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In the home stretch: the legalisation of African traditional healing in South Africa

Summary

The overall aim of this article is to describe the current status of indigenous health care policy and to determine what progress has been made in translating policy principles into action. The article deals with the models for incorporating traditional health care into the official health care system; the present status of traditional health care and the rationale for legitimising it; the many complex issues involved in developing a policy on ethnomedicine, and an assessment of the progress made in respect of the legalisation of this kind of health care five years into the new order. The main conclusion is that, although great strides have been made, there are still some very serious constraints which are likely to inhibit the indigenous health care sector for some time to come.

In die pylvak: wetlike erkenning van tradisionele gesondheidsorg in Suid-Afrika

Die breë doelstelling van hierdie artikel is 'n beskrywing van die huidige stand van inheemse gesondheidsorgbeleid en 'n bepaling van die vordering ten einde beleidsbeginsels ten uitvoer te bring. Aspekte wat aangespreek word, is die modelle om tradisionele gesondheidsorg by die amptelike gesondheidsisteem te inkorporeer; die huidige status en die rasionaal ten einde tradisionele gesondheidsorg te legitimeer; die omvattende en veelkantige problematiek rondom die ontwikkeling van beleid oor etnomedisyne; asook 'n bepaling van die vordering met betrekking tot die amptelike erkenning van inheemse gesondheidsorg vyf jaar na die aanvang van die nuwe orde. Die hoof gevolgtrekking is dat ten spyte van noemenswaardige vordering in hierdie verband, verskeie ernstige beperkinge die inheemse gesondheidsorgsektor vir geruime tyd nog aan bande sal lê.

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Before whites settled in Africa the indigenous health care[1] system exerted great political influence in both the public and the private spheres.[2] Later, under missionary influence, and also as a result of repressive political policies, the colonial administrators prohibited traditional African medical practices, condemning them as 'heathen' and 'primitive'. Yet, for numerous reasons, this kind of healing has survived and is, at the present time, striving both for professionalisation and to become an integral and recognised part of health care in South Africa. The survival and persistence of ethnomedical systems is not a phenomenon limited to a few African countries. It is estimated that half of the world's population continues to rely upon local indigenous health care services for the treatment of a wide variety of physical and mental illnesses.

The legacy of apartheid to South African health care was a system characterised *inter alia* by fragmentation, segregation on the basis of colour, inefficiency, inequity, and a bias towards allopathic health care. The year 1994 heralded a new political dispensation, which also had an impact on the health care scene. The new government's manifesto on health care delivery was contained in the National Health Plan which became policy in 1997 when the government accepted the White Paper on Health. One very important aspect of the new dispensation in health care was the explicit statement that complementary medicine, including African traditional healing would henceforth form part of official health care. Accordingly, consumers would be allowed to choose whom to consult for health care, and legislation was to be changed to facilitate the controlled use of African traditional practitioners.

The overall aim of this paper is to describe the current status of traditional health care policy in this country and to determine whether any headway has been made in translating policy principles into action.

1 'Indigenous health care', 'traditional health care' and 'ethnomedicine' are used interchangeably in this text and refer to a system of health care practised by local African health care practitioners.

2 An abridged version of this article was presented as a paper at the congress of the South African Sociological Association at the Rand Afrikaans University during July 1998.

1. Models for incorporating traditional health care into the official health care system

The authorities concerned have various policy options in respect of the acceptance of traditional healing systems. These may be seen as falling into three broad categories — illegalisation, tacit recognition and legalisation — resulting in four distinct systems, namely exclusive, tolerant, inclusive or integrated systems (Pillsbury 1982; Stepan 1983).

Exclusive (monopolistic) systems recognise only the practice of modern, scientific medicine, while all other forms of healing are illegalised or severely restricted. The illegalisation of traditional healing systems, directly and explicitly prohibiting the activities of traditional healers, has not been consistently implemented as a national policy option in Africa. Numerous developing countries have neither repealed their monopolistic laws nor adopted legislation in support of traditional medicine subsequent to independence. Despite the pressure which has at times been exerted by the Western medical sector in an attempt to prohibit alternative and competing health systems (as was the case in Zaire and in Mozambique), the complete banning of traditional medicine is difficult to enforce. Such action can also have potentially negative consequences, such as organised resistance by traditional healers and general community dissatisfaction. This could be one of the reasons why illegalisation policies have become largely redundant.

