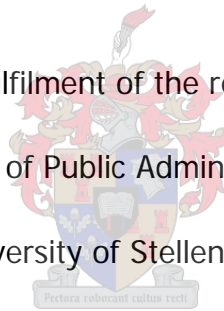


**INTEGRATION OF AFRICAN TRADITIONAL HEALTH PRACTITIONERS AND
MEDICINE INTO THE HEALTH CARE MANAGEMENT SYSTEM IN THE PROVINCE
OF LIMPOPO**

By

Shamila Suliman Latif

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Supervisor: Prof. APJ Burger

School of Public Leadership

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work containing therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

The Department of Health estimates that 80 percent of South Africans consult traditional healers before consulting modern medicine. The aim of this study is to investigate the extent of the use of traditional medicine in local communities in the Limpopo Province, and add value to a draft policy that was introduced by the Minister of Health. (South Africa, Department of Health 2007a)

Traditional healers are regarded as an important national health resource. They share the same cultural beliefs and values as their patients. They are respected in their communities. In South Africa, traditional healers have no formal recognition as health care professionals.

Despite the advantages of modern medicine, there is a dramatic evolution in traditional medicine developing and developed countries. In recognition of the value that traditional medicine has added to people's health needs, government organisations have realised the gap and needed to embark on public participation to bring to light the solution, by implementing a relevant policy (Matomela 2004).

According to research done by Pefile (2005), positive outcomes that resulted from the use of traditional medicine include a more holistic treatment, a wider choice of health care that suits people's needs, and scientific advancement, this paves a way forward for a policy to be put into place for the legal recognition of traditional medicine. New legislations have been brought about in regulating traditional medicine and practitioners.

This paper provides a synopsis of government initiatives to close the gap and address the concerns of integrating traditional and modern medicine. The thesis addresses the challenges involved in incorporating the two disciplines for the best possible impact of local communities in accessing their rights as vested in the constitution.

The study is a qualitative study where relevant practicing traditional healers, users, Western doctors, nurses, managers and government policy makers were interviewed regarding the draft policy on traditional medicine. This was to obtain information on the challenges, gaps and possible solutions regarding the integration of African traditional medicine into the health care system of Southern Africa. Findings show the following: a

majority of traditional healers do not agree to scientific trialling and testing on the herbs that they prescribe, and Western doctors feel that traditional healers should only treat patients spiritually unless they have a scientifically tested scope and limitations on their field. The study also found that traditional healers want to be registered and integrated into the health care system, but do not agree to have regulated price fixing. Other conclusions included that the communities seek traditional help for cultural reasons and more benevolent purposes, but are changing their focus towards seeking medical help from clinics where it is provided for them. However, people within the communities are still confused whether to seek traditional or western medicine and therefore seek both. It was found that medications are not readily available in district clinics and hospital waiting times force people into seeking traditional help. Nurses, doctors and caregivers acknowledge that traditional healers are hampering the health care of patients by delaying hospital treatment of patients hence progressing illnesses. However, they also state that traditional healers help people spiritually and mentally. Therefore policy makers have found solutions to educate healers and create regulatory boards to limit and create a scope of practice for traditional healers.

Recommendations and solutions for the relevant policy are as follows:

It is recommended that traditional health practitioners should only be allowed to practice and train over the age of 21. They must be prohibited from certain procedures, for example: drawing blood, treating cancers, and treating AIDS/HIV. They should only be allowed to practice midwifery if they have had training. They should be prohibited from administering injections and supervised drugs, unless trained at a tertiary level traditional healers can be used as home caregivers, spiritual healers, and traditional advice counselling entities in the communities. Traditional healers must be prevented from referring to themselves as a 'doctor' or 'professor'. This misleads people into believing that they are allopathic doctors. 'Traditional health practitioners' must realise that they are holistic healers, and must be addressed as such. A strong recommendation is to rename 'traditional health practitioners' as 'spiritual practitioners'.

With regards to regulations, it must be imperative that every practicing traditional health practitioner be registered annually with the relevant board. A good suggestion is for traditional health practitioners (THP) to attend formal training courses, under an

experienced herbalist, and it should be documented on paper. A written record of the location of practice, and specialty must also be documented. There must be policies on health and safety, hygiene and sterility that need to be in place. It is suggested that training on patient confidentiality must be taught and implemented. A code of conduct and a standard of professional ethics must also be implemented. Health and safety regulations pertaining to the profession and the citizens must be listed. Efforts towards dispelling myths and making people aware, thereby filtering out the positive side of the traditional medicine (e.g. medical benefits with some herbs), and rooting out the 'quack' practices (e.g. the use of amulets around a patient's body to cure diseases) should be practiced.

Pertaining to co-operative relationships between modern medical doctors and traditional practitioners, it is recommended that the use of exchange workshops between the two professionals needs to be developed. Also scientific information and technology must be available to traditional healers. A continued professional development (CPD) programme should be a mandatory requirement, as for all other health care professionals. It seems the development of traditional hospitals, in which a scope of practice is defined, can be used as a recovery ward and a spiritual guidance centre.

The above recommendations will encourage a healthier, safer and transparent health care system in South Africa, where all disciplines of medicine co-exist in one National Health Care System.

ABSTRAK

Nadat navorsing deur die Departement van Gesondheid gedoen is, is daar gevind dat 80 persent van Suid-Afrikaners tradisionele genesers besoek. Die doel van hierdie navorsing is om ondersoek te doen na die gebruik van tradisionele medisyne deur landelike gemeenskappe in die Limpopo Provinsie, en om ook 'n bydrae te lewer tot die konsepbeleid wat deur die Minister van Gesondheid bekendgestel is (South Africa, Department of Health 2007a).

Tradisionele genesers kan beskou word as 'n belangrike hulpbron in die nasionale gesondheidsdiens. Hulle deel in kulturele gelowe en waardes van hulle pasiente en word ook gerespekteer in hulle gemeenskappe. Suid-Afrika egter, gee geen erkenning aan tradisionele genesers of die feit dat hulle in die gesondheidsdiens is nie.

Ondanks die feit van moderne geneesmiddels, is daar 'n dramatiese evolusie wat besig is om plaas te vind in die Westerse Wêreld. Die erkenning en waarde van tradisionele medisyne wat bydra tot mense se gesondheidkwaliteit, het daartoe gelei dat Staatsorganisasies begin insien het dat daar 'n gaping is en dat publieke peilings gedoen word om 'n oplossing te vind en 'n beleidsdokument saam te stel wat tradisionele genesers insluit (Matomela 2004).

Die ondersoek wat Pefile (2005) gedoen het, het positiewe resultate getoon by die gebruik van tradisionele medisyne wat 'n holistiese behandeling in 'n wyer verskeidendheid van medisyne insluit by gebruikers. Ook die wetenskaplike vooruitgang van tradisionele medisyne het daartoe bygedra dat 'n beleidsdokument in plek gesit word vir die wettige erkenning daarvan. Nuwe wetgewing is in werking gestel om beheer uit te oefen oor tradisionele genesers en tradisionele medisyne.

Hierdie dokument verskaf 'n sinopsis van die Staat se inisiatiewe om die gaping tussen moderne medisyne en tradisionele medisyne aan te spreek en ook om landelike gemeenskappe toe te laat om hulle reg uit te oefen soos wat in die Grondwet vervat is.

Die studie is kwalitatief waar relevante praktiserende tradisionele genesers, verbruikers, Westerse dokters, verpleegkundiges, bestuurders en staatsdiensbeleidvormers ondervra is oor 'n konsep beleidsdokument oor tradisionele medisyne. Dit was gedoen om informasie

rakende die uitdaging , gapings en 'n moontlike oplossing te vind vir die integrasie van Afrika se tradisionele medisyne in die gesondheidsorgsisteem van Suidelike Afrika. Belangrike bevindings sluit die volgende in: die meerderheid tradisionele genesers stem nie saam dat wetenskaplike toetse gedoen word op kruie wat hulle voorskryf nie; tradisionele genesers will geregistreer en geïntegreer word in die gesondheidsorgsisteem maar stem nie saam oor prysregulering en prysvasstelling nie; Westerse dokters is van mening dat tradisionele genesers net pasiënte geestelik moet kan behandel tensy hulle 'n wetenskaplik getoetse doel en beperkings in hulle veld het; Westerse dokters glo dat tradisionele genesers dwarsboom die gesondheidsorgsisteem deurdat hulle behandeling vertraag; die gemeenskap soek tradisionele hulp op vir kulturele redes en ander welwillendheidsredes maar gaan soek mediese hulp by klinieke waar dit aan hulle verskaf word; mense van gemeenskappe is verward en raadpleeg beide tradisionele genesers en Westerse dokters vir hulp; sommige medisyne is nie altyd by klinieke beskikbaar nie en mense sien nie kans om in lang rye te wag by hospitale nie en dit noop dat hulle tradisionele medisyne gebruik; verpleegkundiges en gesondheidswerkers erken dat tradisionele genesers mense vertraag om gesondheidsorg en behandeling by hospitale te kry, maar verstaan ook dat tradisionele genesers aan mense geestelike hulp verleen; en beleidskrywers moet oplossings vind om tradisionele genesers op te voed en om komitees te stig wat tradisionele genesers se ruimte van praktisering in toom te hou.

Die volgende word as voorstelle tot aanpassing van die genoemde beleidsdokument geïdentifiseer:-

Tradisionele genesers mag alleenlik praktiseer en opleiding verskaf na die ouderdom van 21 jaar. Hulle moet verbied word om sekere prosedures, byvoorbeeld die trek van bloed; behandeling van HIV/VIGS; om voor te gee dat hulle mediese praktisyns is; om vroedvroue te wees slegs indien gekwalifiseer daartoe; om inspuitings toe te dien en medisyne uit te reik slegs indien hulle tersiëre opleiding gehad het. Tradisionele genesers se dienste kan gebruik word as gemeenskapsgesondheid hulpwerkers, geestelike genesers, en kan tradisionele advies en begeleiding aan die gemeenskap lewer. Tradisionele genesers moet belet word om die titels "Dokter" en "Professor" te gebruik. Tradisionele genesers moet daarop let dat hulle holistiese genesers is en moet daarvolgens aangespreek word. Hulle moenie pasiënte mislei deur voor te gee dat hulle

allopatiese geneesher is nie. "Tradisionele genesers" moet hernoem word na "geestelike genesers".

Tradisionele genesers moet by 'n erkende organisasie geregistreer word en moet so-ook jaarliks registrasie henu. Formele onderrig wat deur 'n ervare kruiegeneser aangebied word moet bygewoon en gedokumenteer word. 'n Geskrewe rekord van die ligging van die praktyk en betrokke spesialisering moet bygehou word. Beleidsvoorskrifte wat verband hou met gesondheid en veiligheid, hygiene en sterilisasie moet in die tradisionele gesondheidgeneserspraktyk geïmplementeer word. Opleiding in pasiëntkonfidensialiteit moet aangeleer en toegepas word. Samewerking en werkwinkels tussen moderne mediese dokters en tradisionele gesondheidgenesers moet geïmplementeer en ontwikkel word. Mediese wetenskapsinligting en tegnologie moet aan tradisionele genesers bekendgemaak word. Voorts moet 'n voortgesette professionele ontwikkelingsprogram (POP) aan alle gesondheidswerkers voorgeskryf word. Dit blyk wenslik te wees om tradisionele hospitale tot stand te bring waar die bestek van praktyk gedefinieer word. Sulke hospitale kan dien as plekke waar pasiënte aansterk en geestelike onderskraging geniet. 'n Etiese kode en standaard vir professionele etiek moet geskep word vir tradisionele genesers. Gesondheids- en sekureitsregulasies moet van toepassing wees en geïmplementeer word. Pasiënte moet ingelig word oor die wegdoen van mites en fabels. Daardeur kan die positiewe sy van tradisionele medisyne (byvoorbeeld mediese voordele van kruie), en uitroei van "kwakke" (byvoorbeeld dra van gelukbringers om die lywe), verdryf word.

Dit sal die aanmoediging van 'n gesonder, sekuriteitbewuste en deursigtige gesondheidsorg sisteem bewerkstellig in Suid-Afrika waar alle dissiplines van medisyne saam bestaan in die Nasionale Gesondheidsorgsisteem.

DEDICATION

This thesis is dedicated to all those who have committed their time, expertise, and knowledge into the health care profession and for all those involved in community efforts and public health and who have contributed and addressed to the well-established and improved South African health issues.

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Shamila Latif

University of Stellenbosch (15528820)

REFLECTIONS OF MEDICINE AND HEALING

'When health is absent, wisdom cannot reveal itself; art cannot become manifest; strength cannot fight; wealth becomes useless; and intelligence cannot be applied...' - Herophilus

300 BC

'Our thinking in future must be world-wide...' - Wendell Willkie

'No man is wise enough by himself...' - Plautus

'Lucky is he who has been able to understand the causes of things...' - Virgil

'Nothing in life is to be feared. It is only to be understood...' - Marie Curie

'Human beings are the center of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature.' - Principle 1 of the Rio Declaration on Environment and Development

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity...' - World Health Organization

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GLOSSARY

Allopathic doctors: Another term used for modern medicine, western medicine or scientific medicine (*World Book Encyclopaedia* 1996:[sp]).

Ancestors: Ancestors are described as a spirit or guardian angel that appears in dreams, visions or by way of possession. They are claimed to guide the profession to achieve its goals, by making contact with the healer during a consultation (Campbell 1998:17-38).

Apartheid: 'meaning "separateness" in the Afrikaans language. The legal system of rigid racial segregation enforced by the National Party government in South Africa between 1948 and 1991' (*World Book Encyclopaedia* 1996:[sp]).

Bio Medical Research: 'Basic Medical Research' (World Book Encyclopaedia 1996:[sp]).

Ceremony: A ceremony is a conventional and a traditional act which does not involve religious connotations, but ceremonies symbolise the calling together of the ancestors. It is an effective way of calling upon the ancestors (Berglund 1976:197).

Colonialism: 'A policy by which a nation maintains or extends its control over foreign dependencies.' It is a 'practice of domination'. (Stanford Encyclopaedia of Philosophy 2006)

Culture: 'The system of shared beliefs, values, customs, behaviours, and artefacts that the members of society use to cope with their world and with one another, and that are transmitted from generation to generation through learning' (*World Book Encyclopaedia*1996:[sp]).

Endoscope: 'An instrument used to examine the inside of the human body' (*World Book Encyclopaedia* 1996:[sp]).

Heritage: 'Something that is passed down from preceding generations; a tradition.' Something that's been handed over to a person from his ancestors such as land, a trait, beliefs, customs or inheritance (*World Book Encyclopaedia* 1996:[sp]).

Magic: The word magic has been used often in this study. According to Berglund (1976:27), 'the techniques of coercion, based on what we would consider false premises,

by which persons, usually non-literates say to obtain practical ends.’ However, this definition beats the purpose of the study. In this study the traditional health practitioners associate magic with rituals and rites, symbols, and change situations that create pressure for its users within the community (Berglund 1976:27).

Monographs: The writing on a single subject (*World Book Encyclopaedia* 1996:[sp]).

Muti: This is the term used for traditional medicine in South Africa (Berglund 1976:25).

Pharmacology: ‘The science of drugs’ (*World Book Encyclopaedia* 1996:[sp]).

Pharmacopoeia: ‘A book containing directions for the identification of samples and the preparation of compound medications’ (*World Book Encyclopaedia* 1996:[sp]).

Placebo Effect: Holland describes: ‘A placebo is a substance or procedure a patient accepts as medicine or therapy, but which has no verifiable therapeutic activity. The placebo effect (or placebo response) is a therapeutic effect following administration of a placebo, or more generally, is the psychosocial effect of medical treatment. Effective on 30% of humans and only for some conditions, it is also known as the non-specific effect or subject-expectancy effect’ (Holland 2009).

Pluralism: ‘A pluralism definition has the basis in operating under the principles of acceptance and diversity. It is promoted as a system for the “common good” of all. It is a coming together with common recognition and credence to all beliefs and developments of modern social, scientific, and economic societies’ (Farlex 2009).

Stethoscope: ‘An instrument used for listening to internal sounds in medicine’ (*World Book Encyclopaedia* 1996:[sp]).

Symbol: A symbol is a representation or sign or an association of another thing. Articles, acts and sounds are used as symbols of something that someone feels, sees, hears or acts (Berglund 1976:[sp]).

Traditional healer: These are practitioners who are from an African indigenous descent. They are divided into two categories. The first are those that serve the role of diviner-diagnostician, (or diviner mediums) and the second are those that are healers (herbalists).

The diviner provides help through spiritual means, while the herbalist makes use of relevant remedies, as stated by the World Health Organization (Richter 2003).

Traditional Medicine (TM): according to the *World Book Encyclopaedia* (1996:[sp]): 'is the ancient and culture-bound medical practice which existed in human societies before the application of modern science to health. Every human community responds to the challenges of maintaining health and treating diseases by developing some form of medical system. Traditional medicine has been used by all communities in some form.'

Voortrekkers: 'The Voortrekkers (Afrikaans and Dutch for *pioneers*, literally "those who trek ahead") were emigrants during the 1830s and 1840s who left the Cape Colony (British at the time, but founded by the Dutch) moving into the interior of what is now South Africa' (*World Book Encyclopaedia* 1996:[sp]).

CHAPTER 1

INTRODUCTION

For centuries traditional healers have been the only source of health care in South Africa. About 80% of the population still seeks traditional medicine before seeking modern medicine (De Haan 1996:5-7). However, traditional healers' methods of practice are doubted and clouded with many misconceptions. The traditional healers have an in-depth knowledge of medicinal properties of herbs and plants, and act as a holistic and spiritual healer to most communities. In modern times there has been a huge interest in alternate and traditional medicine. African traditional medicine is knowledge that has been accumulated and brought down by generations for centuries. Their practice involves treating mental, physiological and spiritual illnesses (De Haan 1996:5-7).

Traditional healers now seek recognition under a legislation, and scientific verification of their remedies, and they want to be integrated and respected as any other health care professional. The aim in South Africa is to gain the trust of traditional healers and make the most use of their intellectual knowledge properly, instead of making a profit out of it, which will not benefit the healers. The objective of the South African government is to put all traditional healers into a database, provide them with rules and regulations and a scope of practice, work in harmony with them while learning from them, and acknowledge them within the health care profession (De Haan 1996:10-11).

Traditional healers have close ties with the communities, and exert much influence amongst the members. Therefore there is a role for them in community-based primary health care and the South African government needs to make certain that steps are being taken to ensure this (De Haan 1996:12). The traditional healers form a crucial link between western medicine and the community.

In South Africa there are 200 000 traditional healers (TH), and they are sought by 80% of the population, as mentioned above. The senior traditional healers enjoy credibility and they are well-established and well-respected within the communities as

well as trusted by the communities. They are considered as a precious resource for community health, especially within the rural areas where access to information and health care is not accessible (Matomela 2004).

The objective of this chapter is to describe the research methodology of the case study that is presented later in the thesis. The case study was conducted in the Limpopo Province of South Africa. The chapter also gives light to the study design, research methodology, delimitations and procedures and methods that are relevant to the case study presented. The chapter included the delimitations as part of this study report to expose the reader to some of the challenging factors that the researcher encountered in the process of conducting the study. Subsequent chapters tackle the beliefs, views and solutions to traditional medicine in South Africa. The study is broad, and intends to elaborate the notions and issues of the policy. In order to make sense of the importance of the findings, it is appropriate to understand the modernisation theory, the chaos and complexity theories, generic model and the reasons behind issues and problems regarding a policy.

1.1 RESEARCH PROBLEM

The research is primarily based upon the need to integrate traditional medicine into the National Health care system. As mentioned before, traditional healers are widely consulted in South Africa, which is partly due to cultural reasons (PHILA 1997). Due to traditional medicine being so widely believed in, it poses a challenge for the drafting of a national health policy. Public participation and community efforts will prove helpful in adding value to the current draft policy, so that the National Health care system is effectively improved. The problem lies in the challenges faced in fusing the two fields to expedite the decision-making process to the parliamentary level in the public policy life cycle. The traditional healers and the population need to be protected from 'hoax' practitioners, and the profession needs to be regulated. The challenges faced include that: traditional healers' rates are high, conventional health care is not accessible in the rural areas, and traditional healers have no scope of practice and are therefore sometimes overstepping their limits by treating illnesses

that need allopathic help. There is a need to regulate their practice, however, many challenges have arisen.

1.2 RESEARCH QUESTION

Due to cultural beliefs, holistic approaches and the shortage of rural hospitals, communities apparently prefer to seek traditional help instead of modern medicine. This thesis makes use of policies that monitor a traditional healer's code and scope of practice that would be effective in the health management system. Communities view modern medicine as a last resort and turn towards traditional healers because of a shared value system. Therefore, if there is a fusion, it would encourage communities to seek both modalities.

What are the issues for the implementation of a policy on African traditional medicine in South Africa?

1.3 STUDY AIMS AND OBJECTIVES

The draft policy on traditional medicine was designed to provide a framework for the institutionalisation of African traditional medicine into the National Health care system of South Africa. The rationale of the study was the fact that a majority of the patients that were afflicted with an illness sought traditional help primarily at exorbitant prices and later sought allopathic help at the hospitals and clinics. The study aims at achieving the following objectives:

- To verify the extent of the use of traditional medicine in local communities in the Limpopo Province.
- To investigate the reasons behind the preference for traditional medicine amongst the communities.
- To determine the possibilities and difficulties inherent in attempting to fuse the practice of traditional medicine, with that of mainstream medicine, and to improve health management.
- To investigate how communities using traditional medicine view modern hospitals, doctors and their rights to health, given South Africa's transformation to democracy.

- To investigate the challenges involved regarding the incorporation of traditional medicine into modern medicine in terms of current policy initiatives and financial capacity.
- To determine the challenges faced with integrating traditional medicine into the national health care system.
- To add value to the 25 July 2008 draft policy.
- To investigate solutions at improving the use of traditional healers in term of safety and effectiveness.

1.4 DELIMITATIONS TO THE ISSUE

- There is currently no regulation of traditional medicines; they are sold in homes, markets and in private. It remains a challenge to regulate the practice within a certain board.
- In most provinces traditional medicine is practiced without a legal framework to guide the practice.
- There is a lack of scientific evidence for the safety, efficiency and quality of traditional medicines that appear to be effective in curing diseases.
- Due to the negative publicity, it is practiced in secret and has a predisposition that it is only for the poor and illiterate people.
- Cultural beliefs and superstition may hamper implementation.
- Low literacy levels may hamper the effective implementation of policies.
- Western practitioners fail to recognise the importance of traditional medicine.
- Inadequate financial and human resources may hamper implementation, in the case of research and development.

1.5 RESEARCH DESIGN

This research constitutes a combination of a case study and participatory research design. The case study, as mentioned before, was conducted in the Limpopo Province. *Participatory* research involves a combination of education research, social investigations and action within the interrelated process. (Welman *et al*, 2005: 204-208). In order to understand the world of traditional medicine, hands-on research and consultations are essential. The study involves the stakeholders as part of the

study design. Mainly qualitative methods were used to understand and gain an insight into the life of all the participants. The aim was to change the social conditions of the stakeholders (Mouton 2001:150-151).

Fieldwork was conducted in a qualitative manner. The purpose of this analytical study is to find the risks, failures, causes and factors for the success or issues of the policy. According to Mouton (2001:96), qualitative researches aim to provide a focus group of people or communities, therefore the study will follow a qualitative approach with open-ended questions. The strength of the qualitative paradigm will be based on the views of the focus groups of the members within a community who have access to National Health Care but who utilise traditional healers. It will also be based on the views of the traditional healers of the same local community, where there is access to a local clinic or hospital and other professionals that deal with the field of public health. Due to the fact that the thesis is a policy issue paper, that approach requires the importance of all the stakeholders involved.

1.6 RESEARCH METHODOLOGY

The study is based primarily on a literature review, although, the identification of objectives has been based on personal interviews and group face-to-face interviews with community members, traditional healers, medical doctors, nurses and hospital managers. Thereafter the complexity, efficiency and effectiveness of the policy would be established, and therefore the formulation stage of the policy determined. This would involve participation from the community, practitioners and professionals that were used to identify problems and the possible outcomes with solutions.

Stakeholders were selected based on availability, and expert interviews were conducted. The stakeholders of this particular study are: African traditional healers, medical doctors, users of traditional healers, nurses and people who work around the processes and hospital managers (Refer to questionnaires: Appendix A, B, C, D and E).

1.7 STUDY POPULATION

1.7.1 Primary population

The primary population pertains to people from communities within the Province of Limpopo (i.e. Polokwane and the township of Solomondale) where there is accessible health care available as well as traditional health practitioners, medical doctors, nurses and hospital managers that are currently practicing.

1.7.2 Inclusion population

The following people were also included: people from a poorer, more rural community in the Province of Limpopo, who have access to health care, seven high school children who were part of one focus group, traditional health practitioners from the communities, whom are currently practicing and practicing medical doctors, nurses and hospital managers. The above-mentioned individuals' race or sex is inconsequential to the study.

1.7.3 Exclusion population

Children in the community, who are under 15 years of age, are excluded from the study.

1.7.4 Sample size

Questions were asked to six focus groups representing the typical community where traditional healers are widely used. Each focus group consisted of about seven to ten individuals, who were willing to participate. Interviews were conducted with five practicing traditional health practitioners, who practice in an area where there is primary health care available, six medical doctors, and six nurses, who were willing to participate voluntarily as well as four hospital managers and relevant policy makers.

