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The incorporation of African traditional health practitioners into the South African health care system

First submission: August 2005

The need to progress from parallel or merely tolerant health care systems towards integrated systems in countries with both traditional and western health care systems has been acknowledged globally. Underlying this acknowledgement is the need to respond to the expressed health care needs of communities. This article offers a critical reflection on national and international policies as they relate to African traditional medicine and healing in the context of the South African health care system. Key policy documents and laws pertaining to traditional healing are addressed so as to elucidate the current legal and social status of African traditional medicine and health practitioners in South Africa. The Traditional Health Practitioners Act of 2004 is a breakthrough in attempts to legitimise and professionalise traditional practitioners, but this article also identifies aspects of the Act that may evoke conflict.

Oogqirha bemveli baseAfrika kunyamekelo-mpilo eMzantsi Afrika: inkqubo neembonakalo zowiso-mthetho

Imfuneko yokusuka kwiinkqubo ezingaqukwanga kuyiwe kwiinkqubo ezidityaniswe nezinye iinkqubo zeenkonzo zempilo kumazwe asebenzisa unyango lwamachiza nolwasentshona olwamkelwa kwihlabathi liphela. Ngokolu lwazi kubalulekile ukulandela iinkqubo zeenkonzo zempilo ezinika iimfuno zoluntu. Eli phepha libonisa iipolisi zikaZwelonke nezehlabathi malunga nobume bezempilo xa kuthelakiswa imeko yonyango ngamachiza kunye neyasentshona kuMzantsi Afrika. Amaxwebhu aphambili epolisi nemithetho emalunga nenkqubo yonyango ngamachiza iyaxoxwa ukunyusa umgangatho wolwamkelo lomthetho nentlalo kweli xesha langoku eMzantsi Afrika. Umthetho weenkonzo zamachiza ka 2004 unika amagunya asemthethweni iinkonzo zamachiza. Eli phepha liyichaza phandle imiba yoMthetho enokubangela impixano.

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Globally, South Africa has reportedly been the hardest hit by the AIDS epidemic (Global AIDS Foundation 2004).¹ The current impact of HIV/AIDS on all sectors of South Africa remains strongly adverse, and future projections of the effects of the unchecked disease are gloomy. Sustained high HIV infection rates at the national and provincial levels have inspired a renewed urgency in preventing new infections, as well as addressing the health care needs of those already living with HIV/AIDS — hence the development and implementation of an expanded national programme for comprehensive HIV/AIDS prevention, treatment and care, which has been endorsed and supported by the international community. The rapid spread of HIV/AIDS, combined with the limitations and challenges of western health care in providing appropriate treatment for people living with HIV/AIDS, has prompted a turn to traditional health practitioners in the hope of finding a cure. However, the necessary concrete measures for deriving benefit from the large pool of knowledge of traditional practitioners in treating and curing various ailments including HIV-related illnesses are sadly lacking.

Policies and laws that relate to the practice of traditional healing have evolved over time. After Europeans settled in Africa, bringing with them influences of the missionaries, and also repressive political ideologies, the colonial administrators outlawed African medical practices by condemning them as “heathen”, “primitive”, “barbaric” and “uncivilised” (Pretorius 2004: 529). Although traditional health practitioners were permitted to practise their “trade” undeterred, the 1974 Health Act forbade practitioners not registered with the then South African Medical and Dental Council (amended in 1982 to those not registered with the South African Associated Health Services Professions Board) to practise medicine (Freeman 1992, Freeman & Motsei 1992). Traditional health practitioners only gained legal recognition in South Africa as late as February 2005, in terms of the Traditional Health Practitioners Act of 2004 (RSA 2005).

- 1 Special thanks to Profs H C J van Rensburg (Centre for Health Systems Research & Development, University of the Free State), C Ngwena (Faculty of Law, University of the Free State), E Pretorius (Faculty of the Humanities, University of the Free State) and Ms Mtyeku (Eastern Cape traditional health practitioners co-ordinator, Eastern Cape Department of Health, Buffalo City Local Municipality).

This article reflects on national and international policy frameworks in respect of traditional healing, with a view to contextualising the current status and role of traditional health practitioners, especially in terms of national and global responses to the HIV/AIDS epidemic. Furthermore, it highlights the challenges involved in strategically positioning the traditional healing sector in mainstream health care, in view of the legitimisation and institutionalisation of this sector.

1. Legalising and legitimising traditional healing in health care systems

The World Health Organization (WHO) defines four types of health systems in terms of the relationships between western and traditional medicine, particularly in respect of the status and position of traditional healing systems in societies. An exclusive (monopolistic) system recognises only the practice of allopathic medicine, and outlaws, or severely restricts, all other forms of healing. In countries with a tolerant system, national health care is based entirely on allopathic medicine, but certain practices of traditional healing are tolerated by law. An inclusive system recognises traditional healing, but has not yet integrated it into all aspects of health care (delivery, training, education, and regulation) (WHO 2002: 8-9). Such a system may also be referred to as parallel, since more than one system of health care co-exists within the country (Pretorius 2004). In an inclusive system, traditional healing may not be available at all health care levels; health insurance may not cover treatment with traditional medicine; official education and training in traditional healing may not be available at the tertiary level, and the regulation of the providers and products of traditional medicine may be lacking or only partial. This system exists in both developed and developing countries such as Zimbabwe, Guinea, Nigeria, Mali, Ghana, India, Sri Lanka, Indonesia, Japan, Austria and South Africa (Pretorius 2004: 544, WHO 2002: 9).

There is increasing global awareness of the need to move away from exclusive, tolerant and inclusive systems towards integrated systems characterised by the amalgamation of all health care systems available in a society in order to optimise health care for all. The WHO has played a significant role in initiating an unprecedented global up-

surge of interest in traditional medical systems, and in driving their incorporation into national health care systems. Traditional healing systems serve a significant proportion of Africans and should thus be recognised as official health care systems. The WHO (2002) refers to an integrative system, whereby traditional healing is officially recognised and incorporated into all areas of health care provision. This entails including traditional medicine in the country's national drug policy; registering and regulating the providers and products of traditional healing; providing traditional healing at both public and private hospitals and clinics; funding treatment with traditional medicine under health insurance; undertaking relevant research in traditional healing, and making training in traditional healing available. Several developing countries in Africa, Asia and Latin America have attempted to unite traditional and western health care systems into a single national health care network. However, to date, only China, the Democratic People's Republic of Korea, the Republic of Korea and Vietnam have arguably attained integrated health care systems (WHO 2002).