Tolerant systems are characterised by a *laissez-faire* policy or tacit recognition. Here, only systems based on modern medicine are recognised, while the existence and significance of other sectors are officially ignored or non-formally recognised. Although this approach is in some instances practised more by default than by active policy, it remains the most neutral and flexible attitude a government can adopt. There is a tendency for Commonwealth countries to be generally more liberal in their recognition of traditional medical practitioners — a consequence of the former British colonial policy, which was based on minimal intervention with local custom. In colonial South Africa, for instance, the *Natal Code of Bantu Law* (1891) recognised traditional herbalism (Gumede 1990).

The legalisation of traditional health care systems may assume any of the following forms:

- Formal recognition of traditional practitioners and their various institutions.
- Recruitment and training of practitioners for incorporation into a modern primary health care programme. This actually comprises two policy options. One is the 'upgrading' strategy in which traditional practitioners are given training in order to improve the way they perform their traditional repertoire of tasks. In the other, traditional practitioners are recruited to a newly instituted cadre of community/village health workers and then trained in a new repertoire of tasks.
- Licensing or registration of traditional medical practitioners, which may or may not be combined with the above options.
- Actual integration of traditional and modern systems with referral and similar co-operation in both directions.

Legalisation results in two kinds of systems. An inclusive (parallel) system recognises other health care systems besides scientific medicine as being legal, with the result that two or more system of health care often co-exist, as is the case in Zimbabwe. To be suitable for such organisational inclusion, the particular traditional care system must, however, be highly formalised. In an integrated system, allopathic and traditional medicine are united in respect of training and are practised together in a single national care network. Several developing countries in Africa, Asia and Latin America have experimented with such integration of traditional and Western health care systems, but the case of traditional medicine in China is perhaps the best (although most overworked) model for the successful integration of the two medical systems (Leslie 1976).

2. The official status of African traditional health care

Most countries have tolerant policies in respect of traditional medicine. This policy ensures a safe position between the difficulties of prohibition on the one hand and, on the other, the problems associated with official recognition, including the possible scorn of the Western medical sector. Often, however, tacit recognition

implies a government's endorsement of traditional healing systems, frequently in response to the widespread and entrenched nature of traditional medicine, which makes either illegalisation or direct control difficult. This was also the case in South Africa prior to 1994.

Currently, African traditional healers are recognised only in one province in South Africa, KwaZulu-Natal, where the licensing and control of traditional health care practitioners and traditional midwives are covered by the KwaZulu Act (6/1981). Elsewhere in South Africa traditional healers are liable to be prosecuted, because the new Government has not yet repealed the current legislation. This legislation (Health Act 19/1974), forbids healers who are not registered with the Interim South African Medical and Dental Council or with the South African Associated Health Services Profession Board from practising. However, the new Health Bill (31 March 1995) has repealed restraining legislation in respect of certain other categories of complementary healers (homeopaths, naturopaths, osteopaths, herbalists and chiropractors). Despite the lack of enabling legislation, a number of associations, estimated at a hundred, organise traditional healers (The Centre for Health Policy 1991; *Sowetan* 1994: 14).

3. The rationale for legitimising African traditional health care

There are several reasons why the attitudes of the exclusive and tolerant systems towards traditional health care have lately fallen into disfavour, turning global sentiment towards the legalisation of this type of health care. The most significant of these is certainly the change in policy direction initiated by the World Health Organisation (WHO) at Alma Ata, which makes due allowance for traditional health care systems. A greater tolerance of alternative rationalities was, however, not the only impetus behind this swing towards new policies. Rising inflation and the continual need to curb state expenditure on health services make it impossible to expand allopathic health care provision to accommodate the escalating demand of rapidly growing populations. Traditional health care is an alternative or supplementary low-cost system that has to be consi-

dered in this regard. The third major reason is a political one: it is considered a basic right that the actual needs and wishes of communities should be reflected in official health policy. Lastly, combining the two types of health care would also result in the provision of health care in a more holistic manner. This can be attained by integrating the strengths of both systems: the focus of African traditional healing is on the social and supernatural spheres, while biomedicine focuses predominantly on individual physiological well-being and secondarily on environmental causative factors.