1.7.5 PROCEDURES AND METHODS

The participants were asked a series of questions and beliefs. Demographic data were recorded for all participants, however, the names of the persons interviewed are not included. The patients reside, as recorded, in Solomondale and urban areas in Polokwane. The geographical position was recorded. The patients' medical histories were also recorded and used to evaluate the extent of the current policies.

Data Collection: Personal interviews and group discussions were conducted informally with relevant participants, using a predefined set of questions.

Analysis: The questionnaires and discussions will be analysed and conclusions and trends will be deduced. Possible solutions and recommendations will also be recorded.

After discussing the methodology, the anticipated results and analysis of the study is addressed in later chapters. However, the following chapter allows the reader to understand the foundation of health care in South Africa. It allows us to have an insight of how the legacy of apartheid has resulted in the progression of health care along the racial lines, and the prior distribution of health. By understanding the history, it will aid policy makers to understand the importance of African traditional healers, and enable the government to realise that one of the main factors affecting health care was apartheid. In order to address the problems pertaining to poverty and inequality, the South African government needs to make policies that will improve democracy and allow progression to the communities who have been disadvantaged. The subsequent chapter also focuses on where we are as a nation and where we intend to be, the future roles of traditional health practitioners (THPs) in South Africa and the current Government initiatives towards the policy. Folk medicine has been discussed as a way forward and a solution. Much later in the thesis, we revisit the foundations of policy making, modernisation, chaos and complexity theories, and the reasons behind policy issues. Lastly the results and recommendations tie in with a recommended framework.

CHAPTER 2

THE HISTORY OF HEALTH CARE, AND THE GOALS FOR TRADITIONAL MEDICINE IN SOUTH AFRICA

2.1 THE HISTORY OF HEALTH CARE IN SOUTH AFRICA

This chapter aims to discuss the history of health care in South Africa, and thereby understand and explore the inequality within the health care sector of South Africa before the democratic elections in 1994. The chapter brings to light the contributing factors of apartheid and colonialism on health care in South Africa. The history of apartheid and colonialism played a role, at times detrimental in the health care sector within most areas in South Africa. After 1994, when the ANC (African National Congress) came to power, it recognised that traditional health practitioners (THP) play an important role in the primary health care of South Africa, and hence it has sought to legitimise and regulate their practice. This chapter also looks towards the current situation regarding traditional medicine, in terms of accessibility, accountability and availability of Traditional Medicine (TM) in South Africa. It looks at the current and future visions and the latest government initiatives. The chapter adds value to the literature review to give us a complete understanding of where we are in South Africa regarding the legislative policies and pragmatic overview of the legislation.

2.1.1 Early South African health care trends

After the era of colonisation until 1910, the following characteristics pertaining to health care in South Africa have been noted by Benatar (1997:891).

From the early introduction of western medicine by the colonists, there existed two forms of health care in the country. This laid a foundation where the two existed parallel to each other, and in two different forms which were the western medicine and the indigenous tribal medicine. The one was scientific based medicine and the other magico-religious based medicine. After 1807, the western medicine was given legal status, whereas, the traditional medicine was made illegal, but was still

practiced. The French Huguenots, the Dutch colonists, the British conquerors, settlers, colonialists and the Boers were mostly predominantly white and western. Therefore the differences between South African people were not only between western and indigenous people, but also between white and non-white people. Therefore the divisions and white domination that existed in South Africa started at an early period in history. Another characteristic that was noted was that there was pluralism within the health sector. Some private and public sector health care centres started to develop, and the capitalistic political economy concentrated on the free-market health care system. Health care during that period was known to be haphazard and unplanned. The health services were isolated to white and urban areas and health care had no structure within the rural areas.

Later on in the 1890's, the process of urbanisation gained momentum in the country. This was mainly due to the discovery of gold and diamonds, and this urbanisation gained further momentum into the 20th century. In health care, rural-urban changes brought structural changes, and therefore health care increased in the urban areas. Urban whites became the dominant health care providers of western health care, and concentrated mainly in the urban areas, which resulted in the inequality of health care within the country. The private practices that were established were generally profit-motivated. It was much easier for whites and Asians to urbanise and so health care grew vastly in the urban areas while the rural areas were left unattended. This set a trend for health care for many years to come. After 1910, the development of the 'Union in South Africa' created a change in the country's history. After the 20th century, there was a spreading and legitimisation of modern and western medicine, and this was the 'dominant' form of health care in South Africa. There was a large scale of specialisation and technology. There was also an increase in chronic degenerative diseases after colonialism. However, the racial segregation continued and became a structural feature within the country.

In 1948, after the coming of power of the National Party, segregation policies were implemented in South Africa. This was known as the era of 'grand apartheid', and had impacted the health care where the colonists and whites became privileged and the period of inequality was prevalent. In health care too, apartheid was rife, and

each race group had its own health care facility and the blacks from the homeland were served separately. In that era only white individuals were allowed to train as doctors.

2.1.2 The effects of apartheid on the progression of health care in South Africa

South Africa has been an example of inequality in every aspect, prior to the democratic elections in 1994. All sectors were affected, but the health care system affected the majority of the rural population of South Africa. Before the period of democracy, racial discrimination was legalised and executed, this caused inequality of health care amongst its people. In the apartheid era, South Africa consisted of 4 provinces, and the administration of the health care was distributed as 14 separate services. According to research done by Kale (1995b:1182), the apartheid system produced only white doctors, who did not practice in the rural areas and deep rural areas, and black townships where majority of the population resided, and there was the greatest need for medical care. According to statistics done in 1981, one doctor would treat 330 whites, as opposed to one doctor for 91000 blacks. This has been the worst form of inequality where the best first world medicine was available, but was not made accessible, and the “worst” third world medicine was used. It was evident in health in the sectors of infant mortality, life expectancy, childbirth and the incidences of infectious diseases such as tuberculosis and measles. For example, in 1985 infant mortality amongst white infants was 13.1/1000, but 70/1000 amongst blacks (Kale 1995a:1119). The effects of apartheid have left the poor missing out on essential health care.

After the post apartheid era, there was a restructuring of the health system. A central health system was developed with a provincial health department in each province. Free health care for pregnant woman and children was introduced (Kale 1995a:1119).

According to statistics (South Africa. Statistics of South Africa 2007), the estimated population of South Africa was 47.9 million. Blacks or Africans were in the majority,

estimated at 38 million, and constituted 79.6% of the population. While 4.4 Million (9.6%) were whites, 4.2 million (8.9%) were coloured, and 1.2 million (2.5%) were Asians (South Africa. Department of Government Communication and Information systems 2008:[sp]). The population grows at 2.2% a year, compared to the 2.1% in other developing countries and 0.6% in developed countries.

In order to evaluate the future of health care, it is relevant to explore the history and the effects of apartheid on the health care of the population of South Africa. The World Health Organization, in *Apartheid and Health* (WHO 1983), proves the inequality and devastations in the earlier times of apartheid in the South African health care system (Dommissie 1988:325).

In a critique of the apartheid era, Benatar and Landman (2006:239), said:

‘Racial discrimination, the creation of economically unviable ‘homelands’ with rapidly increasing populations, the inadequate development of primary health care services and community hospitals, the inadequate allocation of resources to health, the malnutrition of medical personnel, and other political regulations and injustices combine to contribute to the prevailing disparity in health and access to medical care amongst the people of South Africa. Such disparities will be reduced only when apartheid is abolished, a bill of rights established, and urgently needed political, social and economic progress made towards a more just society.’

2.1.3 The ANC’s role in health care in South Africa

The African National Congress (ANC) has had a vision of what they wanted in terms of health care. This was documented in the Freedom Charter, which was drawn up at a congress in Kliptown in 1955 (Dommissie 1988:325).

The document states:

‘A preventative health scheme shall be run by the state; free medical care and immunisation shall be provided for all, with special care for mothers and young children... The aged, the orphans, the disabled and the sick shall be cared for by the state; rest; leisure and recreation shall be the right of all. The laws which break up families shall be repealed.’

According to Dommissie (1988:325), the ANC has reviewed documents of traditional healers and sangomas (THP), and stated that traditional health practitioners and midwives have always played an important role in primary health care, both physically and mentally to the people of South Africa. Dommissie (1988:325) further stated in this article that the colonial regime and white medical professionals tried to get rid of the use of traditional medicine. They viewed it as mere superstition, ignorance and taboo. The article continued to state that traditional medicine is unscientific and if it's harmful should be rejected, however, they are still used by many people and some of the remedies are very effective. The ANC suggested that the remedies should be analysed and legitimised.

The ANC initiated the concept of primary health care to strive to promote optimal health care for the people of South Africa. This includes the right for everyone to receive education on health care and health care services and specialised care be available to all the people of the country, even those within deep rural areas.

The ANC acknowledged that by not giving traditional healers recognition within the country, it would contribute towards the oppression that communities have already endured. It would mean forcing citizens into a specific medical system.

From immemorial times, the communities of Africa have made use of ethno-medicine that was prepared by the clan or tribe. From those days it was believed that illness and misfortune originated from ancestral spirits, taboos, witches and spiritual evil spells. However, despite the fact that western/modern medicine has been introduced into Africa, it seems that African traditional medicine remains the most important method of primary health care and is still the most accessible. It is remarkable that it has continued to survive and has still remained popular and that most beliefs and customs have remained intact. The reason for this is the strong cultural beliefs, and the fact that Western medicine has not yet reached the deep rural areas, making African traditional medicine more accessible and affordable to communities in these areas. African traditional medicine deals with the aetiology, diagnosis and treatment of diseases spiritually, religiously as well as herbally.

In the 7th century the Arabs introduced Islam into Africa. They were the ones who introduced Africa to the fundamentals of modern/western medicine. The Arabs

linked Greek and Renaissance medicine and therefore created an acceptance of western biomedicine (Van Rensburg, Fourie and Pretorius 1992:[sp]).

2.1.4 The Reconstruction and Development Programme (RDP)

As discussed above, the history of colonialism and apartheid have divided the country. Rich whites were living in developed suburbs whereas poor blacks were living in rural townships and had no basic needs such as shelter, food or fresh water. In April 1998, the country had realised that they had won the first step towards democracy and prosperity. However, a new government just was not enough, so a plan of action that was devised to rebuild and develop the country was implemented. This programme is the Reconstruction and Development Programme (RDP).

The RDP had five key programmes. These five programmes included: 'meeting basic needs like food, housing, water and jobs, developing the human resources, democratising the states and society, building the economy and implementing the RDP (South Africa. *RDP of the Soul* 2007).

Concerning health care, it was stated that millions of people had inadequate health care, therefore the following aspects, concerning health, were looked into. It was noted that the environment was being misused and that natural resources and awareness of the environment and the careful monitoring of waste and pollution needed to be assessed. Laws and policies were set up to promote healthy living and working conditions to protect the environment.

Another aspect that was looked into was hunger. A three-year hunger programme to wipe out malnutrition was proposed. The programme was implemented by: cutting down VAT off basic foods, curbing marketing boards that influence food prices, and creating jobs and land reform to tackle malnutrition.

The RDP came up with a programme to offer adequate health care for all. The focus was to create a primary health care to promote health and disease prevention. The National Health system came up with policies to give free medical care to children under the age of six and to homeless children. Other important

areas that were tackled were: improvements in maternity care for woman, free medical services to unemployed, aged and disabled individuals, mental health care and counselling to victims of rape, child abuse and violence, and prevention programmes for diseases like AIDS and Tuberculosis (TB). Occupational health clinics and community participation were also encouraged (South Africa 1999)

The reason why the RDP is an achievable plan is because it had proposed three spheres of government, each autonomous but functioning with the notion of co-operative governance as is described in the constitution. The government spheres will operate at a national, regional and local level. It was proposed that each sphere will carry out duties on their own level. It was designed so that not only does the government play a role, but also the communities, unions, workers and the business community who all participate to bring the nation together. Policies have been formulated and put into place, which will be discussed later on in the thesis.

2.2 GOALS FOR TRADITIONAL MEDICINE IN SOUTH AFRICA. FACTORS AND TRENDS LEADING UP TO THE POLICY

2.2.1 Alternative/traditional health care in South Africa - history and trends

In 1948 WHO defined health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity'. The reason why this definition is acceptable and used was because it acknowledged the mental and psychological aspect of a human's well-being.

Alternative or traditional medicine is generally associated with a holistic medical movement. African traditional care in South Africa, as in most countries dominates the official form of health care, but it does not constitute the total health care supply. Traditional care is a cultural form of seeking help and is reliant on community persuasion. Most of the traditional medicine in South Africa has acquired no scientific verification and is not evidence-based. It is referred to as 'natural, traditional, non-scientific or marginal' (Van Rensburg *et al* 1992:[sp]).

As stated by WHO, it is believed that health is mental and physical and that the mind, body and spirit are interconnected and viewed as inseparable. There is also a

view that holistic care is more natural because there is no ingestion or intake of artificial pharmaceuticals or chemicals. The main goal is the prevention of disease, and the promotion of health rather than the treatment of diseases. Holistic care concentrates on the total physical, spiritual, mental, emotional, nutritional and ecological factors which can influence an individual's health.

Cobb (1977:1) stated that traditional/alternate medicine has three phases that needs to passed through before legal acceptance into the health care management system (Van Rensburg, Fourie and Pretorius 2004:[sp]), and these phases are deviation, legitimating and co-option.

First Phase: During the first phase, any form of alternate/traditional medicine is known as deviant. It is viewed by professionals as being sorcery, cultic, quackery and non-scientific. At this stage, traditional/alternate healers are discredited while they are attempting to be incorporated.

Second Phase: Despite the resistance from the modern medical side, they become partially legitimised. Practitioners start to be licensed, certified and be accredited at tertiary institutions.

Third phase: This happens when the dominant western medical group cannot succeed in preventing legitimisation. Traditional/alternate healers are then finally incorporated into mainstream health care.

2.2.2 The position of traditional medicine in South Africa

The practice of traditional medicine is widespread over South Africa, and these practitioners have gained the confidence and respect of the people. Traditional health practitioners understand the socio-cultural background of the population that they service. However, there is a negativity attached to their practice in that they do not have the academic background and the scientific knowledge of medicine, and have been known to be 'vague' in their practice. Their diagnosis is based on assumptions and is made without an in-depth analysis (Benatar and Landman 2006:239).

According to research done by Coe (1978:413), the evaluation and legitimisation of the current role of THPs can be done by using five guidelines: 'Availability, affordability, acceptability, acceptability and accountability'.

2.2.2.1 Availability

Availability is classified in two ways: firstly the supply of services or personnel, and secondly the geographical distribution. According to the *South African Yearbook 2007/2008*, it has been recorded that there is an estimated 200 000 traditional health practitioners. In the rural areas, due to the cultural and spiritual availability of traditional practitioners, about 80% of the population consults them. The ratio of traditional health practitioners to western doctors is about 1:500, while the ratio of medical doctors is 1:40 000. (South Africa. Department of Government Communication and Information systems 2008). Therefore, THPs are readily available in South Africa.

2.2.2.2 Accessibility

It has already been established that traditional healers are more accessible both in service and in geographic location, compared with modern medicine. So it has the advantage of cultural, social, psychological and geographical proximities. Traditional healers are expensive due to inflation and the cost of travelling to seek certain herbs, and because of the conditions of global warming with climate changes, certain species of plants are rare or have become indigenous or threatened by extinction. Some of the plants are unavailable due to urbanisation, population growth, droughts or bush-fires.

Given the figures of their availability it clearly indicates that traditional healers are easily accessible.

2.2.2.3 Affordability

It has been established that this type of treatment is easily accessible as mentioned before, however, it is relatively costly. According to Green and

Makhuba (1984:1074), Swaziland has attempted to regulate traditional healers' fees, however, the regulations failed as the cost of undertaking healing were not at par with the regulated fees. It was researched that in Swaziland traditional healers had just as many patients as western doctors in private practices had, and were long practicing and affluent within the communities. Green and Makhuba (1984:1074) observed that in Swaziland traditional healers would charge between \$120–\$130 US dollars per consultation.

In South Africa a survey was done in 1989 in Mangaung, which is a township near Bloemfontein, and it indicated that the consultation fee of diviners is twice as high as that of western doctors. It seems that even though traditional healers are accessible within the same community, individuals prefer to travel out to another traditional healer so that the healer can identify the problem without someone advising him within that same community. This therefore becomes more expensive when the cost of travelling is also taken into consideration (Van Rensburg *et al* 2004:[sp]).

2.2.2.4 Acceptability

It is imperative that a certain service is acceptable with the communities before the service is legitimised. In South Africa there is no doubt as to whether traditional healing is acceptable within society and communities, because research has proved this many times. However, it has been a challenge as to whether it is acceptable to policy-makers and to modern/western doctors, but the practice cannot be obliterated or prevented. Karlsson and Moloantoa (1986:26) had launched a campaign in 1989 to obliterate the practice of traditional medicine and concluded that he could not win the battle and therefore decided that communication and co-operation between the traditional practitioners and western doctors was the answer. The belief that supernatural forces do exist is vast, and even the educated believe that sources of diseases are caused by evil spirits (Study done at Medunsa) (Van Rensburg *et al* 2004:[sp]). The survey was done using first year medical students, nurses and paramedics. The findings of the study were as follows: two thirds of the students have a strong belief in the

supernatural, sorcery is a real force in the world, and diseases can be the source of many ailments. It seems that sorcery is accepted as a real force in the world and has a general acceptance.

According to Van Rensburg *et al* (1992:[sp]), it seems that traditional medicine will be accepted by society for a long time, therefore it needs to be incorporated in an open system and must be able to be flexible to new knowledge and ideas. Structural and non-structural systems must be put in place. Structural, refers to traditional healers conducting their consultations similar to medical doctors, and non-structural refers to hygiene, dress codes, appointment methods and so forth.

According to Benatar and Landman (2006:239), some medical/western doctors also accept traditional healers and make use of their skill, however, a lot of western doctors are against their practice. Most western doctors rationalise traditional healers as herbalists and must only make use of herbs, minerals and natural substances. Traditional healers are generally accepted, however, when it comes to western doctors it may be a question of competition. Understandably it seems natural for a university-trained doctor to want to fight for control over the medical profession. Though traditional healers have dominated this profession for centuries before, the allopathic doctor is still in a position to struggle for a higher hierarchy within the work force.

2.2.2.5 Accountability

Accountability can be defined using the words reliable or responsible. In the field of traditional medicine this is a challenging requirement. However, legal frameworks and associations have been formed to act as an official recognition and to hold accountability for traditional healers in the country. This will give traditional healers strong recognition from authorities. It seems that traditional healing has a great openness, indulgence and tolerance (Van Rensburg *et al* 1992:[sp]).

2.2.3 Future role of traditional health care in South Africa

2.2.3.1 Legislation

In previous centuries, legally and within the Christian world, traditional medicine had 'no right to exist', however, it survived into the 21st century. It was outlawed by the Health Act 19 of 1974 which restricted traditional healers to perform medicinal practices, but still it continued to survive. This act only allowed health practitioners that were registered with the South African Medical and Dental Council or the Associated Health Services Professions Act (Republic of South Africa, Act 63 of 1982). At the time traditional health care was not recognised, mainly because of the nature of this practice. Yet in spite of the prohibitive laws traditional health care has: survived, is well-established in urban and rural areas, and a large client base amongst rural dwellers, educated people and through vast socio-economic levels (Campbell 1998:106).

Previously the traditional healers were presumed under witchcraft, and were prohibited due to the Witchcraft Suppression Act (Republic of South Africa, Act 3 of 1957), and this outlawed divination, witchcraft and sorcery. In 1977, according to the Health Act (Republic of South Africa, Act 19 of 1977), traditional healers were even liable for prosecution.

With colonial rule, traditional healers had to work in secret, because their practice was banned. Later within the colonial regime, however, a tolerant approach was developed. Due to the recognition amongst the people it was almost impossible to keep it banned. There was consideration in viewing it in law as a parallel system as well as the intention to legalise it, but feared that the policy would fall short (Van Rensburg *et al*/2004:[sp]).

The 'National Health Plan' (South Africa 1994), stated the possible institutionalisation of traditional health care. The Constitution and the Bill of Rights changed it from illegitimacy to endorsement. This was based on citizens' constitutional right to choose to access traditional healers, because of their indigenous cultural heritage. It was realised that traditional health may have many benefits, and it would be advantageous to create co-operation with the allopathic and non-allopathic practitioners.

In 1997 there was a 'White paper on the Transformation of the Health System in South Africa' (South Africa 1997). This document discussed the policy objectives and principles of the Health System in South Africa that needed to be altered, and the ANC decided that there will be a transformation of a new health system. It stated: 'regulation of traditional healers should be investigated for their legal empowerment'. This was clearly an indication of progress (Van Rensburg *et al* 2004:[sp]).

Within the South African Constitution of 1996 (South Africa, Act 108 of 1996) there are constituents that base a principle on equity and diversity, and that proves that people have the right to consult a traditional healer or health care of their choice. This is clearly enshrined in the Bill of Rights. Also traditional healers have the right to practice their trade and profession freely, provided that they are registered (South Africa, South African Constitution, Act 108 of 1996 Chapter 2- Bill of rights).

As there are so many different tribes within South Africa, different healing, and different traditions apply to traditional healers. Therefore within traditional healing there is an internal disunity, enmity, division, rivalry and also envy (Van Rensburg *et al* 2004:[sp]). This is the reason for many different traditional healers organisations that were formed. This is when the Department of Health has affiliated attempts at unifying the traditional healers under one board.

South Africa was inspired by countries such as Zimbabwe and Ghana for their pragmatic policies regarding traditional medicine, as will be discussed. In 1995 the South African Government called public hearings to discuss the viability of traditional medicine. In 1997 there was a proposal from the statutory council to scientifically investigate traditional healing. In 1998, the Interim Co-ordinating Committee for Traditional Medical Practitioners of South Africa came into being. Their function was to regulate traditional healing, research, and development within the profession, and to develop an ethical code of conduct. It was also ultimately to create a co-ordination between medical professionals and traditional healers, so that a database and research can be facilitated. Evidence-based

research is needed. The legislative framework is discussed in detail at a later stage of the thesis.

There are various reasons for scientific evidence and evidence-based research that is needed in the field. These reasons include: reducing production costs will ensure affordability, reducing piracy will enhance the African ownership of their resources, improving manufacturing of the products will improve the economy and make use of the common plants that are used, and ensuring the accountability, safety and effectiveness of the medicines. According to Van Rensburg *et al* (2004:[sp]) it was proven that many herbal remedies can be poisonous and harmful. However, not much research has been conducted in this light. Evidence-based health care is discussed in further detail in Chapter 3.

2.2.4 Government initiatives regarding traditional medicine in South Africa

There have been many initiatives done by the government for the acceptance and accommodation of African traditional medicine. Several private practices and companies have provided their employees the benefits of using traditional healers (Benatar and Landman 2006:239). Another initiative was the establishment of a traditional healing hospital located in Mpumalanga. The hospital, named the 'Samuel Traditional Hospital', had five different traditional doctors, two wards and 245 beds (South Africa 2006:[sp]).

There were several projects that were run within the health care sector, which aimed at respecting the profession, concerning the two main epidemics, i.e. HIV/AIDS and TB. A community-based project in Hlabisa in 1992 was conducted, where a research was run concerning the DOTS (directly observed treatment short course) treatment plan for TB patients. There was a positive outcome to this study as it was noted that 89% of the patients had responded to taking their treatment effectively when they were supervised by traditional healers compared to the 69% of the patients who were supervised by others (Van Rensburg *et al* 1992:[sp]).

An initiative was done by the AIDS Control and Prevention Project (AIDSCAP) wherein 27 000 traditional healers were educated as councillors and were taught:

AIDS prevention and information practices, and how to provide care and emotional support to people living with HIV/AIDS. The initiative was so positive that it was evident that traditional healers played a role in health care in South Africa (Benatar and Landman 2006:239).

The South African Medical and Burial Savings Scheme have recognised traditional health practitioners so that their clients can consult with a traditional healer. The chamber of mines and the National Union of Mineworkers of South Africa now allow a panel of traditional healers at the mines for staff to consult. The Thamba Medical Aid scheme was formed by the South African Council of Traditional Healers in 1977, and offers traditional health to 3 million people. The Medical Universities of Pretoria, Witwatersrand and Cape Town include discussions of traditional healers for the use of collaboration (Campbell 1998:106).

TRAMED (South African traditional medicines research) is an initiative of the University of Cape Town and the Medical Research Council (MRC) to research the pharmacology of traditional medicines. They also have a database for all researched plants/herbs, named TRAMED III.

Benatar and Landman (2006:239) and Van Rensburg *et al* (1992:[sp]), both have stated that it seemed that the Department of Health underestimated the positives of traditional medicine and focused only on the complexities, and hence delayed its legitimisation.

However, there are some setbacks. The intellectual property rights of the traditional healers need to be safeguarded. This is why the WHO came up with 'the protection of indigenous knowledge, and intellectual property rights'. The National Research Program, promoted programmes to link national strategies to local knowledge and expertise with the aim to sustain human development (WIPO, Leaflet no. 12).

