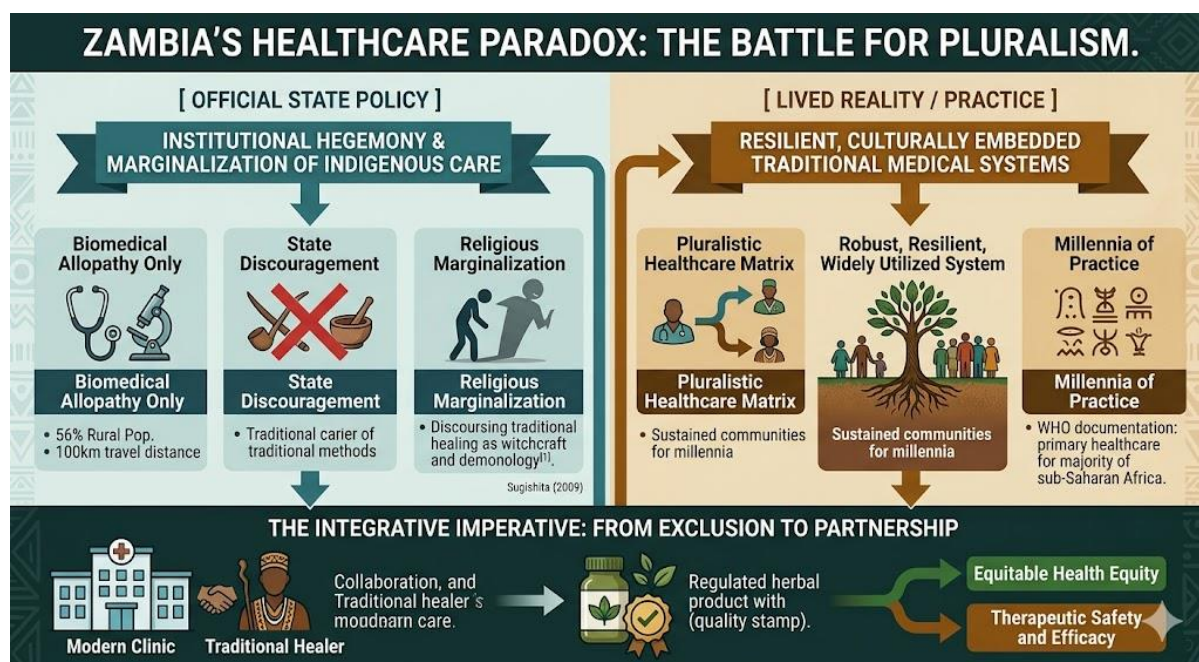
The Paradox of Pluralistic Healthcare in Contemporary Zambia

The contemporary Zambian healthcare ecosystem is characterized by a profound systemic paradox. Officially, the state endorses biomedical allopathy as the sole legitimate therapeutic modality, structurally and discursively marginalizing indigenous medical practices. This state-sanctioned marginalization is further reinforced by dominant religious institutions, particularly mainstream Christian denominations, which frequently relegate traditional healing to discourses of demonology and witchcraft (Sugishita, 2009). However, beneath this framework of official erasure lies a resilient, deeply entrenched pluralistic healthcare matrix. Traditional medicine continues to serve as a primary locus of care, sustaining Zambian communities through a complex web of cultural continuity and pragmatic utility that resists simplistic categorization as superstition or charlatanism (Ngulube et al., 2021).

The persistence of traditional medicine in Zambia reflects broader continental patterns. Across Africa, an estimated 80% of the population relies on traditional medicine for primary healthcare needs (WHO, 2003; Kasilo et al., 2019). This utilization is not merely a vestige of pre-colonial practices but represents an active,

adaptive response to contemporary healthcare realities, including biomedical access constraints, cultural preferences, and the holistic orientation of indigenous healing systems (Peltzer & Pengpid, 2019). However, as Lungu et al. (2026) observe in their analysis of Zambia's intellectual property and innovation framework, the country exhibits a persistent pattern of "ceremonial compliance", where progressive policies and legislative frameworks exist on paper but lack the institutional will, enforcement mechanisms, and resource allocation necessary for meaningful implementation. This phenomenon is strikingly evident in the healthcare sector, where policy documents acknowledge traditional medicine's importance while statutory frameworks continue to exclude it from formal recognition and regulation.

Table 1: Zambia's Healthcare Paradox



Consequently, this paper argues for a paradigm shift in Zambia's healthcare architecture. Moving away from its current exclusionary and colonial-inherited posture, the state must transition toward an integrated, pluralistic framework that recognizes traditional medicine as a legitimate, regulated, and complementary stream of healthcare delivery (Bodeker & Kronenberg, 2002). Far from representing a regression from scientific rationalism, the systematic integration of traditional medicine acknowledges pluralism as an indispensable asset for achieving equitable health equity.

Historical Foundations: Traditional Medicine in Pre-Colonial Zambia

Before examining the specific contours of traditional medicine in Zambia, it is essential to situate indigenous healing practices within their proper historical and epistemological context, as the conventional tendency to view these systems through a colonial lens, as primitive, static, or superstitious, has profoundly distorted both scholarly discourse and contemporary policy formulations that continue to justify their exclusion from formal healthcare structures (Sugishita, 2009). Far from representing an unchanging, monolithic tradition, the historical foundations of Zambian traditional medicine reveal a sophisticated, dynamic, and adaptive knowledge system that has evolved over millennia in response to shifting disease ecologies, environmental challenges, and sociocultural transformations through a remarkable capacity for innovation, empirical observation, and systematic intergenerational knowledge transmission (Chinsebu, 2016).

Antiquity and Intergenerational Knowledge Transmission

Archaeological, ethno-historical, and ethnographic evidence demonstrates that indigenous healing modalities have co-evolved over millennia alongside shifting ecological niches, changing disease ecologies, and macro-sociocultural transformations. This historical depth is corroborated by the World Health Organization (WHO), which recognizes that traditional medical systems have been deployed for millennia to fulfill preventative,

therapeutic, and socio-ceremonial functions (WHO, 2000). These traditions comprise a highly comprehensive, pluralistic paradigm encompassing complex botanical pharmacopoeias, zootherapeutic and mineral preparations, psychospiritual interventions, manual therapies, and systemic prophylactic protocols (Chinsembu et al., 2015).

Far from relying on static or unscientific methodologies as posited by colonial and Eurocentric historiographies, African ethnomedical systems are structurally grounded in empirical observation, iterative clinical experimentation, and dynamic adaptation. Epistemic preservation and refinement within these systems are sustained through highly formalized, institutionalized modalities of intergenerational knowledge transmission, including regulated apprenticeship structures, lineage-based oral archives, and ritualized esoteric pedagogy (Chinsembu, 2009). Specializing practitioners undergo protracted, often decades-long training regimens to master not only complex pharmacology and phytotherapy, but also sophisticated diagnostic taxonomies, holistic etiological frameworks, and diversified therapeutic protocols.

Lungu et al. (2026) highlight that Zambia's intellectual property framework, despite its progressive provisions, has failed to adequately protect traditional knowledge and indigenous innovations, a failure that has profound implications for traditional medicine. The absence of effective legal protection for traditional medical knowledge leaves it vulnerable to biopiracy and misappropriation, while simultaneously undermining the incentive structures that would support systematic documentation, validation, and development of indigenous pharmacopoeias. This represents a critical dimension of the "ceremonial compliance" phenomenon, where legislative provisions exist in form but lack substantive enforcement and practical application.

Holistic Paradigms of Health and Healing

Traditional African medicine, including its localized Zambian expressions, is underpinned by an expansive, holistic epistemology that stands in stark contrast to the Cartesian dualism and reductionist frameworks characteristic of Western biomedicine (WHO, 2000). Within this indigenous paradigm, etiology, the study of illness causation, is conceptualized as a multi-layered, concurrent matrix encompassing natural (biophysical), social (interpersonal), and spiritual (cosmological) dimensions. Physical symptomatology is rarely viewed as an isolated physiological malfunction; rather, it is interpreted as the somatic manifestation of systemic disturbances originating from fractured social relationships, disrupted ancestral communication, environmental disharmony, or spiritual imbalances (Chinsembu, 2016). Consequently, therapeutic interventions are not merely symptomatic or curative in a narrow physiological sense, but are fundamentally restorative, aiming to re-establish multidimensional equilibrium across the patient's entire existential network (WHO, 2003). This integrated ontological framework accounts for the enduring sociocultural and psychological resonance of traditional medicine across contemporary African populations (Peltzer & Pengpid, 2019).

The Colonial Rupture: Dismantling Indigenous Healthcare Systems

The imposition of European colonial administration enacted a profound structural and epistemic rupture upon African indigenous healthcare networks, operating through a matrix of institutional, religious, and legal mechanisms (Sugishita, 2009). Missionary Christianity served as a primary ideological apparatus, systematically pathologizing indigenous healing modalities as pagan superstition or demonic practices; this ideological erasure was frequently accompanied by the violent suppression of therapeutic rituals and the deliberate destruction of sacred material culture (Sugishita, 2009). Concurrently, colonial medical authorities established a hegemony of biomedical exclusivity. By codifying statutory prohibitions, such as various iterations of Witchcraft Suppression Acts across Southern and Eastern Africa, the state effectively criminalized traditional practitioners. Crucially, as highlighted by modern critiques of global health equity, this systematic dismantling of indigenous medical infrastructure occurred without the state providing scalable, socio-economically accessible biomedical alternatives to the colonized populace, creating a severe and enduring void in healthcare delivery (Ahmadiani & Nikfar, 2016).