4. The point of view of the traditional healing system on legitimisation

Because of the number of bodies organising traditional health care in this country, there is no one particular point of view regarding collaboration. These groupings are divided by historical, geographical and political factors.

Traditional healers very often accept that in certain instances modern medicine is preferable and can cure health problems that they cannot. Ethnographic studies consistently report that the attitudes of traditional healers are similar to those of their clients. They are pragmatic and curious about new therapies, readily assimilating into their practice any available techniques that seem to work. The main task of health planners is to find ways to make appropriate forms of modern scientific knowledge and technology more accessible to traditional healers. They will integrate what they learn into their own culture — a task that no outsider can perform for them (Leslie 1976). On the other hand, they believe that their system of healing is extremely powerful and necessary. It is also believed that African medicines have strong healing powers and that, if administered by qualified people to appropriate patients, they are at least as good as, and in many cases better than many modern medicines.

Some traditional healers view any contact with either modern medical practitioners or bureaucracy as a risk, whether in terms of legal procedures and taxes, or because of potential humiliation or threats to their cultural heritage and intellectual property rights.

Others believe that their legitimacy comes from the people they serve and from their ancestors' history and that they therefore do not need 'modern' legislation to recognise them. They not only feel that it is unnecessary, but may be or may become restricting. They think that registration may force them to change in some way.

5. The final bend: progress towards legitimisation

The most common manifestation of the legalisation option has been the licensing of healers. Botswana is a case in point. Control over the issuing of licences enables a government to restrict and channel the development of traditional healing systems, yet may also reflect an attempt at a more subtle form of control. On the credit side, legalisation may lead to the pooling and sharing of health knowledge not only among traditional healers themselves, but between the differently oriented health sectors. In this context, supportive legislation has an important role to play in attempts to enhance the collaborative, combined use of Western and traditional medical resources.

The new government's position *vis-à-vis* the traditional health care sector was stated in the National Health Plan published soon after the April 1994 elections. Two of the principal tenets regarding traditional healers were that people have a right to access to traditional practitioners as part of their cultural heritage and belief system, and that there are numerous advantages in co-operation and liaison between allopathic and traditional health practitioners and that interaction should thus be fostered. The question which must now be addressed is whether traditional health care has advanced in any way towards legalisation and professionalisation since this declaration of intent.

- The examples of Zimbabwe and Ghana illustrate that the feasibility of linking traditional medicine to national health care coverage depends not only on favourable government policies and supportive national legislation, but on government initiative. The South African Minister of Health took such an initiative during November 1995 when she requested that public hearings be held on the viability of traditional health care. These were subsequently

held during May to June 1997 and during February 1998. Proposals were submitted by numerous national role-players, such as the national health committee of the ANC, several traditional healers' associations, political parties, labour unions, the National Progressive Primary Health Care Network (NPPHCN) and *Doctors for Life*. Except for the last-mentioned all parties were in favour of the incorporation of traditional healers into the formal health care system. The report on the hearings, compiled by the National Council of Provinces' Select Committee on Social Services and the National Assembly Portfolio Committee on Health, was presented to the Department of Health in July 1998 and tabled before the National Council of Provinces on 12 November 1998. The report recommends that traditional healers be formally recognised. To this end it suggests that an Interim National Council for Traditional Healers be set up to draft legislation that will legalise and regulate the profession. The report also recommends that traditional healers be allowed to issue medical certificates and to claim expenses from medical insurances (Portfolio Committee 1998; *The Citizen* 1998: 5).