There were also many cases concerning the potency of the traditional medicines (Benatar and Landman 2006:239). Benatar and Landman (2006:239) describes a case study where the San people used a "HOODIA" plant as an appetite suppressant and with this known knowledge a large prominent research

organization patented this ingredient, known as Pg57, and sold it to a multi-national pharmaceutical company (name will not be stated). Despite knowing that it was an ancient San remedy, the San people received no compensation for this knowledge. Yet this product was successful and economically viable. This was the landmark case where indigenous people are required to claim their intellectual property and profits that need to be gained for it, despite the absence of legislation (Tellez [sa]).

2.3 DEDUCTIONS

The history of apartheid in South Africa has vastly influenced the health care sector. After having learned about the history of health care, we have seen the reasons why health care has been regressive. The disparity in gaining access to healthcare meant that traditional medicine has, for centuries, been the only choice of health care for citizens living in rural areas, perhaps all across the African continent and undoubtedly across various sections of South African society as well. What makes it more interesting in South African history, is the fact that oppression and inequality in the country as well as apartheid has curtailed the progression of traditional health care.

The previous chapter gives light to the current situations in South Africa, and the next few chapters discuss the policy itself. It discusses the government's vision towards traditional medicine, and the role THPs' play and will play in the future of South Africa. The policy has been drafted and is currently in the monitoring and evaluation stage, but still needs to be moved into the implementation stage. Inevitably challenges need to be explored and solutions need to be found. The next chapter highlights the realities concerning traditional medicine in its entirety. The subsequent chapters also move on to the fundamentals of western and traditional medicine and explore its integration within the national health care system.

CHAPTER 3

THE FUNDAMENTALS AND INTEGRATION OF WESTERN AND TRADITIONAL MEDICINE

3.1 INTRODUCTION

At present there are many modalities of alternate treatments available in South Africa. However, all around the world people crave to have healthy lives and the right medications. People seek remedies that are safe and effective. As discussed above, for years people have sought traditional healing, but modern medicine has ruled the western culture since its inception. People seek medicine, because it has the ability to heal and relieve, and it affects billions of people each year. Although both modern medicine and traditional medicine is available in South Africa, the question remains whether all options are safe? In order to feel safe and secure, people need to choose the best option and it is up to the government and policy makers to take responsibility for the health and safety of communities. This chapter points out the facts and realities about western medicine and traditional medicine, then goes into detail about integrating both modalities equally into one national health care in South Africa.

3.2 EXPLORING MODERN MEDICINE

This section addresses the fundamentals and realities of western/modern or allopathic medicine. This section highlights the realities of the scientific aspects of medicine: its history, progression, and current status. It illustrates to us that the initiation of scientific medicine began as traditional medicine. It highlights the fact that scientific doctors have a scope to their practice, regulations and limitations. In order for any medical professional to be part of the National health care (NHC) system there needs to be accountability, a certain level of education, and continued professional development. This section is merely drafted to: understand the level of accountability, create a comparative study, and to bear in mind that limitations must be accounted for and be more ethical and fair within the field. This section creates an understanding that each professional should have a rightful place within

the National health system (NHS). It is merely to make us understand: the reasons as to why allopathic doctors do not agree entirely with traditional medicines, and the level of scientific evidence that healers require for a field to be legitimised. It helps us to gain an understanding towards evidence-based health care and the importance thereof.

3.2.1 Definition of western/modern medicine

According to the *World Book Encyclopaedia* (1996:[sp]), medicine is defined as 'the art and science of healing'. It involves a range of health care practices that evolved to maintain and restore health by the prevention and treatment of illnesses.

Contemporary or western medicine makes use of biomedical research, medical technology and health sciences to treat and diagnose injuries and diseases. The word 'medicine' is derived from Latin meaning 'the art of healing'. Medical expertise and clinical trialling are pivotal to modern medicine, however, they cannot remove the element of fear in people.

3.2.2 The history of western/modern medicine

Prehistoric medicine initially began with the use of plants, herbs, animal parts and minerals. In the prehistoric era, a lot of these items were also used as magical amulets and charms by priests, medicine men and shamans. Prehistoric medicine can also be classified in four categories namely: 'animism' (meaning solid objects having spirits), 'shamanism' (an individual possessing mystic powers), 'spiritualism' (the appealing to God or ancestral spirits), and 'divination' or magical powers through which one can obtain the truth. Medical anthropology studies the field of prehistoric medical systems (*World Book Encyclopaedia* 1996:[sp]).

The first traces of medicine can be traced back to the discovery of early Ayurvedic medicine in ancient Egypt, ancient Greece and ancient Indian continents. Medicine began by a Greek doctor named Hippocrates, who was called the western 'Father of Medicine'. Later there were more discoveries that led to more approaches to medicine. For example, after the fall of Rome there were discoveries made by Islamic physicians which led to more breakthroughs in the medical profession.

Modern biomedical research, in which results are tested and researched, began in the late 1800s and early 1900s. Modern-western medicine began, when Robert Koch discovered that bacteria cause the spread of diseases and later discovered the anti-biotic around the year 1900. The discoveries made after the 1800s brought many great breakthroughs in modern medicine from Europe. The development of science and technology made modern medicine and medications more reliable. Pharmacology was initially also derived from herbs, and most medicines are still made from plants. Thereafter the modern medical world developed 'evidence-based medicine' as the most effective form of doing things, this was achieved through systemic and analysing reviews. It was a movement that was practiced globally and included information science that allowed evidence to be collected and analysed according to a bureau of standards, before being distributed to the health care professionals (*World Book Encyclopaedia* 1996:[sp]).

3.2.3 Clinical practice and Diagnosis

Qualified doctors or general practitioners (GP) use personal assessment to diagnose, treat and prevent diseases according to clinical judgment (*World Book Encyclopaedia* 1996). The doctor-patient relationship is an important one as the doctor interacts with the patient. The doctor initially interviews the patient for previous histories or medical records and then physically examines the patient. Tools and devices such as the stethoscope, endoscope or many other instruments are used. After the doctor has examined the patient to look for signs and has heard the symptoms, the medical doctor sends the patients for clinical evaluation through the use of relevant diagnostic tests such as blood tests, biopsy's and radiology. The doctor then treats the patient with pharmaceutical drugs or other forms of therapy. The doctor uses the method of 'differential diagnosis' to rule out certain illnesses with all the information provided. During this consultation, all the relevant facts are relayed to the patient, this then develops a trust relationship between the doctor and the patient. All the information is then entered into a report, which holds as a legal document and is used in many jurisdictions.

3.2.4 The methods used by western/modern doctors in their diagnosis

The practitioner is bound to transparency, ethical manners and dedication, without being biased towards any patient. How western doctors diagnose their patients is to exert the patients' verbal complaints, which are referred to as 'symptoms'. The doctor gathers the patient's history and investigates the symptoms. Factors like the patients' health, occupation, living conditions, medicines, herbal treatments, past and family history are enquired about and documented. The doctor converses with the patient and a set of relevant questions concerning the human body are asked.

This is followed by a physical examination which constitutes four chief methods: inspection, palpitation (feel), percussion (tap to determine resonance), and auscultation (listening). The practitioner also uses smell as a sign of diagnosis. The physical examination involves the study of the following: vital signs, temperature, pulse, blood pressure, the patient's appearance, as well as checking vital organs like the head, eyes, nose and throat. The doctor then evaluates the heart, lungs, abdomen and pregnancy status, in addition the muscular, neuromuscular, skeletal and mental state is evaluated. Laboratory testing and different imaging techniques are used for further investigation and scientific evidence.

They then use the differential diagnosis method. This is known as the medical decision-making process. The practitioner uses the above information, and comes up with a list of possibilities that could be the diagnosis, until the practitioner has a definitive diagnosis that would enable him or her to treat the patient. The treatment plan and diagnosis may either take a few minutes or it may be a longer period depending on whether the patient is hospitalised or not (Holland 2009).

3.2.5 Western doctor's role in society

According to the Kirch (2008:613) 'public health' is described as the 'science and art of preventing disease, prolonging life and promoting health through the organized efforts of society'.

The College of Family Physicians of Canada (2005), states that doctors are the main providers of primary health care. The same article states that doctors are providers

of care and are leaders in four areas of public health. The four areas are as follows: 'health promotion', 'disease and injury prevention', 'chronic disease management', and 'health surveillance'. 'Health promotion' means that doctors provide advice and care for individuals and families. Doctors are also dedicated to improving health and well-being, while implementing and advocating public health policies. 'Disease and injury prevention' refers to counselling and screening for acute and chronic diseases. Doctors thus provide and promote disease and injury prevention. In 'chronic disease management', doctors play an important role in the community. This means that the diagnosis, treatment and prevention of secondary diseases are related to chronic diseases. 'Health surveillance' refers to medical doctors' reports that suspect and confirm diseases that threaten areas in which civilians reside. They also identify, prevent and treat outbreaks through a screening process and they reduce the severity of the spread of outbreaks.

In addition to the above roles, medical/western doctors also: act as advisors in developing community health programmes, deliver the public health programmes to each and every patient in the hospital, apply population based indicators to the population, provide counselling and support, implement self-help programmes for patients, such as healthy eating and physical exercise, participate in research initiatives, work hand in hand with other health care professionals, and participate in the education and training of medical students and other health care professionals.

Another integral part of the role of the western doctor is to provide emergency care and co-ordinate medical care with other health care professionals within the public health care system.

3.2.6 Formal training of medical western/modern doctors

Medical training curriculum's may vary around the world, but it involves an entry-level tertiary education at a university followed by an internship period and community service. All medical practitioners also need to be registered by a professional body and accredited by a medical board.

Medical doctors need a school level education as a primary requirement. Thereafter formal education takes six years to complete with an additional two years of community-based education.

Community-based education (CBE) is a core part of the curriculum to any health science. For instance at the University of Pretoria all students need to work and gain experience and skills in a community setting and not only within an academic set up (University of Pretoria 2008).

3.2.7 Laws supporting western medicine as well as pharmacy and medical boards required for health professionals

All doctors and pharmacists are trained according to medical laws and are required to be trained under evidence-based medicine. Doctors who are negligent or guilty of malpractice are faced with charges and are subjected to punishment as civil criminals or professional sanctions.

The following is a list of Medical Boards that are required for all health professionals:

- Health Professions Council of South Africa (HPCSA);
- South African Medical and Dental Council (SAMDC);
- South African Medical Association (SAMA); and
- Medical Association of South Africa (MASA).

The HPCSA comprises of a list of different registered medical professionals. The above-mentioned Boards oversee most of the health professions in South Africa.

3.2.8 Evidence-based health care

Gilliam, Yates and Bandrinath (2007:[sp]), defines evidence-based medicine (EBM) as:

...the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systemic research.

Evidence-based health care (EBHC) is founded on scientific research that all professionals base soundly on science.

The tools needed to practice evidence-based health care requires five essential steps and are discussed as follows (Gilliam *et al*/2007:[sp]):

- 1) 'Convert the information into an answerable and focused question'. This would mean by asking a question that would include: the population or quantity, the intervention, the comparison, and the outcome of the particular field. It entails asking a question that is clear, open and answerable.
- 2) 'Tracking down the best evidence'. This would refer to searching for research evidence, instead of relying on textbooks and journals. Once the question has been formulated, the research base is to search for the best evidence that is authentic.
- 3) 'Appraise evidence critically'. This is a method to critically evaluate the study of interest. In other words, we need to determine if we trust the results so that we can act on it to change the question.
- 4) 'Change practice in the light of evidence'. This means that in light of the evidence studied, we need to implement it. This is the most difficult of all the steps. This normally requires the assistance of mostly all public health practitioners. Managing people is important in this step.
- 5) 'Monitoring and Evaluation of the performance'. This is the auditing phase. This can be evaluated a few months later. The evidence is under scrutiny and is being tested to see if it works.

3.2.9 What is public health care and what is the importance of it in South Africa?

After 1994, there was a reformation of health care. The 'Reconstruction and Development Programme-1994', and the 'National Health Plan 1994' were the initiatives for the new reformation. There was more emphasis on public health, community development and preventative and curative care. This new public health care approach emphasised on full community participation to reduce the

inequalities within communities. It was proposed that the national health system (NHS) would be operated at central, provincial and local levels. The district health system oversees all health care within the district (Benatar and Landman 2006:239).

According to the Gilliam *et al* (2007:[sp]) public health is defined as 'the art and science of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals.'

Public health is concerned with the general public, and the overall health of the community. There are two important determinants of public health that deals with preventative rather than curative aspects of communities. The science of public health concentrates on the diagnosis of the population, rather than just the individual. It determines health problems, it establishes the causes of the problems, and determines solutions for the problems on a national level (Gilliam *et al* 2007:[sp]). Public health is made up of health improvement, health protection and social care quality.

Health improvement refers to not only improving health, but also to the promotion of good health. It aims to reduce inequalities within communities and it sees to family and community health, education and healthy lifestyles.

Health protection refers to providing: pure water, hygienic food, clean air, infectious disease control, protection from dangerous radioactive substances, chemicals and poisons, and protecting the environment from health hazards and social disorder.

Health and social care quality refers to the quality and place of relevant health policies and planning. It seeks to: improve health quality and standards of service delivery, maintain evidence-based health care, and to have good clinical governance. Health efficiency, research, monitoring and evaluation are also included (Gilliam *et al* 2007:[sp]).

3.2.10 Health promotion and population health.

Health promotion focuses on the social, economic and environmental determinants of health and it aims at helping people increase control over their own health. Health promotion encompasses health policy, education, legislative action and community development. Disease prevention is increasing and this has the potential to improve community health. Physiological models on behaviour change helps to manage change.

High levels of poverty, unemployment and inequality can impact the high levels of morbidity and mortality in any community in South Africa. There is an intrinsic link between morbidity, mortality and poverty.

Improving support and community cohesion is important in protecting health, also ensuring access to essential facilities and services. Valid policies and initiatives must be aimed at improving living conditions as this is vital for reducing health inequalities. Services and facilities must be required to: promote health, include a decent living and working environment, and ensure access to goods and services that are essential today. What constitutes 'essential' varies from culture to culture.

After having addressed and understood the fundamentals of modern medicine clearly, the following section explores the fundamentals of traditional medicine so that the two disciplines can be compared and assist each other into a fair integration. In order for the reader to fully understand why modern medical doctors have not embraced TM, the following section has to shed light on the fundamentals of traditional medicine and it gives a brief overview into the field to illustrate the facing differences.

3.3 EXPLORING AFRICAN TRADITIONAL MEDICINE

The objective of this section is to formulate an understanding towards the realities, fundamentals and factual observation relating to traditional health practitioners. In order to legitimise a policy and to understand the aspects of the field, it is of the utmost importance to gain a deeper insight and address the roots, facts and realities. Policy makers need to take into consideration the realities that are faced in making a wise and fair decision. This way, fair and ethical policies can be drawn up and implemented. This section assists us to understand and gain a broader insight

into the relevant subject. Another important point that is highlighted in this section is the progression of folk medicine. The implication of folk medicine suggests a way forward and is an important example as to where to direct traditional medicine. The section also points out some imperative examples of regions where traditional medicine has had positive and negative connotations to people around the processes and outside communities.

3.3.1 History of traditional healing

During a public hearing, the minister (Manto-Tshabalala Msimang) stated that an estimated 60% of South African babies are delivered by traditional birth assistants and 80% of the South African population make use of Traditional healers (PHILA 1997).

Pefile (2005) researched legislation on traditional medicine. In his article he stated that 30 million people consult traditional healers in South Africa. Traditional medicine generates an income of about \$200 million per year and creates employment for 30 000 people every year. He stated that the use of medicinal plants in South Africa creates a valuable health system. Research has been done in natural plant remedies and is an established area of science. The recognition of indigenous knowledge led to the introduction of legislations and policy. Pefile (2005) posed that a national framework will address the concerns of the exploitation of traditional medicines and will incorporate the interests and clients of the practitioners. He stated that the Department of Health's efforts to improve health care services started off with a national drug policy. The policy aimed at improving the efficiency of traditional medicine with the objective of incorporating it into the national health care system. It also aimed at compiling a code of practice for traditional healers and providing the registration and control of traditional medicines.

The origins of African traditional medicine are unknown. However, even before the Europeans had settled in South Africa, this form of health care was dominant and had political influence in the public and private sectors. Later under missionary influence it was condemned as 'primitive', 'barbaric' and 'uncivilized' (Benatar and

Landman 2006:239). Even though African traditional medicine was regarded as being an inferior quality, it has survived more than three centuries of white settlement, in both rural and urban areas where Western medicine was prevalent. In the past it was the only form of primary health care for the black population, but even today where modern/western medicine is freely available, and not because they have no alternative, the African population still uses traditional medicine and finds it acceptable.

3.3.2 What is a traditional health practitioner (THP)?

The World Health Organization (WHO) describes a traditional health practitioner or traditional healer as:

‘Someone who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community.’

Traditional healers in South Africa are commonly known as a *sangoma* (Nguni language), *Nyanga* (Sotho/Tswana language) or herbalist (Van Rensburg *et al* 1992:[sp]).

Traditional healers perform different tasks and have different methods of treating. They also have different specialties and treat different ailments. A traditional healer is in charge of his own medicines and treats patients with his own manner that he has been trained in.

The president of the Traditional Healers Organisation of South Africa states that:

‘A traditional healer has a multifaceted role which includes training, knowledge, power and ability to serve in a number of medico-religious functions, such as a herbalist, seer, ceremonial leader, physician, spiritual leader and psychologist, priest and mystic all rolled up in one (Zungu 2002).’

The philosophy that gives a foundation to African Traditional Medicine (ATM) is ‘Ubuntu’: ‘*Umuntu ngumuntu ngabantu/motho ke motho ka batho/ a human being is a human being through other human beings.*’ This ultimately refers to the

relationships existing between an individual and other individuals, those living and those that have passed on. Therefore they have a religious, spiritual, psychiatric and physiological approach to healing (South Africa, Government Gazette 2007:[sp]). ATM regards nature as something that can be manipulated to achieve goals and it uses nature as an 'instrument' for human beings. They regard nature as a force, and can be manipulated to a will of your own. Within the field of traditional medicine (TM), they regard nature as a high priority and create a relationship between nature and the human being (South Africa, Traditional Health Practitioners Act 22 of 2007).

The African culture believes in the ontology of harmony and balance in the field of health. They believe in cosmic life forces, that power and energy is the universal force that is responsible for illnesses. The belief is that God is the regulator of the force, but ancestral spirits have an access to this force. The traditional healers are manipulators of this force and they have the power to call upon the force to aid in healing any ailment. The traditional belief is that magic and witchcraft can also be the cause of illness, misfortune and evil. It is believed that equilibrium needs to be restored between social and natural forces. Sorcery and witchcraft makes use of special medications and powers to harm human health, this is mostly known as 'black magic'. Traditional health practitioners (THP) have been referred to as 'witch doctors' until recently. However, they are said to have benevolent (white magic) forces that benefit the community and health. Therefore there is a difference between traditional healers and witch doctors, even though they have been thought of as the same profession, this is what causes the negative connotation towards the field (Van Rensburg *et al* 1992).

The two main types of traditional healers are diviners and herbalists (Van Rensburg *et al* 1992). Most of the time, traditional practitioners overlap these roles. Once a patient has been diagnosed, the traditional practitioner decides what type of treatment they may require. Either through divination or by using herbs (*muti*), the ailment is treated. The person will be treated either for benevolent (*Ngaka*) or malevolent (*baloi*) purposes. The third type of healer is the faith healer or prophet, who heals with the framework by way of the church. Lastly there is the traditional birth attendant who

serves as a mid-wife within communities. More in-depth explanations of the types of healers are as follows:

3.3.2.1 Diviner

Diviners solve the mysteries of why occurrences happen in an individual's life. They analyse and interpret the signs given to them by the 'ancestors' or spirits, through dreams and visions. They use divination and special powers of prophecy to solve problems. The ancestors or spirits also provide the recipe for the herbs or *muti* used to treat the specific case that is diagnosed. Becoming a diviner requires a special 'calling' from the ancestral spirit and is an inherited gift and a vocation. The African culture believes that only those who received that calling have the true art of magic and are considered within the communities as a true healer. The calling is usually via dreams or an illness, that is to say the individual begins to show signs of a mysterious disease. It seems that they are so physiologically and physically affected that they cannot live normal lives. These symptoms project fear, hallucinations, dreams and visions, this is portrayed as the ancestral spirits communicating with the individual as a calling. This condition brings about a change of life for the individual and in African culture the word '*Twasa*' (Xhosa) is used which means 'reborn'. The 'illness' will be medically, then this is when the individual consults a master healer to proceed with training (Van Rensburg *et al* 1992).

Training as a diviner takes place secretly and is a complicated process that is filled with many different rituals from start to end. The trainer must be remunerated. During the first two years of training the trainee is an observer during consultations. Divination is achieved through the spirits and ancestral spirits of the deceased and it is only these diviners who have the ability to communicate with these sources for guidance. Most of the divination is done by using divination tools, mostly known as 'the bones'. The diviner reveals what is the cause and makes the diagnosis using the position in which the bones fall. This way the bones are interpreted and *muti* is prescribed. Where the fear of sorcery is the cause of the problem, the diviner combats it with a charm.

Apart from dealing with illnesses, diviners: are advisory councillors to the members of the community, provide social work and pastoral advice, offer prayers for the community, such as mix certain herbs as a form of prayer for rain or protection of the fields and crops, and prescribe sacrificial animals.

In the past, traditional health practitioners were often confused with witch doctors as mentioned above. Witch doctors are said to use evil spirits to cast spells on people, with the malicious intention of harming people. This has caused negative connotations to the field of diviner or herbalist, hence there was a social stigma attached to it (Campbell 1998:38-60). This is discussed in more detail later in the thesis.

3.3.2.2 Herbalist

Hammond-Tooke (1974) describes herbalists as 'ordinary people who have acquired an extensive knowledge of magical technique and who do not, typically, possess occult powers.'

These are practitioners who have developed knowledge on prescribing medicinal herbs to treat ordinary ailments, however, according to (Berglund 1976:136-155), it seems there is some overlap with diviners. Herbal practitioners do not use the occult, but have extensive knowledge about the magical powers that exist and have acquired some of these techniques. These practitioners provide protection against sorcery and misfortune and promote happiness and good health. Empirical and overall knowledge plays a role in the herbalists' procedures. They must have the ability to make an accurate diagnosis and provide healing herbal remedies that have been prescribed by the ancestors. The remedies are believed to be charged with magical powers as well. Often amulets or protective devices are provided that are believed to be potent and have empowering properties.

Herbalists also acquire their knowledge by means of an apprenticeship with an experienced herbal practitioner. They learn how to diagnose and treat diseases, dig roots and prepare medicines. The remedies are normally inherited and passed down from generations. Herbalists have a close alliance with diviners, however,

they specialise more in herbs, using ancestral guidance. A lot of the herbal medicines have strong symbolic significance. For example, within the Tswana tradition the crocodile is used for skin remedies as it symbolises coolness (Van Rensburg *et al* 1992).

It has been documented that even if the remedies of the traditional healer have not been effective, the faith in the remedies is so great that the patient recovers due to the following reasons (Kibukamusoke and Coovadia 1998):

- 1) Patients would recover with the body's natural healing properties and the diviner simply strengthens the conviction of the healing.
- 2) The efficiency of the treatment has not been established. The treatments are not empirically verified.
- 3) Success rate is high and this is why faith in the medicine is not destroyed.
- 4) It is attributed to incorrect application, sorcery or bad luck.
- 5) The 'placebo effect' takes effect, where the medicines provide the psychotherapeutic value, patients feel better without having their pathological condition improved.

3.3.2.3 Faith healers/Prophets

These types of healers interpret in the same category as priests or a practice of Christianity, but are reconcilable with the traditional culture. They are not typical traditional healers, but they share common trends with traditional healers.

There is shared theory on disease and health, but the faith healer's divination is through God, Jesus and the Holy Spirit, rather than through the ancestral spirits. They treat diseases the same as the culture-related diseases.

This type of healer is related to the African Independent Church, according to Van Rensburg *et al* (1992). He estimated that there are approximately 12 000 of these churches with about 30 million members. According to research conducted by Van

Rensburg *et al* (1992), the traditional indigenous views of a supreme being were initially underdeveloped. The missionaries, at the time of colonialism, used this to their advantage as it was a reason for reducing complexities. However, they tried to instil a Christian belief and provide an adequate understanding to the people who had faith in ancestor beliefs. They believed that if a Christian God was not provided as a substitute, there would be a need for another superior being. Hammond-Tooke (1974), reinforced this when he stated that 'if the Christian God had not been introduced, an indigenous substitute would have had to be created'.

In 1914 an American-based church was introduced, called the *Christian Catholic Apostolic Church of Zion*. Many people all over South Africa are followers of this church and its headquarters is in the Limpopo Province. This church is characterised by the baptism in the Holy Spirit. They teach the power of a superior being and the Holy Spirit. The church also symbolises values, power, love, religion, justice, authority and of course punishment and resentment as well. The concept of 'power' is very strongly respected within the African culture and is hence present in all the rituals and magical spirits of the ancestors as well. In the past the beating of drums in the African culture was more symbolic and induced a trance of 'possession' by the spirit of the dead and was therefore that the Zionist movement was said to have a 'pure' element. Another difference between a faith healer and a herbalist is that of ancestral worshipping, and respect towards the ancestors, which was replaced by the belief of the unseen. When people offered sacrifices towards the ancestors it symbolised respect towards the deceased and not worship (Van Rensburg *et al* 1992).