2. Traditional healing globally: policies and proclamations

National legal and policy frameworks for the inclusion of traditional healing in the mainstream of health care in South Africa are guided by international standards and trends, which aim ultimately at attaining an integrated system of health care as defined by the WHO (WHO 2003). Whether or not this is achievable, and whether it would be to the benefit or the detriment of the traditional healing system, remain debatable questions in the light of the differences between the paradigms and ideologies of the the traditional and the western health care systems.

One view is that a parallel system is the appropriate choice, with the two health care systems functioning independently, in mutual recognition and respect. This view is based on a fear that one system might be compromised in the process of integration (WHO Kobe Centre 2002). Thus fear of traditional health practitioners being suppressed in the process of integration is held, too, by traditional health practitioners themselves (Summerton 2005). Be that as it may, at least partial integration of traditional health practitioners into national health programmes and systems is necessary in order to provide comprehensive and holistic

health care to a population that utilises both western and traditional healing systems. Inclusive or parallel health systems do not cater sufficiently for clients whose health care needs are pluralistic, as the health services available to this segment of the population are largely fragmented. This is currently the case in South Africa, although efforts to attain partial integration are under way. It is of the utmost importance to engage both traditional and western health practitioners in decisions on the optimal extent and nature of integration, in order to ensure mutual understanding and co-operation. Thus, an integrated health care system, as referred to in this article, should be understood as enjoying integration at a level that enhances health care for clients who consult both traditional and western health practitioners, while protecting either system from being compromised.

It is surprising that traditional health practitioners in South Africa only began to gain recognition in the 1990s, since the inclusion of traditional health practitioners in formal health care systems was endorsed by the international community in the late 1970s.² In 1977, the thirtieth World Health Assembly of the WHO passed a resolution promoting the development of training and research in traditional systems of medicine (Pretorius 2003: 545). Additional resolutions supporting the utilisation of indigenous practitioners in government-sponsored health care systems were passed in 1978 at the International Conference on Primary Health Care held in Alma-Ata. A goal was set 28 years ago at this conference: to provide primary health care for all by 2000. The Alma-Ata Declaration highlighted the mobilisation of traditional medicine as an important step in ensuring that health care for all could be a reality (Seneviratne 2000, WHO 1978). This did not imply that the integration of traditional medicine into a national health care system would be problem-free. One obstacle relates to the difficulty in evaluating the efficacy of traditional medicine, and safeguarding and

2 In 1974, the WHO Regional Committee for Africa decided that the topic for the technical discussions at its 26th session would be 'Traditional medicine and its role in the development of health services in Africa'. This was followed in 1977 by the adoption of a resolution on the promotion of training and research relating to traditional medicine (Pretorius 2003: 545). A year later, at Alma-Ata, it was declared that African traditional healers should be part of the primary health care team (WHO 1978: 2).

promoting the quality of care. Another obstacle relates to attaining equitable distribution of power among different medical systems' providers, in order to control health care systems and medical resources (Chi 1994: 310). Nonetheless, in the quest to provide health care for all, it is imperative that these and other obstacles do not prevent the inclusion of traditional health practitioners in national health care systems.

The WHO has played a pivotal role in fostering a global interest in traditional medical systems and promoting the inclusion of traditional health practitioners in national and donor-specific health programmes. After the Alma-Ata Declaration, other international donor organisations such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) followed suit by adopting similar policies indicating acceptance of the utilisation of traditional practitioners in health care programmes financed by them (Pillsbury 1982: 1830). The WHO then spearheaded certain initiatives aimed at improving the status of systems of traditional healing. The aim of these initiatives was to assist countries to formulate policies on traditional healing; study the usefulness of traditional medicines; upgrade the knowledge of practitioners, and educate the public about proven traditional health practices (Pretorius 2004: 545). Many other organisations and government agencies have also called for closer collaboration between traditional and western medicine over the past decade. The African Union, for example, declared the period 2001-2010 the Decade of African Traditional Medicine, while the New Partnership for Africa's Development (NEPAD) identified traditional medicine as an important strategy in its plan (AU 2001).³ 31 August has been declared African Traditional Medicine Day, held in Ethiopia (WHO 2004). Despite these declarations, however, the legislation and official recognition of traditional health practitioners has been characteristically slow in the legislatures of African countries (Gbodossou *et al* [2003]). In defence of the South African Government, Ndaki (2004) points to two factors which have slowed down the process of drafting legislation for traditional health practitioners: the lack of interest in structuring the sector prior to 1994, and the daunting size of the traditional healing profession.

3 NEPAD proposes, as one of its human resource development objectives for health: "to encourage cooperation between doctors and traditional practitioners" (AU 2001: 31).

3. Traditional healing nationally: South African policies and laws

In many instances, the relationship between traditional and western health practitioners is one of co-existence rather than collaboration. South Africa is a case in point. Government has accepted the existence and institutions of traditional health practitioners. However, this acceptance manifests itself in allowing traditional health practitioners to co-exist in a pluralist health care system rather than in incorporating traditional practitioners in the official national health care system (Pillsbury 1982: 1828). Government policy on the transformation of the National Health Service (the 1997 White Paper for the Transformation of the Health System in South Africa) states:

[T]raditional practitioners and traditional birth attendants should not, at this stage, form part of the public health service, but should be recognised as an important component of the broader primary health team (Ministry of Health 1997: 34).⁴

At the same time, there has been a growing awareness of the urgent need to integrate traditional healing into the national health care system, rather than permitting the two systems to co-exist.