Furthermore, colonial governance structures actively destabilized the sociopolitical foundations of ethnomedical practice. By co-opting or undermining traditional chieftaincy systems, fracturing lineage networks, and disrupting rural economies, the state severely compromised the institutional frameworks

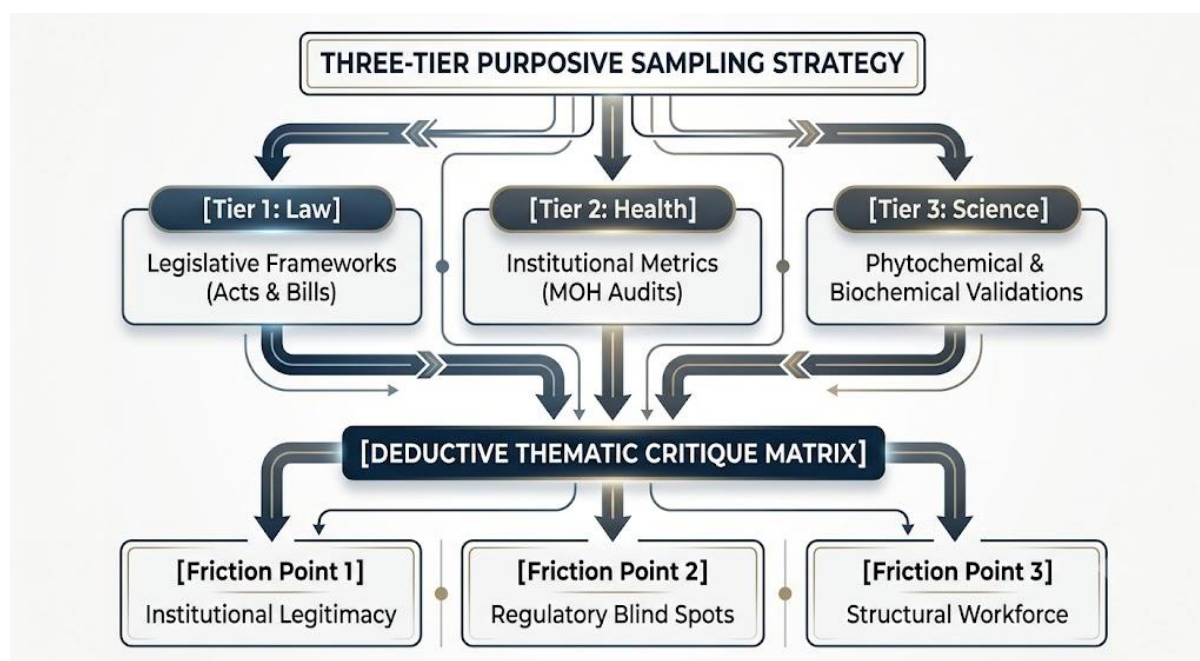
essential for regulated apprenticeship and intergenerational knowledge transmission (Leonard, 2003). Lungu et al. (2026) note that this colonial legacy continues to shape contemporary institutional responses to indigenous knowledge systems, with post-independence legal frameworks often perpetuating rather than rectifying colonial-era exclusionary approaches. The persistence of legal provisions that fail to recognize or protect traditional knowledge, coupled with the absence of enforcement mechanisms for those that do, exemplifies the broader pattern of “laws without life” that characterizes Zambia’s approach to indigenous innovation and intellectual heritage.

METHODOLOGY

A Critical Policy Review and Theoretical Synthesis Matrix

By employing a macro-institutional lens, this methodology shifts the focus away from individual healer-patient dynamics to systematically critique how power, legislation, and biomedical hegemony shape the country’s current health system governance. This analytical approach is informed by the theoretical insights of Lungu et al. (2026), who demonstrate that policy analysis in the Zambian context must attend carefully to the gap between formal legal provisions and actual implementation, a gap that is particularly pronounced in areas where colonial legacies, competing institutional interests, and limited enforcement capacity intersect.

Table 2: Three-Tier Purposive Sampling



Data Corpus and Three-Tier Purposive Sampling Strategy

The primary data corpus consists of a carefully curated assembly of statutory legislative acts, ministerial strategic portfolios, institutional audits, and peer-reviewed ethnobotanical and clinical literatures ($n = 44$ distinct primary and secondary texts) spanning from the early colonial era to the contemporary period. To guarantee a comprehensive, multi-dimensional evaluation of the Zambian health system, documents were selected using a rigid, three-tier purposive sampling strategy designed to capture the cross-sections of law, state infrastructure, and empirical science (Beach & Pedersen, 2019):

i. Tier I: Formal Legislative and Statutory Frameworks: This tier isolates the foundational legal architecture governing medical practice in Zambia. Primary focus was directed at historically exclusionary pieces of legislation, such as the colonial-era Medical and Allied Professions Act, the Zambia Medicines Regulatory Authority (ZAMRA) Act No. 2 of 2013, and successive, heavily contested iterations of the Traditional Health Practitioners Bill (Government of the Republic of Zambia, 1995; Zambia Medicines Regulatory Authority, 2022). Examining these texts allows for an unmasking of the statutory mechanisms used

to enforce biomedical exclusivity. Lungu et al. (2026) emphasize the importance of examining not only what legislation says but how it is implemented, noting that Zambia's legislative landscape is characterized by "ceremonial compliance" where progressive provisions coexist with systematic non-enforcement.

ii. Tier II: Institutional Performance Metrics and Strategic Portfolios: To assess the operational realities, task-shifting limitations, and human resource deficits of the formal sector, this tier extracted macro-level data from official publications issued by the Ministry of Health (MOH). Key documents included successive National Health Strategic Plans (NHSPs) and the Human Resources for Health Audit Reports (Ministry of Health Zambia, 2021; Republic of Zambia, Ministry of Health, 2020). These records provide the empirical baseline for analyzing current healthcare access disparities, particularly within underserved rural peripheries.

iii. Tier III: Empirical Phytochemical and Pharmacological Validations: To bridge the gap between indigenous knowledge and biochemical validation, the corpus incorporates peer-reviewed laboratory and clinical evaluations of flora indigenous to the Miombo woodland ecosystem. This includes scientific research profiling the therapeutic efficacy, active compounds, and toxicological thresholds of widely utilized botanical agents such as *Cryptolepis sanguinolenta*, *Cassia abbreviata*, and *Terminalia sericea* (Chinsembu et al., 2015; Chinsembu, 2016). Including these texts ensures the policy review is anchored in the material reality of the indigenous pharmacopoeia.

Analytical Framework and Deductive Synthesis

The extracted textual data were subjected to a rigorous qualitative content analysis and cross-examined using a deductive thematic matrix. Rather than allowing themes to emerge purely inductively, textual evidence was systematically catalogued against three pre-defined operational friction points that historical and structural forces have carved into the interface between traditional medicine and allopathic medicine (Beach & Pedersen, 2019):

i. Institutional Legitimacy: Dissecting the epistemic hierarchies, religious discourses, and legal boundaries that define what constitutes legitimate medicine versus superstitious or illegal practice (Sugishita, 2009).

ii. Regulatory Oversight Blind Spots: Evaluating the legislative gaps, quality control challenges, and structural mismatch created when centralized, biomedical regulatory bodies (such as ZAMRA) attempt to standardize decentralized, oral, and secret indigenous healing traditions (WHO, 2011; Zambia Medicines Regulatory Authority, 2022). Lungu et al. (2026) identify this as a manifestation of the broader pattern where centralized, formal institutions struggle to accommodate decentralized, informal knowledge systems, resulting in regulatory frameworks that are structurally misaligned with the realities they purport to govern.

iii. Structural Workforce Distribution: Mapping the stark disparities between the highly concentrated, urbanized biomedical workforce and the widely distributed, rural-based traditional practitioners, evaluating how these dynamics impact Zambia's broader quest for Universal Health Coverage (UHC) (Ministry of Health Zambia, 2021).

By integrating these diverse textual streams into a unified matrix, this methodology explicitly prioritizes the macroeconomic, historical, and institutional mechanics of health system governance over isolated clinical outcomes. The resulting synthesis provides a highly structured, conceptually rigorous framework capable of converting fragmented policy records into an actionable roadmap for sustainable, pluralistic health integration.

Structural Compensations and Systemic Gaps

A critical function of the traditional health sector is its structural compensation for systemic deficiencies within the biomedical infrastructure. In locales where allopathic facilities remain geographically inaccessible, financially prohibitive, or culturally incongruent, Traditional Health Practitioners (THPs) serve as the primary, and often exclusive, point of clinical contact (Ngulube et al., 2021; Peltzer & Pengpid, 2019).

For instance, the widespread patient preference for traditional management of sexually transmitted infections (STIs) is not merely an expression of cultural conservatism; rather, it represents a rational choice strategy in response to institutional failures within the state healthcare apparatus, such as (Chinsembu, 2016):

- i. Breaches of clinical confidentiality and privacy violations
- ii. The social stigmatization of patients by biomedical staff
- iii. Prohibitive geographical barriers and transportation friction

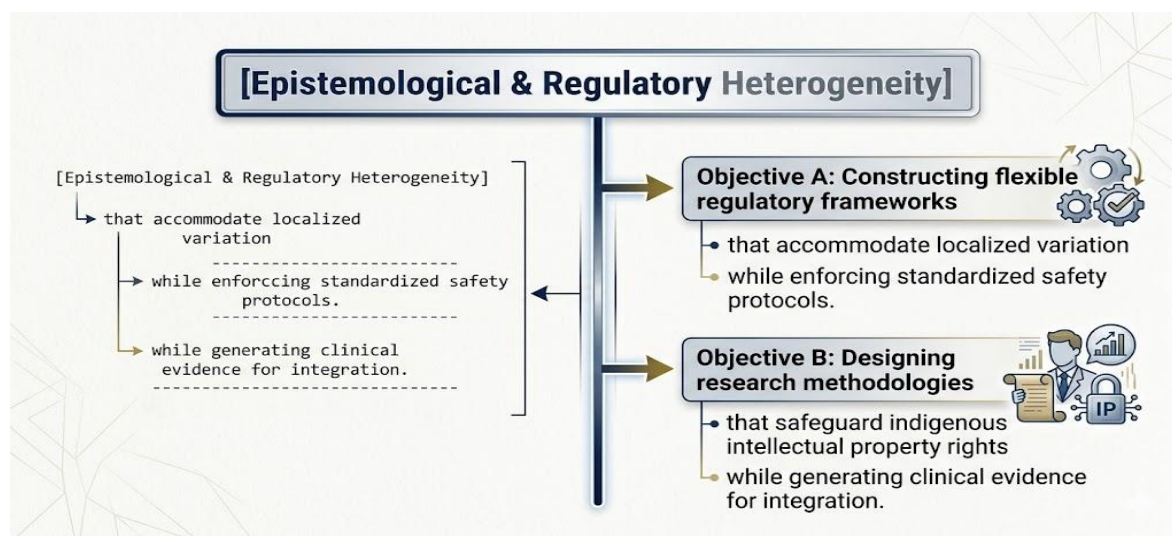
Lungu et al. (2026) would characterize this as an adaptive response to what they term "institutional failure", where state institutions, despite their formal mandates and legal authority, fail to deliver essential services effectively, creating space for alternative institutional arrangements to emerge and persist.