A prophet, not unlike a diviner, has the same means of qualifying by becoming ill, which is characterised as a 'calling' towards becoming a prophet. The role of a diviner or prophet is also initiated just as the one of a herbalist in that he responds to a calling whereas the Zionist is possessed by the Holy Spirit instead of the ancestral spirit. Food and rituals also play a vital role, whereby the ingested items have been prayed on for healing. The diviner and faith healer both acknowledge that some illnesses have been caused by bad luck, witchcraft or sorcery. The customs may differ slightly and different cases have differing customs and ideas.

3.3.3 The traditional healer's role in the community

The World Health Organization (WHO) defines traditional healing as:

... comprising therapeutic practices that have been in existence for hundreds of years, before the development and spread of modern scientific medicine and are still in practice today. These practices vary widely, in keeping with the social and cultural heritage of different countries (Campbell 1998:77).

Even though modern medicine has the concept that traditional healing is primitive, that it has not evolved and that it is stuck in a cultural past, the reality in South Africa is that it is readily available even when clinics and doctors are not. Traditional healers provide support and act as community leaders.

Traditional healing has been passed down through generations for centuries, even items and articles that are used are still original. And these items will continue to be passed down from generation to generation (Campbell 1998:48-56). As mentioned above, traditional healers seek guidance from the ancestors. These ancestors are spirits that they call upon and that they have a way of being possessed by. It is through these voices that they base their diagnosis and guidance and take instructions from (Campbell 1998:48-56).

African traditional healers address the healing of the body and the spirit. They act as leaders in the community or as a sage where the community seeks advice and guidance, as they have the ability to communicate well with the community members. They are the catalyst for a change in mindset, and psychologically help the community to cope with health or spiritual problems, often using the 'placebo effect'. The healer also understands the needs of the community from all the sources, ranging from educated to more primitive societies (Campbell 1998:38-60).

3.3.4 African culture and the fundamentals and realities of traditional medicine in South Africa

Culture may be defined as 'the way of life which a group of people has worked out to enable them to cope with the problems of daily living in a particular environment. It determines all ways of thinking, feeling, believing and behaving' (De Haan 1996).

Culture normally determines our way of life: how we dress, talk, our moral values, the language we speak, the food we prepare, and how we raise our children. All aspects of our lives are determined by culture and in the same way many diseases are rooted within the communities and modes of treatments.

Traditional healing is a deep-rooted part of the way of life in Africa. It has been practiced for many centuries and will survive for as long as the African culture does. South Africa is blessed with a rich culture and a variety of healers. The traditional healers are classified into four, as discussed previously: the traditional birth attendant, the herbalist, the faith healer and the prophet. The 'ancestors' choose the master healer whom they possess. It has a positive connotation to cultures and in African culture represents a link with God (Campbell 1998:38-60).

The herbalist's knowledge is based on years of experience in assisting a sangoma (experienced herbalist). The 'technicians' are able to diagnose and treat patients by using herbal remedies and spiritual guidance. These herbalists are important contributors to the primary health care system.

The traditional healer is an integral part of the health care system as they have provided support and healing amongst many of the communities within South Africa for centuries. Their concoctions and mixtures have been the only source of health care for many years, even before modern medicine emerged. Therefore traditional healers are classified as an integral part of African culture. They were trusted as healers and leaders for many years. In modern times, due to the misconception about their practice, it has been practiced in secret (Campbell 1998: 77-98).

Today, with traditional healing uncovered in South Africa and an increasing world curiosity about alternate medicine and natural therapies, traditional healers are prepared to practice as openly as any other health care professional. Their deep-rooted knowledge of indigenous plants and the medicinal properties of nature that have been maintained and captured for centuries will now be made available to South Africans through a policy allowing traditional healers to practice freely and fairly. Holistic treatments, herbs and other remedies have proved to be an integral part of health care and are thus recommended (Campbell 1998:77-98).

Even though the majority of the population turn towards African traditional healers, it seems that in South Africa there have been many attempts to discredit their efforts and modern medicine insists on remaining sceptical about them (Campbell 1998:77-98).

3.3.5 The apprenticeship and training of a traditional health practitioner

3.3.5.1 The Calling:

As discussed above, traditional healers cannot simply choose to become healers as a mere career decision. In African culture it is believed that it requires a certain 'calling', which qualifies an individual to become a traditional health practitioner. The healer is coached by the ancestors in his/her dreams and visions. Initially the 'calling' is identified by means of an illness. This 'illness' has no physical or medical condition and can only be combated by accepting the calling to begin training as a sangoma (THP).

It is believed that the reason the 'calling' is by means of an illness, is to coax the individual to go through a tedious training program (Campbell 1998: 17-38).

3.3.5.2 The training:

People of all ages who have had the 'calling' can attend training. The training period of the sangomas or traditional healers can be anything from one to ten years. During this time the trainees are forbidden to see their spouses or children. They must abstain from any form of sexual contact with the opposite sex. This is known as the cleansing process and is preparation for their task ahead. This isolation enables them to focus and isolate any form of distraction in their education (Campbell 1998:56-66).

In their training traditional healers: are taught to use pure herbs and that even poisonous ones may have healing properties, learn how different plants and herbs heal, learn how to approach the spiritual world, and learn different herbal concoctions to treat different ailments.

The trainees are not only taught this speciality by the trainers, but are also taught by the ancestors. The ancestors reveal the type of herb and dosage to be mixed in visions and dreams (Campbell 1998:56-66).

The most difficult part of the training program is at night where the trainees have to become 'possessed'. The group of trainees work every night by beating drums and praising the ancestors that come to them through possession (Campbell 1998:56-66).

'Possession' is described as a spirit that physically takes over the body of a sangoma (THP) and then talking through the voice of the qualified sangoma (THP). This 'possession' is part of the training as a way for the ancestors to reveal truths (Campbell 1998:56-66). It is stated that a good spirit will direct a sangoma (THP) and is very helpful. Thus this is another way to gain information from the ancestors. Consequently it is also why traditional healing has often been accused of being witchcraft.

After they have qualified, traditional healers continue to be consistent in listening to the guidance that is received from the ancestors. Even the clothing that traditional healers wear promotes the relationship that they have with their spiritual guides (Campbell 1998:56-66).

If an individual has disappeared for some time and returns with a water python, it symbolises the fact that that the individual is a born healer. For this reason they do not need training, but instead are shown the signs through the ancestors in dreams and visions (Campbell 1998:56-66).

3.3.5.3 Place of practice, residence, tools and instruments of the traditional health practitioner

A diviner will have a hut inside a homestead and is the sole occupant in this hut. Visitors and friends may be invited only to enter it, but not to reside in it. The hut is closely linked with the spirit and presence of the ancestors. The medicines are kept in clean glass bottles and are placed above the doorway. In the cold whether a fire is made, but only by the diviner himself or by children who have not yet reached puberty. The diviner discards the burnt ashes into a river. The diviner hides an amulet or charm above the doorway, in the thatch of the hut. It is placed

there by the diviner himself. The charm consists of white beads or of the vertebrae of an animal that was slaughtered at the ritual graduation ceremony. The symbolism in this is to guide the ancestors to the owner of the house and also confirms who resides there (Berglund 1976:136-155).

3.3.5.4 Dress

Usually diviners use animal skin, however, not all diviners use it. Traditional healers' hair is sometimes braided and is about 5cm in length. There is also a lot of importance placed on a black piece of cloth that is thrown over the diviner's shoulders when the bones are thrown. The cloth is needed to 'cast a shadow' over the bones, which is a way of divining. Diviners cover their shoulders and never expose it to the sun, or alternatively they don't divine in the sun. They claim to become sick if their shoulders are exposed to the sun. They believe in using the shade as darkness, so that they can diagnose or see clearly. Sometimes their black clothes are covered in white and used only for divining (Berglund 1976:176-184).

3.3.5.5 Diviner's vessel

The traditional tools include sticks, bowls, stampers and shells. One of the tools is the diviner's vessel. They have a separate vessel in which they cook and eat, however, they often have a clay vessel which is considerably important and is used for preparing medicines. This clay vessel is obtained during training and is used throughout the diviner's life. Should the vessel be destroyed it is said to be a calamity. The vessel must be made of clay, in order for it to be recognised by the ancestors. Sometimes they have a white, black or red background as the different colours symbolise different things (Berglund 1976:180-184)

3.3.5.6 Knife

During training, the trainer purchases a knife and presents it to the trainee (diviner). It was previously believed that a diviner would become ill if they did not

receive a weapon at the time of training (Berglund 1976:80-184). The diviners' weapons are used in ritual killings and at celebrations or ceremonies.

3.3.5.7 The diagnosis

The healers make use of the 'ancestors' to instruct them on what to do. The ancestors are described as angels, guardians or spirits who speak to them and guide them on what to do. They make contact with the healer in a consultation or through dreams (Campbell 1998:56-66).

Most frequently THPs' use bones to make an overall diagnosis of the patient. The 'bones' refer to actual bones. These bones are often from the goat that was used and eaten at the graduation. Included, with the bones, are shells and dominoes. After the training the sangomas (THP) take the bones home, and it becomes a tool for the rest of their practice.

'Bone throwing' is a way to determine the diagnosis. Thus the bones decide what is wrong with the patient and what treatment is required. The guides and ancestors speak to the sangoma (experienced healer), by means of how and in what direction the bones fall. The ability to throw bones is easily learned and often accurate (Campbell 1998:56-66). Each bone has a certain or different meaning, and denotes a diagnosis in a different way. So each bone, domino or shell represents something different. For example if the domino falls the right way up, it means that everything is well (Campbell 1998:56-66).

3.3.5.8 Healer graduation

The graduation ceremony is the acknowledgement of completion and is the most difficult part of becoming a healer.

A fire is made with special incense that burns all day in order to increase contact with the ancestors. Also to increase contact with the ancestors there is: dancing, chanting, drum beating, herb burning, and muti drinking (Campbell 1998:66-77).

A certain stick is used that is made out of hair from a rhino's tail. At the end of this stick there is muti, which arouses the ancestors. The scent of the stick is potent and this is what arouses the ancestors (Campbell 1998:66-77).

All the trainees are dressed in traditional clothing, and all the healers, from the master healer to the matrons that were trained under the same healer, engage in dancing. The graduates are then each given a goat, chosen by their ancestors. While the goat is still alive, its throat is slashed and then the graduate needs to drink the fresh blood of the goat. Immediately after this, they are given a herbal drink which will make them nauseous and induce vomiting. After throwing up, the graduates are given some porridge to settle their stomachs and then allow the ancestors to come to them more easily. If in the event the graduate was unable to vomit then it means that they have dishonoured the ancestors in some way and that they have broken a regulation. The particular rule that was broken is related to the abstinence from intercourse (Campbell 1998:66-77).

The graduates are then escorted to the river where they throw the rest of the blood, from the goat, over their bodies. They allow the blood to remain there for fifteen minutes after which they wash it all off in the river water. They are then presented with specialised traditional clothing that they are given to wear for the first time (Campbell 1998:66-77).

Afterwards they undergo a final test, where the master trainer takes hair and skin from their respective goats and hides it in different places. It is up to ancestors, through possession and visions, to help the trainees find where the items have been hidden (Campbell 1998:66-77).

After the graduation, the new graduates must stay together in a hut for one month in solace. During this period they fix their bones and prepare themselves for traditional practice. At the end of that month, they again must be cleansed at the river and find objects that are hidden. Through possession the ancestors must assist them one more time (Campbell 1998:66-77).

3.3.6 Some traditional treatments

The healing is acquired by correcting the disturbance or imbalance at the physical, psychological, mental and spiritual levels. The following methods are known to be curative, natural and ritual. These are some of the procedures that are used (Campbell 1998:66-77):

- Herbal remedies: These are administered orally, vaginally, into the ear or nose, or subcutaneously.
- Steaming: This penetrates through the pores of the skin for relaxation and healing. It also washes off bad luck and offers spiritual cleansing.
- Blood Cleansing: This provides circulation and detoxifies the blood.
- Charms: This influences other people and promotes good luck.
- Incisions: These are made to introduce medicines into the blood.
- Dancing: This is a stress reliever and a communication tool for the ancestors.

3.3.7 African traditional healers' fees and financing

User fees are usually monetary fees that patients pay at the time of receiving treatment from the practitioner. According to (Green and Makhuba 1984), attempts were made in Swaziland to regulate fees with traditional healers. However, it failed due to THPs stating that patients were found to be suffering from mysterious diseases that were more expensive to treat, when prices were regulated. Therefore healers charge differently when treating different ailments. They thus charge what they feel is necessary. A study done in South Africa, according to Van Rensburg *et al* (1992), proved that the consultation fees for a traditional healer were twice as much as that of a western practitioner.

Another factor that is the reason as to why healers are so expensive is that patients travel far to consult them. Patients, due to the stigma attached, fear being recognised when they are at a traditional healer in their own community. The patient expects the traditional healer to identify the problem without knowing any background information that can be passed through to the community. The patients therefore safeguard themselves by consulting a healer that is at a distance from their own residence (Van Rensburg *et al* 1992).

3.3.8 The positives and negatives of African traditional medicine

According to Richter (2003) it seems that there is a certain amount of friction between medical or biomedical professionals and traditional healers. Traditional healers usually look towards a 'spiritual' origin, and seek answers by using the ancestors and not displeasing the ancestors. However, western medicine looks towards 'material causation' and look for scientific means to cure an illness (Krich 2008).

In African tradition it is believed 'that if a person does not seek treatment and dies, his spirit will continue to cause a further disease'. It is important to note that traditional medicine and healers' belief system varies from clan to clan (Richter 2003).

As previously mentioned, the MRC (Medical Research Council) of South Africa has established a 'Traditional Medicine Research Unit', and together with the University of Cape Town, they have created a database for Traditional Medicines, called TRAMED. This is also supported by the *National Drug Policy*, which emphasises the safe and effective use of medicines including in the field of traditional medicine (TRAMEDIII 2009). This is very positive for the future of traditional medicine in South Africa.

A company called Phyto Nova (PTY) Ltd. is a South African based company that researches, distributes and promotes African indigenous medicine. A product called *Sutherlandia*, has shown a positive impact on people living with HIV. The company has shown that over 4 000 HIV/AIDS patients have used this drug. And within six

weeks of using this product, patients have shown: an increase in appetite and exercise tolerance, weight gain, and mood changes. There were studies done by the MRC that show that there are no signs of toxicity. However, a conference in Nigeria proved that in the last two to three decades not a single traditional medicine that was found to be scientifically effective had lead to international distribution (Richter 2003).

Richter discussed a case study that implied that traditional medicine is negative within the health care industry of South Africa. She investigated the first and only Traditional Hospital in the province of Kwa-Zulu Natal, where patients are treated *only* by traditional healers. The hospital fees were R800 on admission and it was clearly stated that only opportunistic diseases would be treated. The traditional healers had diplomas in alternate medicine and the nurses had completed a first aid course. Richter stated that all the patients had advanced AIDS and were very weak, however, she learned from the director of that hospital that the patients did not have AIDS but suffered from: *amagobongo* (ancestral wrath due to the ritual of puberty not being performed), *amandawo* (a kind of spiritual possession), *imimoya* (a witchcraft spell that causes brain damage), or *ukutwasa* (an ignored calling to become a healer). It seems that the patients were all discharged from Edenvale hospital (Pietermaritzburg State Hospital) because Western doctors could not help them there. A situation like this can clearly create negative publicity for traditional healers. That is to say, this situation may produce negative connotations with traditional healing.

3.3.8.1 Negative Publicity:

An example of negative publicity towards traditional healers was a live broadcast on ETV's *3rd Degree*. On the 12th of May 2009, South Africa's investigative journalist, Debora Patta investigated the reasons behind Albino Murders in Tanzania. Albino people are those who have a hypo-pigmentary congenital disorder, this is caused by hypo-malenosis (*Dorlands Medical Dictionary* 1974) in their skin tone, eyes and hair and therefore they have a white complexion. They are often treated in a derogatory manner within African cultures. In Sub-Saharan Africa, an Albino is known as a 'Zeru-Zeru' or ghost person. Recently the Tanzanian government had addressed this problem.

Most people within the culture believe that Albinos have special magical powers associated with this disorder, and as a result their body parts are sold to people who wish to boost their businesses. For example, fishermen are known to use Albinos in order to boost their fishing. This is common in Tanzania and has been experienced around Lake Victoria. It has also been investigated that these body parts have also been used by miners to boost their industry. Neighbouring countries like Zambia, Kenya, Congo and Burundi have experienced the same problems.

The traders earn up to about 500 000 Tanzanian shillings (R15 000) for harvesting Albino body parts. Debora Patta interviewed families of the victims and Tanzanian Government projects. She even had an undercover journalist who confirmed that the victims of the murders are used as muti, therefore the murderers are Tanzanian witch doctors.

As stated previously, traditional healers were often thought of as witch doctors, because they use the ancestral powers of healing. It is therefore that publicity like the above creates a negative connotation towards the legitimisation of traditional healers and causing them to be shunned (*3^d Degree* 2009).

In South Africa, the need to regulate and legitimise traditional medicine has been ongoing. It seems that traditional medicine has to undergo the same standard procedures of clinical testing and regulating as any other type of medicine. On August 1, 2007 the MCC (Medicine Control Council) established a reference centre for all Traditional Medicines. This is called the 'National Reference Centre for African Traditional Medicines' (NRCATM). However, a number of problems have arisen due to the 'Protection of the Human Indigenous People' that was presented by the United Nations Industrial Property laws. This law stated that 'old' knowledge is patentable (Richter 2003).

3.3.9 How is the heritage of the indigenous people protected?

The World Intellectual Property Organization (WIPO) is a UN specialised agency that promotes the protection of intellectual property worldwide. WIPO defines intellectual property as 'literary, artistic and scientific works, inventions in all fields

of human endeavour, scientific discoveries, and all other intellectual activity in the industrial, scientific, literary or artistic fields.'

This 'cultural' and intellectual heritage comprises of the knowledge and way of life that is particular to a certain group of people. This heritage is determined by customs, laws and practices of a community, individuals or a group of people (WIPO, Leaflet no. 12). The document states that once traditional and intellectual property is removed from that society, the community loses the knowledge as to how the information was used. Cultural knowledge has been practiced for many centuries and has evolved over time. It is therefore the community's right to protect the intellectual knowledge against exploitation or inappropriate use.

Also, while indigenous people are seeking protection from commercial exploitation, the world of science and technology is seeking information on traditional healing for commercial and scientific reasons. It seems that cultures are protecting their knowledge from pharmaceutical companies who want to claim ownership over plant remedies that were used for centuries. In most cases these companies do not award or recognise the indigenous people for their knowledge and deprive these people of their fair share in the economy. These companies also do not grant them social security in exchange for their use, knowledge and practices in traditional healing.

The rights of the cultural and indigenous people were recognised in several international conferences including the 'Human declaration of Human Rights' and the 'UN declaration on the rights of indigenous people'. However, there have been many initiatives and attempts that have addressed the inadequacy of international law to protect the cultural rights of communities thus the WIPO (World Intellectual Property Organization) was formed. Several United Nations agencies were also formed to protect the culture and heritage of intellectual property.

The Rio Declaration (known as Agenda 21) and the Convention on Biological Diversity, held in 1992 in the Earth Summit in Rio de Janeiro, Brazil, also emphasised the need to protect and conserve the practice and knowledge of cultural and indigenous people. At the same conference, an article on biological diversity stated that each state has legal obligations to respect and preserve this

knowledge. It recognised the rights of the indigenous people to obtain economic and social benefits for their knowledge (WIPO, Leaflet no. 12).

The summary of leaflet no. 12 from the WIPO was as follows:

‘Despite international recognition of the right of indigenous peoples to preserve and protect their traditional practices, knowledge and ways of life, the cultural heritage of many indigenous peoples is under threat, and many indigenous peoples are prevented from enjoying their human rights and fundamental freedoms. However, various initiatives have been launched to protect the intellectual property rights of indigenous peoples.’

The following section is an example of ‘Folk Medicine’. These are ancient farm remedies that were used by the Voortrekkers. These ancient remedies are indications of what they were used for. The significance of having them in this chapter is to demonstrate the progression of these herbal treatments that were tested and trialled as safe and effective and is now commercialised successfully and is readily available.

3.3.10 The development and progression of folk medicine in South Africa

Folk medicine was a source of traditional medicine in South Africa, amongst the farmers, migrant workers and the Voortrekkers. It provided the main source of health care in the 19th century. Even though the majority of the providers were authentic there were still a large number of quacks at the time. ‘Wonderdoeners’, shopkeepers, and travelling medicine were also an important part of health care delivery.

During the 1800s, there was a request for legal requirements for folk medicine and these health care agents. Folk medicine was sustained due to the fact that professional doctors were inaccessible and scientific medication was unavailable. Therefore this field of medicine became very lucrative. At the time it seemed that there were many “quacks” and these quacks were clearly in competition with the western doctors.

In the 1950s and 1960s many of the herbal remedies were recorded, described and studied. This was studied by the ‘*Suid-Afrikaanse Akademie vir Wetenskap en Kuns*’

(Loosely translated as: 'The South African Academy for Science and Art') formed in 1965.

The Voortrekkers also had folk nurses, who were traditional birth attendants, and they were known as *ou-tantes*. It seemed that many of the folk medicine, or Voortrekker medicine, originated from the Khoi-khoi people. An example of this was the use of animal fat and bile to treat boils. It was stated that many of these remedies are still prevalent amongst the African traditional practitioners today (Van Rensburg *et al* 1992).

Here is an example of some of the farm or folk medicine that was used by the Voortrekkers:

Patent Remedies:

- *Borsdruppels*: Chest drops that are used for lung colds and coughs
- *Levensessens*: Used for indigestion, swelling and headaches.

Remedies containing animal material:

- *Aasvogelvet*: (Vulture fat) This is used as embrocating for lumbago.
- *Bokkenmest*: (Goat dung) This is used as an infusion for measles and severe chest pain.
- *Hondebloed*: (Dog blood) This is used for convulsions and severe inflammation.
- *Slangvel*: (Snake skin) This is used to wrap around a rheumatic limb to ease the pain.
- *Rooi laventel*: Used for soothing properties, cramps and chest oppression

Plant Remedies:

- *Nat tabak*: (wet tobacco leaves) This is used to dress wounds.
- *Blougom*: (Blue gum) This is used to draw abscesses from wounds.
- *Kamfer (olie)*: (Camphor) This was used for kidney complaints and muscular aches and pains.

- *Roosmarijn*: (Rosemary) This was used as a scalp tonic and treatment for dandruff.

The above medications: are found at local pharmacies, are still widely used by all communities, and have shown to be effective in people's lives (Japie Visser pharmacy 2009). Folk medicine illustrates how traditional medicine can progressively be utilised in combination with western medicine.

The preceding section has contributed towards understanding the facts of where we stand considering traditional medicine (TM). It has given vital examples of where we intend to direct African traditional medicine (ATM) in order for us to have a fair and democratic health care set up and to avoid exploiting citizens or the THPs. This section aimed at bringing to light a vast knowledge that can be used to understand the culture and traditions that we are faced with as well as understand the factors needed towards contributing to a more democratic and developed nation. However, the policy states that THPs want recognition in the health care profession and to be integrated into the National Health Plan. In fusing the two disciplines it is vital to understand the realities of both sectors and create collaboration between the two, so that they can co-exist and understand the nature of each other for policy makers to make realistic decisions.

After having addressed and understood the fundamentals of traditional medicine and modern medicine clearly, the following section explores the harmonising of the two the disciplines within one health care management system. The section draws essence from the previous sections that describe a pattern of beliefs, behaviours and values and this knowledge is vital to understand for the systems to be integrated effectively.

3.4 INTEGRATION OF TRADITIONAL MEDICINE INTO THE HEALTH CARE SYSTEM

The rationale of this section allows readers to understand the different perspectives and manners of integrating the two disciplines of medicine into one NHS. It highlights the needs and challenges pertaining towards the integration, and illustrates dual modalities using a model where the two disciplines correspond with

each other. The section explains in detail what experts have found whilst integrating the two modalities. This chapter is valuable within the literature to give an overview of recommended different professional views.

3.4.1 Integration of traditional medicine with modern medicine

According to an article by WHO (2009), integration has three different perspectives, as follows:

- 1) Firstly, it may mean the incorporation of traditional medicine into the national health care system. That means the use of traditional medicine in the mainstream health system.
- 2) Secondly, it may mean the integration of the practice of traditional medicine with that of modern medicine. This would mean that doctors need to incorporate remedies used by traditional healers into their normal daily routine. Traditional and modern medicine must be practiced side by side.
- 3) Thirdly, it may mean the integration of traditional and modern medicine as two individual branches of medical science. According to the same article, efforts have been made to synthesise the two branches in order to form a new branch of medical science. This would mean using both elements.

3.4.2 Challenges pertaining to the integration of traditional and modern medicine

Bodeker (2001:164) has highlighted some important points that the integration of traditional and modern medicine will result in the loss of some concepts and in the loss of the traditional medicine systems. Another important issue is the ability to sell and prescribe herbal medicines and licensing of traditional practitioners. He quotes that it was recognised that the regulation of traditional medicine in most countries is weak, which leads to the misuse of the medications and the system loses credibility. It was noticed that in most cases practitioners and manufacturers tend to oppose the strengthening of the regulation, as it may stifle the ancient methods of making medicine.