Before the election of the democratic government in 1994, the African National Congress (ANC) proposed including traditional health practitioners as an integral and recognised part of health care in South Africa. The ANC claimed that clients would thereby be granted the right to consult a provider of their choice for their health care, and that legislation would be changed to facilitate controlled use of traditional practitioners (ANC 1994: 33-4, Peltzer 2000: 88). The 1997 White Paper for the Transformation of the Health System in South Africa states:

[T]he regulation and control of traditional healers should be investigated for their legal empowerment. Criteria outlining standards of practice and an ethical code of conduct for traditional practitioners should be developed to facilitate their registration (Ministry of Health 1997: 34).⁵

There is a palpable shift towards closer collaboration between traditional and western health practitioners. The move is based on two principal tenets, namely that people have the right of access to traditional

4 Chapter 4, paragraph 4.1.1 (a) vii

5 Chapter 4, paragraph 4.1.1 (a) vii

health practitioners because of their cultural heritage and belief system, and that there are numerous advantages to co-operation and liaison between western and traditional health practitioners. The government's stance on recognising traditional practitioners in the national health care system is evident in the policy objectives and principles upon which a unified health care system in South Africa is to be based, as stipulated in the 1997 White Paper. Furthermore, the Constitution provides a framework for accommodating the traditional health care system in the Bill of Rights (RSA 1996).⁶ In the first place, it is a basic human right to be able to consult practitioners of one's choice to meet one's health care needs. Secondly, traditional health practitioners have the right to choose and practise their trade, occupation or profession freely, provided that they are subject to legal regulation (Pretorius 2004). The Constitution also guarantees equality by protecting all citizens from unfair discrimination on the grounds of ethnic or social origin, belief or culture (RSA 1996).⁷ Therefore, according to the Constitution, health care planning and provisioning in South Africa should address the health care needs of all citizens, including those who have faith in African traditional healing.

The shift in legislation has recently been marked by the passing of the Traditional Health Practitioners Act (RSA 2005). This Act was initiated in an attempt to recognise and regulate traditional health practices in South Africa, and is the product of a lengthy consultative process. This process and the Act itself will be discussed below.

6 Chapter 2 of the Bill of Rights states:

15 (1) Everyone has the right to freedom of conscience, religion, thought, belief and opinion.

27 (1) a. Everyone has the right to have access to health care services, including reproductive health care.

31 (1) Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community:

a. to enjoy their culture, practise their religion and use their language; and

b. to inform, join and maintain cultural, religious and linguistic associations and other organs of civil society.

7 Chapter two of the Bill of Rights states:

9 (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

4. Taking the lead: a WHO policy framework

In view of the fact that many African people utilise the services of traditional health practitioners, it is surprising that traditional medicine still remains illegal in many African countries. What is more, no African country exemplifies an integrated health care system (Gbodossou *et al* [2003]). In 2000, the WHO Regional Committee for Africa adopted a resolution which recognised the value and potential of traditional medicine for the achievement of health for all in the region. The resolution recommended the acceleration of the development of locally-produced traditional medicines. It further urged member states to translate the proposed strategy into realistic national policies on traditional medicine, supported by appropriate legislation and plans for specific interventions at both the national and the local level, and to collaborate actively with all partners in implementation and evaluation (WHO 2000). The WHO's most recent global policy framework for traditional medicine systems is a five-year strategic plan which highlights five key priorities, namely:

- promoting policy, safety, access and rational use relating to traditional medicines;
- prioritising the integration of traditional medicine into official health care systems;
- a global information resource on the integration of medicines (knowledge base);
- formulating guidelines on regulatory and quality assurance standards for traditional healing; and
- building an evidence base for tackling priority diseases such as HIV/AIDS, using comparative research (Bodeker [*s a*], WHO 2002: 43).

The WHO's Traditional Medicine Strategy for 2002-2005 (WHO 2002) has outlined four key objectives to promote the inclusion of traditional medicine in plans for improving health. Table 1 outlines each objective, aligned with components and expected outcomes.

International policies are important in that many financial and technical resources are provided by donor organisations to enable developing countries to extend their national health care services. For most developing countries the existence of supportive international policy is a major facilitator of progress. However, the important role played by international policy in facilitating the adoption of a particular strategy

Table 1: The WHO Traditional Medicine Strategy and Plan of Action 2000-2005 for promoting the inclusion of traditional medicine (WHO 2002)

Objective	Components	Expected outcomes
<i>Policy</i> Integrate traditional medicine (TM) ⁸ into national health care systems, as appropriate, by developing and implementing national TM policies and programmes	<i>Recognition of TM</i> Help countries to develop national policies and programmes on TM	Increased government support for TM, through comprehensive national policies on it Relevant TM integrated into national health care services
	<i>Protection and preservation of indigenous TM knowledge relating to health</i> Help countries to develop strategies to protect their indigenous TM knowledge	Increased recording and preservation of indigenous knowledge of TM, including development of digital TM libraries
<i>Safety, efficacy and quality</i> Promote the safety, efficacy and quality of TM by expanding the knowledge-base on it, and by providing guidance on regulatory and quality assurance standards	<i>Evidence base for TM</i> Increase access to and extent of knowledge of the safety, efficacy and quality of TM, with an emphasis on priority health problems such as malaria and HIV/AIDS	Increased access to and extent of knowledge of accurate information Technical reviews of research on use of TM for prevention, treatment and management of common diseases and conditions Selective support for clinical research into use of TM for priority health problems such as malaria and HIV/AIDS, as well as common diseases
	<i>Regulation of herbal medicines</i> Support countries in establishing effective regulatory systems for registration and quality assurance of herbal medicines	National regulation of herbal medicines, including registration, establishment and implementation Safety monitoring of herbal medicines and other TM products and therapies
	<i>Guidelines on safety, efficacy and quality</i> Develop and support implementation of technical guidelines for ensuring the safety, efficacy and quality control of herbal medicines and other TM products and therapies	Technical guidelines and methodology for evaluating safety, efficacy and quality of TM Criteria for evidence-based data on safety, efficacy and quality of TM therapies

8 The WHO (2002) makes use of the comprehensive term “traditional medicine” (TM) to refer to traditional medicine systems and the various forms of indigenous medicine practised in Africa, Latin America, South-East Asia, and the Western Pacific.