Another political step towards the legalisation of indigenous medicine is the South African Medicines and Medical Devices Regulatory Act (Bill 114-98). The primary object of the South African Medicines and Medical Devices Regulatory Authority (SAMMDRA), which is to replace the Medicines Control Council, is to attend to the monitoring, evaluation, regulation, investigation, inspection, registration and control of medicines, complementary medicines, vererinary medicines, medical devices, clinical trials and other related matters (RSA 1998: 64). The Bill explicitly states that it "gives long overdue attention to the proper recognition and regulation of complementary medicines" and that it takes into account thar "the disciplines of orthodox and complementary medicines are in many ways different" (RSA 1998: 65). In this Act "complementary medicine" is described as referring to the disciplines of Western herbal medicine, African traditional medicine, traditional Chinese medicine, traditional Dutch medicine, homeopathy, ayurveda, aromatherapy and food supplementation. For this reason sections 22 to 25 of the Bill also

make provision for the establishment of technical standing committees of experts and persons with skills and experience in the area of medicines and medical devices, with a view to assisting SAMMDRA in registering and regulating medicines and devices. In the case of African traditional medicine this body will be the Interim Co-ordinating Committee of Traditional Medical Practitioners of South Africa (RSA 1998: 19-20). Section 34 of the Bill also makes provision for the licensing of manufacturers or distributors of African traditional medicines (RSA 1998: 32).
The *Indigenous Knowledge Systems Programme* will further facilitate the recognition of the traditional health care system as it addresses, among other things, the problems pertaining to the intellectual property rights of African traditional healers. To this end it is conducting an audit of indigenous knowledge and technology in South Africa (Parliamentary Press Release 1998: 1).

- Apart from government initiatives, the private sector has also made strides towards recognising the indigenous health care system. Several large companies and organisations, like Medscheme, South Africa's largest medical aid administrator, have introduced limited benefits in respect of traditional healers. Early in 1994 Eskom allowed employees to claim a limited number of visits to traditional healers on the company's medical plan. Despite management worries that fraudulent healers would abuse the system and that legitimate healers would sometimes overcharge the medical scheme, an Eskom spokesperson reports that the idea has been a limited success. Another example is the Medical and Burial Savings Scheme, which has wholeheartedly embraced traditional healers by giving them equal standing with ordinary physicians. The scheme has screened and recognised more than 40 healers whom clients can consult. The Chamber of Mines and the National Union of Mineworkers have also signed a formal agreement on traditional healers. In a payment agreement reached during October 1994 the Chamber agreed to allow a panel of traditional healers at mines and to grant their employees three days' leave to consult such healers (*Beeld* 1994: 13; *Business Day* 1997: 22; *Sowetan* 1994: 14).

- There have also been other non-governmental initiatives that could advance the professionalisation of traditional healers. One such initiative is the Traditional Medicines Programme (TRAMED). During 1997 the Medical Research Council, the Department of Pharmacology at the University of Cape Town, the School of Pharmacy at the University of the Western Cape and several traditional healers entered into a collaboration agreement. The aims of this ongoing multidisciplinary project are to bridge the gap between allopathic and traditional medicine without compromising scientific standards, to improve the quality of traditional medicine and to recognise the work done by traditional healers. More specifically the research team liaises at the national level with traditional healers, companies and researchers in order to obtain medical and botanical information on healing plants with a view to setting safety standards for herbal remedies. In addition it aims to include traditional healers in primary health care services such as immunisation programmes, the treatment of tuberculoisis, anti-smoking campaigns, and combating alcohol abuse and family violence. To this end TRAMED has compiled a comprehensive manual on primary health care: *South African traditional healers' primary health care handbook* (Felhaber 1997). The manual is to be translated into two African languages to make it more accessible (*Die Burger* 1997: 9; 1998: 9). This project also collaborates with similar projects in Kenya, Zimbabwe and Malawi.
- One factor that could jeopardise the recognition of African traditional medicine is the allopathic point of view. Just how important the attitude of medical practitioners is was described by Freidson (1970: 232), albeit in a totally a different context:

> [N]o effective and widespread program using such workers (i.e. midwives, medical assistants, medical corpsmen) is possible without the active co-operation of the dominant profession. If the profession does not trust them, or if it resents or fears them, it will not refer patients to them nor will it graciously receive patients referred from them. Given the strategic position of the profession in health services, mere administrative fiat establishing the right of other occupations to supply health services is not enough to assure integrated and co-ordinated care. Optimal forms of co-ordination of health services require that physicians be positively interested in working with other personnel.