Other challenges present are as follows (Bodeker 2001):

- 1) The public and users of traditional medicine (TM) request safe, quality and effective remedies.
- 2) Western health practitioners and scientists doubt that TM is useful and require scientific based evidence to trust its safety and effectiveness.
- 3) Governments need to regulate and update traditional medicine using scientific based evidence which will make it more credible.

3.4.3 The need for harmonisation of traditional and modern medicine

According to an article by WHO (2009), an increase in cross-cultural communication has resulted in the need for traditional medicine to be integrated with modern medicine. However, there are various negative responses by medical doctors and modern health care professionals. This is why there is a need for harmonisation between the two disciplines. Within the model of harmonisation, it aims to develop a good understanding of other approaches to health care. In this way modern medical practitioners are required to gain more education on TM, and likewise, THPs need to have an understanding of their practice and the strengths of modern medicine. The approach used by WHO to harmonise modern and traditional medicine will promote a clearer understanding of the strengths and weaknesses and encourage the best therapeutic options for patients. Collecting evidence-based research is an essential step.

It is very apparent that WHO is considering many policies for the integration of the two approaches into a national health care system, since WHO has established that both have many common approaches that make integration possible.

Using the following model (Fig. 3) below, the two systems correspond with each other. It is apparent that in every aspect of modern medicine, there is an opposite traditional method that can be used and vice versa. Traditional medicine has been prevalent for many years and will be present for future generations. In order to

integrate the two disciplines, this model was developed to ease the profession of traditional medicine into the health care system.

Traditional mid-wifery has its counterpart, and corresponds to the field of maternal and child care. Herbalism has its modern version of pharmaceutical services. Modern medical surgery can be done via ritual manipulative traditional techniques, which can be bone setting and cupping techniques. And lastly traditional taboos, prescriptive and preventative traditional methods coincide with modern preventative techniques.

3.4.4 The bio-medical model versus the traditional medical model

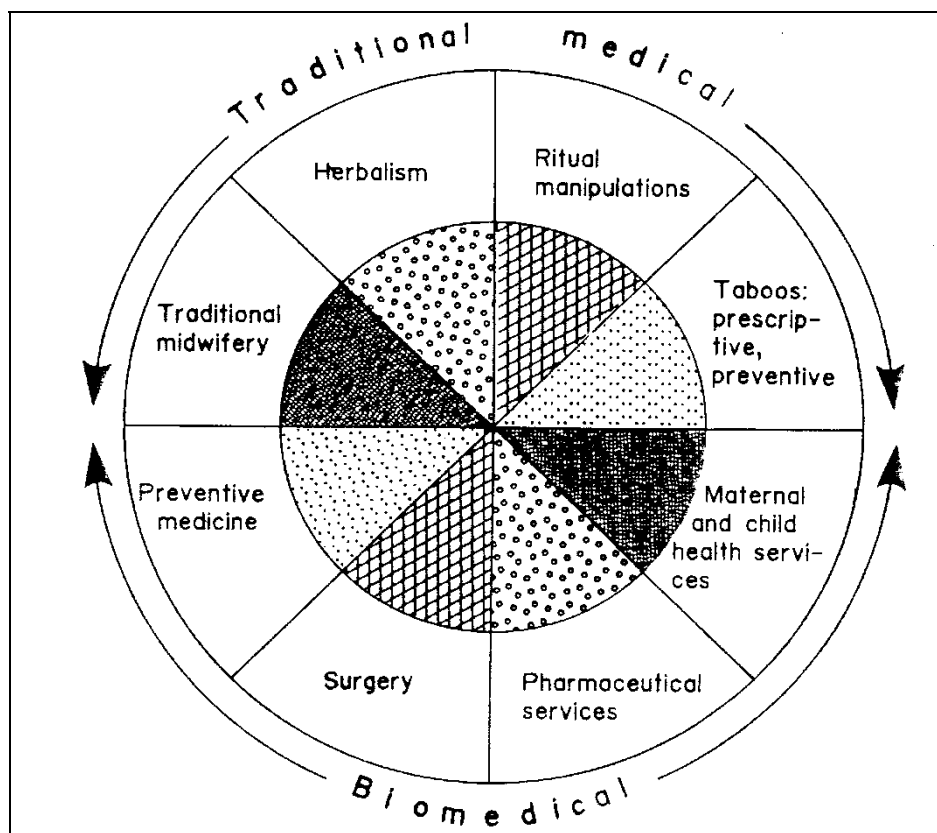


FIGURE 1: The Bio-Medical VS. The Traditional Medical Model, Van Rensburg *et al* (1992).

3.4.5 Recommended different views in integrating the two disciplines, (Benatar and Landman 2006:239)

3.4.5.1 Complementarily

This denotes that the two co-exist as independent practices and each one respects the skills of the other. Each is co-operative towards each other and they

develop a working relationship with each other. They make use of the referral system. However, this would require knowledge about each other professions and the professionals must undergo training.

3.4.5.2 Professionalisation

This denotes the legal institutionalization of both professions fairly and equally. The formation of professional boards will enable control and regulation and protect the users and the practitioners. This implies that each field must have a framework of practice and share knowledge.

3.4.5.3 Integration

This denotes that the traditional healers form part of the medical profession. This would require that modern medical professionals would need to be taught the skills that traditional practitioners have and vice versa. It means that there will have to be linkages between the modern medical practitioners, traditional healers, communities and authorities.

The integration of traditional healing practitioners could protect the clientele from malpractice and irrelevant cultural approaches.

The above chapter assists in pointing out the important aspects for policy makers to: understand the different views as to what will make the integration easier, understand the need for the two disciplines to be in harmony for the public health sector to improve, and to ensure that the health care in South Africa is optimal. The chapter adds value in understanding the needs and means of integration, and assists to understand the importance of integration rather than termination of the current policy. By reflecting on global policies, it will assist on benchmarking regarding integration factors. The following chapter highlights global data that will provide an insight and overview of the international standards.

CHAPTER 4

THE GLOBAL PERSPECTIVE OF TRADITIONAL MEDICINE

In order for South Africa to implement a successful policy, it is of the utmost importance to view other already functioning policies and to have a broad-spectrum view of global societies. This chapter bears importance for policy makers to understand the literature of policies involving traditional medicine and the health care system across the world. In order to draw up a policy effectively and for it to be successful, one should always look into the global views and other functioning policies, so that the best policy decisions can be met. A global view of traditional medicine (TM) gives us an insight of how TM has developed and modernised in different countries. It also points out the setbacks and challenges that can be experienced and highlights relevant concerns. The current chapter looks into policies from Europe, America, Africa and Asia. It assists us into deciding which policies resemble our situation and gives us a brief overview in which other countries have traditional healing been legitimised. The chapter creates a discussion towards what has worked in other countries and how South Africa can avoid repeating mistakes by implementing a successful policy from the onset. The end of the chapter looks into common elements of world views on traditional medicine and a conclusion can be drawn into being on par with the rest of the world and other African countries.

4.1 A GLOBAL PERSPECTIVE

'A national policy is urgently needed in those developing countries where the population depends largely on traditional medicine for healthcare, but without it having been well evaluated or integrated into the national health system. Many developed countries are now also finding the traditional medicine issues concerning, for example, safety and quality, licensing and providers and standards of training, and priorities for the research, can best be tackled within the framework of a National Traditional Medicine policy (South Africa, Traditional Medicine Act 22 of 2007).'

Bodeker (2001) looks at the global perspective of traditional medicine and the way it is integrated in China. In China the integration of traditional medicine was guided

by officials trained in modern medicine and the harmonisation with modern medicine was the goal. This was guided by a science-based approach to the education of traditional Chinese medicine and the emphasis was on research. In China, hospitals practicing traditional Chinese medicine treat 200 million outpatients and 3 million in-patients annually.

South Korea began with a parallel system of two independent medical systems in 1952. Its goal for full integration was set for the year 2001. In South Korea there were many political conflicts between modern and traditional medicine due to fees and the absence of a strong central control mechanism.

In India a parallel model was adopted by the Indian Central Council Medicine Act of 1970. The council was established to maintain good overall standards of practice and training. In 2000, there were new regulations set to improve standard manufacturing practices and quality control. Drug testing laboratories were established to provide licensing authorities with high quality evidence on the safety and quality of herbal medicines.

Malaysia has adopted a self-regulation by complementary professions approach to integration. In Malaysia they use the approach of having five different umbrella organisations where Indian, Malaysian, Chinese and complementary medicine as well as homeopathy are all under different organisations. Each body recognises, accredits and trains their own discipline and separate code of ethics is determined.

Most African countries use a parallel model between western and traditional medicine. In 2004 herbal medicines were prescribed and dispensed in hospitals in Ghana. Nigeria has developed regulations for traditional medicine, but only a draft policy has been prepared (Bodeker 2001).

Traditional medicine is used in all communities. It remains a form of private practice outside the formal health system and cannot be easily organised by the government (Van der Geest 1997).

The use of medicinal plants has left a gap for further development in primary health care as well as research and clinical trials on the involved herbs. According to the African Union Conference (April 2007), it was estimated that in many developing

countries, a large portion of individuals rely on traditional practitioners to meet their health care requirements. Although modern medicine is available, traditional medicine remains popular because of cultural reasons (Van der Geest 1997).

The World Health Organization (WHO) estimates that 80% of the population in Africa uses traditional medicines. In sub-Saharan Africa for every 500 people there is one traditional healer, but for every 40 000 people there is one medical doctor. It was said that 80% of South Africa's population uses traditional medicine (Aidsbuzz-Treatment 2008). According to the African Union's plan for traditional medicine, a large number of AU countries, under the World Health Organization African Region, have policies in place and have institutionalised traditional medicine. Some of these countries are Burkina Faso, Cameroon, Ethiopia, Kenya, Ghana, and Malawi. These countries have made progress towards recognising the importance of traditional medicine and have attempted to empower traditional medicine as part of the public health care system (Van der Geest 1997). This will, however, be discussed more extensively later in the thesis.

4.2 COMPARATIVE INTERNATIONAL PRACTICES REGARDING THE PRACTICE AND INSTITUTIONALISATION OF TRADITIONAL MEDICINE, AS SET OUT BY THE WORLD HEALTH ORGANIZATION

The World Health Organization (WHO) surveyed 123 countries on the regulation of traditional medicine. The WHO has acknowledged the efficacy of traditional medicine in: the treatment of mental health, the prevention of disease, and the improved quality of life in elderly people.

The World Health Organization (2001) views national policies towards traditional medicine as:

'...a way of defining the role of traditional and complementary/alternative medicine in national health care programmes, ensuring the necessary regulatory and legal mechanisms are created for promoting and maintaining good practice; assuring authenticity; safety and efficiency of traditional and complementary/alternative therapies; and providing equitable access to health care resources and information about those resources.'

With regards to the international legal status of traditional medicine, the countries are divided into different categories by means of dealing with policies regarding

traditional medicine. Although, not all the countries are discussed, countries of relevance for a South African comparison are explored (South Africa, Draft policy on African traditional medicine 2008). The countries discussed fall within the following categories:

- Countries where traditional medicine is allowed to be practiced by allopathic doctors. Examples are Argentina, Cuba, Italy, Japan, Germany and Spain.
- Countries where traditional medicine is illegal, but tolerated include Austria, France, Malaysia, Nigeria, Switzerland and the United States of America.
- Countries where traditional medicine is promoted and attempts are being made to make it part of the National Health care system are Chile, Mexico, Peru, Philippines, Zimbabwe and South Africa.
- Countries where traditional medicine is already part of the National Health care system. In some of these countries the policy is systemised and exists parallel to the allopathic system. This includes China, Germany, India, Indonesia, Mali, Thailand, Great Britain, Pakistan, Myanmar and the Republic of Korea.

The following summaries are comparative reviews of a few global countries, in which the following is highlighted: the backgrounds of traditional healers, the theoretical legal frameworks, the efforts towards training and education, and the legal pharmacopoeia. This review allows a global view as to which countries have policies that allow traditional medicine to exist in a parallel system to allopathic medicine. This has been researched by the World Health Organization and is ongoing in a worldwide review.

4.2.1 Africa

4.2.1.1 Botswana

Traditional health care practitioners in Botswana were the only form of health care for centuries until the first part of independence which was in 1966. WHO had investigated that the use of traditional medicine in Botswana has decreased with the younger generation and more educated people. However, traditional health

practitioners remain respected individuals in communities and still service most rural communities.

In 2001, there were approximately 3 100 traditional healers practicing in Botswana and it was estimated that 95% of them reside in rural areas.

The regulatory issues of Botswana have been accepted and are recorded in the National Development Plan of 1976–1981. The Ministry of Health in Botswana was looking for ways to bring a closer co-operation with traditional healers and allopathic doctors. However, no full-scale integration was encouraged, but referrals between modern medical doctors and traditional health practitioners are encouraged.

Medical, Dental and Pharmacy Amendment Act of 1987 is a regulating board in Botswana which outlines: chiropractors, neuropaths, acupuncturists, osteopaths, and alternative medical professionals.

4.2.1.2 Ghana

The background of Ghanaian traditional medicine is based on herbs, wisdom and spiritual beliefs. However, missionaries introduced allopathic medicine to Ghana in 1957 during the colonial period.

In 1972, the Medical and Dental decree allowed traditional practitioners to practice. In 1975 a Centre for Scientific Research into Plant Medicine was established. This centre's aim was to promote and integrate traditional medicine into the health care system. In 1999 a directorate was established which developed programmes to promote traditional medicine and to develop formal training courses and apprenticeships. In 2000, the Traditional Health Practice Act of 2000 regulated traditional medicine and provided traditional health practitioners with licenses, but the practitioners had to register themselves. The Ministry of Health is currently looking towards introducing a curriculum of traditional medicine in allopathic medical schools and a diploma in traditional medicine at a postgraduate level. There are already formal training courses available for traditional birth attendants. The government later formed one umbrella

association for traditional medicine called the Ghana Federation of Traditional Medicine Practitioners Association.

In Ghana there is 1 traditional health practitioner for every 400 people and 1 modern doctor for every 12 000 people. There are approximately 100 000 traditional practitioners distributed throughout Ghana. Ghana has set aside the third week of March every year as a traditional medicine week.

All the registered medicine is labelled by the Traditional Medicines Act of 2000. The Ghana Herbal Pharmacopoeia compiles all herbal medicines in Ghana and is published by the Science and Technology Research Institute (STEPR).

4.2.1.3 Kenya

In Kenya there is not much literature on the background of traditional medicine, however, it has been established that 75% of Kenyan babies are delivered by traditional birth attendants.

Traditional medicine started being regulated into Kenya as early as 1970. The Kenya Developmental Plan of 1989–1993 was committed to promoting traditional medicine. Practitioners are registered by the Ministry of Health. In 1999, the Kenya Patent Law included the protection towards traditional medicine.

In Kenya, traditional birth attendants undergo formal training courses in some parts of the country.

4.2.1.4 Lesotho

Lesotho has the Natural Therapeutic Practitioners Act of 1976, which gives natural therapies the provision of preventing and healing illnesses and curing pain. Professionals under this act are: homeopaths, acupuncturists, neuropaths, osteopaths, and all other alternate medicinal practices.

The Lesotho Universal Medicine men and Herbalist Council Act of 1978 followed. It controlled the activities of traditional health practitioners and aimed at improving

their skills. It is responsible for the membership fees and registering of all practitioners. In Lesotho, this act forbids any individuals under the age of 21 to be registered and all practitioners must be qualified by the Natural Therapeutic Practitioners Association of Lesotho. Authorised persons under this act cannot carry out certain procedures like: practicing midwifery, drawing blood, performing operations, administering injections, treating cancers, and performing internal examinations. These practitioners may also not mislead people into making them believe they are allopathic doctors.

4.2.1.5 Mali

The traditional medicine in Mali is based on the wisdom of holistic, herbal and oral traditional system-based medicine. A National Research Institute of Medicine and the Department of Traditional Medicine were established in 1973. A 'Scientific and Technical Committee' was later established in 1980.

Local officials are responsible for the registration of traditional health practitioners and most of the practitioners are involved in primary health care. The regulations involve strict rules and regulations for administering and manufacturing traditional medicine. In Mali the use and collection of certain plants is not allowed. Only cultivated plants may be used for traditional medicine. The production of all traditional medicine is supervised by pharmacists and other professionals of relevance. All traditional practices are regulated even the herbal stores and the production and manufacturing of the traditional medicine.

Seminars and workshops are often hosted by traditional health practitioners through their respective organisations, concentrating on AIDS and family medicine. These have been government initiatives for traditional health practitioners to be utilised as intermediaries and informing the public. It also allows the practitioners to be more involved in patient care.

4.2.1.6 Uganda

Traditional health practitioners in Uganda outnumber the amount of allopathic doctors. The National Traditional Healers and Herbalists Association proposed that a hospital in Mengo be opened, where traditional health practitioners will offer care and support.

A non-governmental association called the 'Traditional and Modern Health Practitioners together against AIDS' (THETA) was established. They are dedicated to improving the collaboration between modern/allopathic doctors and traditional healers to enhance the primary health care in Uganda. THETA has a training centre where it offers training courses in traditional medicine in which one can collect information regarding traditional medicine and practices. They train traditional health practitioners in AIDS counselling, education and clinical care for people.

The Ministry of Women in Development, Culture and Youth is a council that presides over traditional practitioners. The Ugandan Government has set up, under the Ministry of Health, the Natural Chemotherapeutic Laboratory to study natural products. They will eventually fall under the Ministry of Health if these products are effective and evidence-based. Also in Uganda the government is busy developing a health policy that concentrates on primary health care. It proposes to work closely with traditional health practitioners so that they can be a part of primary health care.

4.2.1.7 Zimbabwe

The background of traditional medicine is also holistic and spiritual and based on the oral traditional system.

In 1980, the Zimbabwe National Traditional Healers Association (ZINATHA) was formed. Zimbabwe is known to have the most comprehensive policy on traditional medicine. The practitioners are registered and subsequently they may use the title 'Registered Traditional Medical Practitioner'. The Traditional Medical Practitioners

Council Act of 1981 recognised ZINATHA as the association of Traditional Medical Practitioners Council of Zimbabwe.

The objectives of ZINATHA include: promoting research into traditional medicine, promoting the true art of spiritual healing, the prevention of abuse and quackery, creating better working relationships between traditional and allopathic doctors, the regulation and supervision of the practitioners, and the training, education and development of the field.

In 1994 there were approximately 11 000 allopathic doctors and 24 000 traditional health practitioners. At present there are about 55 000 registered traditional practitioners with ZINATHA.

The Ministry of Health has appointed a register for traditional health practitioners. This register has been established for practitioners who have a good character and the necessary skills and expertise. The ministry of health can also grant certain applicants a registration as an honorary traditional health practitioner, for special standing. These practitioners can also be registered as a 'registered spirit medium'.

Any person who claims to be a spirit medium or registered traditional health practitioner, but is not registered may be punished by law for up to two years imprisonment. The law is against 'improper or disgraceful conduct' in terms of traditional medicine in the case of registered practitioners. A practitioner who is found to be incompetent or unethical will be faced with suspension.

4.2.2 America

4.2.2.1 Cuba

In Cuba, 60% of allopathic doctors are also trained in traditional medicine and 60% of the population makes use of traditional medicine. There are an estimated 800 registered herbal products in Cuba.

After the revolution in 1969, traditional healing was not legally allowed in Cuba, with the exception of traditional birth attendants. These practitioners were slowly incorporated into the health services.

The Cuban Public Health Law of 1983 stated that only individuals with relevant qualifications are entitled to practice and all other practitioners are prohibited from practicing any form of health care. These were strict regulatory requirements and all health professionals had to meet these requirements.

In 1992, the Ministry of Health recognised homeopathy and in 1995 a traditional medicine programme was institutionalised. Courses on homeopathy are now offered at medical universities.

4.2.3 Europe

4.2.3.1 Germany

The principles of herbal medicine in Germany are linked to Galenic medicine, meaning that it is linked to the four elements: earth, fire, water, and the humours (blood, phlegm, black bile, yellow bile). In Germany, herbal remedies are popular and are supportive rather than curative medication. Other fields are acupuncture, oxygen therapy, chiropractor, cell therapy and massage.

In Germany all medical practitioners are called *Heilpraktikers* and if licensed can practice medicine, whether modern or traditional. However, both allopathic and non-allopathic medicine functions as two different entities within the health care system. Though, in Germany more than 75% of allopathic doctors use traditional medicine.

There is a registration wherein traditional healers are allowed to practice legally, but within certain restrictions. Some restrictions include that: only dentists can extract teeth, a traditional healer may not treat sexually transmitted diseases or cancers, and they may not perform operations.

Germany is known to have the most comprehensive and pragmatic system of regulating traditional medicines and is harmonised with the systems presented in

the European Union. The German system regulated the traditional medicines over a certain amount of years. In 1978 a panel was appointed to evaluate the traditional medicines in which they were allowed 12 years to establish evidence of safety, quality and effectiveness.

The pharmacopoeia was an important factor in regulating herbal medicines and research over plants was extensive. From 1978 to 1994, 380 monographs were published in a Gazette, where each herb, indications, contra-indications, method, dosage and the general therapeutic properties of the herb were recorded. The monographs included only three African traditional herbs: aloe, devils claw, and buchu leaves.

4.2.3.2 United Kingdom

Medicine is regulated by the British Research Council on Complementary Medicines (1982). In Europe, the United Kingdom is the only country where some forms of traditional medicine have been practiced in public hospitals.

The Government has sanctioned all access to alternative treatment, however, the practitioners have to be covered by insurance and they must adhere to a Code of Professional ethics. Not all practitioners are registered, but they are somewhat tolerated by law. The system of registration relies on a proven tradition that was used previously, and successful.

There is an official pharmacopoeia. The pharmacopoeias are: British Herbal Pharmacopoeia (1983,1990,1996), Pharmacopoeia XLI(1988), The Pharmaceutical Codex (1979), British Pharmaceutical Codex(1934-73), Martindale (1989), and The extra Pharmacopoeia 29th ed.

4.2.4 Asia

4.2.4.1 India

Indian traditional medicine is called 'Ayurvedic' medicine and originated in the 10th century BC. Ayurveda means 'the science of life' and resembles Galenic medicine. It

is based on body odours and the five basic elements: sky, earth, water, fire, and air. In Ayurveda either a somatic or psychic diagnosis is made. The technique is based on the fundamentals of harmony between the environment and the individual, the one influences the other. Ayurveda is not only a medical system, but is a way of life, it contains herbal medicines and medicinal baths.

The legal framework fully integrates Ayurveda medicine and also other healing techniques such as yoga, unani, siddha, naturopathy and homeopathy. During the colonial period in India, traditional medicine was not recognised, however, there was a formal recognition after the Central Council of India Medicine Act of 1970. This council has set regulations for traditional medicine, which includes a registration process and a code of ethics and standards for professional conduct. Registration is essential for all practitioners. In India there are several institutes that deal with traditional medicine. Approximately 3 000 hospitals provide traditional medicines and 20 000 dispensaries exist.

The pharmacopoeia involves many boards namely: the Pharmacopoeia of India II (1966), III (1965), the Indian Pharmaceutical Codex (1953), and Pharmacopoeia (1996).

4.2.4.2 Indonesia

Indonesia's framework is significant, because they have similarities with African traditional medicine. They have four groups that are divided as follows:

1. herbalists;
2. skilled practitioners (traditional birth attendants, bonesetters, masseuses, and traditional dentists);
3. spiritualists; and
4. supernaturals.

Traditional medicine was promoted by the Health Law Act (1992). The profession provides training and research in traditional medicine at the Centre for Traditional

Medicine. Training is offered by the Ministry of Health, however, birth attendants do not need to be registered to practice.

In Indonesia there are approximately 300 000 practitioners and over 800 manufacturers. Traditional medicine is regulated by the Ministry of Health and is divided into two categories:

1. Traditional remedies used by individuals and families. They do not need to be registered and are made by the practitioners for their own patients.
2. Medicines that are used for commercial use. These medicines have to be registered and evidence-base research has to be applied. All safety requirements need to be met.

Regulating is also controlled by the General of Pharmacy and Medical Devices Services of the Ministry of Health. There is also a Pharmacopoeia Board (Farmakope Indonesia 1995).

4.2.4.3 Thailand

In Thailand the traditional medicine system is based on ancient Chinese and Indian traditional medicine. It encompasses holistic philosophy and involves herbs, steam baths, traditional massage, acupuncture and reflexology.

In 1993, the National Institute of Thai Traditional Medicine was formed. The aim was for the full integration and re-integration into the public health system. Thai traditional medicine is integrated in the national health system by about 75% and several schools have been established for effective training. The Medical Registration of Public Health is responsible for the registration of traditional health practitioners. The apprenticeship, supervised by the Commission for the Control of the Practice of the Art of Healing, is a three-year course wherein formal examinations are written. Thailand had made provision for increasing the use of Herbal medicines which was stated in the Eight Public Health Development Plan (1997-2001).

There are 2 Pharmacopoeia: Thai Herbal Pharmacopoeia Volume 1 (1995) and Volume 2 (2000).

4.2.4.4 China

Chinese traditional medicine is based on the philosophy of 'Yin and Yang' which originates from 8th century BC. 'Yin and yang' is a philosophy of opposites and it influences the five elements: metals, wood, water, fire, and earth. 'Yin' represents the earth, femininity and cold. In contrast, the 'yan' represents the sky, masculinity and heat.