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Table 1: The WHO Traditional Medicine Strategy and Plan of Action 2000-2005 for promoting the inclusion of traditional medicine (WHO 2002) (continued)

Objective	Components	Expected outcomes
<i>Access</i> Increase the availability and affordability of TM, as appropriate, ⁹ with an emphasis on access for poor populations	<i>Recognition of role of TM practitioners in health care</i> Promote recognition of role of TM practitioners in health care by encouraging interaction and dialogue between them and western practitioners	Criteria and indicators, where possible, to measure cost-effectiveness and equitable access to TM Increased provision of appropriate TM through national health services Increased number of national organisations of TM providers
	<i>Protection of medicinal plants</i> Promote sustainable use and cultivation of medicinal plants	Guidelines for good agriculture practice in relation to medicinal plants Sustainable use of medicinal plant resources
<i>Rational use</i> Promote therapeutically sound use of appropriate TM by providers and consumers	<i>Proper use of TM by providers</i> Increase capacity of TM providers to make proper use of products and therapies	Basic training in commonly used TM therapies for western practitioners Basic training in primary health care for TM practitioners
	<i>Proper use of TM by consumers</i> Increase capacity of consumers to make informed decisions about use of TM products and therapies	Reliable information for consumers on proper use of TM therapies Improved communication between western practitioners and their patients concerning use of TM

does not guarantee that this will actually happen (Pillsbury 1982). As it is, very few countries have developed a national traditional medicine policy. Such policies are imperative for defining the role of traditional medicine in national health care systems, as well as its potential contribution to health sector reform. National traditional medicine policies also play an important role in ensuring that the necessary regu-

9 “Appropriate” refers to TM health care that does not cost more, and which is no less safe and efficacious, than recommended western health care for the disease or health problem (WHO 2002: 43).

latory and legal mechanisms are in place for promoting and maintaining good practice; that access to traditional medicine is equitable, and that the authenticity, safety and efficacy of the traditional medicine therapies used are assured. In the absence of national traditional medicine policies, traditional medicine is practised without regulation and, thus, without patient/consumer protection (WHO 2002: 20).

5. Traditional health practitioners and the battle against HIV/AIDS in South Africa

Considering that many South Africans utilise traditional health practitioners, this form of care must be factored into the national health care system. Efforts are currently under way to include traditional medicine in the realm of health care by means of legislation, albeit gradually. Integrating traditional medicines into western health care systems urgently requires appropriate policies for integration. Although no national integration policy has not come into play as yet, traditional medicine has been factored into policies aimed at combating some priority diseases such as TB, STIs and HIV/AIDS. Two policy frameworks, namely the STD/HIV/AIDS Strategic Plan for South Africa 2000-2005 (Strategic Plan) and the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 2003 (Operational Plan), form the foundation of South Africa's response to the HIV/AIDS epidemic (Dept of Health 2000, 2003). Both documents refer to traditional health practitioners as partners in the national response to the HIV/AIDS pandemic.

5.1 The Operational Plan and traditional healing

Recognition of the significant role of traditional health practitioners in the health care sector at large and, more specifically, in the implementation of the Operational Plan, is based on two premises. It is estimated that 70-85% of South Africans consult traditional health practitioners, and up to 97% of people living with HIV/AIDS first use complementary or traditional medicines (Dept of Health 2003: 88, Matomela 2004). For these reasons, the Department of Health recognises traditional health practitioners as essential in strengthening the implementation of the Operational Plan. It predicts that traditional health practitioners will fulfil the following benevolent functions in enhancing the implementa-

tion of the antiretroviral therapy component of the plan (Dept of Health 2003):

- mobilising communities;
- drawing patients into testing programmes;
- promoting adherence to drug regimens;
- monitoring side effects;
- sharing expertise in patient communication with biomedical practitioners, and
- continuing to enhance patients' well-being and quality of life.

The anticipated contribution of traditional health practitioners in the implementation of the Operational Plan should not be that of traditional practitioners taking on the role of assistants to western health personnel, or community health workers. There should be a move towards utilising the rich knowledge and skills of traditional health practitioners in treating and caring for people living with HIV/AIDS in order to optimise the effectiveness of the Operational Plan. It is vital that traditional health practitioners be utilised with a view to providing treatment, care and support to all South Africans, including those living with HIV/AIDS who opt for traditional healing and medicine. The findings of a study conducted in the Eastern Cape reveal that traditional and western health practitioners hold contrasting views on the role of traditional practitioners in the treatment and care of people living with HIV/AIDS. Western health practitioners tend to perceive traditional health practitioners as providing secondary health care to supplement and support western health care services, whereas traditional practitioners regard their role in the battle against HIV/AIDS as equally important as, and sometimes even more important than that of western medicine (Summerton 2005: 149-53).

The Operational Plan has taken cognisance of the need to promote collaboration between traditional and western health practitioners in the successful implementation of the comprehensive programme for treatment and care. To this end, it has highlighted five fundamental steps which, in essence, entail developing protocols and guidelines for the nature of the collaboration between the two cadres of practitioners, as well as addressing the needs of people living with HIV/AIDS and South Africans in general. This entails, *inter alia*, defining the role of tradi-

tional health practitioners within the programme; defining the level of interest of traditional health practitioners in participating in the programme; assessing community infrastructure and the special skills offered by traditional health practitioners; assessing the expectations of traditional and western health practitioners in relation to their collaboration; formalising quality assurance methods for traditional medicine in terms of the programme, and providing bi-directional training to educate traditional health practitioners about antiretroviral drugs (ARVs) and HIV care and, on the other hand, to educate western health practitioners about the role and methods of traditional practice (particularly in terms of their communication skills with patients) (Dept of Health 2003: 87-92).