Epistemological and Regulatory Heterogeneity

Documenting indigenous medical practices presents distinct methodological challenges, primarily driven by Zambia's rich ethnolinguistic diversity, which encompasses 72 distinct groups (Central Statistical Office Zambia, 2022). This diversity manifests in localized variations regarding specific pharmacological preparations and botanical selections; however, cross-comparative analysis reveals profound underlying unities in therapeutic philosophy, nosology, and conceptual frameworks (Chinsembu, 2016).

Deciphering this dialectic between localized variation and structural unity is an essential prerequisite for two critical objectives:

Table 3: Epistemological and Regulatory Heterogeneity



Lungu et al. (2026) observe that Zambia's legal and policy frameworks consistently fail to accommodate the decentralized, pluralistic nature of indigenous knowledge systems. The state's preference for centralized, uniform regulatory approaches creates a fundamental mismatch with the diverse, locally-embedded character of traditional medical practice, a mismatch that renders regulatory frameworks largely ineffective and perpetuates the "ceremonial compliance" phenomenon where policies exist on paper but lack practical application.

Multidimensional Applications of Traditional Medicine

Zambia's 72 ethnolinguistic groups possess diverse localized therapeutic modalities that are structurally unified by shared conceptual paradigms and distinct therapeutic domains (Central Statistical Office Zambia, 2022; Chinsembu, 2016). In the domain of preventive applications, traditional medicine encompasses sophisticated, proactive epidemiological countermeasures that closely parallel biomedical public health approaches. Healers

employ localized ecological knowledge to formulate seasonal botanical prophylactics, design environmental protection measures, and administer individual immunomodulatory treatments, as exemplified by indigenous malaria prophylaxis where practitioners administer targeted phytotherapeutic compounds to vulnerable cohorts during high-transmission cycles (Chinsembu et al., 2015). These targeted preventive applications demonstrate structured empirical observation linking specific botanical inputs to a reduced incidence of seasonal pathologies within the community.

Curative interventions constitute the most visible domain of traditional medicine, addressing a clinical spectrum ranging from acute infectious etiologies to complex, chronic degenerative pathologies (Chinsembu, 2016). In the specific management of sexually transmitted infections, patient cohorts consistently demonstrate a preference for traditional healers over biomedical providers due to perceived deficits in clinical confidentiality, economic barriers, and the geographical inaccessibility of state health facilities (Chinsembu, 2016). Furthermore, malaria, respiratory tract infections, acute gastrointestinal disorders, and complex psychiatric conditions are heavily managed within this traditional sector (Ngulube et al., 2021).

Traditional surgery represents a specialized, highly technical domain that is frequently overlooked in conventional discussions of African medicine. Zambian traditional surgeons perform complex operative interventions, including ritual and therapeutic male circumcision, the excision of pathological subcutaneous growths, mechanical wound debridement, and the drainage of deep-tissue abscesses. These surgical procedures are supported by locally developed ethno-anesthetic preparations, botanical antimicrobials, and structured postoperative regimens that dictate specific hygienic practices and dietary restrictions (Chinsembu, 2009).

Metaphysical interventions form an integral, epistemological pillar of traditional healing, requiring analytical delineation from pejorative or colonial characterizations (Sugishita, 2009). Healers typically operate as institutional intermediaries, maintaining relationships with ancestral spirits, clan divinities, or territorial entities who communicate diagnostic variables and therapeutic protocols via dreams, visions, or mediumistic states. This nosological framework interprets specific afflictions as manifestations of fractured psychosocial relationships, ritual omissions, or spiritual aggression, etiologies that fall entirely outside the diagnostic taxonomy of biomedical psychiatry (Sugishita, 2009).

Demographic Patterns of Utilization

While aggregate data from the World Health Organization estimates that approximately 80% of the Zambian population utilizes traditional medicine, a critical disaggregation of this metric reveals distinct socioeconomic and geographic variations across the country (WHO, 2003; Ngulube et al., 2021). Rural populations exhibit the highest rates of dependence, a phenomenon driven by both structural accessibility constraints and cultural continuity. However, urban utilization remains highly resilient, with urban practitioners maintaining dense, active clinical spaces catering to metropolitan populations who engage in medical pluralism by navigating both indigenous and biomedical networks either sequentially or simultaneously (Ngulube et al., 2021).

Socioeconomic stratification highlights the vital safety-net function of traditional medicine among marginalized demographics. The lowest income quintile, structurally excluded from the formal health sector by biomedical consultation fees, prohibitive transportation costs, and privatized pharmaceutical procurement, relies on traditional practitioners (Peltzer & Pengpid, 2019). These healers lower economic barriers by accepting payment in kind, extending flexible credit lines, and pricing services significantly below biomedical alternatives. Furthermore, women, who bear disproportionate structural responsibility for household health security, emerge as the primary consumers, navigators, and institutional advocates of the traditional sector (Leonard, 2003).

The Healthcare Access Crisis: The Structural Context for Integration

While the cultural embeddedness of traditional medicine is well established, the imperative for its formal integration into the national framework is driven by severe, structural failures within Zambia's biomedical delivery infrastructure (Ministry of Health Zambia, 2021). The persistence of the traditional sector is not merely a reflection of cultural preference, but is a rational response to the stark limitations of the allopathic

system (Ngulube et al., 2021). Shifting the analytical focus to these systemic deficits reveals that traditional medicine functions as an indispensable component of the health sector rather than a simple alternative. Dissecting the geographic, human resource, and economic barriers defining this access crisis establishes the pragmatic foundation for policy integration. The central argument is clear: traditional practitioners operate as de facto primary care providers in an environment of scarcity, making their ongoing official exclusion both structurally irrational and ethically untenable. Formal integration is therefore a necessary strategy for achieving universal health coverage (WHO, 2013).

Lungu et al. (2026) would frame this as a consequence of the state's failure to fulfill its core institutional functions, providing accessible, equitable healthcare, which creates a legitimacy vacuum that alternative institutional arrangements (such as traditional medicine) inevitably fill. This represents a critical insight for understanding why integration efforts have historically failed: they attempt to impose formal regulation on practices that have flourished precisely because of the state's institutional failures, without first addressing the underlying conditions that make traditional medicine necessary and valuable to communities.

Geographic Barriers to Biomedical Access

Zambia's public health infrastructure exhibits severe spatial maldistribution, concentrating resources within urban centers while leaving rural populations underserved (Ministry of Health Zambia, 2021). Rural health posts, designed to deliver localized primary care, are entirely absent across vast areas. Communities throughout the Eastern, Western, Luapula, and Northern provinces must routinely travel between 50 and 100 kilometers to access a functional health facility, journeys typically undertaken on foot or by bicycle along unpaved networks that become impassable during the rainy season (Republic of Zambia, Ministry of Health, 2020).

The clinical consequences of this spatial isolation are severe, resulting in elevated maternal mortality rates during transit to distant facilities, high paediatric mortality from easily treatable infectious conditions, the accelerated progression of manageable chronic pathologies, and long-term disability resulting from conditions responsive to timely intervention (Ministry of Health Zambia, 2021). Traditional health practitioners, residing directly within these communities and available without travel friction, fill this structural vacuum by providing immediate primary care that would otherwise be entirely unavailable (Ngulube et al., 2021).

The Mathematical Impossibility of Biomedical Parity: Cross-Examining the Mid-Level Workforce Matrix

The Ministry of Health's 2020 Human Resources for Health Audit exposes a stark, aggregate doctor-to-population ratio of approximately 1:12,000, but evaluating health system capacity solely through the lens of fully credentialed physicians presents an incomplete analytical picture (Republic of Zambia, Ministry of Health, 2020). Historically, Zambia has attempted to mitigate these severe rural-urban imbalances through aggressive task-shifting strategies. The operationalization of mid-level cadres, specifically Clinical Officers and Community Health Assistants, under successive National Health Strategic Plans has fundamentally reconfigured primary care at the rural interface (Ministry of Health Zambia, 2021).

Process tracing of these task-shifting frameworks reveals that mid-level cadres are structural mitigations rather than permanent systemic corrections (Republic of Zambia, Ministry of Health, 2020). While Community Health Assistants bridge basic geographic gaps, they lack the diagnostic training and prescriptive mandates required to manage complex chronic pathologies or systemic epidemiological shifts, leaving the rural population in a state of clinical vulnerability. Traditional Health Practitioners, by contrast, exhibit a pervasive, decentralized network density that mid-level allopathic task-shifting has failed to replicate (Ngulube et al., 2021). Even when accounting for optimal future graduation rates of Clinical Officers and a 2% annual population growth baseline, the allopathic apparatus cannot bridge the rural primary diagnostic gap within the coming generation (Ministry of Health Zambia, 2021). True structural equity requires moving beyond allopathic task-shifting to formally integrate this preexisting, culturally synchronized indigenous workforce.