Chinese medicine has co-existed with modern allopathic medicine for centuries. Acupuncture is a big part of Chinese medicine and is used in many parts of the world. Each city in China has a traditional hospital. There are more than 2600 such hospitals and 95% of these hospitals have separate units for traditional Chinese medicine (TCM). There are also 170 research institutions for traditional Chinese medicine.

Traditional Chinese Medicine (TCM) is registered in the same way as allopathic practitioners. The method of apprenticeship, after 1960, was changed to a formal education system, which is a five-year course. There are 28 universities in China that offer the course in TCM and traditional pharmacology.

All the herbal drugs are regulated and registered by the State Drug Administration (SDA), using criteria from the Pharmacopoeia of China and Minstrel Drug Standards and the pharmaceutical standards of SDA.

4.3 COMMON ELEMENTS OF THE POLICIES

- A. There is an increased interest in traditional and alternative medicine in the formal sector of most international and African countries.
- B. A common trend is the regulation, registration and licensing of traditional health practitioners and the development of formal training and education.

- C. Evidence-based medicine and concerns about the safety, efficiency, quality, and scientific research for the production of the traditional medicine has become an important factor.
- D. Developments of a National Pharmacopoeia are part of the regulation.
- E. The harmonisation of policies is according to international standards.

National policies are a way forward in the role of traditional medicine in the national health care system. This ensures that regulations and legal requirements are created for promoting good practice, ensuring safety and efficiency and providing access to health care resources (WHO 2001).

Having viewed worldwide aspects regarding TM, we now have to establish where South Africa's journey to legitimising a successful policy is directed and how we as a united nation can decide what lessons to extract from the world. South Africa, as a developing nation, needs to implement a selective policy to eradicate poverty and improve on the health care system, especially after the impact that the history has had on this field. The subsequent chapter focuses on where we are as a nation and where we intend to be and the future roles of THPs in South Africa. The reasons behind researching global views are mainly to have an overall view so that we are on par with the rest of the world.

The prior chapters give light to the current situations in South Africa, the current chapter discusses global views, and the next chapter discusses the policy itself. It discusses the vision government has towards traditional medicine and the role THPs play and will play in the future of South Africa. The policy has been drafted and is currently in the monitoring and evaluation stage. The policy needs to be moved into the implementation stage. Inevitably challenges need to be explored and solutions need to be found, but prior to that, the subsequent chapter discusses the legislative framework from start to end.

CHAPTER 5

LEGISLATIVE FRAMEWORK AND THE DRAFT POLICY

The previous chapters gave a brief historical account of the development of medicine in South Africa. One can now understand that TM has a long history of practice and is popular amongst many in South Africa, especially in rural areas. This chapter further delves into understanding how the initial recognition of traditional medicine into the health care system fits within the existing health care system guided and structured by Western medicine and the acts and bills leading up to the current draft policy. No understanding of TM is possible without understanding the legal scope within which it would need to be operated. One has to realise that trying to understand various issues associated with TM are complex and require developing an understanding of several interwoven issues, if one is to witness the successful formulation of a policy and its implementation.

5.1 THE INITIAL RECOGNITION OF TRADITIONAL MEDICINE

A public hearing on traditional medicine was held as early as 1977 wherein the World Health Organization (WHO) called for the recognition of traditional healers. At the 30th World Health Assembly in 1977, a resolution was adopted and decided to promote traditional medicine worldwide.

A year later the Alma-Ata Declaration of 12 September 1978 (USSR) was formed and it stated that traditional healers should be part of the primary health care team. This declaration was called upon by all governments in 1978 and included the following (Alm-Ata 1978):

- The declaration re-affirms the human rights of all patients to health care. It realised the worldwide goal that the optimal and highest level of health care for all individuals is of utmost importance.

- It recognised that social and economic development is important. The gap in the health sector needs to be filled in developing and developed countries thus giving individuals the right to the optimal health care of their choice.
- It gives the people the right to actively participate in the planning and implementation of health care.
- Handing over the responsibility for the health of all the people by developing health care that will lead people to an economically and socially productive life.
- Primary health care is essential and should be based on practical, sound and socially acceptable methods and technology that is accessible to individuals. The aim was to bring health care as close to the people as possible.
- It was proposed to launch policies and plans of action to sustain primary health care.

In South Africa at that time, the only legislation which related slightly was the Witchcraft Suppression Act of 1957. This law was mandated in order to suppress the practice of witchcraft and similar practices in South Africa. This law put a restraint on the practice of traditional medicine for the practitioners and users of it. It also prohibited diviners from their practice (South Africa. Department of Health 2007a; PHILA 1997). Therefore, in the 1970s traditional healers were encouraged to form associations to facilitate registration and licensing. At the time there was not a code of conduct or any standard of training in South Africa.

5.2 ACKNOWLEDGING THE ROLE OF TRADITIONAL MEDICINE IN SOUTH AFRICA

In South Africa in 1997, there was a public hearing with the aim of making the Council for Traditional Healers an equivalent board to the Health Professions Council of South Africa (HPCSA). Medical aid coverage, treatment provided by traditional healers as well as the issuing of medical certificates was also mentioned (PHILA 1997).

The Government's policy for transformation of the National Health Service, outlined in the White Paper for the Transformation of the Health System in South Africa, states that:

...' traditional practitioners and traditional birth attendants should not, at this stage, form part of the public health service, but should be recognized as an important component of the broader primary health team. The 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 (PHILA 1997).'

5.2.1 The traditional medicine strategy - World Health Organization 2002

A workshop in Geneva in 2002 , hosted by WHO, stressed the importance of traditional medicine in developing countries. It lay emphasis on countries developing policies that included 'Reconstruction and Development' and the integration of traditional medicine in the national health care system.

In this meeting it was noted that the activities and products used by traditional healers could produce a profit and be a contribution to health care. Other conclusions were that countries need to develop national policies on traditional medicine (TM) and there should be an organisational function of TM and the development should be strengthened and given recognition. With the support of WHO, strategies should be developed and laws need to be mandated to protect TM. Local communities and the WHO should devise models for TM, and support Government efforts to protect and promote traditional medicine.

5.2.2 Traditional Health Practitioners Bill

The Bill was established to the interim of the Traditional Health Practitioners Council of South Africa (Health Practitioners Bill, 2003). It provides: a regulatory framework to ensure the efficiency, safety and quality of traditional health care services, for the control and management over the registration, the training, development and conduct of the practitioners, and specified categories of the traditional medicine profession. (South Africa 2003).

The establishment, objectives functions and constitution of the council are discussed in the Bill, whereby quality health care is established within the traditional health sector. The bill protects the interests of the members of community and maintains professional standards for traditional health practitioners. It provides a code of conduct and complies with universally acceptable values and norms. (South Africa, Traditional Health Practitioners Bill 2003).

On 15 September 2004, there was a public hearing by the then minister, Manto Tshabalala-Msimang, who stated that the bill would affirm the dignity and respect of the health sector in this section. She quoted that the absence of the regulation of practice has had a negative impact on society and practitioners. She also stated that the bill recognises the situation of the circumstances and it empowers traditional healers to regulate their practices. It was estimated that 200 000 THPs will benefit from the bill. Tshabalala stated that the council will regulate four types of practitioners: diviners (sangomas), herbalists (*izinyangas*), traditional birth attendants, and traditional surgeons (*iingcib*). The bill of rights protects practitioners against 'hoax' practitioners. Thus the body would also act as a watchdog against 'quacks', and only registered practitioners will be able to practice, and they will not be able to treat diseases like Aids, cancers and other terminal diseases. At the time the bill was intended to be made a law. (Matomela 2004).

5.2.3 Traditional Health Practitioners (South Africa, Act 22 of 2007)

The act was established to develop a Traditional Health Practitioners Council of South Africa, and to provide a regulatory framework to ensure safety and quality of traditional health care services. The act also provides the management and control over the registration, training and conduct of practitioners and students in the traditional health care practitioner's profession (South Africa, Traditional Health Practitioners Act 2007). It also serves and protects the members of the public who use the services of the Traditional health practitioners.

The objectives of the council are to:

- promote health awareness;

- ensure the quality of health services within the traditional health practice;
- promote and maintain ethical and professional health standards required from traditional health practitioners;
- develop interest and encourage research and training;
- compile and maintain a professional code of conduct; and
- ensure that traditional practice complies with universal health care norms

On 11 October 2006, the then minister of Health, Manto Tshabalala-Msimang, established a task team to attend to the traditional medicine situation in South Africa. Their aim was to make references to a national policy and an appropriate legal framework for the institutionalisation of African Traditional Medicine (ATM) in the South African Health care system (South Africa, Department of Health 2006). They were also appointed to create appropriate models to protect ATM, and devise policies to promote it into the National health system. They were to make recommendations on any steps taken by Government to create an enabling environment for the institutionalism of ATM in South Africa. This was based on theory and practice of traditional medicine in South Africa. Their task also involved the training and development of practitioners and researchers, creating linkages between TM and modern medicine and the production and processing of ATM in South Africa. Another aim is to investigate research, develop a Pharmacopoeia and survey international practices.

The African Union Conference of Ministers of Health, from 9 April to 13 April 2007, was held to evaluate the current status of traditional medicine in Africa. The conference was hosted by South Africa and the theme was the 'Strengthening of Health Systems for Equity and Development'. South Africa needed to review the progress on the African Union and to view its implementation and the plan of action. The congress was hosted to view African traditional medicine and its place in the health sector. The congress also addressed expert views in the institutionalisation of traditional medicine in the broader health sector. It was stated at this conference that there should be an objective approach towards traditional

medicine in Africa, its structures and tools should be of good quality, easily accessible, safe and sustainable for the communities of Africa.

The conference addressed ten priority areas which were labelled as strategic activities, these included:

- the sensitisation, formal legislation and institutionalisation of the Society on traditional Medicine;
- the information, education, research and training of traditional healing;
- the cultivation, conservation and the protection of medicinal plants and knowledge;
- the local production, evaluation, monitoring and reporting mechanisms of traditional medicine; and most importantly
- the institutionalisation of traditional medicine into the Public Health Care system in the region by 2010.

According to the *Mail & Guardian* (24 February 2008), it was stated that Manto-Tshabalala-Msimang commented that traditional medicine should not be bogged down by clinical trials and scientific research. She stated that western models of protocols and clinical trials cannot be used. She pointed out that TM has been used for centuries and the image of the sector must not be tarnished. Manto-Tshabalala related that the lack of documentation on TM created a serious problem.

After reviews and efforts were made regionally and internationally, South Africa has now effectively drafted a policy and is now in public scrutiny. Concerns needs to be addressed and amendments made to implement the policy.

5.2.4 Draft Policy on African Traditional Medicine for Public Comment, 21 July 2008 - Government Gazette (South Africa. Department of Health 2008)

A policy was drafted on the institutionalisation of African TM on the health care system of the country. It addresses the right to health care as enshrined in the Bill of Rights, chapter 2 section 27 of the South African Constitution (South Africa

1996). It was drafted to provide adequate health care range disciplines for the citizens. It stated the draft policy came into being when public health care system needed to reflect the diversity of health disciplines which citizens utilise for their health care needs in South Africa. The draft policy remains in the boundaries of the Alma-Ata declaration to strengthen primary health care. It provides a transformational process of protecting TM and its knowledge and strengthening the National health care system. It acknowledges the heritage of the country and is committed to institutionalising African Traditional medicine, using the draft policy and the policy making progress effectively. (South African. Department of Health 2008).

5.3 THE DRAFT POLICY: GOVERNMENT GAZETTE, REPUBLIC OF SOUTH AFRICA, VOL 517 PRETORIA 25 JULY 2008, NO 31271 - FOR PUBLIC COMMENT (South Africa. Department of Health 2008)

The policy was designed to institutionalise and provide a framework for African traditional medicine (ATM) in the Republic of South Africa and towards the delivery of 'cost-effective and accessible client-based care'. This was urged by WHO, the AU and the SADC Inter-Ministerial sub-committee, to provide rules and regulations pertaining to the practice. It intends to implement the 'Plan of Action', called the Decade for African Traditional Medicine (2001-2010). This was adopted at the QUA/African Union at the Lusaka Summit of heads of State. The main objective is to recognise, accept, develop and integrate ATM into the public health care system by 2010. African health strategy (2007-2015) calls for the equality and equity of ATM.

The policy aimed at the institutionalisation of ATM and not its integration with allopathic medicine, but the aim is for the two systems to function side by side in the health care system. The rationale for this institutionalisation was due to 80% of the Sub-Saharan population making use of traditional medicine and it recognises the need in providing health care according to the Alma-Ata declaration in 1978. According to the draft policy, studies have shown that THP, are knowledgeable in health cultural norms and they are highly respected within the communities.

The South African government has played its role in developing strategies towards the aim of institutionalisation, by enacting the Traditional Health Practitioners Act, No 22 of 2007, and establishing the Traditional Health Practitioners council. The government has also provided funding for the control and management of diseases.

The draft policy defines African Traditional Medicine as:

...‘a body of knowledge that has been developed over thousands of years which is associated with the examination, diagnosis, therapy, treatment, prevention of, or promotion and rehabilitation of the physical, mental, spiritual or social well being of humans and animals.’ (South Africa. Department of Health 2008).

The rationale towards developing the policy was that it was recognised that the majority of South Africans still make use and rely on African traditional medicine for their primary health care needs. WHO recognised the need to promote the use of it to reduce the morbidity and mortality rate within the country. It was realised that there was a need for this policy to be regulated and institutionalised.

South Africa is a member of the World Health Organization, and WHO has provided a framework to reduce the morbidity and mortality of disease by promoting the use of the ATM in a positive light.

In the draft policy it states that WHO has recommended three areas to be provided and evaluated for a national policy. These areas include:

- The safety, efficiency and quality of traditional medicine. This would mean that practitioners would have to be registered and have a valid licence. Herbal medications also need to be registered and regulated and remedies need to be monitored for safety reasons. Pharmacopoeia of the medicinal plants also needs to be developed. Moreover there needs to be a form of support with regard to the research of traditional medicine for treating common health problems. In doing so, the standards and guidelines for safety, security and quality as well as developing policies of traditional medicine are recognised.
- Access to traditional medicine. When it comes to access, traditional medicine and product transparency need to be identified as well as safe and effective.

That is to say that the treatments of diseases that have the greatest burden in society need to be researched for safety and efficiency. The policy needs to recognise the role of a traditional health practitioner when it comes to primary health care. The need to upgrade the skills of the practitioners also has to be addressed. The protection of traditional knowledge through research, recording and preserving and the conservation of plants to ensure its use, must be implemented.

- Rational use of traditional medicine. The need to develop guidelines for commonly used traditional medicine is acknowledged. The need to improve the relationship and co-operation between the traditional healers and the health care professionals is recognised. Information regarding the proper use of traditional medicine and information to the users must be seen to. Improve the communication between the health care providers and the patients concerning traditional medicine must be encouraged.

The policy states clearly that the country acknowledges the reality that ATM had been the centre of primary health care for many people long before the era of colonialism and western civilization. It also acknowledges that the community of South Africa still continues to make use of the traditional healers.

It seems that prior to the draft policy on ATM, there was no legislative framework that regulated the profession. The boards that were established aimed at protecting the interests of members of the public who are the users of the traditional healers. The Traditional Medicine Act was a start to integrating the framework from the initiation until the finalisation of the policy.

The policy is further broken down into the following chapters, which are discussed:

- Comparative international studies, with country cases, and global views.
- The legal framework and regulation on ATM in South Africa.
- Education, training, research and development of traditional medicine.
- Cultivation and conservation of South African medicinal plants and animals.

- Pharmacopoeia.

5.3.1 International trends

Within the policy, the global trends have been reviewed and recommendations from international countries have been recognised. According to the policy it seems that there is a global trend towards traditional medicine and most countries have already incorporated it into the health care system. Country cases were reviewed and many common elements were recorded, however, according to WHO it was recognised that each country needs to create policies to suit their own environments.

5.3.2 Research and development

According to the policy it is noted that the need for research is important, because there are an estimated 3000 plant species in South Africa that are used for medicines. Seven hundred of these plants are informally traded and it was recognised that there is a 'hidden economy' due to the 27 million consumers of these plant medicines. The other important factor to consider is that the control of quality and safety is essential for this trade.

Environmental factors also need to be seriously considered as many plants have adverse reactions and can be harmful. The need to research also fulfils an ethical and social obligation for the users and all South Africans.

Some plants or drugs may have the following effects, which has been the reason for the need to research as stated clearly in the policy:

- 1) An addiction to a certain plant or drug that may be therapeutic.
- 2) Environmental contamination.
- 3) Adverse effects.

- 4) Drug and herb interactions (in cases where patients make use of allopathic and traditional medicine together).
- 5) Factors that may misinterpret the effects of the drug.

According to the reviewed literature within the policy it clearly states that scientific research into African traditional medicine is still very poor. It states that the knowledge of African medicine is vanishing due to disease and poverty. It seems that African medicine needs to enter a new era of collecting research data on traditional medicine. Due to the discipline being multi-disciplinary, it would need the action of chemists, pharmacologists, taxonomists, traditional healers, communities, public health departments and the public collectively.

It is recommended that a 'National Institute of African Traditional Medicine' (NIATM) should be developed. The NIATM should be government dependent and funded in order to aid in the research of medicinal plants. The African Union's Plan of Action proposed that it should be met by the year 2010. The aim will be: research and development, to devise strategies to provide a leadership in the research of African Traditional Medicine (ATM), and to collaborate these findings with other institutions. The policy also proposes an ethical committee for ATM practitioners, consisting of clinical trials with experienced practitioners.

The following were recommendations at the AU and the objectives were to adopt the following components:

1. A school for traditional medicine and primary health care must be formed, where education and training is provided. Students of modern medicine who wish to use ATM within their practices should be offered short courses. Bridging courses and full traditional medicine courses can be offered and taught by experienced traditional healers.
2. A research institution must be developed. This is to produce the highest quality, safe and evidence-based traditional medicine to be researched and developed.

3. A hospital used for traditional medicine exclusively can be formed. It can operate in conjunction with modern doctors. This should also include aseptic techniques and a separate pharmacy for dispensing traditional medicine.
4. An experimental garden, where medicinal plants are grown and used for the purpose of education and research. The department of Science and Agriculture should be involved as well.
5. A research library where documentation and data must be stored and collected.

The proposed institutes must be in conjunction with the Medical Research Council (MRC) and must be involved in formalising and documenting all the research and education regarding the faculty.

It was stated that the research must be based on evidence and on primary, safety, and efficiency of the ATM and that everything needs to be laboratory tested. The aim is to reach a high level of research and scientific evidence. The research plan aims at gaining the highest level of the product, standardising the botanical extraction conducted with the supervision of the NIATM, which intends to produce evidence-based traditional medicine. This will result in regulations and a national pharmacopoeia of medicinal plants. The importance of the preservation of traditional medicine, for its treatment and research purposes has been recognised. The need to record all the data used by African traditional healers is imperative to collect and preserve.

The policy aims at educating the public and the practitioners for development of the field. It is stated that ATM is economically viable and would enable job creation.

5.3.3 Conservation and cultivation of the medicinal plants

The policy also recognises the conservation and cultivation of South African medicinal plants, and it has been proposed to divide these into two categories: the first being plants, animals and other biological materials used for domestic use, and the second is the medicine or plants used for commercial production. It was

recommended that: commercial medicinal plants will be limited when it comes to harvesting and will only be allowed under exceptional conditions, that National Pharmacopoeia in South Africa must be developed, a committee be set up to ensure collaboration between government departments, and that the institutionalisation must be developed. The policy recommends that information and communication tools to be put into place to promote ATM and ensure acceptance and inclusion in the National Health care system, and to aid with the integration between the two disciplines. The following departments are some of the role-players that need co-ordination, collaboration and co-operation:

- Department of Environmental Affairs (promotes and assists with the conservation of the plants);
- Agricultural research council (advises on the cultivation of the plants);
- Department of Science and Technology (involved in research of the plants, collaborating with the national indigenous knowledge system);
- The Medical Research Council (assists in research); and
- The Private sector (commercialises and produces the ATM)

The Bio-Diversity Act serves as a regulation towards cultivating and conserving plants and animals for commercial purposes.

It was recommended in the relevant policy that the National Institute of traditional medicine must accept the role of the safety and effectiveness of ATMs. Another recommendation is that an Advisory Board on medicinal plants must be established. It was recommended on global views that medicinal products must be limited to cultivate raw materials and wild harvesting must be done only under exceptional circumstances. The aim of this section is to obtain long-term sustainability.

5.3.4 Pharmacopoeia

According to international reviews, it seemed that most countries have a process of regulating TM and recording it into a National Pharmacopoeia. This is a list of

medicines that can be sold over the counter and is considered safe and effective to use.

It was therefore recommended in the policy that a legal framework for producing a national pharmacopoeia and a pharmacopoeia commission be appointed. Also the evaluation of different medicinal products and developing monographs of indigenous medicinal plants is recommended. The monographs must be available in different languages and the pharmacopoeia must be published, after it has been reviewed with an international panel.

5.3.5 The current interventions by the South African government (the draft policy)

In South Africa, the National Department of Health has made the following efforts towards the recognition of the institutionalisation of TM into the health care system:

- *The National Drug Policy (1996)*: This recognises the role and benefits of the remedies of ATM in the health care system, and the role of ATM to the formal health care sector.
- *The Directorate, Traditional Medicine*: A new directorate was established to manage work related to TM within the health department.
- *The Ministerial Task Team on the New Regulatory Authority*: This made provisions for the registration and regulation of ATM.
- *Traditional Health practitioners Act (Act 22 of 2007)*: Its purpose is to establish the 'Traditional Medicine Council' to monitor and create a framework and regulatory body for ATM.
- *Funding*: This is for the research and development of the ATM to control diseases.

- *African Traditional Medicine Day and Traditional Medicine Week*: This is in line with the African Union's Plan of Action (The Decade for African Traditional Medicine 2001-2010).

5.3.6 Additional Acts

The following acts do not deal with African traditional medicine directly, but impact the profession and needs amendments: (South Africa. Department of Health, Draft Policy on Traditional Medicine 2008:[sp]).

- *The Medicines and Related Substances Act*: This act defines medicine as, 'any substance or mixture used or suitable for use or manufactured or sold for use in the diagnosis, treatment or prevention of disease or its symptoms'. However, the current registration requirements apply only to allopathic medicine currently and this act will have to be amended to suit the new policy pertaining to traditional medicine.
- *The National Health Act of 1994*: This act will have to accommodate a chapter on traditional medicine to facilitate planning.
- *The National Environmental Management/ Biodiversity Act 10 (2004)*: This act was passed on 2 November 1995. The objective was to manage and conserve the biodiversity in South Africa. It ensures the sustainable use of indigenous biological resources and provides a sharing of benefits that arises from the indigenous knowledge in South Africa. This act covers ATM and protects traditional healers and the growers of traditional plants from exploitation and sustainability. The discipline of ATM requires the co-operation and involvement from the Departments of Health, Science and Technology and the Departments of Land and Agriculture.
- *The Patent Act*: This applies to a new product that has been invented or discovered. It applies to traditional medicine as an inventive step in the industry of agriculture. However, it seems that traditional medicine is knowledge that has been passed from a spiritual source, hence has no definable creator. So even if the traditional healer may wish to patent his knowledge, he will

experience difficulty in proving the novelty. Also plant-based medicine is not patentable without being modified.

Another problem lies in the fact that no method of surgery or therapy is patentable. Traditional medicine contains plants, animals and other materials. Also the lack of written reports of the patent materials creates difficulties when it comes to international access to the information. The Patents Amendments Act was amended to incorporate the Bio Diversity Act. It protects the knowledge of traditional knowledge, indigenous resources, genetic material and so forth.

- *Medicines Control Council*: This is a council that is responsible for the registration of medicine. According to information on the draft policy, it seems that there are difficulties in registering traditional medicines due to lack of regulations. The new minstrel task team intends to rectify this.

Within the policy the following action points were noted on institutionalisation:

- i. There is a request for policy finalisation.
- ii. Developing a legislation using the TM as a contribution towards improving the quality of life of South Africans.
- iii. The recognition and practice of ATM in South Africa.
- iv. The development of new systems towards the service delivery of African traditional medicine.
- v. Creating environments conducive to traditional medicine.
- vi. Protecting the rights of traditional health practitioners and the users of it against incompetent individuals selling medicine, or acting as registered practitioners.
- vii. Protecting the heritage and knowledge and intellectual rights of the profession.
- viii. Training and development of practitioners and the researchers, and improving research which is current and new.

- ix. Conservation of the medicinal plants and animals and sustainable harvesting manners.

5.4 THE DRAFT POLICY OF TRADITIONAL MEDICINE AS RECOGNISED BY THE BILL OF RIGHTS

The draft policy on African traditional medicine based on the constitution of the Republic of South Africa: (Bill of Rights, chapter 2 section 27 of the constitution of the Republic of South Africa 1996.)