Discussions about initiating collaboration between traditional and western health practitioners in provincial HIV/AIDS programmes have been and are still taking place. Proclamations to this effect, such as the Operational Plan, have reached the ears of many traditional health practitioners, who have generally reacted with enthusiasm. However, progress in effecting these proclamations has been less than satisfactory for traditional health practitioners. The slow pace at which plans to include them in the mainstream of HIV/AIDS programmes, and in South African health care *per se*, has caused them to question the government's commitment to their sector, and has simultaneously evoked a sense of distrust in the intentions of the western health care fraternity. Despondency among traditional practitioners could seriously hamper forthcoming endeavours aimed at collaboration between traditional and western health practitioners. Traditional health practitioners are an essential part of the continuum of care, and they are generally enthusiastic about contributing to the well-being of South Africans, and more especially about efforts to expand treatment and care for people living with HIV/AIDS. However, fundamental obstacles on the side of both traditional and western health practitioners stand in the way of incorporating traditional practitioners into mainstream health care, particularly in national HIV/AIDS programmes. One such hindrance of note is the absence of a unified traditional healing system in South Africa (Summerton 2005: 34).

Traditional health practitioner organisations are viewed as an important potential catalyst for collaboration between traditional and western health practitioners since they can co-ordinate the participation of tra-

ditional health practitioners in health care issues and programmes. According to the Department of Health (2003), several such organisations have held discussions with the government about various health care programmes to which traditional health practitioners have already begun to contribute. However, the heterogeneity and lack of organisation among traditional health practitioners make it difficult for governments to collaborate with them, thus retarding quality enhancement in traditional health care (World Bank 2006).

The Traditional Health Practitioners Act may represent a breakthrough in the South African government's efforts to regulate and legislate traditional healing, as well as to integrate it into the national health care system. The Act emanates from a consultative process initiated by the government in 1995. Provincial governments were required to conduct public hearings on the viability of traditional health care in order to obtain comments on three pertinent issues, namely a statutory council for traditional health practitioners; the issuing of medical certificates by such practitioners, and medical aid coverage for traditional health care (NPPHCN 1997). The outcome of these hearings was a report presented by the National Council of Provinces (NCOP) to the National Assembly Portfolio Committee on Health in 1997. It recommended that a statutory council for traditional health practitioners be instituted.¹⁰ In 1998 public hearings for national stakeholders were conducted by the Portfolio Committee on Health with a view to making recommendations to Parliament on legislation. National stakeholders who took part in this process included the National Health Committee of the ANC, several traditional health practitioner associations, the Inkatha Freedom Party (IFP), the National Education, Health and Allied Workers Union (NEHAWU), the National Progressive Primary Health Care Network (NPPHCN) and Doctors for Life. The recommendations included the legal recognition of traditional health practitioners; the establishment of a forum to ensure the inclusion of all relevant parties; and the establishment of an Interim Council for traditional health practitioners. Also included were the composition and functions of the Interim Council and the categories of traditional health practitioners that would fall under its jurisdiction (Pretorius 1999: 254, 2004: 551-2).

10 Reports were received from seven of the nine provinces. The Northern Cape and the North-West Province did not send submissions.

6. The Traditional Health Practitioners Act of South Africa

Antiquated laws, which are the legacy of European colonisation, technically, still outlaw the practice of traditional healing in some African countries. However, these laws are often overlooked, so that traditional healing practices are accepted and tolerated throughout the continent. In South Africa traditional health practitioners were recently (February 2005) officially recognised as health care personnel. Prior to the Traditional Health Practitioners Act, the Witchcraft Suppression Act of 1957 was the only legislation which related to traditional health practitioners, albeit indirectly. That Act sought to outlaw the practice of traditional healing (Gbodossou *et al* [2003], NPPHCN 1997: 1). The Traditional Health Practitioners Act may be documented as the most significant breakthrough in attempts to legalise traditional healing in South Africa. Disunity among traditional health practitioners has sabotaged previous attempts to unite the various associations into a single governing body in order to regulate the training, registration and practices of traditional health practitioners, which is a prerequisite for a legitimate profession. The Act aims to provide for the following:

- the establishment of the Interim Traditional Health Practitioners' Council of the Republic of South Africa;
- a regulatory framework to ensure the efficacy, safety and quality of traditional health care services;
- control over the registration, training and practice of traditional health practitioners, and
- matters incidental thereto.

The Interim Traditional Health Practitioners' Council of South Africa will consist of a maximum of 22 members appointed by the Minister of Health. It is intended to play a regulatory role through the implementation of the Traditional Health Practitioners Act. The chairperson will be a registered health practitioner appointed by the Minister of Health, while its vice-chairperson will be elected by its members. The nine provincial representatives will be traditional health practitioners from each of the nine provinces who have been actively practising as such for a minimum of five years (RSA 2005: 12). The Interim Council will exist for a period of three years during which it will make propo-

sals for the character and composition of a full-fledged permanent council as well as for supporting legislature (Pretorius 1999: 254).

The Traditional Health Practitioners Act is committed to enhancing the quality and credibility of the traditional healing system in South Africa by means of the execution of numerous objectives and functions, some of which are in line with the international resolutions and frameworks promoting the development of training and research in traditional systems of medicine, such as the Alma-Ata Declaration and the WHO Traditional Medicine Strategy and Plan of Action 2000-2005 (WHO 1978, WHO 2002). Some of the proposed functions of the Interim Traditional Health Practitioners' Council are (RSA 2005: 8):

- (a) to assist in the promotion of the health of the population of the Republic of South Africa;
- (g) to promote and develop traditional health practice by encouraging research, education and training in traditional health practice;
- (h) to promote liaison in the field of training in traditional health practice in the Republic of South Africa, and to promote the standards of such training, and
- (j) to promote traditional health practice which complies with universally accepted health care norms and values, with a view to improving the quality of life of patients and the general public.

6.1 Grey areas of the Traditional Health Practitioners Act

A study in the Eastern Cape has shown that legislation to regulate the practice of traditional healing in South Africa is welcomed by many traditional and western health practitioners. However, such support remains conditional. Traditional health practitioners view the Act as progressive only if it is designed to promote and support traditional practitioners rather than to restrict and oppress them (Summerton 2005: 124-6). The findings point towards insufficient knowledge and comprehension of the content and purpose of the Act among traditional health practitioners in particular. It was exposed to comments and amendments prior to its enactment, but it would appear that it will be subjected to further criticism by the very health practitioners whom it is intended to legalise and legitimise, once the implications of its content are fully known to them. One potential area of dispute is the inconsistency between one

of the stipulations of the Act and the role that traditional health practitioners themselves believe that they play in combatting illnesses. According to the Act, traditional health practitioners not registered as such will not be permitted to diagnose, treat, or prescribe any form of treatment for prescribed terminal illnesses, such as cancer and HIV/AIDS. Anyone found guilty will face a fine or imprisonment of up to twelve months (RSA 2005,¹¹ Ndaki 2004, Matomela 2004).