Economic Barriers to Biomedical Access

Out-of-pocket healthcare expenditures impose catastrophic financial burdens on vulnerable Zambian households. Although user fees have been officially eliminated at the primary care level, health costs persist through informal charges, transport costs, the opportunity costs of prolonged waiting times, and mandatory pharmaceutical purchases from private outlets when public stocks are exhausted (Leonard, 2003). The economic accessibility of traditional healers, characterized by flexible pricing structures, payments in kind, and the provision of credit, effectively removes the financial barriers that exclude the poorest populations from biomedical care (Peltzer & Pengpid, 2019). The economic argument for formal integration extends from individual household affordability to macro-systemic efficiency. Incorporating the traditional health sector into the official framework leverages existing community infrastructure, reduces demand pressure on overwhelmed biomedical facilities, and lowers aggregate public healthcare expenditures while expanding universal health coverage (WHO, 2013).

Empirical Phytochemical Validation of the Indigenous Pharmacopoeia

To counter biomedical contentions that indigenous healing paradigms lack empirical validation, it is necessary to examine the specific chemical profiles of prominent Zambian botanical agents whose therapeutic applications are well-documented in rural ethnopharmacology (Chinsembu et al., 2015). Shifting the analytical focus from unverified proprietary compounds toward peer-reviewed botanical isolation clarifies the biochemical mechanisms driving indigenous therapies.

For instance, *Cryptolepis sanguinolenta*, frequently utilized by traditional practitioners across Southern and Central provinces for febrile conditions, contains the indoloquinoline alkaloid cryptolepine. Laboratory and clinical evaluations confirm that cryptolepine exerts potent antiplasmodial activity by inhibiting β -hematin formation, directly mirroring the mechanisms of classical quinoline allopathic therapeutics (Chinsembu et al., 2015). Similarly, the bark extracts of *Cassia abbreviata* (locally known as mubanga or mputu) reveal high concentrations of proanthocyanidins and taxifolin glucosides. These compounds exhibit broad-spectrum antiviral, antioxidant, and antimicrobial properties, demonstrating activity against *Staphylococcus aureus*, *Escherichia coli*, and *Candida albicans* in laboratory assays, which validates its systemic deployment against chronic inflammatory, gastrointestinal, and sexually transmitted syndromes (Chinsembu, 2016). Furthermore, *Terminalia sericea* (mususu) extracts yield significant quantities of sericoside and ellagitannins, triterpenoids with verified antibacterial efficacy against Gram-positive strains, notable wound-healing bioactivity, and demonstrated activity against *Plasmodium falciparum* (Chinsembu et al., 2015). These empirical data demonstrate that the traditional Zambian pharmacopoeia operates on verifiable biochemical mechanics rather than mere placebo effects or metaphysical alignment, satisfying the objective criteria required for integration into a formalized national formulary.

Emerging Evidence and the Dilemma of Unregulated Botanicals

The majority of Zambia's estimated 1,000 to 1,500 medicinal plant species remain uncharacterized, and few have progressed beyond preliminary screening to toxicological assessment, pharmacokinetic study, or controlled clinical trials (Chinsembu, 2016). This knowledge gap represents both a critical research imperative and a mandate for regulatory caution (WHO, 2011). Lungu et al. (2026) would identify this as a research and innovation gap that is perpetuated by the absence of effective intellectual property protection and benefit-sharing mechanisms, without such protections, there is little incentive for systematic investment in traditional medicine research and development.

Methodological Considerations in Traditional Medicine Research

Evaluating traditional medicine through conventional biomedical research paradigms presents epistemological challenges requiring methodological innovation. Randomized controlled trials (RCTs), the gold standard for pharmaceutical evaluation, are often structurally inadequate to capture traditional medicine's holistic effects, highly individualized treatment protocols, and outcomes that extend beyond symptom reduction to encompass social and spiritual dimensions (WHO, 2000; Chinsembu, 2009).

Safety, Standardization, and Quality Assurance

Legitimate concerns regarding traditional medicine safety require a systematic response rather than institutional dismissal or prohibition (WHO, 2011). Adverse events, including organ toxicity, drug-drug interactions, and microbial or heavy metal contamination, occur with traditional preparations just as they do with biomedical pharmaceuticals. However, robust prevalence estimates remain speculative due to the complete absence of pharmacovigilance surveillance systems (Zambia Medicines Regulatory Authority, 2022). Ironically, the absence of regulation increases public risk by permitting unqualified vendors to market preparations of unknown composition, dosage, and quality.

Standardization efforts must balance safety requirements with respect for traditional knowledge and practice (WHO, 2011). Regional monographs describing authenticated plant species, preparation methods, quality indicators, and dosage ranges can guide safe clinical practice without imposing inappropriate pharmaceutical manufacturing frameworks. Quality assurance systems adapted to local resource constraints, including village-level authentication, structured macroscopic and organoleptic inspections, and simplified chemical assays, can significantly enhance patient safety while remaining accessible to practitioners.

Legal and Regulatory Frameworks: Current Gaps and Reform Imperatives

The current regulatory landscape is defined by an institutional divide between a statutory vacuum created by exclusionary legislation and the voluntary self-regulatory initiatives that have emerged to fill this void (Zambia Medicines Regulatory Authority, 2022; Government of the Republic of Zambia, 1995). The Pharmacy and Poisons Act's explicit exclusion of traditional medicine from its purview, combined with the corresponding mandate limitations of the Zambia Medicines Regulatory Authority (ZAMRA), has created a jurisdictional gap wherein traditional medical products and practices operate beyond formal oversight (Government of the Republic of Zambia, 1995; Zambia Medicines Regulatory Authority, 2022). This absence of regulation produces cascading harms: consumers face unregulated markets where product quality and authenticity remain unverified; genuine healers suffer reputational damage from association with fraudulent practitioners; and public health authorities lack the surveillance systems needed to monitor adverse events, track utilization patterns, or generate evidence for policy development (Kasilo & Trapsida, 2010).

Lungu et al. (2026) would characterize this regulatory vacuum as a classic example of "ceremonial compliance", where the state has formally legislated in certain areas (biomedical regulation) while systematically neglecting others (traditional medicine), creating a fragmented and inconsistent legal landscape that serves institutional interests rather than public health needs. The absence of statutory recognition for traditional medicine is not merely an oversight but reflects deeper institutional biases and path dependencies that perpetuate colonial-era exclusionary approaches.

The emergence of the Traditional Healers and Practitioners Association of Zambia (THAPAZ) as a self-regulatory body represents an indigenous response to this governance deficit. THAPAZ's efforts to register practitioners, establish practice standards, and maintain disciplinary mechanisms demonstrate the feasibility and desirability of structured oversight. However, operating without statutory authority, THAPAZ's effectiveness remains constrained by voluntary compliance, limited enforcement powers, and insufficient resources, limitations that allow unregistered practitioners and street vendors to continue operating with impunity while undermining the association's regulatory ambitions.

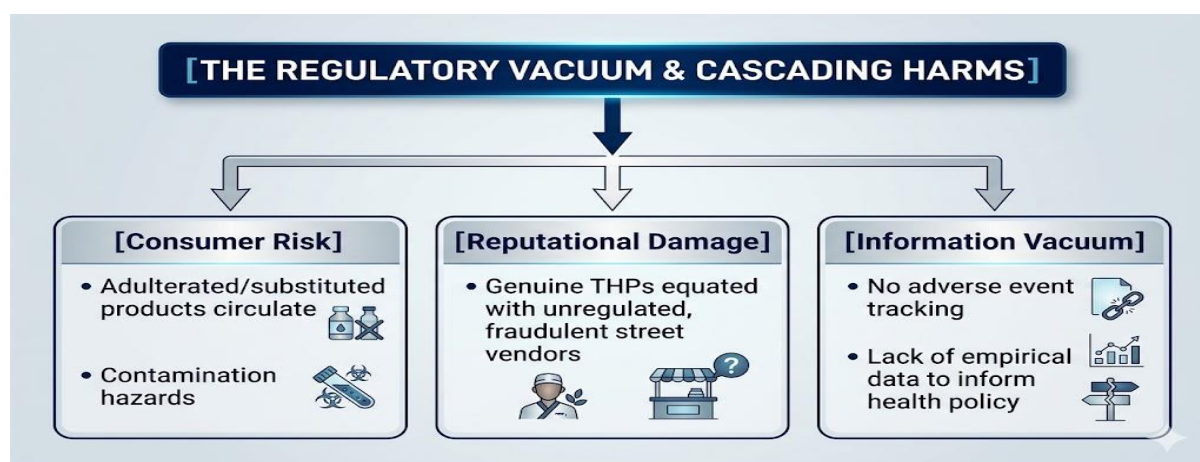
Examining comparative regulatory models from jurisdictions that have integrated traditional medicine within formal governance structures provides valuable templates for Zambia. China's systematic incorporation of traditional medicine within its national health infrastructure, India's establishment of dedicated departmental frameworks (such as AYUSH) for pluralistic healthcare regulation, and African models including Ghana's Traditional Medicine Practice Act and South Africa's Traditional Health Practitioners Act offer adaptable frameworks (Nkiwane et al., 2020; Health Professions Council of South Africa, 2022). These models illuminate essential regulatory elements, including practitioner registration, scope of practice definition, educational standards, pharmacopoeial specifications, and enforcement mechanisms, while highlighting the

importance of contextual adaptation to Zambian resource constraints, cultural specificities, and institutional landscapes.

The Regulatory Vacuum

Zambia currently lacks a comprehensive legal framework governing traditional medicine practice and products. The Pharmacy and Poisons Act, Chapter 299 of the Laws of Zambia, explicitly excludes traditional medicine from its regulatory scope, creating a stark jurisdictional vacuum (Government of the Republic of Zambia, 1995). The Zambia Medicines Regulatory Authority (ZAMRA), established under this statutory framework, possesses no legal mandate over traditional medicines, rendering it powerless to address safety concerns, quality defects, or fraudulent therapeutic claims (Zambia Medicines Regulatory Authority, 2022). This regulatory absence produces multiple systemic harms:

Table 4: Regulatory Vacuum and Cascading Harms



The resulting information vacuum perpetuates institutional scepticism while failing to generate the data necessary to inform evidence-based health policy (Kasilo & Trapsida, 2010). Lungu et al. (2026) would observe that this regulatory vacuum is not an accident but a predictable outcome of institutional path dependencies that privilege biomedical knowledge systems while marginalizing indigenous alternatives, a pattern that has persisted from the colonial era through independence and into the contemporary period.