The Bill of rights is known as the 'corner stone of democracy'. It enshrines the rights of people and affirms the democratic values. The following aligns traditional healing to human rights according to the constitution:

- Section 9: 'Everyone has the right to equality and non-discrimination.' It states that everyone is equal before the law. Traditional health practitioners must not experience any form of discrimination with regard to modern medicine, in the event it fulfils the same standards of safety, effectiveness, ethics and efficiency.
- Section 10: 'Everyone has the right to human dignity'. Traditional practitioners and their users have the right to be treated with respect and dignity. Patients must not be subject to degrading rituals or procedures.
- Section 14: 'Everyone has the right to privacy.' Traditional healers must have confidentiality when addressing patients and any medical information must not be disclosed to third parties.
- Section 15: 'Freedom of religion, belief and opinion.' Everyone has the right to freedom of conscience, religion, thought, belief and opinion. Traditional practitioners and the users may not be prevented from practicing their beliefs and cultures, except where suffering infringes of the rights of other human beings.
- Section 22: 'Right of freedom of trade, occupation and profession.' Traditional practitioners have the right to trade their profession freely as long as it is regulated by law.

- Section 24: 'Everyone has the right to have their environment protected.' This law is important for traditional practitioners not to contribute to environmental degradation and promote conservation and ecological sustainable development while preparing treatments.
- Section 27: 'Everyone has the right to access health care services.' Everyone should make use of the health care provided and have the choice of health care that suits them, even if it is holistic care.

Democratically we have a duty towards the people of South Africa. The preceding chapter has pointed out the main legislative framework and has identified the manner in which policy makers have incorporated a comprehensive framework which is in accordance to global views, but still adheres to legal limitations of the country. The chapter has focused on the legal boundaries, but at the same time it has assisted to understand the policy in terms of the bill of rights, legislature and democratic rights in accordance with the South African Constitution. After having all the theoretical knowledge from literature review, the following chapter discusses the case study, from a pragmatic point of view, that was undertaken to identify all the challenges and objectives pertaining to the relevant framework.

CHAPTER 6

RESULTS AND ANALYSIS

This section, aimed at providing research findings, will be written in a narrative form using a brief explanation. In this chapter the data will be presented directly and then analysed using trends that were found within each group. The results will be tied together and be linked to the literature with the objective of finding key elements. The theories and models described in the previous chapter will be used in the solutions as a way of moving forward towards successful implementation.

At this point the original research questions presented in the study will be revisited and the relevant findings will be presented. This data will be used with the purpose of identifying trends.

6.1 QUESTIONNAIRES AND RESULTS OF THE TRADITIONAL HEALTH PRACTITIONERS (THP)

(See Appendix A)

Five practicing traditional health practitioners were interviewed, four of which are registered by the Board of Traditional healers. Two of the five traditional healers are based in the urban areas of Polokwane while another two are based in the rural areas surrounding Polokwane. Of the five: one was based in Solomondale, a rural township; one was based in Lebowakgomo, a region in a township; and another one was based in Seshego, which is a semi-rural area with a large working community.

Semi-formal interviews were conducted with all five THPs. An interpreter was present as only two of them were fluent in English and one spoke Afrikaans. I consulted three of the practitioners as a paying patient.

The rationale behind interviewing traditional health practitioners is because they are consulted daily. In addition, the researcher wanted to identify their opinions

regarding the draft policy, and their perspective on the integration of their existing professions into the medical field. Their beliefs, views and values were questioned; a fact-finding mission on their perspectives of medicine or their roles in the community. The researcher wanted to identify what their practice entails, and whether they were aware of the integration and their feelings or reservations towards it. The researcher also wanted to identify how they wanted to move forward in evidence-based medicine as well as their views, issues and understanding regarding the new policy.

The questions (asked in an open discussion) and the relevant answers were as follows:

What type of traditional healer are you?

All five traditional health practitioners used dual modalities of practice, a combination of spiritual and herbal healing. They all use the method of the ancestral guidance to heal their patients, after that they prescribe a series of home-made remedies, home-grown and wild herbs, or remedies from wild animals.

Would you prefer to be integrated into a government hospital? Would you prefer to be registered under a board to protect your scope of practice and field?

All five the practitioners would prefer to be integrated into a regulated national health care system. However, all of the traditional health practitioners want to practice privately and not within the confines of a hospital. Their reason being, that the ancestral spirits will be more potent at their place of practice. They will not work in hospitals, because the spirits may not be as effective there. They believe that they can only practice where the ancestors allow them to practice. They will only be allowed to practice in a hospital if they have received 'permission' from the ancestors. Their practice is original and will not work with western doctors, because of the difference in belief of the traditional versus the scientific way of practice. One healer mentioned that western doctors would not understand their culture system.

One THP agreed to a traditional healer regulation if he is paid by the government for such a regulation. He was not aware of the concept of gaining a practitioner's license for professional protection.

**What is the difference between spiritual healers and traditional healers?
Do they have different treatments?**

The five traditional health practitioners were found to be a combination of both herbal and spiritual healers. The relevant description of the different healers is highlighted in the literature reviews. It is believed that through herbal treatments and spiritual healing, they provide overall holistic healing.

**Would you prefer to have your prices regulated? Do you have a fixed fee?
Does your consultation include dispensing medicine?**

All five did not agree to price fixing. Their reasons were that some herbs were not easy to obtain as they are usually far. Thus one has to consider the travelling costs in obtaining these distant herbs. Other reasons were the varying amounts of time it takes to heal people or that some ailments were more difficult to heal.

According to one traditional healer, a patient is charged in relation to the status that is held in a community. A poor person would pay less than an individual who is employed and working. It is part of their culture to pay whatever you can afford. In the past people made payments with cows, animals or belongings.

While conducting the interviews, I was a paying patient to three of the traditional healers. The consultation fee was R100 as a standard diagnosing fee, which entailed throwing and reading the bones. However, the dispensing fee of the relevant treatment ranged from R1 000 to R5 000.

I consulted three of the five practitioners within the confines of their huts. One healer diagnosed that I had pain in my legs, which was due to jealousy and bad luck. His fee for the treatment would be around R1 000 for a herbal concoction. The second healer diagnosed that the condition was due to a family upheaval. His treatment would be a special steaming to remove all the bad karma, which would cost about R3 000 to R5 000. The last healer diagnosed me with a mild stomach

problem, which would likely be due to anxiety. His dispensing fee would be decided upon after the treatment was approved.

I did not reveal any of my medical conditions to any of the traditional health practitioners. All of them did not ask questions before the consultation, but proceeded to throw the bones and revealed to me what the bones read. After each consultation, I asked their permission to question them about their practice wherein all of them obliged.

Do you ever refer clients to a local hospital, general practitioner or medical doctor?

All five healers agreed that they do in some cases refer some patients to a hospital, whilst in other cases it is a common practice to refer the patient to other traditional healers. As viewed in the literature review, all healers develop a different specialty. Three of the five traditional healers admitted that when they are unable to treat an ailment after some time, the healer will then refer patients to a hospital. One traditional healer instructs the patients to have their blood drawn to diagnose whether the patient has HIV/AIDS. He then treats his patients and refers him back to the hospital for a second series of blood tests to check the status after treatment.

Do you ever prescribe medication from the chemist?

All the healers use only mixed herbs that they source themselves, from wild life or self-grown herbs, which are used for the treatment of the patients. The treatments are combined with spiritual healing.

Would you prefer to be educated about health issues by the government and regulated in your scope of practice and field?

All the healers agreed to further their education and attend exchange workshops that will be provided by the government. One healer will only educate himself if he is paid by the government to do so.

Would you like your medication to be scientifically tested, so that it can be utilised in hospitals? If no, why is it not possible?

All the traditional healers would not agree to the scientific testing of the medications and herbs. Three of the healers said that their recipes are cultural secrets. One healer proclaimed that he may die if he releases the herbal concoctions. The other healer is willing to share the remedy for lymphadenopathy if he is paid for it. The last traditional practitioner said that he is afraid of commercialisation and will therefore never release his herbal recipes. The general consensus amongst the healers is that the ancestors will not permit them to release these medications and it should always remain cultural secrets.

If there is integration, would you be prepared to work hand in hand with medical doctors to the patients preferred method of treatment? How do you feel about the referral system? How do you feel about registration? Would you refer patients that you are not permitted to treat?

The first traditional healer is willing to work with doctors, but is afraid to be ridiculed by the doctors because he has realised that medical doctors do not always understand their culture. The other three healers refuse to work hand in hand with doctors, however, will refer patients to hospitals if they are unable to treat the patient. The last healer is open to working with a doctor, but after he has consulted with the ancestors.

Why do some THPs practice secretly?

All the THPs have stated that it is part of their culture to practice in secret. Even their remedies are cultural secrets. Their patients consult with them in secret and the patient's ailment will always be a kept secret to the practitioner. All the healers strictly enforce the rules of patient confidentiality.

Will you study at university? Will the ancestors allow this? Why should this profession be legitimised?

To avoid a conflict and not to intimidate less privileged groups who were previously disadvantaged these questions could not be asked directly, however, all the healers

want training and are prepared to attend government initiatives. The healers do not want formal training, but still need to have *twasa*, as discussed in the literature review, however want short courses to understand the nature of illnesses.

One healer expressed that traditional healers treat illnesses using the past, present and the future (divination) and therefore it will be helpful to attend courses to improve their knowledge. Meaning that they treat illnesses: from hereditary origin, with chronic and acute conditions, that originate from a psychological aspect, and that happen due to witchcraft.

Do you make your own medicine? Or do you have it made? Do all THPs have the same medicine?

All five healers make their own mixtures, using the recipes that they have been taught by their trainers or their ancestors. Not all THPs use the same mixtures. Traditional health practitioners use herbs, roots, animal parts and spiritual forces to make concoctions.

How do you differentiate between diseases? Who trains you? Do you treat all diseases?

All five the THPs use the method of 'throwing the bones' to make a diagnosis. They are trained by the *twasa* method using their own training techniques. The five healers are all experienced practitioners and have been training for many years.

The first healer explained that he treats only certain ailments and refers his patients if need be.

The second healer treats mental and supernatural diseases. He believes he is more powerful in terms of spiritual healing and gets his herbs from all over the country.

The third healer is a bone specialist and treats high blood pressure and lymphadenopathy. He can also treat HIV and Tuberculosis (TB) if the patient consults him in the early stages of the disease.

The fourth healer specialises in fertility and womb disorders. His sources are mainly plants and roots. He cannot treat HIV/AIDS or TB.

The last healer is an expert on marriage, fertility, relationships, change of luck and removing witchcraft. He also combats the *tokoloshe*. He uses mountain herbs which are very expensive to maintain. He also treats HIV/Aids and TB if the patient consults him in the early stages of the disease.

Can you tell me some success stories, and some difficult cases where patients did not recover well?

One of the healers denoted a story where he miraculously cured a patient of AIDS in the early stages. Another healer cures lymphadenopathy. The general trend was that they see much progress in patients after consulting with them and if they cannot treat an ailment, they refer the patient to a hospital after some time.

Who in your community is seen as a 'hoax' and who is for real?

All the THPs agree that due to financial challenges, there are some 'quacks' within the profession. They agree that most quacks are ruled out by word of mouth or by communities. One practitioner admitted that some healers only aspire to be superior, but a true healer will not practice without formal training.

One healer stated that THPs from other parts of Africa are impostors or "Hoax" and have not gone through the ritual training procedures.

One healer has stated that some healers call themselves healers, but practice witchcraft. Individuals must consult a traditional health practitioner to combat witchcraft with charms and amulets.

Do THPs work together?

All THPs have agreed that they treat patients within their own specialty, however, they do refer patients to each other and to hospitals.

Is ritual killing part of the profession of a THP?

All the healers strongly reject ritual killings. They believe their healing is a powerful source of the supernatural with the intention of curing. A true healer will never

harm another human being and ritual murders are a form of witchcraft. They all agreed that this is not part of their practice.

If you were sick, where would you go? Do THPs make use of western doctors?

Four of the five healers do not consult medical doctors if they are ill themselves. They self-medicate and believe that all sickness come from a spiritual origin, therefore use their own remedies for help.

One THP will consult a hospital if need be.

Who is your client base? How many educated people consult with you? What are their main reasons?

Their patients are made up of people from a variety of different demographic backgrounds and professions, namely: medical doctors, lawyers, parliament employees, and nurses. The general consensus is that they consult THPs to be treated for benevolent purposes and evil spells.

However, two healers were in the heart of the homeland and admitted that the entire community consults them.

Another healer was also in a rural township and said that his client base ranges from all types, examples are uneducated people, educated people, adults, children and all races groups.

Two healers are based in Polokwane and claim that their client base is people of all origins. They have seen: Muslims, Christians, blacks, whites, Indians, coloureds, and educated and uneducated individuals. The general consensus was that not only do black African people consult, but all races and religions consult them depending on the location. They stated that other nationalities are also developing a trust in African traditional healers.

The reason why educated people would come to consult traditional healers was a topic of interest, however, the answers were vague. One healer stated that doctors and lawyers consult to bring success and luck to their practices. Young people

consult to bring love into their lives and white people have consulted recently to change their luck with their jobs.

6.2 QUESTIONNAIRES AND RESULTS OF THE SERVICE USERS (See Appendix B)

The questions were directed at service users in the rural communities and urban areas within the Limpopo Province. The questions were used as a basis of obtaining trends, using the questions in six informal focus groups consisting of five to seven people. However, one group was a large group of approximately 45 people within the heart of the township of Solomondale. A lot of information and trends were deduced using this group. The questions were asked, and the following trends were noted.

The reasons behind interviewing the users were to establish their trust, views, beliefs and reasons behind seeking TM above modern medicine, or vice versa. The researcher wanted to understand their feelings towards the integration, their issues with both modalities and their preferences. Their views, opinions, negative or positive feedback will assist in determining if the policy is pragmatic on a bottom up basis. Their views and solutions will assist the policy on a practical level.

Trends:

Group 1:

This group consisted of six African people within Polokwane. The trend was that the majority of the group makes use of THPs, trusts in them and consults them primarily before consulting a medical doctor or going to a hospital. Consulting a traditional healer dates back to their cultural beliefs and they prefer using traditional healers, because they are recommended by their families. Another deduction was that the THPs are easily accessible and that more care is given to the patients than from a medical doctor or nurse. Going to hospitals are found to be a tedious task and the long waiting periods force them into trusting the healers

more. It seems the healers are more personalised and they treat holistically overall, from diagnosing health problems to removing bad omens.

All the patients of this group prefer to use a THP above a medical doctor. The main consensus was that patients seek traditional help above medical help due to trust, culture and limited help within the hospital environment.

Group 2:

This group consisted of about 45 individuals from a rural area (the township of Solomondale). This group agreed that they visit THPs, however, seek modern medicine as well. It was found that there was a changing attitude towards the THPs since there is a district clinic within the area. There was an agreement amongst the group that due to their culture they first went to the THP and then visited the clinic as well.

The reasons why they prefer the district clinic is because the treatment is free and the nurses take good care of them. The people in this community would prefer the THP to be integrated into the health care profession and into the clinics, as they feel they can get the best of both worlds and they will not be overcharged. The main complaint was that the district clinic does not have relevant medications in stock and they are therefore compelled to use traditional medicine. They believe that they overpay, but due to accessibility and spiritual guidance they have been consulting THPs. Their solutions were that: THPs should have a set price, traditional healing should be integrated, and district clinics should offer better service with shortened waiting periods.

Group 3:

This was a group of seven domestic workers within a community who live in rural areas. The consensus of this group is that they trust and make use of THPs. However, they have realised that THPs cannot treat AIDS, TB and other serious conditions. The group stated that they make use of THPs for benevolent purposes and mild illnesses. They trust the THP and believe that the healer is a leader of their communities.

The group reached an agreement that they would prefer THPs to be integrated into the government health care system so that the price fixing is standardised and they are readily available to their services. They also stated that if the THPs are integrated into the hospitals they would obey them if they referred them to certain doctors.

Group 4:

This was another group of five people from the same rural township in Solomondale. The group had reached a consensus that they do not entirely trust THPs and so have resorted to the church for spiritual healing and western doctors for health. They do, however, agree that if THPs were legitimised and showed a scope of practice with price fixing they may consult with them. Many people in this group are changing their beliefs and are becoming church believers, so seek divinity in the Apostle church instead of THPs for spirituality.

Group 5:

This was a group of eight youths. The consensus was that their parents encourage them to seek traditional help, however, they prefer to seek help from clinics when they are ill. They have agreed to the integration due to the fact that it would be cheaper and they could seek spiritual help from THPs.

Group 6:

This group was also a set of individuals from Solomondale. This group was reluctant towards seeking traditional help due to previous unsuccessful consultations with THPs and was therefore forced to seek medical assistance. A person in this group has been diagnosed with HIV and therefore the THP had worsened her condition until she sought medical attention for Anti-retro viral drugs (ARVs). The only concern that was noted was the long waiting periods and the accessibility of medication from the clinic. The consensus of this group looked more towards the church for spiritual healing. The group believes that they cannot afford THPs treatment for any type of help, therefore they feel cheated financially.

6.3 QUESTIONNAIRES AND RESULTS OF THE WESTERN DOCTORS

(See Appendix C)

Interviews were conducted with six qualified medical doctors (DR) of different specialties. Four doctors were government employees and two were from private practices. The doctors' ethnicities are as follows: two of the six doctors were black, and four were white. All the doctors were based in the Province of Limpopo. The four state doctors all work at the Polokwane State Hospital and the two private doctors service rural and urban communities with practices based in an urban area. All six doctors have an urban and rural clientele and have had much contact with the African traditional medicine culture.

Most medical doctors in this province are familiar with the practice of traditional healers. Their views, experiences and solutions towards the management and integration would be advantageous to the draft policy. The researcher wanted to enquire about their personal experiences and opinions on trailing traditional medicine. It is important to ascertain their experience regarding the combination of treatments. Their personal opinions regarding the positives and negatives can be beneficial in finding solutions to the policy issues.

Have you been exposed to traditional healers in your medical career?

What was it?

All six doctors have previously been exposed to traditional healers, but not directly. All the doctors have had patients who have previously sought help from traditional healers and used the hospital as a second means of treatment. Most of these patients have come with far progressed diseases and complications.

How would you feel about getting referrals from traditional healers?

The general consensus of all these doctors is that THPs must refer patients to primary health care clinics as a first point of treatment.

DR 1: The doctor prefers traditional healers to refer patients to a medical doctor. The traditional healer (referee) must give a full detail of the medical symptoms, in order for a proper diagnosis. The doctor suggests that THPs need to refer patients to primary health care clinics and not directly to the hospitals. The doctor still seems to believe that when a patient is referred from a traditional healer, the medical treatment must begin from primary care and healers need some medical background to relate to the medical profession.

DR 2: The medical doctor finds it important to refer as soon as possible, due to the usual delay that patients have when coming from traditional healers. He feels that traditional healers slow the progress down towards sooner treatment.

Will you treat a patient that was referred to by a traditional healer? Do you feel any different to patients who have sought traditional medicine?

All the doctors agreed that patients are the most important aspect of medicine and they will not be ridiculed after seeking help from a traditional healer. However, five doctors have stated that they do explain the importance of medical attention to the patients and they advise them not to drink the herbs from the traditional healer after having sought western medicine.

What percentage of patients that come to you have initially sought traditional healers?

All the doctors could not put an exact figure on it, however, these were their estimations:

DR 1: More than 50%; quite a few.

DR 2: A very large percentage.

DR 3: Not sure, because it was a private doctor.

DR 4: About 40%; more from the rural communities.

DR 5, 6: A large percentage.

Have you received any complaints from patients about their traditional healers when they seek modern medicine?

All the doctors' responses were that 'only patients who had come for treatment after being sought by a THP and their illnesses were far progressed'.

Do you believe traditional medicine must be trialled?

All the doctors have the same opinion in that traditional medicine could have several benefits, but it is unethical to administer herbs to patients if the relevant scientific trials have not been done. One doctor gave the example of folk medicine while another doctor gave an old African remedy that worked. However, none of the doctors feel comfortable administering herbs that have not been trialled. It was stated that some herbs may be toxic and reactions to scientific medicine need to be ruled out. One doctor totally refused to prescribe traditional medicine to patients.

The general consensus was that homeopathic medicine works, however, it cannot be administered to patients without being scientifically trialled, because it is unethical and can be harmful. He stated that the traditional medicine could have reactions when administered in combination with scientific medicine.

How do you feel about traditional healers, and merging the scope of practice and integrating them into the health care system?

All the relevant doctors have agreed to integrate traditional medicine into the health care system, provided that the THPs are registered as all other medical professions and the herbs are in the purest form after they have been trialled and tested. One doctor stated that the only reason they should be integrated, is so that they can be policed or monitored not to do further damage to the patients.

How do you feel about combined management of diseases? Would you feel comfortable working hand in hand with traditional healers?

DR 1: This doctor will work hand in hand with traditional healers provided they have a scope of practice and treat patients within their field of medicine.

DR 2: The doctor stated that he will only work hand in hand with the healers to control them. He feels that working in combination with them would be unfeasible, because they are on different levels of education. However, he feels that on a primary health care level, it could be holistic for the patient.

DR 3: The doctor believes that if policies and practices are in place, then perhaps they can be merged into the healthcare system. They need rules, regulations, safety policies and accountability exactly like any other health care professional.

DR 4: This doctor stated that traditional healers have no medical background and finds it impossible to work hand in hand with them, unless formal tertiary training is done and doctors also have an understanding towards their field.

DR 5: The doctor stated that patients cannot seek traditional healing and doctors at the same time due to drug interaction. However, if healers were only spiritual healers then it would be more suitable.

DR 6: As long as there is regulation and a limit to their practice, the scope of practice can be maintained.

The general consensus was that most of the doctors agreed not to work hand in hand with THPs, due to the difference of the level of education, however, suggested that the THPs should be on a primary health care level, working as spiritual healers. The doctors also feel that a combined treatment would not be possible, due to a drug interaction between the traditional and scientific medicine. The only solution would be that traditional medicine should be trialled and tested and be considered safe before administering it to patients.

Do you believe that traditional medicine hampers the health and overall medical care in the province?

DR 1: Traditional healers hamper the patients from attending hospitals in time for the sake of making money out of patients, hence many people are exploited. They have no accountability and their diagnosis is vague. There are negative connotations involved, for example: muti-murders, killing of animals, destruction of the environment, and so forth. The doctor feels that it is unacceptable to integrate

them into the medical profession. They definitely hamper the health care in South Africa.

DR 2, 4: Yes, they exploit patients by the fees that they charge, and delay patients from seeking medical attention early.

DR 3: Yes, they must only provide care on a psychological level. They must have the same rules, regulations and accountability as any other health care professional.

Dr 5: Yes, they change the way people deal with illness and make decisions based on a personal belief. Patients are discouraged from the public health sector by the THPs.

Dr 6: Yes, because the field has been commercialised and people are exploited by some healers.

What challenges do you think we will face by merging the two disciplines?

DR 1: Many challenges, because they need to be carefully analysed at what their scope of practice is and create limitations. It needs to be determined if each one is a traditional healer or not. That is, their authenticity needs to be decided upon and each one needs to be individually determined. A criteria needs to be formulated. Policing and regulating is needed.

DR 2: The challenge is to put them into a rightful place. THPs can only treat on a spiritual level and need to stop charging patients large rates. The way to deal with the situation is through the media (example: television, radio, etc.) and to train primary health care nurses to educate patients.

DR 3: There are no solutions, unless medicines are trialled and tested. The masses need to be educated, thereby eliminating poverty.

Dr 4: There are no solutions, but suggested to encourage educating the public. Perhaps also educate the healers to gain insight on major diseases.

Dr 5 and 6: Regulations, rules, accreditation and accountability as with all other health care professionals need to be implemented. Educate healers and have courses in place. An apprenticeship must be completed and their courses scrutinised closely. They should have a common aim, which is to save lives. The biggest challenge is to trial the medicines and to educate the public, so that it eliminates the confusion as to which mode of treatment is best.

Have you found anything positive approaching a *sangoma* (THP)?

The doctors acknowledged that traditional medicine may have some benefits, but the benefits cannot be recognised and effective if the herbs are not clinically trialled and tested. THPs work well as spiritual healers and assist when the 'placebo effect' is needed.

What methods would you propose to try to educate traditional healers, and up to what level?

The western doctors maintain that THPs must have limitations to their scope of practice. They must be taught to refer early and be able to recognise certain medical conditions. Their courses must have scientific value and the courses must be scrutinised closely with the aim to save lives.

Is the Public Health care trying to escape its responsibilities?

DR 1: No, they are doing their best, but have no choice due to culture. However, if the PHC (public health care) system continues to allow the THPs to treat patients then they would be failing their real responsibilities. Medical aids must only cover traditional healers if they have a scope of practice.

DR 2, 5: Yes, perhaps there is not enough accessibility within the rural areas and this could be a contributing factor. Ministers may possibly be avoiding the policy, because of the culture. The doctor believes that even ministers seek a traditional health practitioner.

Dr 3: Yes, medical aids are suffering, patients arrive late for proper treatment and therefore it costs money and lives.

DR 4: Yes, but only in the way that the Public Health Care system is allowing people to be exploited, is by legitimising traditional healers.

DR 6: Perhaps accessibility to health care could be a problem, however, culture cannot be overlooked. We need to find a way of collaboration.