At present, very few traditional health practitioners are registered with the national Traditional Health Practitioners' Association. In October 2004, 584 traditional health practitioners (namely diviners, herbalists, spiritual healers, traditional birth attendants and traditional surgeons) in the Eastern Cape were registered with the Association. At the same time, of all practising traditional health Practitioners in the Buffalo City Local Municipality, only 20 were registered with the Association. Although the registration process is ongoing, its pace is rather slow, especially in Buffalo City, and thus is of concern in the light of the large number of practising practitioners.¹² Various reasons, some of which are valid, are given by traditional health practitioners for their non-registration and reluctance to register with the national Association. These point mainly towards a lack of knowledge and understanding about the Association, especially its main aim, as well as towards scept-

11 Chapter 5 — Offences — states:

49 (1) A person who is not registered as a traditional health practitioner or as a student in terms of this Act is guilty of an offence if he or she —

(g) i. diagnoses, treats or offers to treat, or prescribes treatment or any cure for cancer, HIV and AIDS or any other prescribed terminal disease;
ii. holds himself or herself out to be able to treat or cure cancer, HIV and AIDS or any other prescribed terminal disease or to prescribe treatment therefore; or
iii. holds out that any article, compound, traditional medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer, HIV and AIDS or any other prescribed terminal disease.

(4) A person found guilty of an offence in terms of this section is liable on conviction to a fine or to imprisonment for a period not exceeding 12 months or to both a fine and such imprisonment.

12 It is not uncommon to find an average of three traditional health practitioners within a 2km radius, or more than one residing in a single household, as observed during the fieldwork of the research undertaken (Summerton 2005: 85).

ticism about the benefits and implications of membership, based on previous experiences with similar associations.

Since only a small proportion of practising traditional practitioners are registered with the Association, section 49 of the Act thus directly contradicts the views held by many traditional health practitioners pertaining to their role in combatting diseases such as cancer and HIV/AIDS. The fundamental discrepancies between perceptions and the proposed legislation is best expressed in the statement of the national organiser of the Congress of Traditional Leaders in South Africa (Contralesa) in response to the approval of what was then the Traditional Health Practitioners' Bill by Parliament:

We are excited about the latest developments, but western medical practitioners should not say we must not claim to have a cure for HIV/AIDS. Through our own research, we can find a cure for HIV/AIDS, and let's hope that Government involvement will not westernise our profession (Pelesa 2004: 1).

This cautious attitude of traditional health practitioners towards legislation is substantiated by research findings (Summerton 2005). The discrepancy between the Act and traditional health practitioners' expectations of it reveals the absence of a fully consultative process in the development of the Bill. This has serious implications for the implementation of the Act, since such implementation requires the support of the primary stakeholders and role-players, namely traditional health practitioners. Support will be determined to a large extent by the degree to which the Act addresses the perceived needs of traditional health practitioners *vis-à-vis* the perceived needs of western health practitioners and government. In other words, if the Act is perceived as oppressing traditional health practitioners, support for it will not be forthcoming from their side.

An additional concern relates to the mandate of the Interim Traditional Health Practitioners' Council to enforce the minimum requirements and standards of practice required for the recognition and licensing of traditional health practitioners. The Act, however, fails to delineate a clear set of criteria for granting a licence (such as what the minimum requirements are, or what training and practice standards need to be met), or the mechanisms for monitoring traditional health practitioners. At present, an open-door licensing system has been adopted, where recog-

nised traditional health practitioners use their discretion in determining the minimum requirements for qualification of a traditional practitioner and peers have to attest to the capacity of practitioners on the basis of empirical evidence of performance. This mechanism of determining qualification and issuing of licences is potentially very subjective and biased (Cartillier 2004, Ndaki 2004, Pelesa 2004, RSA 2005). This type of licensing system was witnessed in one sub-district of the Eastern Cape where the provincial and Local Service Area (LSA) co-ordinators of traditional health practitioners were responsible for evaluating their authenticity before issuing licences. The two co-ordinators relied solely on their discretion without any standardised guidelines or formal criteria for assessing the legitimacy of traditional practitioners. Nor were they well versed in all the categories of traditional healing, namely herbalism, divination, spiritual healing, etc. Accordingly, they were not fully competent to assess the legitimacy of all the categories of traditional healing, which cast doubt on the quality of licensed traditional health practitioners in the sub-district (Summerton 2005: 120-1).

The two aspects of the legislation which have sparked the most controversy are the issuing of medical certificates by traditional health practitioners and the recognition of traditional health practitioners by medical aid schemes. Licensed traditional practitioners will be issued with registration numbers as proof of registration. Employers may check these before accepting medical certificates. In fact, traditional health practitioners, licensed or not, have been issuing medical certificates for some time. In this regard, the Act endeavours to weed out the less *bona fide* practitioners who issue medical certificates. As to the second controversy, traditional health practitioners will also be recognised by medical aid schemes, although this has met with wary reactions from schemes which anticipate an escalation in premiums and related costs. However, the benefits to patients are invaluable since they will now finally have a choice of which health care provider to consult, and will be protected by law against charlatans (Ndaki 2004, RSA 2005). The challenge is for medical aid schemes to devise mechanisms that will contain the costs associated with premiums, and to ensure that all clients receive equal medical cover irrespective of their choice of health care provider.