The Traditional Healers and Practitioners Association of Zambia (THAPAZ)

THAPAZ represents a localized initiative toward indigenous self-regulation, registering members and issuing licenses intended to distinguish qualified practitioners from fraudulent actors. Operating without statutory authority, THAPAZ's operational effectiveness remains severely limited by voluntary compliance, an absence of legal enforcement powers, and acute resource constraints (Kasilo et al., 2019). Consequently, many street vendors and unregistered practitioners operate openly without THAPAZ affiliation, facing no legal sanctions and ignoring the association's code of standards.

Despite these structural limitations, THAPAZ provides an essential foundation for national regulatory development. Its membership database, established practice standards, and informal disciplinary mechanisms offer an existing infrastructure upon which statutory regulation could be built (Kasilo & Trapsida, 2010). Incorporating this structure into a formal legal framework would transform THAPAZ from a voluntary association into a statutory professional body equipped with enforcement powers, mandatory membership requirements, and institutional accountability mechanisms.

Comparative Regulatory Models

International experience offers distinct regulatory models that can be adapted to the Zambian context. China's integration of traditional medicine within its national health system, including standardized education, formalized licensing examinations, and dedicated research infrastructure, demonstrates the feasibility of

systematic institutional incorporation (WHO, 2013). India's Department of AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homoeopathy) provides an institutional framework for pluralistic medical regulation (WHO, 2013). Regionally, Ghana's Traditional Medicine Practice Act and South Africa's Traditional Health Practitioners Act offer continental templates (Nkiwane et al., 2020; Health Professions Council of South Africa, 2022).

Lessons from Previous Reform Attempts in Zambia

Zambia's previous attempts to establish regulatory mechanisms for traditional medicine have consistently faltered due to specific political and structural barriers (Ministry of Health Zambia, 2021). In the late 1990s, the Ministry of Health initiated a traditional medicine program that included practitioner registration pilots in Lusaka and Copperbelt provinces. This initiative collapsed within five years, undermined by inadequate funding, an absence of statutory authority, institutional resistance from biomedical professional bodies, and a lack of political continuity following ministerial reshuffling (Kasilo & Trapsida, 2010). A subsequent 2004 draft Traditional Health Practitioners Bill, modelled partly on Ghana's legislation, was circulated for stakeholder comment but was never tabled in Parliament, due to opposition from conservative religious constituencies and concerns regarding the constitutional separation of church and health governance (Sugishita, 2009). More recently, the 2017–2021 National Health Strategic Plan included policy language supportive of traditional medicine integration, but implementation indicators were never operationalized, and the subsequent 2022–2026 National Health Strategic Plan retreated to vaguer, non-committal language (Ministry of Health Zambia, 2021).

Lungu et al. (2026) would characterize these repeated failures as manifestations of the "ceremonial compliance" phenomenon that pervades Zambia's policy landscape. Each successive policy iteration acknowledges the importance of traditional medicine, yet each fails to translate this acknowledgment into meaningful institutional change. This pattern reflects the persistence of colonial-era institutional biases, the influence of religious opposition, professional territoriality from biomedical associations, and the absence of sustained political advocacy for integration.

Analysis of these historical failures yields several critical lessons for current integration proposals (Kasilo et al., 2019; Ministry of Health Zambia, 2021):

i. Political Mobilization: Legislative reform without sustained political advocacy and cross-sectoral constituency mobilization is insufficient; draft bills require long-term champions across multiple parties and ministries.

ii. Statutory Authority: Pilot programs without statutory enforcement mechanisms cannot transition to scale; the absence of legal penalties for non-compliance renders registration voluntary and structurally incomplete.

iii. Pre-Legislative Negotiation: Opposition from biomedical professional associations must be addressed through early, structured pre-legislative negotiation rather than simply overridden; the 2004 Bill failed in part because the Zambia Medical Association was not adequately consulted or accommodated.

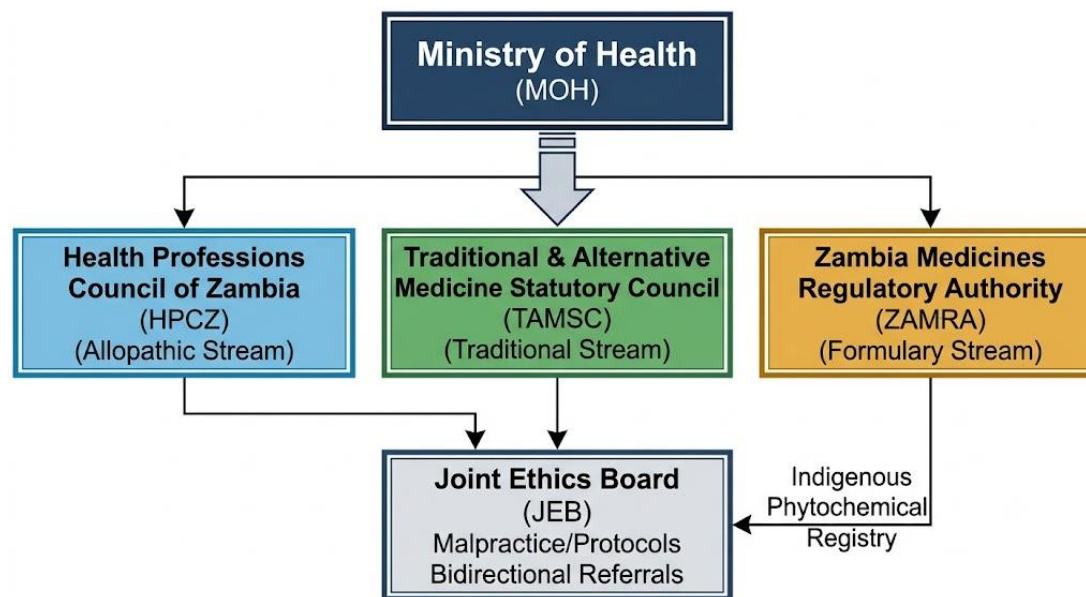
iv. Neutralizing Coalitions: Religious opposition, though often framed as theological, operates through influential political channels that can block legislative progression; successful reform requires either neutralizing this opposition through deliberate interdisciplinary dialogue or building sufficiently broad civil coalitions to overcome it (Sugishita, 2009).

v. Institutionalization: High ministerial turnover within Zambia's political system (where the average tenure for Ministers of Health between 2011 and 2021 was approximately 18 months) demands that integration be institutionalized beyond ministerial discretion, utilizing permanent statutory bodies rather than fragile, program-based initiatives dependent on individual political champions.

Operationalizing Pluralism: The Tripartite Statutory Council Architecture

Transitioning from theoretical integration to structural execution requires a total overhaul of Zambia's current compartmentalized regulatory landscape. We propose the establishment of a **Traditional and Alternative Medicine Statutory Council (TAMSC)**, structured as an independent legal entity operating in parallel and direct coordination with the Health Professions Council of Zambia (HPCZ) and the Zambia Medicines Regulatory Authority (ZAMRA) (Zambia Medicines Regulatory Authority, 2022; Ministry of Health Zambia, 2021).

Table 5: Tripartite Functionality of Regulatory Institutions



Under this governance model, the operationalization of integration will be managed via three specialized regulatory streams:

i. Licensing and Practitioner Registry: TAMSC will decentralize registration through modernized district-level chapters of the Traditional Health Practitioners Association of Zambia (THAPAZ). Practitioners will be credentialed based on verified apprenticeship lineages and basic competency standards in sanitary protocols and red-flag symptom recognition (e.g., acute respiratory distress, severe haemorrhage), moving them out of legal ambiguity.

ii. Pharmacovigilance and Toxicological Control: ZAMRA's mandate will expand to include a dedicated Indigenous Phytochemical Registry. Rather than demanding costly allopathic phase-III clinical trials for crude herbal extracts, ZAMRA will implement an optimized safety-first tier: validating botanicals based on documented historical use profiles coupled with accelerated qualitative laboratory screening for heavy metals, microbial contamination, and absolute cytotoxicity levels (WHO, 2011).

iii. The Joint Ethics and Referral Board: A unified disciplinary board comprising equal representatives from the Medical Association of Zambia (MAZ) and TAMSC will govern medical malpractice, patient confidentiality, and cross-system referral failures. By formalizing a bidirectional referral protocol, backed by statutory disciplinary powers, the state can eliminate predatory or fraudulent practitioners while providing rural patients with an officially monitored, dual-lineage continuum of care.

Lungu et al. (2026) would recognize this tripartite architecture as an attempt to move beyond the "ceremonial compliance" paradigm by creating institutional structures with clear mandates, statutory authority, and enforcement mechanisms. However, they would also caution that institutional design alone is insufficient; sustained political will, adequate resourcing, and effective oversight are essential for translating formal provisions into substantive practice.

Impediments to Integration: Analysing Resistance

The path toward integrating traditional medicine within Zambia's formal healthcare system confronts multiple and intersecting forms of resistance that extend far beyond technical questions of efficacy, safety, or regulatory design. These impediments are deeply embedded in historical legacies, religious worldviews, professional identities, and political calculations, factors that together constitute a formidable barrier to policy reform despite the demonstrated utility and widespread utilization of traditional medicine (Sugishita, 2009; Chinsembu, 2016). Understanding the nature, origins, and dynamics of this resistance is essential for developing strategies that can address opposition constructively while advancing toward integration.