As a result of the socio-political history of South Africa, there has up to now been little contact between traditional healers and formal medical practice, despite the fact that an estimated 66 to 80% of black people currently use traditional medicines, and that there are between 150 000 and 200 000 traditional healers of all kinds (The Centre for Health Policy 1991; *Sowetan* 1994: 14). Here, as elsewhere, the options for improving the status of traditional medicine in health care systems are constrained by the global status of modern or cosmopolitan medicine. When traditional medical practitioners campaign for legal changes in health care, they challenge the dominance of modern medicine with its technological advantages, scale of organisation, and international character, which put the traditional system at a great disadvantage. Except in revolutionary situations, state policies concerning traditional medicine are largely negotiated and supervised by people trained in modern scientific medicine. The irrational element in this situation derives from the fact that for more than a century the movement to professionalise modern scientific medicine has used the state to eliminate or drastically to curtail and subordinate other forms of practice. This movement has shaped the education of health professionals, giving them an occupational perspective that distorts their comprehension of other systems. Thorsten Veblen called an education of this kind a "trained incapacity" (Kleinman 1978: 86). Specialists in health care are incapable of even-handedly observing traditional health concepts and practices. The more common action is to tolerate traditional medicine by attributing a placebo effect to practices that are considered harmless. The generosity of this judgement assures health professionals that they have taken a liberal view, justifying their perception of the rest of traditional medicine as a manifestation of ignorance, superstition and quackery. Kleinman (1978: 86) describes this trained incapacity:

> So dominant has the modern profession become in the health care systems of most societies (developing and developed) that studies of health care often equate modern medicine with the entire system [...] Professional socialisation of modern health professionals causes them to regard their own notions as rational and to consider those of patients, the lay public, and other professional and folk practitioners as irrational and 'unscientific' [...] It is amazing to see

> how intensely this professional ideology is held by otherwise sensitive and responsible health professionals.

Due to the differences that exist within the sector, there is no single position which can be said to be 'the modern health sector point of view' on the legitimisation of traditional health care. While most modern medical practitioners would appear indifferent to traditional healers, there are those who enthusiastically advocate their utilisation. Yet another group strongly objects to traditional medicine. Often these are the people who encounter and have to rectify the failures of traditional healers (or so-called traditional healers). This is also the position of *Doctors for Life,* who fear that the incorporation of traditional healers into the official health care system will lead to greater exploitation and suffering, especially among the rural poor. This view is shared by Dr Nthatho Motlana, a Sowetan doctor (*The Cape Times* 1998: 6; Gilbert *et al* 1997: 73).

At its general meeting in 1995 the Medical Association of South Africa (MASA) discussed its position on collaboration between the allopathic and complementary health care sectors. Here guidelines for co-operation, in particular mutual referrals, were formulated. That MASA was committed to co-operation, and also to bridging the gap, was illustrated by the fact that it commissioned the South African Medical Research Council in 1998 to investigate the current role of African traditional healers in health care delivery and to make recommendations regarding their potential role in the South African health care system. One of the most important recommendations of the MRC's report was that the medical fraternity should be educated about traditional healing.

In general there is a growing awareness in the medical fraternity that traditional healers can play an important role in the dissemination of correct and factual information to the population at large, particularly in respect of health education, hygiene, sanitation, family planning, and other health-related matters. With regard to training, representatives of the modern health sector would prefer traditional healers to be subject to norms and standards similar to those set in their own training, but they concede that the traditional healers' practice is not scientifically based, but addresses the spiritual, social and

psychological aspects of patient care.

Modern and traditional healers operate from quite different perspectives. Modern medicine functions within a scientific, empirical framework, whereas traditional medicine is rooted in an African cosmology that includes the 'supernatural'. Consequently, negotiating agreement is, understandably, rather difficult. More significant than the problems, though, is the fact that the modern and traditional sectors are now talking to each other, and beginning to understand each other's problems (The Centre for Health Policy 1991).