7. Tapping into a reservoir of indigenous resources (traditional medicines)

Traditional health practitioners are often consulted solely for HIV/AIDS prevention. It is equally important to explore the value of traditional healing in HIV/AIDS treatment and care, with a view to complementing western interventions. According to Gbodossou *et al* [2003], scientific research into the efficacy of African traditional medicines is imperative. Such research — with the appropriate protection of intellectual property rights — will not only provide answers to the age-old question of whether traditional medicine actually works, but it will also contribute significantly to eliminating the fraudulent “canes” that are inflicted on the public under the guise of traditional healing. Applying western scientific research principles to African traditional healing practices such as divination would be a rather complex process. These scientific principles are an appropriate measure for testing the efficacy of herbal medication, for example.

In 2002, the African Advisory Committee for Health Research and Development (AACHRD) passed a resolution calling for enhanced research into traditional medicine in the African region. It also prepared a working document which outlined current research activities (AACHRD 2002). It is extremely disappointing that only 21 of the 46 African countries have research institutions which conduct research into traditional medicine. Equally disappointing is that, with a few exceptions, African universities, medical schools and research institutions have not significantly embraced research into traditional medicine (Gbodossou *et al* [2003]). The South African Government has invested an estimated R6 million in such research, especially for the treatment of HIV/AIDS. Furthermore, the Department of Health has demonstrated its commitment to traditional medicines by developing the National Drug Policy with the aim of investigating their safe, effective use in primary care (Dept of Health *et al* 2003, Pelesa 2004).

A number of South African institutions have developed programmes to promote the use of safe, effective, high quality traditional medicines; ensure the documentation and scientific validation of traditional medicines; contribute to primary health care by providing appropriate information to traditional health practitioners; support industrial deve-

lopment in the traditional medicine sector, and contribute to the training of traditional health practitioners. A partnership between tertiary academic institutions and the Department of Education has the potential to yield valuable results in setting up training programmes and infrastructure for traditional medicine. Institutions which have undertaken research into traditional medicines include certain university departments (the University of Cape Town's Dept of Pharmacology and the University of the Western Cape's School of Pharmacy), government departments (the Department of Health) and research institutions such as the Medical Research Council (MRC) and the Council for Scientific and Industrial Research (CSIR). Nonetheless, these efforts remain minimal and leave ample room for greater involvement on the part of academic and research institutions.

Conducting scientific research into traditional medicines which will meet international standards is a complicated and costly undertaking for traditional health practitioners. Western pharmaceutical companies have to consider the cost/benefit ratio in supporting such research. For instance, inexpensive herbal remedies will cause a drop in the lucrative market for antiretroviral drugs, especially if these remedies are accessible to large markets in developed countries. This dilemma highlights conflicting interests between the objectives of pharmaceutical companies and the need to accord traditional medicines priority and identity in order to facilitate their speedy development. This, in turn, raises questions about the role of pharmaceutical companies as partners or collaborators in investigating the efficacy of traditional medicines (Gbodossou *et al* 2003: 6). Hence, it is important that the government and national academic research institutions adopt a more active and prominent role in the areas of training, research and the clinical study of traditional medicines.

In response to reported concern that the quantity and quality of data on the safety and efficacy of traditional medicine did not meet the criteria to support its use globally (WHO 2002: 21-2), the South African government launched the National Reference Centre for African Traditional Medicines (NRCATM) in August 2003. The NRCATM is an independent unit co-ordinated by the CSIR, the MRC and the Department of Health. Its core function is to research African traditional medicines. It is estimated that one-third of the 700 plant species traded in

South Africa have medicinal properties (Ndaki 2004). The NRCATM is guided by the stringent criteria of the Medicines Control Council (MCC) — whose primary task is to ensure the safety, quality and efficacy of medicines — for the registration of a product or compound. The MCC has established an expert committee on African traditional medicines to advise it on their regulation, registration and control. The MCC's main concerns and challenges relate to herbal medicines that are pre-packed and sold in shops, as well as herbs being sold informally across the country (Dept of Health *et al* 2003: 12). African countries need to grasp fully the urgency of developing adequate and acceptable research methods for evaluating the safety, efficacy and quality of traditional medicines. The WHO (2002: 44) notes that there is a vast amount of published and unpublished data into various African countries, but that it requires further research on safety and efficacy if these remedies are to qualify for registration and official use in health care.

8. Conclusion

A key factor in ensuring the effective delivery of comprehensive HIV/AIDS treatment and care is the capacity of the national health system as a whole. This remains a challenge in developing countries with fragile health systems. Expanding comprehensive treatment and care to people living with HIV/AIDS in South Africa will require a collaborative approach. Community involvement is an essential part of any comprehensive approach to HIV/AIDS. Moreover, the challenges posed by the Operational Plan necessitate community involvement in working towards a more effective health system.

Traditional health practitioners are an integral part of communities and are viewed by community members as important providers of health care. Therefore, their integration into official health care systems is supported and encouraged by the international community. The WHO has played a significant role in developing policy frameworks to guide the integration of traditional healing into health care systems, especially in developing countries. However, the lack of unity among the traditional healing sector in South Africa means that it is unregulated, thus hampering government to achieve collaboration between traditional and western health practitioners. According to Hirst (1999), the regulation of traditional health practitioners will not only serve a prac-

tical purpose but also to some extent short-circuit accusations of witchcraft by harnessing the assistance of registered health practitioners and devising mechanisms to oust charlatans. Generally, traditional health practitioners have signified their support for the inclusion of traditional medicine in health regulation legislation, which entails the medico-legal recognition of the traditional healing sector. The South African government has made its stance on traditional healers clear by including them as allies in combatting epidemics such as TB and HIV/AIDS, as well as granting them legal status. In its campaign to integrate traditional health practitioners into mainstream health care, the government will need to use international policy frameworks as guidelines for developing a national generic integration policy. Despite the breakthroughs in legalising traditional healing, the real challenge lies in effecting change at the grassroots level. Regulating the traditional healing system in its entirety and implementing the relevant legislation demands more than policies and laws on paper; it requires changes in budgetary, personnel and time allocation at all levels of government: national, provincial and local.

Bibliography

AFRICAN NATIONAL CONGRESS (ANC)

1994. *A National Health Plan for South Africa*. Pretoria: African National Congress.

AFRICAN ADVISORY COMMITTEE FOR HEALTH RESEARCH AND DEVELOPMENT (AACHRD)

2002. Enhancing research into traditional medicine in the African region. A working document presented at the 21st session of the AACHRD in Mauritius, 22-25 April.