Religious opposition, examined in depth here, represents perhaps the most visible and emotionally charged barrier to traditional medicine recognition. Mainstream Christian denominations, encompassing the overwhelming majority of Zambia's population, maintain theological frameworks inherited from colonial missionary traditions that conflate indigenous healing with witchcraft, sorcery, and demonic activity (Sugishita, 2009). This conflation operates at multiple levels: pastoral teaching that explicitly prohibits members from consulting traditional healers; spiritual discourses that frame illness and healing within binary categories of divine versus demonic; and social pressures that stigmatize those who seek traditional care as spiritually compromised (Sugishita, 2009). The sincerely held nature of these beliefs renders religious opposition particularly resistant to purely empirical or rational argumentation, demanding instead approaches that engage theological frameworks, cultural meanings, and pastoral practices with nuance and respect.

By examining these impediments comprehensively, this section establishes the foundation for understanding why integration has proven so elusive despite widespread utilization and growing evidence of traditional medicine's contributions to healthcare access (Kasilo et al., 2019). The resistance analysed here is not merely irrational prejudice or unenlightened traditionalism but rather a complex system of opposition rooted in genuine beliefs, legitimate concerns, and institutional interests that must be addressed with corresponding complexity in reform strategies.

Religious Opposition and the Witchcraft Conflation

Religious opposition constitutes perhaps the most formidable barrier to traditional medicine recognition. Mainstream Christian denominations, encompassing the majority of Zambia's population, maintain theological frameworks that conflate traditional healing with witchcraft, sorcery, and demonic activity (Sugishita, 2009). Pastoral teaching explicitly prohibits members from consulting traditional healers, framing such consultation as spiritual infidelity with eternal consequences (Sugishita, 2009).

This theological opposition, while sincerely held, rests upon problematic assumptions. The conflation of healing with sorcery reflects colonial missionary frameworks rather than indigenous distinctions. Traditional healers themselves distinguish between therapeutic practice and harmful magic, categories elided in religious discourse (Sugishita, 2009). Furthermore, many Christians continue consulting healers discreetly while maintaining church affiliation, suggesting dissonance between official theology and practical healthcare navigation (Ngulube et al., 2021).

Lungu et al. (2026) would identify this as an instance where cultural and religious factors intersect with institutional dynamics to perpetuate exclusionary practices. The religious opposition to traditional medicine reinforces and is reinforced by state policies that marginalize indigenous knowledge systems, creating a mutually reinforcing cycle of exclusion that is resistant to change.

Biomedical Hegemony and Professional Territoriality

Medical professionals frequently resist traditional medicine integration, citing safety concerns, lack of evidence, and professional boundaries (Chinsembu, 2009). This resistance, while partly grounded in legitimate quality concerns, also reflects professional territoriality and biomedical hegemony, the assumption that allopathic medicine alone constitutes legitimate healthcare (Bodeker & Kronenberg, 2002). Medical education,

reinforcing biomedical exclusivity, produces graduates unprepared to engage traditional medicine constructively (Leonard, 2003).

Policy Inertia and Political Economy Constraints

Policy inertia reflects multiple factors: competing health priorities, limited resources, absence of advocacy coalitions, and political sensitivity (Ministry of Health Zambia, 2021). Traditional medicine lacks organized constituencies comparable to pharmaceutical industry, medical associations, or international health agencies (Leonard, 2003). Politicians, wary of religious opposition and professional resistance, avoid championing controversial integration (Kasilo et al., 2019).

Lungu et al. (2026) would characterize this policy inertia as a manifestation of institutional path dependency, where existing institutional arrangements, despite their demonstrated inadequacy, persist because they serve the interests of powerful actors and because the costs of change appear higher than the costs of maintaining the status quo. Breaking this path dependency requires building alternative coalitions, demonstrating the tangible benefits of integration, and creating institutional mechanisms that make change politically feasible and practically sustainable.

Pathways to Integration: A Comprehensive Framework

Having examined the historical foundations, contemporary utilization patterns, regulatory gaps, and impediments to traditional medicine integration in Zambia, this section advances from analysis to prescription, offering a comprehensive framework for systematic incorporation of traditional medicine within the national healthcare system (WHO, 2013). The pathways proposed here are neither speculative exercises nor uncritical endorsements of traditional medicine in its current unregulated form. Rather, they represent evidence-informed, contextually grounded strategies designed to achieve the complementary objectives of protecting public health, respecting cultural heritage, expanding healthcare access, and generating knowledge for continuous improvement (Bodeker & Kronenberg, 2002).

Education and training systems address the human capital dimensions of integration, preparing both traditional healers and biomedical practitioners for collaborative practice (WHO, 2000). For traditional healers, training in literacy and record-keeping, anatomy and physiology fundamentals, hygiene and infection control, referral criteria, and business management will enhance practice quality while respecting traditional knowledge (Chinsembu, 2009). For biomedical practitioners, education regarding traditional medicine awareness, cross-cultural communication, collaborative competencies, and research collaboration methods will prepare them for productive partnership (Bodeker & Kronenberg, 2002). Dual-trained practitioners qualified in both systems could serve as particularly valuable integration catalysts.

Collaborative practice models address the service delivery dimensions of integration, demonstrating through carefully designed and evaluated demonstration projects how traditional and biomedical practitioners can work together to improve patient outcomes (Chinsembu, 2009). Co-located services at primary care facilities, referral networks with bidirectional consultation, joint management of complex cases, shared education activities, collaborative research, and community health education partnerships all offer promising models for evaluation and potential scaling (WHO, 2013).

By articulating this comprehensive framework, the section aims to move beyond general advocacy for integration toward specific, actionable strategies that policymakers, practitioners, researchers, and communities can implement. The pathways described here are ambitious but achievable, grounded in both international experience and Zambian realities, and oriented toward the ultimate goal of a healthcare system that draws on all available therapeutic resources to serve the health needs of all Zambians.

Recognition and Legitimation

The foundational step toward integration involves formal recognition of traditional medicine as legitimate healthcare practice. This recognition should encompass (WHO, 2013; Kasilo et al., 2019):

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- i. Constitutional or legislative acknowledgment** of traditional medicine as a component of national health system
 - ii. Policy statements** affirming traditional medicine's contribution to health access
 - iii. Official terminology** replacing pejorative characterizations with respectful descriptors
 - iv. Cultural rights affirmation** recognizing traditional medicine as indigenous knowledge heritage

Recognition does not imply uncritical acceptance but rather creates a framework for constructive engagement, regulation, and development (Bodeker & Kronenberg, 2002). Lungu et al. (2026) would emphasize that such recognition must be accompanied by substantive institutional mechanisms that translate formal acknowledgment into practical implementation, without such mechanisms, recognition risks becoming yet another instance of "ceremonial compliance."

Regulatory Architecture

Comprehensive regulation must address multiple dimensions (WHO, 2011; Kasilo & Trapsida, 2010):

Practitioner Regulation:

- i.** Mandatory registration and licensing
- ii.** Training and competency standards
- iii.** Scope of practice definition
- iv.** Ethical codes and disciplinary mechanisms
- v.** Continuing professional development requirements

Product Regulation:

- i.** Quality specifications and monographs
- ii.** Manufacturing standards
- iii.** Labeling and packaging requirements
- iv.** Adverse event reporting systems
- v.** post-market surveillance

Practice Regulation:

- i.** Facility standards
- ii.** Record-keeping requirements
- iii.** Referral protocols
- iv.** Collaborative practice guidelines
- v.** Research ethics frameworks

Regulatory development should proceed incrementally, prioritizing highest-risk areas while building institutional capacity (WHO, 2011).

Research and Development Infrastructure

Systematic research investment must address knowledge gaps while respecting traditional knowledge rights (WHO, 2000; Chinsembu, 2009):

- i. Ethnobotanical documentation and conservation
- ii. Phytochemical and pharmacological investigation
- iii. Clinical effectiveness studies using appropriate methodologies
- iv. Safety assessment and toxicological screening
- v. Quality control method development
- vi. Traditional knowledge documentation and protection

Research governance should include traditional practitioner representation, community engagement, and benefit-sharing mechanisms ensuring equitable returns to knowledge holders (Chinsembu, 2009; African Regional Intellectual Property Organization, 2010). Lungu et al. (2026) would emphasize the importance of strengthening intellectual property protections for traditional medical knowledge, moving beyond the current "ceremonial compliance" approach to create effective mechanisms for preventing biopiracy and ensuring that communities benefit from the commercialization of their traditional knowledge.

Education and Training Systems

Professional education must prepare practitioners for integrated practice (WHO, 2000; Chinsembu, 2009):

For Traditional Healers:

- i. Literacy and record-keeping skills
- ii. Anatomy, physiology, and pathology fundamentals
- iii. Hygiene and infection control
- iv. Referral criteria and collaboration protocols
- v. Business management and ethics

For Biomedical Practitioners:

- i. Traditional medicine awareness and respect
- ii. Cross-cultural communication skills
- iii. Collaborative practice competencies
- iv. Referral and consultation protocols
- v. Research collaboration methods

Dual-trained practitioners, individuals qualified in both systems, could serve as integration catalysts and bridge figures (Chinsembu, 2009).

Collaborative Practice Models

Demonstration projects should develop and evaluate collaborative models (Chinsembu, 2009; WHO, 2013):

- i. Co-located services at primary care facilities
- ii. Referral networks with bidirectional consultation
- iii. Joint management of complex cases
- iv. Shared education and training activities
- v. Collaborative research initiatives
- vi. Community health education partnerships

Evaluation should assess health outcomes, cost-effectiveness, patient satisfaction, and practitioner experiences to guide replication and scaling.

International and Regional Context

While the integration of traditional medicine into Zambia's healthcare system must ultimately be designed according to national priorities, cultural specificities, and institutional capacities, the endeavour does not proceed in isolation. A rich body of international experience, regional policy frameworks, and comparative lessons offers valuable guidance for Zambian policymakers, practitioners, and advocates seeking to navigate the complex terrain of integration (WHO, 2013; Kasilo et al., 2019). Understanding this broader context serves multiple essential functions: it provides normative frameworks and technical standards against which national efforts can be benchmarked; it offers tested models and practical lessons that can inform policy design while avoiding predictable pitfalls; it establishes platforms for experience sharing, technical cooperation, and collective advocacy; and it situates Zambia's efforts within global movements toward healthcare pluralism and universal health coverage (WHO, 2013).