6. Conclusion

There is thus concrete evidence that the legalisation of indigenous healing systems is no longer merely a pipe-dream. Most of the key role-players are committed to change. The government has taken definite steps to legalise the traditional health care sector. It has embarked on a lengthy and comprehensive investigation which included several public hearings in all parts of the country. Health MEC's in all provinces were given until February 1999 to consult with traditional healer associations on issues such as training standards and methods of accreditation (*Sunday Times* 1998: 5). In all probability the necessary legislation will be promulgated during 1999 (Portfolio Committee 1999). Another major role-player, namely the modern health care sector, seems positively inclined towards the official recognition of traditional healers, and has set guidelines for mutual co-operation. The traditional sector already possesses some of the qualities needed for professionalisation. It is organised in associations, with training programmes and ethical codes of conduct. However, the complexities involved in developing and implementing a policy on traditional health care are intricate and multifaceted.

The first problem relates to the implementation of government policy. It is well-known among policy analysts that policy performance usually falls short of policy promises — that the goals and targets of the formulators of policy become diluted, deferred or, even forgotten as the implementers take over. Any national policy may be ignored unless a particular individual, interest group, or

regulatory body of sufficient administrative authority and capability actively campaigns to have the policy implemented and enforced. Thus a policy calling for the involvement of traditional practitioners may be adopted on paper but unless people with conviction and clout are — and, more importantly, remain — in a position to see the policy through, to implement the actual changes in budgetary, personnel, and time allocation at the central and regional levels, little will change on the ground. It is equally true that policy decisions cannot be made in a vacuum without taking existing structures and vested interests into account. Political interests, cultural values and historical legacies therefore have to be balanced in deciding which policy to implement.

The problems with regard to the practicalities of legalisation are manifold. The testing and certifying of traditional remedies, as well as the licensing and monitoring of traditional healers, will not only be extremely difficult to implement, but also very costly. Agreement among the main stakeholders will not easily be reached, despite the positive reaction from MASA. The legalisation of traditional health care challenges deep-rooted attitudes, and what is more, there is a fundamental irreconcilability between the allopathic and the traditional paradigms. Because of this gap between the two types of health care, a serious question mark can be placed over one of the central principles of government policy, namely that of mutual education between the two health systems. Traditional practitioners are typically mature adults with set ideas, developed through and put into real-life everyday practice in a way that makes them less likely to accept training material, or other instructions, unless these are clearly linked to the realities of the people and environment that make up their world. Moreover, much of their work is shrouded in mystification. Medical practitioners, on the other hand, are accustomed to their position of professional dominance and control. The potential for change which other, or newer health occupations might bring to health care is therefore blocked.

Not only is there divergence between the modern and the traditional sectors, but also within the traditional health care sector. In order to obtain a voice at the national level and thereby to obtain true political power in the wider social context, traditional healers

must be controlled by a single recognised and accepted body. Disunity in the ranks of traditional healers is entrenched to such an extent that all attempts so far to unite the various traditional healers' associations and to have them speak with one voice, have failed.

As has been shown, there are two policy models available for the legalisation of the traditional health sector, the first being the option of integrating the two kinds of medical systems. This is, however, virtually impossible because of the irreconcilability between the paradigms of the modern and the traditional health care sectors. The only viable option left is that of an inclusive or parallel system comprising two independent sectors, each respecting the unique character of the other. Current government legislation gives a strong indication that they are opting for the latter model. The legalisation of traditional health care can only be acceptable if it denotes a new era for this type of health care, characterised by the institutionalisation of more standardised training of traditional healers, as well as the authority and mechanisms to oust quacks and charlatans who tarnish the image of these healers. Legalisation and professionalisation will be undesirable if they imply the medicalisation of traditional therapies, i e, the control and regulation of these healers by allopathic medicine, resulting in pressure to concentrate only on those elements of traditional medicine — such as herbalism — that are empirically based and that can be accommodated within the framework of modern medical thinking (Van Rensburg *et al* 1992: 341). Although the legalisation of traditional healers seems to be an imminent reality, such healers will have to accept that for a long time to come theirs could be considered one of the "lesser professions" as compared with the so-called "leading professions" (Blane 1984: 216).

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