AFRICAN UNION (AU)

2001. *New Partnership for Africa's Development (NEPAD)*. Abuja: African Union.

BODECKER S A

[s a]. Policy development in traditional and complementary medicine: learning from the developing world's experience. University of Oxford Medical School & Global Initiative for Traditional systems (GIFTS) of Health.
<<http://www.bpfk.gov.my/versibm/pdfworddownload/1>>

CARTILLIER J

2004. Traditional healers to be recognised.
<<http://iafrica.com/news/sa/346119.htm>>

CHI C

1994. Integrating traditional medicine into modern health care systems: examining the role of Chinese medicine in Taiwan. *Social Science & Medicine* 49(3): 307-21.

DEPARTMENT OF HEALTH, RSA

2000. *HIV/AIDS and STD Strategic Plan for South Africa 2000-2005*. Pretoria: Department of Health.

2003. *Operational Plan for comprehensive HIV and AIDS care, management and treatment for South Africa*. Pretoria: Department of Health.

DEPARTMENT OF HEALTH, MEDICAL RESEARCH COUNCIL & CENTRE FOR SCIENTIFIC & INDUSTRIAL RESEARCH

2003. *National reference centre for African traditional medicines: a South African model*. Pretoria: Department of Health.

FREEMAN M

1992. Traditional healer policy — views in a changing South Africa. Centre for Health Policy: University of the Witwatersrand. Paper presented at the Conference on Ethnomedicine and Health in the SADCC Region in Lesotho, 26-30 October, Maseru Sun Cabanas.

FREEMAN M & M MOTSEI

1992. Planning health care in South Africa — is there a role for traditional healers? *Social Science & Medicine* 34(11): 1183-90.

GBODOSSOU E V A, V D FLOYD &
C I KATY

[2003]. AIDS in Africa: scenarios
for the Future. The role of tradi-
tional medicine in Africa's fight
against HIV/AIDS.

<[http://www.prometra.org/
Documents/AIDSinAfrica-
ScenariofortheFuture.pdf](http://www.prometra.org/Documents/AIDSinAfrica-ScenariofortheFuture.pdf)>

GLOBAL AIDS FOUNDATION
2004. South Africa HIV/AIDS
Statistics.

<[http://www.pgaf.org/pressreleases/
south_africa_stats.html](http://www.pgaf.org/pressreleases/south_africa_stats.html)>

HIRST M M

1999. Belief in witchcraft disguise
for abuse.

<[http://www.dispatch.co.za/1999/
07/19/editoria/LET7.htm](http://www.dispatch.co.za/1999/07/19/editoria/LET7.htm)>

MATOMELA N

2004. Recognition for traditional
healers.

<[http://www.southafrica.info/what
_happening/news/traditional-
healersbill.htm](http://www.southafrica.info/what_happening/news/traditional-healersbill.htm)>

MINISTRY OF HEALTH, RSA

1997. *White paper for the transforma-
tion of the health system in South Africa*.
Cape Town: Ministry of Health.

NATIONAL PROGRESSIVE PRIMARY
HEALTH CARE NETWORK (NPPHCN)

1997. Public hearings on traditional
healers. *Summary Brief* 3(23): 1-5.

NDAKI K

2004. Regulating traditional
healers.

<[http://www.health-e.org.za/
news/easy](http://www.health-e.org.za/news/easy)>

PELESA M

2004. SA recognises its healers —
at last. *City Press* 11 September: 1.
<[http://www.news24.com/City_
Press/City_Press_News/0,,186-187_
1587707,00.html](http://www.news24.com/City_Press/City_Press_News/0,,186-187_1587707,00.html)>

PELTZER K

2000. The perceived efficacy of
western and traditional health care
in an urban population in the
Northern province, South Africa.
Acta Academica 32(2): 87-103.

PILLSBURY B L K

1982. Policy and evaluation
perspectives on traditional health
practitioners in national health
care systems. *Social Science &
Medicine* 16: 1825-34.

PRETORIUS E

1999. Traditional healers. *South
African Health Review*. Durban:
Health Systems Trust: 249-56.

2004. Complementary/alternative
and traditional health care in
South Africa. Van Rensburg (ed)
2004: 506-60.

REPUBLIC OF SOUTH AFRICA (RSA)

1996. *Constitution of the Republic of
South Africa Act, 1996. Statutes of
the Republic of South Africa* —
Constitutional Law. Pretoria:
Government Printers.

2005. Traditional Health Practi-
tioners Act, 2004. *Government
Gazette* 476(27275).

Summerton/African traditional health practitioners

SENEVIRATNE K

2000. Traditional medicine often lauded but neglected.
<<http://www.twinside.org.sg/title/lauded.html>>

SUMMERTON J V

2005. The role of practitioners of traditional medicine in the treatment, care and support of people living with HIV/AIDS. Unpubl PhD thesis in Sociology. Bloemfontein: University of the Free State.

VAN RENSBURG H C J (ed)

2004. *Health and health care in South Africa*. Paarl: Van Schaik.

WHO KOBE CENTRE

2002. Formalisation of traditional health services. Planning for cost-effective traditional health services in the new century.
<http://www.who.or.jp/tm/research/bkg/5_formalisation.html>

WORLD BANK

2006. Issues in traditional health delivery. Health Systems Development.
<http://www.worldbank.org/hnp/hsd/services_healer.asp>

WORLD HEALTH ORGANIZATION (WHO)

1978. Declaration of Alma-Ata. International conference on primary health care. Alma-Ata, 6-12 September 1978.

2000. *Promoting the role of traditional medicine in health systems: a strategy for the African Region 2001-2010*. Harare: World Health Organization.

2002. *WHO Traditional Medicine Strategy 2002-2005*. Geneva: World Health Organization.

2003. *Report on Traditional Medicine Strategy 2002-2005*. Geneva: World Health Organization.

2004. Celebration of African Traditional Medicine Day. Geneva: World Health Organization.
<<http://www.who.int/countries/eth/news/events/atmd/en/print.html>>