Third, the section distils lessons from countries that have successfully integrated traditional medicine within their national health systems, examining both Asian and African exemplars (WHO, 2013). China's experience demonstrates the feasibility of comprehensive integration at scale: traditional medicine constitutes approximately 20% of outpatient visits nationally, supported by an extensive infrastructure of traditional hospitals, education institutions, research facilities, and regulatory frameworks operating alongside biomedical systems (WHO, 2013). India's Department of AYUSH (Ayurveda, Yoga, Unani, Siddha, Homoeopathy) provides institutional architecture for pluralistic regulation encompassing six distinct traditional systems, with corresponding educational standards, research protocols, and service delivery structures (WHO, 2013). African examples including Ghana's Traditional Medicine Practice Act, Nigeria's traditional medicine policy, and South Africa's Traditional Health Practitioners Act offer regionally relevant models adapted to resource constraints and cultural contexts similar to Zambia's (Nkiwane et al., 2020; Health Professions Council of South Africa, 2022; Mothibe & Sibanda, 2019). These comparative cases illuminate both the possibilities and the practical requirements for successful integration.

By examining these international and regional dimensions, this section aims to demonstrate that Zambia's integration efforts need not proceed through trial and error alone but can draw upon a wealth of accumulated experience, established frameworks, and tested approaches. The challenge for Zambian policymakers is not to invent integration *de novo* but to adapt global and regional lessons to national circumstances, learning from both successes and failures elsewhere while designing approaches that respond to Zambia's unique cultural landscape, institutional capacities, and health system priorities (Kasilo et al., 2019).

WHO Traditional Medicine Strategy

The WHO Traditional Medicine Strategy 2014-2023 provides a policy framework supporting member states in

integrating traditional medicine into national health systems (WHO, 2013). Key strategy objectives include: building knowledge base for active management through appropriate national policies; strengthening quality assurance, safety, proper use and effectiveness; and promoting universal health coverage by integrating traditional medicine services and self-health care (WHO, 2013). Zambia's alignment with this strategy would access technical support, normative guidance, and international cooperation.

African Union and Regional Initiatives

The African Union's Agenda 2063 recognizes traditional medicine as a contributor to health and well-being (African Union, 2015). The AU's African Traditional Medicine Day (August 31) promotes awareness and integration (Kasilo et al., 2019). Regional economic communities, including SADC, have developed traditional medicine policy frameworks (WHO Regional Office for Africa, 2023). These regional initiatives offer platforms for experience sharing, harmonized approaches, and collective advocacy.

Several patterns emerge from this comparison (Kasilo & Trapsida, 2010; Nkiwane et al., 2020). First, legislation alone is insufficient; implementation requires sustained funding, political will, and administrative capacity, all of which have proven fragile across the continent. Second, mandatory registration provisions are routinely subverted when enforcement mechanisms are weak, leaving large proportions of practitioners unregistered despite legal requirements. Third, educational standardization remains the most challenging dimension, with no African country having achieved comprehensive, nationally implemented training requirements for traditional healers. Fourth, genuine integration with biomedical systems, beyond symbolic recognition, has been achieved only in limited pilot projects, never at scale. Fifth, the South African experience demonstrates that even well-designed legislation can remain unimplemented for decades if political will falters or professional opposition persists (Mothibe & Sibanda, 2019).

For Zambia, these comparative lessons suggest that a phased approach, beginning with voluntary registration and non-punitive quality improvement mechanisms before advancing to mandatory requirements, may be more feasible than attempting comprehensive regulation immediately (Kasilo et al., 2019). Legislation should prioritize protection of vulnerable populations (product safety, prohibition of harmful practices, consumer information) before attempting full practitioner registration or educational standardization (WHO, 2011).

A note on interpretive caution regarding comparative models is warranted. The countries cited as successful integrators have experienced substantial implementation challenges that the scholarly literature often minimizes (Kasilo & Trapsida, 2010; Nkiwane et al., 2020). In Ghana, the Traditional Medicine Practice Council has registered fewer than 10% of an estimated 100,000 practicing traditional healers, and enforcement of registration requirements remains virtually absent outside the Greater Accra Region (Nkiwane et al., 2020). In South Africa, the Traditional Health Practitioners Act of 2007, despite being lauded as progressive legislation, had not achieved a fully constituted, operational regulatory council as of 2024, a delay of 17 years attributable to disputes over representation, educational requirements, and scope of practice (Mothibe & Sibanda, 2019). In Nigeria, the absence of a unified federal framework has produced a patchwork of state-level initiatives, none of which has achieved comprehensive coverage. Zimbabwe's Traditional Medical Practitioners Act, while legally robust, operates with a budget that supports only six inspectors for the entire country. These implementation realities do not invalidate the integration imperative but do counsel against unrealistic expectations. For Zambia, the lesson is not to abandon integration but to design frameworks that remain functional under conditions of limited enforcement capacity, recognizing that partial regulation may be preferable to the current vacuum, but that even partial regulation requires sustained political and financial commitment (Kasilo et al., 2019).

Lungu et al. (2026) would observe that these comparative examples underscore the centrality of the "ceremonial compliance" challenge that pervades African governance contexts. Even in countries with progressive legislation, the gap between formal provisions and substantive implementation remains substantial, reflecting the persistence of institutional path dependencies, limited enforcement capacity, and the absence of sustained political will. For Zambia to avoid replicating these patterns, integration efforts must attend carefully to implementation mechanisms, accountability structures, and the cultivation of sustained political commitment.

Economic Analysis: Costs and Benefits of Integration

Policy decisions regarding healthcare integration are inevitably shaped by economic considerations alongside clinical, cultural, and ethical dimensions (Leonard, 2003). In resource-constrained contexts such as Zambia, where public health budgets are stretched thin and competing priorities demand attention, the question of whether traditional medicine integration represents a sound investment, rather than merely a desirable aspiration, becomes paramount (Ministry of Health Zambia, 2021). This section provides a comprehensive economic analysis of traditional medicine integration, examining both the costs of implementation and the potential returns across healthcare system, economic development, and fiscal dimensions.

The economic case for integration has received insufficient attention in policy discourse, which has tended to focus on cultural rights, clinical efficacy, or regulatory concerns (Leonard, 2003). Yet economic arguments may prove particularly persuasive to policymakers facing difficult resource allocation decisions. If integration can be demonstrated not merely as culturally appropriate or clinically useful but as economically advantageous, generating returns that exceed investment costs, the case for reform becomes substantially more compelling (WHO, 2013).

Healthcare System Costs

Integration entails initial investments: regulatory infrastructure development, research funding, education programs, and service delivery pilots (WHO, 2013; Leonard, 2003). However, these investments may generate substantial returns through (Leonard, 2003; Ministry of Health Zambia, 2021):

- i. Reduced demand pressure on biomedical facilities
- ii. Lower per-visit costs compared to facility-based care
- iii. Leveraging existing community resources
- iv. Reduced transportation and opportunity costs for patients
- v. Prevention and early treatment reducing expensive complications

Cost-effectiveness analysis should compare integration scenarios with alternatives: biomedical expansion alone, continued parallel systems, or prohibition (WHO, 2013).

Economic Development Opportunities

Traditional medicine integration could stimulate economic development through (African Union, 2015; Leonard, 2003; African Regional Intellectual Property Organization, 2010):

- i. Sustainable harvesting and cultivation enterprises
- ii. Processing and manufacturing industries
- iii. Tourism and wellness services
- iv. Intellectual property commercialization
- v. Export markets for quality-certified products
- vi. Employment generation, particularly for women and rural communities

Benefit-sharing mechanisms should ensure returns flow to knowledge-holding communities rather than external commercial interests (African Regional Intellectual Property Organization, 2010). Lungu et al. (2026)

would emphasize the importance of strengthening intellectual property protections to enable effective commercialization while preventing biopiracy and ensuring equitable benefit-sharing.

Fiscal Implications

Integration would generate fiscal impacts through multiple channels (Leonard, 2003; Ministry of Health Zambia, 2021): formalization enabling taxation of previously informal economic activity; reduced healthcare expenditure through lower-cost service provision; and development of new economic sectors generating tax revenues. Fiscal analysis should model these dynamic effects rather than focusing solely on integration costs.

Ethical Dimensions and Human Rights Frameworks

Second, the section examines the right to health and its implications for healthcare access equity (United Nations, 2007). The right to health, recognized in international law and domestic frameworks, encompasses not merely the provision of healthcare services but their accessibility, physical, economic, and cultural (United Nations, 2007). Where biomedical services remain inaccessible to substantial portions of the population, as documented throughout this analysis, traditional medicine may constitute the only available healthcare (Ngulube et al., 2021). Recognizing traditional medicine within official systems thus advances right to health realization, while continued exclusion perpetuates access inequities that disproportionately burden rural populations, the poor, and other marginalized groups (Ministry of Health Zambia, 2021).

Third, the section addresses informed consent and patient autonomy as ethical principles that integration would strengthen (Bodeker & Kronenberg, 2002). Current arrangements leave patients navigating traditional medicine without professional guidance, reliable safety information, or quality assurance mechanisms that would support informed healthcare choices (WHO, 2011). Regulatory frameworks, by contrast, would provide patients with accurate information regarding traditional medicine options, risks, and benefits, enhancing rather than restricting autonomous decision-making (Bodeker & Kronenberg, 2002). Integration thus aligns with core bioethical principles while addressing current information asymmetries that disadvantage healthcare consumers.

Fourth, the section examines intellectual property rights and benefit-sharing obligations concerning traditional medical knowledge (African Regional Intellectual Property Organization, 2010). Traditional medicine represents not merely healthcare practice but intellectual heritage developed and preserved by communities over generations (African Regional Intellectual Property Organization, 2010). International frameworks including the Nagoya Protocol on Access and Benefit-Sharing and WHO guidelines address the protection of traditional knowledge from misappropriation and the equitable sharing of benefits arising from its commercialization (African Regional Intellectual Property Organization, 2010; Ministry of Commerce, Trade and Industry, 2010). Zambia's integration efforts must incorporate mechanisms preventing biopiracy, ensuring community control over traditional knowledge, and sharing benefits from knowledge commercialization with the communities that developed and preserved it.

Lungu et al. (2026) would emphasize that intellectual property protection for traditional knowledge represents a critical dimension of the broader challenge of moving beyond "ceremonial compliance" in Zambia's innovation framework. The current intellectual property regime, despite containing provisions that could protect traditional knowledge, lacks effective enforcement mechanisms and has failed to prevent the misappropriation of indigenous knowledge. Strengthening these protections is essential not only for ethical reasons but also for creating the incentive structures that would support investment in traditional medicine research, development, and commercialization.

Cultural Rights and Indigenous Knowledge

International human rights frameworks protect cultural rights including traditional medical practices (United Nations, 2007; African Union, 2015). The UN Declaration on the Rights of Indigenous Peoples affirms rights to traditional medicines and health practices (United Nations, 2007). The African Charter on Human and

Peoples' Rights recognizes cultural rights as fundamental (African Union, 2015). Zambia's constitutional protections for cultural rights provide domestic legal foundation for traditional medicine recognition.

Right to Health and Healthcare Access

The right to health, recognized in international and domestic law, encompasses accessible healthcare (United Nations, 2007). Where biomedical services remain inaccessible, traditional medicine may constitute the only available healthcare (Ngulube et al., 2021). Recognizing traditional medicine within official systems thus advances right to health realization, while continued exclusion perpetuates access inequities.

Informed Consent and Patient Autonomy

Integration would enhance informed consent by providing patients accurate information regarding traditional medicine options, risks, and benefits (Bodeker & Kronenberg, 2002). Current arrangements leave patients navigating traditional medicine without professional guidance, safety information, or quality assurance (WHO, 2011). Regulatory frameworks would support autonomous healthcare choices through improved information and protection.

Intellectual Property and Benefit Sharing

Traditional medical knowledge constitutes intellectual property requiring protection from misappropriation (African Regional Intellectual Property Organization, 2010). International frameworks including the Nagoya Protocol and WHO guidelines address traditional knowledge protection and benefit sharing (African Regional Intellectual Property Organization, 2010; WHO, 2000). Zambia's integration efforts should incorporate mechanisms preventing biopiracy, ensuring community control, and sharing benefits from knowledge commercialization.

Implementation Roadmap

Translating the comprehensive framework for traditional medicine integration from aspiration to reality requires more than sound analysis and compelling arguments, it demands a practical, sequenced, and realistic implementation strategy that recognizes the complexity of the undertaking while maintaining momentum toward clearly defined goals (WHO, 2013; Kasilo et al., 2019). The implementation roadmap presented in this section provides such a strategy, organizing integration activities across three-time horizons: short-term priorities (1-3 years), medium-term objectives (3-7 years), and long-term vision (7-15 years), while specifying concrete actions, responsible actors, and success indicators for each phase.

The roadmap's design reflects several guiding principles essential for successful implementation (WHO, 2013; Ministry of Health Zambia, 2021). First, it proceeds incrementally, recognizing that comprehensive integration cannot be achieved overnight but must build through successive phases that establish foundations, demonstrate feasibility, and generate political momentum. Short-term priorities focus on foundational activities, establishing multi-stakeholder governance structures, conducting situation analysis, developing draft policies, piloting regulatory mechanisms, initiating research, and launching public education, that create the conditions for subsequent progress. Medium-term objectives build on these foundations to enact legislation, establish statutory institutions, develop registration systems, create quality standards, integrate educational content, and demonstrate collaborative practice. Long-term vision articulates the ultimate destination toward which these incremental steps lead.

Second, the roadmap emphasizes multi-stakeholder engagement throughout all phases, recognizing that integration cannot be imposed by any single actor but requires sustained collaboration among healers, biomedical professionals, researchers, policymakers, religious representatives, and communities (Chinsembu, 2009). The proposed multi-stakeholder task force for the short-term phase exemplifies this collaborative approach, while subsequent phases maintain emphasis on participatory governance, community engagement, and professional partnership.

Third, the roadmap incorporates learning and adaptation mechanisms, acknowledging that implementation will encounter unforeseen challenges and that strategies must evolve in response to experience (WHO, 2013). Pilot projects, demonstration initiatives, and evaluation frameworks built into each phase generate evidence for continuous improvement while providing models that can be scaled as confidence and capacity grow.

Fourth, the roadmap balances ambition with realism, setting targets that are challenging yet achievable within Zambia's resource constraints and institutional capacities (Ministry of Health Zambia, 2021; Kasilo et al., 2019). The 15-year vision for full integration recognizes the long-term nature of systemic transformation while providing clear direction for near-term action.

Lungu et al. (2026) would emphasize that this implementation roadmap must be designed to address the "ceremonial compliance" challenge directly, by building accountability mechanisms, ensuring adequate resourcing, creating institutional structures with sustained mandates, and cultivating the political will necessary for meaningful implementation. Without such measures, even the most well-designed framework risks becoming another instance of "laws without life", progressive on paper but ineffective in practice.

Short-Term Priorities (1-3 Years)

- i. Establish multi-stakeholder task force including healers, biomedical professionals, researchers, policymakers, and religious representatives (WHO, 2013; Chinsembu, 2009)
- ii. Conduct comprehensive situation analysis documenting traditional medicine practices, practitioners, and products (Chinsembu, 2016)
- iii. Develop draft policy framework for traditional medicine recognition and regulation (Ministry of Health Zambia, 2021)
- iv. Pilot regulatory mechanisms in selected districts (Kasilo & Trapsida, 2010)
- v. Initiate research program documenting and validating priority traditional medicines (WHO, 2000)
- vi. Launch public education campaign addressing traditional medicine's role and safe use (WHO, 2011)

Medium-Term Objectives (3-7 Years)

- i. Enact comprehensive traditional medicine legislation (Government of the Republic of Zambia, 1995; Zambia Medicines Regulatory Authority, 2022)
- ii. Establish statutory regulatory authority with enforcement powers (Kasilo & Trapsida, 2010)
- iii. Develop practitioner registration and licensing systems (Nkiwane et al., 2020)
- iv. Create pharmacopoeial standards for priority traditional medicines (WHO, 2011)
- v. Integrate traditional medicine content into health professional curricula (Chinsembu, 2009)
- vi. Establish traditional medicine research institute (WHO, 2000)
- vii. Implement collaborative practice demonstrations at district hospitals and health posts (Chinsembu, 2009)

Long-Term Vision (7-15 Years)

- i. Full integration of traditional medicine within national health system (WHO, 2013)
- ii. Traditional medicine services available at all primary care facilities (Ministry of Health Zambia, 2021)
- iii. Registered traditional practitioners as recognized health professionals (Kasilo et al., 2019)

- iv. **Zambian traditional medicine products meeting international quality standards (WHO, 2011)**
- v. **Research evidence guiding evidence-based traditional medicine practice (WHO, 2000)**
- vi. **Traditional medicine contributing to universal health coverage achievement (WHO, 2013)**
- vii. **Zambian traditional medicine recognized regionally and internationally (African Union, 2015; WHO Regional Office for Africa, 2023)**

CONCLUSION

Beyond Either/Or Toward Both/And

The question whether Zambia should include traditional medicine in its healthcare system poses a false dichotomy. Traditional medicine already constitutes healthcare for the majority of Zambians, operating alongside biomedical services through patient choices and community practices (Ngulube et al., 2021; Peltzer & Pengpid, 2019). The policy question is not whether to include traditional medicine but how to engage constructively with existing reality.

Zambia faces a choice between two futures (Bodeker & Kronenberg, 2002; WHO, 2013). In the first, continued exclusion maintains regulatory vacuum, consumer vulnerability, missed opportunities for health improvement, and perpetuation of colonial attitudes delegitimizing indigenous knowledge (Sugishita, 2009; Zambia Medicines Regulatory Authority, 2022). In the second, thoughtful integration establishes regulatory protection, quality assurance, research advancement, and collaborative practice while respecting traditional medicine's distinctive contributions and cultural foundations (Kasilo et al., 2019; WHO, 2013).

Lungu et al. (2026) would frame this choice as a decision between perpetuating the "ceremonial compliance" paradigm, where policy acknowledges traditional medicine's importance but fails to translate this acknowledgment into meaningful institutional change, and moving toward genuine integration that addresses the root causes of institutional failure. The challenge of integration is not merely technical but deeply political and institutional, requiring sustained commitment to address the path dependencies, vested interests, and structural biases that have historically excluded traditional medicine from formal recognition.

Zambia's traditional medicine heritage represents not an obstacle to modern healthcare but a resource for its enhancement (Chinsebu, 2016; WHO, 2013). The knowledge accumulated over centuries of observation and practice, the healers embedded within communities providing accessible care, the pharmacopoeias developed through empirical testing, these constitute assets for achieving universal health coverage rather than liabilities to be suppressed (Leonard, 2003; Ministry of Health Zambia, 2021). Recognizing this heritage within official healthcare systems, while establishing appropriate regulatory safeguards, would honour Zambia's cultural foundations while advancing population health (African Union, 2015; United Nations, 2007).

Zambia stands at a crossroads where policy must align with reality, where recognition must replace denial, where integration must supersede exclusion (Kasilo et al., 2019; WHO, 2013). The path forward, though challenging, leads toward a healthcare system truly serving all Zambians, drawing on both allopathic and traditional resources, respecting both scientific and indigenous knowledge, and ultimately fulfilling the right to health for every citizen regardless of geography, economy, or culture. As Lungu et al. (2026) argue, moving beyond the "ceremonial compliance" paradigm requires not merely legislative reform but a fundamental reorientation of institutional culture, sustained political commitment, and the creation of accountability mechanisms that ensure progressive policies translate into meaningful improvements in people's lives.

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