6.4 QUESTIONNAIRES AND RESULTS OF THE NURSES AND THOSE WHO WORK WITHIN AND AROUND THE PROCESSES

(See Appendix D)

Interviews were conducted with about ten nurses who work within and around the processes, and the following trends have been noted:

The reasons and motivations behind interviewing nurses and health professionals are because they work closely with people within the communities. Therefore they also have hands-on experience in dealing with the community as well as have experience in evidence-based medicine. Their knowledge regarding the realities of the situation may have value in finding solutions regarding the integration of the field. They may also have insight into issues, and their experiences may contribute positively towards the policy.

Trends:

1. Nurses have stated that doctors ridicule patients who have come to seek medical help after their conditions have deteriorated.
2. The nurses believe that THPs should only treat smaller conditions by their alternative ways, but not treat any AIDS, TB or cancer cases.
3. The nurses believe that if the THPs are integrated into the hospital, they can be taught how and when to refer a patient properly and therefore save lives.

4. It was also noted that traditional healers are used due to the trust factor and insecurity issues, however, people are moving more towards using hospitals due to exorbitant rates.
5. The nurses stated that some people prefer healers due to culture and trust. The patients then later realise that they need a hospital. However, it can be due to long waiting periods at hospitals that people seek traditional help.

6.5 QUESTIONNAIRES AND RESULTS OF HOSPITAL MANAGERS AND PROVINCIAL HEALTH DEPARTMENT MANAGERS

(See Appendix E)

Public administrative managers were interviewed because they have insight into the national policies, and they understand the needs of the citizens. Their policy knowledge and interaction within communities will help address the problems and may provide solutions towards taking the policy forward. This will be of value toward amending policies, if necessary.

Manager 1:

The interview was with a manager at the health department, who is a former doctor and is now in public health care management. The manager is African and a qualified medical doctor who understands the concepts of basic medicine and African traditional medicine. He believes that African traditional medicine is filled with secrets and the skill is not fully understood or known. He stated that one does not really know the competencies and traditional healers' level of education.

The manager did not know too much regarding the policy, but had good input that would assist towards the research.

He believes that the medical staff cannot work side-by-side with the traditional healers, because traditional healers delay the patients' treatments.

The manager understands the cultures, beliefs and insecurities of the rural dwellers. He believes that the traditional healers work well on a psychological and benevolent level.

The manager believed that a way forward would be to learn more of their skills and regulate them with policies and restrictions within their professions.

Manager 2:

The interview was conducted with a manager in a local hospital. The manager is African and understands the needs and beliefs of the rural population of the Limpopo Province.

The manager states that traditional healers cannot be incorporated into the National health care system. He states doctors must discourage patients from herbal medication and look for solutions in which the two disciplines can meet and work together, due to the fact that traditional healers delay treatment for the patients. He also acknowledges that the herbs from the traditional healers interfere with the medicines given to them from doctors. His solution is to educate traditional healers and patients.

Manager 3:

The interview was conducted with a manager who is in charge of the official policy. The manager states that the policy is in draft form. The policy makers were still busy at the time. In June 2009 when interviewed the policy had not yet reached the stage of evaluation.

The policy makers believe that the traditional healers have solved health problems for many years before the emergence of modern medicine and therefore have a place in the health care system. However, many challenges have arisen and are as follows:

1. Traditional healers do not agree to western trialling and thus western trialling has not been done extensively.

2. There is a challenge in differentiating between the 'quack' or 'hoax' healers and identifying the real healers.
3. The National Health Plan needs to be altered to cater for the Traditional Health Practitioners policy.

The policy maker explained that traditional health practitioners will make use of the 'referral system and traditional hospitals will be implemented'.

According to the data gathered, the general trend that was found amongst traditional healers is that the majority of them will not agree to western trialling on traditional medicines.

6.6 TRENDS AND FINDINGS

6.6.1 Traditional Healers: Noted Trends:

The majority of the THPs prefer regulation with a recognised board and want to be integrated into the health care system. However, they do not want:

- their herbs to be trialled or researched upon;
- their expertise to be shared with allopathic doctors;
- regulation on the fee system or price fixing;
- be based within a hospital environment; and
- to be restricted on where to cultivate herbs.

6.6.2 Service Users (Focus Groups): Noted Trends

- The majority of the people interviewed had previously sought traditional medicine.
- The general consensus is that the views are changing from using THPs to district clinics.

- People all feel that THPs need to price fixing due to exorbitant rates that are unaffordable.
- Many of the people are moving more towards using the church for spiritual healing.
- The people feel that waiting times, lack of medication and the distance to a district clinic forces them to seek traditional help.
- Most people prefer the integration of THPs into the health care system due to being protected against 'quacks' and high fees.

6.6.3 Western Doctors: Noted Trends

- The consensus is that medical doctors prefer THPs to refer patients to hospitals and district clinics as a primary service to prevent progression of the diseases.
- Medical doctors are reluctant for THPs to be integrated into the health care system, unless THPs have a scope of practice, limitations towards the field, accountability and ethics as every other health care professional.
- Doctors are not satisfied for patients to be treated with traditional medicine, unless the medicines have been scientifically tested as safe to use.
- Doctors have proposed a solution to train THPs to recognise diseases and the importance of immediate referral to save patients from progressed conditions.
- Medical doctors do not agree to a combined treatment, due to the possible drug interaction of the herbs with the scientific medicine.
- The doctors acknowledge that traditional healers have a positive impact on the majority of people, but only by way of spiritual healing.
- Doctors believe that traditional healers hamper the health care system, by way of delaying treatment for their own financial gain.

6.6.4 Nurses and those who work within and around the processes: Noted Trends

- Nurses have all noted that doctors ridicule patients who have sought traditional healers prior to western medicine, due to the fact that they come to the hospitals with long progressed diseases.
- Nurses have noted that traditional healers give good spiritual guidance and they are trusted by people of the African culture.
- The nurses believe that people seek traditional healing, because of culture and trust. However due to high fees that are charged and evidence of the progression of diseases they resort to medical doctors.

6.6.5 Hospital Managers and Policy Makers: Noted Trends

- The managers have acknowledged the cultural factors attached to traditional healers, but also believe that they need to have a scope of practice and regulation as a way forward.
- Managers are aware of the challenges involved, and have stated that we cannot rule out or eradicate traditional healers, so the way forward is to legitimise their practices and try to find solutions to prevent the exploitation of people.
- Regulation, scientific western trialling and education were the solutions proposed by the managers.
- Managers proposed to try to understand the profession of THPs and to educate traditional healers to refer patients when necessary and create limitations on their scope of practice.

This chapter has brought to light many practical issues that were found regarding the official policy. The next chapter addresses relevant models and solutions which can be considered as a foundation towards assisting the draft policy to move forward.

CHAPTER 7

RELEVANT MODELS, RECOMMENDATIONS AND DISCUSSIONS

The purpose of this chapter is to understand how the integration of traditional medicine, with the existing western medicine, will take place. This chapter will also examine models that policy makers could benefit from in order to implement the policy effectively. The following theories look towards successfully finalising the relevant policy and set a way forward for the completion of the process. The models link up with the recommendations and solutions. The models discussed below include a model that describes the modernisation of countries, which will eventually impact the modernisation of health care. Critics of the modernisation theory have questioned the validity of this theory in the context for which it was initially proposed, however, I believe that this model is important in describing the path that TM should take towards development and progress. The 'chaos and complexity theory' is also described and, as suggested in the previous chapters, policy makers need to understand that these complexities are important when making decisions regarding policy. In order to solve the issues and problems regarding the policy processes, we can utilize and understand the models to reduce the gap to achieve a consensus.

Insight into the different models adds perspective towards the policy makers' processes and the relevant steps to be taken towards successfully finalising a policy. Thus the below mentioned policy models can be taken into consideration for the policy process. The above theories give us an indication that the literature presented enables us to apply the knowledge in finding solutions for the problem.

The preceding chapters have shed some light on the theoretic aspects of the impacts of traditional healing on the lives of the people of South Africa. The following chapter will explain various recommendations that may enhance the quality of the policy and improve understanding towards South Africa progressing towards a more modernistic approach in the light of public health.

The chapter discusses the recommendations by various boards and later moves on to recommendations that have been discussed with different professionals through conclusions throughout the fieldwork. Lastly the chapter defines a framework for traditional healing, towards the modernisation of the country and a direction to which traditional healing should be directed.

WHO (2001) describes the problems with traditional medicine clinical data as follows:

'The quantity and quality of the safety and efficacy data on traditional medicine are far from sufficient to meet the criteria needed to support its use worldwide. The reasons for the lack of research data are due not only to health care policies, but also to a lack of adequate or accepted research methodology for evaluating traditional medicine. It should also be noted that there are published and unpublished data on research in traditional medicine in various countries, but further research in safety and efficacy should be promoted, and the quality of the research improved.'

7.1 THE POLICY MAKING PROCESS

Public policy as stated by Cloete, Wissink and De Coning (2004:50), has a policy life cycle from problem structuring, forecasting, recommendation, and monitoring to evaluation.

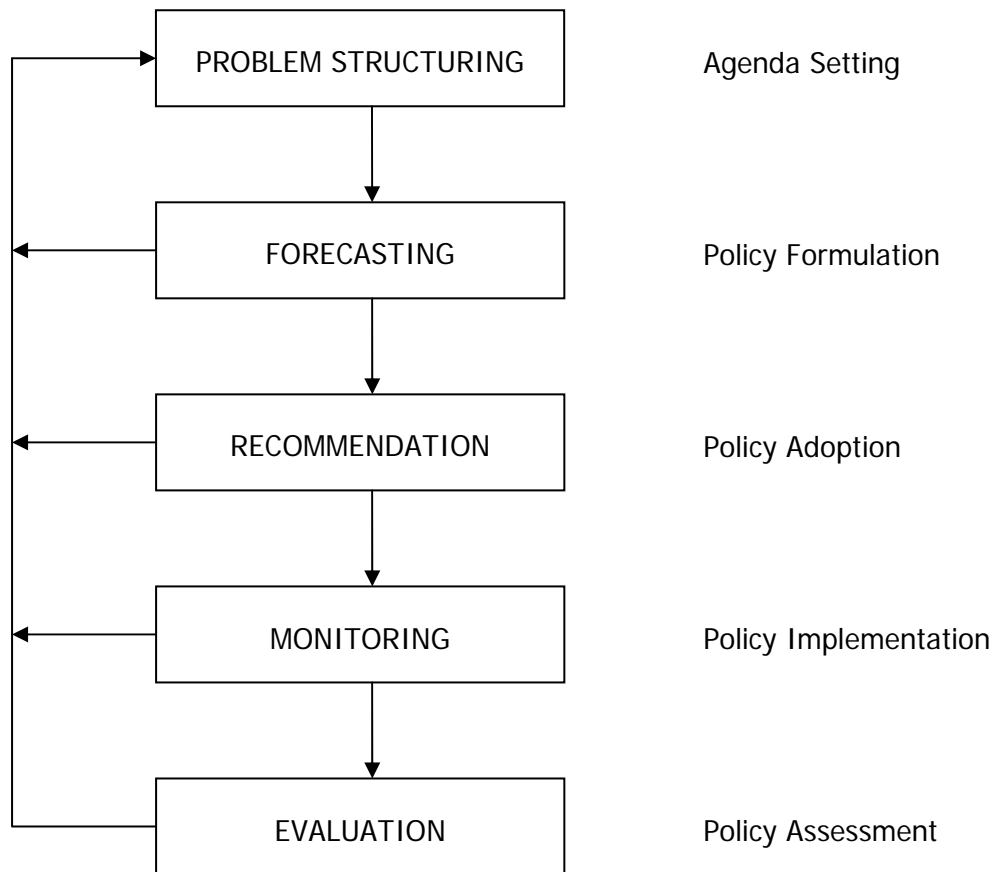


FIGURE 2: Dunn's Policy Making Model: Cloete *et al* (2004).

Public policy is understood by using Dunn's policy-making model. I intend to illustrate that we have identified the problem, and we need to link the policy formulation stage to the monitoring and evaluation stage. This is understood later on in the thesis after discussing the actual policy of relevance.

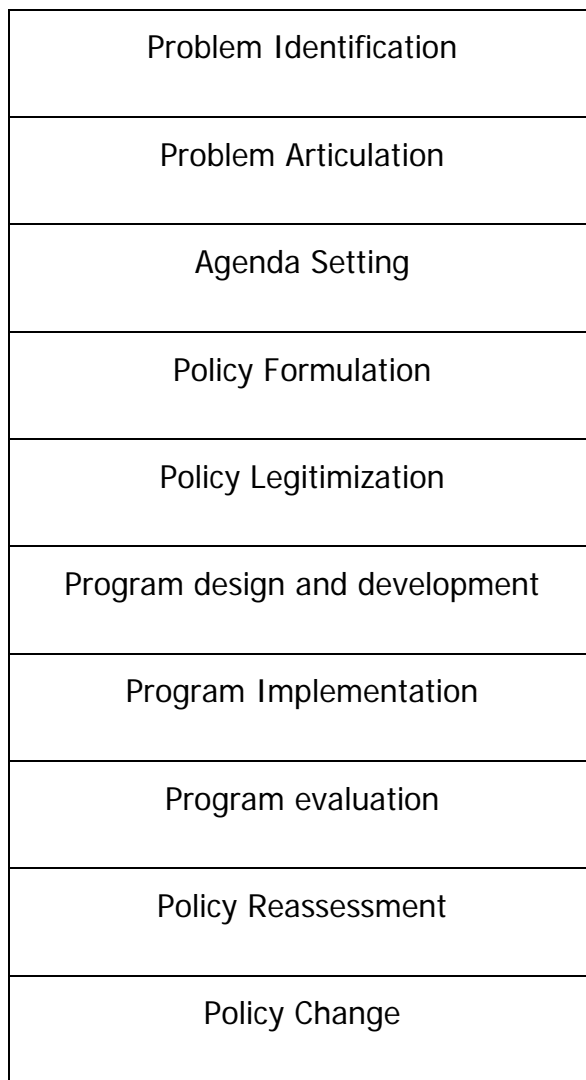


FIGURE 3: Policy Making Process: Cloete *et al* (2004)

Public policy, according to Cloete *et al* (2004:50), is better understood by linking the policy design to the actual implementation. If the design and actual formulation of the policy is effective and the actual drafting of the policy is optimal, the evaluation and implementation will be effective. This study will be based on the forecasting and formulation stage of the proposed policy. This is illustrated in Fig. 1 and Fig. 2 above.

Cloete *et al* (2004:50), has stated and focused on the contributions to policy making and all interrelated forces. He states that policy making requires public participation and public choice. It involves direct representation, empowerment and

active decision-making. He clearly states that public participation is of primary importance. However, theories are used to explain policy making, but models are used to present the related problems.

7.2 THE GENERIC POLICY PROCESS

Cloete *et al* (2004:112), describes that the involvement and participation of the community benefits the results of the policy. He describes different ways in which community participation can occur, for instance: ratification, consultation, negotiation, and execution. This can be initiated through interest groups working with the community, which is a bottom-up approach. Another manner in which community participation can take place is through an individual or organisation using a top-down method. Community participation is a prerequisite to any stage of the policy life cycle and should be implemented in every step of policy making.

There are various models of policy making, however, I have selected the 'Generic Policy Process' to illustrate the linkage between drafting policies and the implementation stage. The draft policy on traditional medicine is in the formulation stage, so if we practically apply this model we can understand the processes involved.

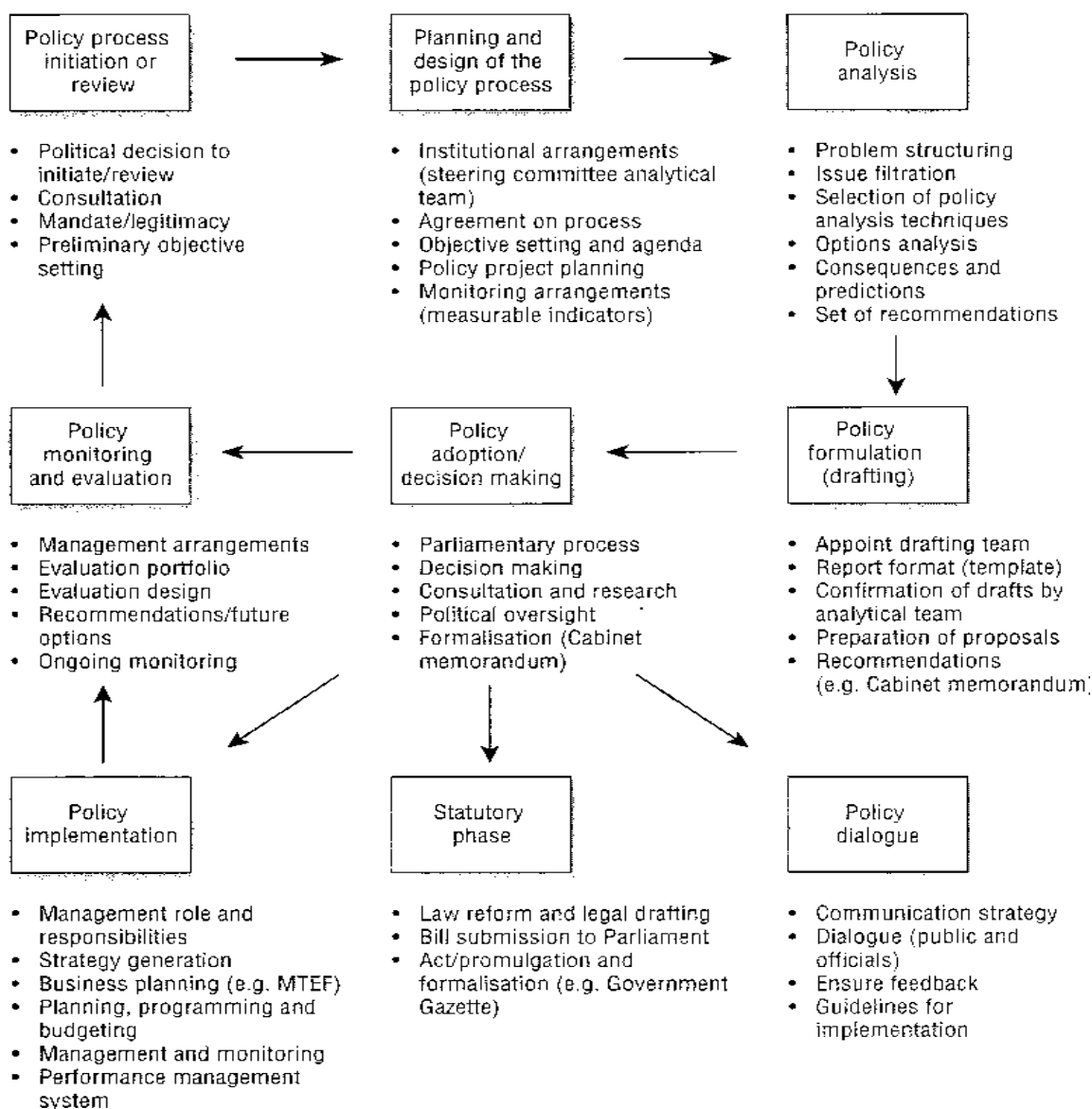


FIGURE 4: The Generic Process Model, (De Coning and Fick 1995:[sp]).

The aim of the research intends to link the policy formulation stage to the implementation stage and ultimately to the evaluation stage. A good draft, taking public participation into consideration, intends the government to do research and make an effective decision so that implementation can be successful.

7.3 MODERNISATION

While drafting policies, it is imperative to consider 'development' and look at different schools of thought on what development theory can be applied to lead the country towards development. The modernisation paradigm is a western stream of thought. This model is criticised, because it ignores the positive within traditions. It states that less-developed countries should follow the path of 'developed' countries

and that tradition is considered 'primitive' and 'backwards'. This model was included into the paper as a progressive means towards completion and logically ties in with the recommendations in chapter 8.

'The Rostovian Take-off Model' (also called 'Rostow's Stages of Growth Theory'), is a practical example of the modernisation paradigm and is a historical model that was designed for economic growth. This illustrates that his theory is a model of stages of growth (Davids and Maphunya 2005):

- *Stage 1 Traditional society*
- *Stage 2 Preconditions for take-off.* Society overcomes the limitations of tradition and there is western invasion.
- *Stage 3 Take-off.* There is rapid economic growth and western technology.
- *Stage 4 Drive to maturity.* The economy has technological and entrepreneurial skills.
- *Stage 5 Age of high mass consumption.* Economy is a developed country and has the patterns of an industrial country of the world.

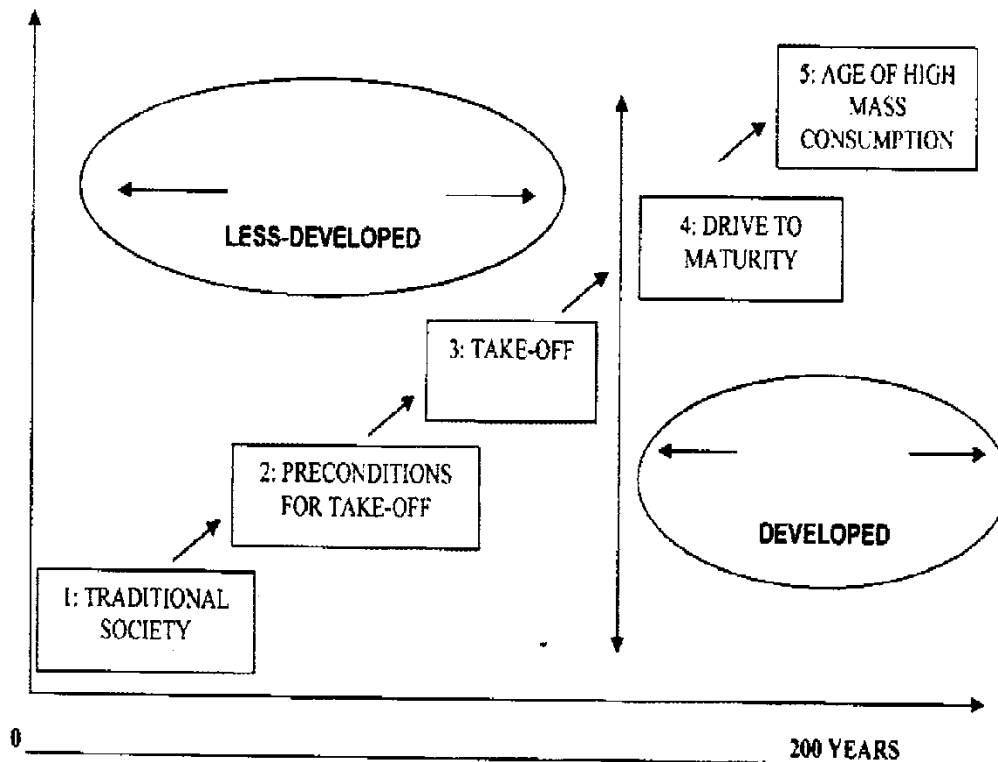


FIGURE 5: Rostow's Stages of Growth Theory (Davids and Maphunya 2005:[sp]).

The above model is used as a recommendation, however, as mentioned above some have criticised it and have noted its shortcomings. Some of the issues include:

- The oversimplification of factors relating to developments. Coetzee, Graaff, Hendricks and Wood (2001:[sp]) expresses that modernisation and traditions are interrelated and need each other. He adds that modernisation includes traditionalism and then eventually forms its own traditions.
- The model is described as highly predictable and controllable. The model also ignores complexity and therefore has potential for regression (Coetzee *et al* 2001:[sp]).
- It considers modernisation as western. This gives the impression that western countries don't have a history or a previous tradition. It also assumes that colonisation and other western historical occurrences have had no impact on development (Coetzee *et al* 2001:[sp]).

The abovementioned are a few examples of how critics regard modernisation. However, in this thesis, I use this theory as a solution and a recommendation even after acknowledging these shortcomings.

7.4 THE COMPLEXITY AND CHAOS THEORY

The 'complexity and chaos theory' is a theory that studies situations in which their futures are too complex or difficult to predict within the field of politics. It may be helpful to understand the theory, whilst dealing with the policy of traditional medicine. Later on in the thesis, the challenges will be highlighted and we may have to apply this theory to solve the problems encountered.

The theory suggests that a problem be broken down into smaller pieces so the problem can be easily understood. The 'chaos and complexity theory' is a modern approach to the social science. 'Chaos' is defined as deterministic and is a chaotic and complex organisational behaviour.

Cloete *et al* (2004:[sp]) has highlighted the forces behind a natural phenomenon which is 'complexity'. This theory assumes that these complex natural forces may drive the psychological and social process in society. This will all be noted once we have encountered the challenges in the relevant policy.

According to Cloete *et al* (2004:[sp]), the characteristics of a complex system is that it is difficult to understand and multi-dimensional. There is an interaction and sharing of information, but these interactions are non-linear or short-ranged. He states that complex systems are influenced by the environment and involve history.

The two types of complexity theories are 'Quantum complexity' (random chaos) and 'Generic complexity' (deterministic chaos). Quantum complexity theory, also known as the 'Heisenburg uncertainty principle', is defined as indeterministic, random and subjective. It is an approach to public administration when complexities arise and regards a pattern of change. Quantum complexity theory refers to randomness, which implies it has no fixed pattern, structure or order. It is more stereotypical and postmodern than the generic complexity theory. The Quantum complexity theory cannot be objective, real, certain or causal. Through observation it can determine the outcome.

Generic complexity theory is known as the postmodern approach to science. This system restores equilibrium by inputs, conversion processes and outputs that create a balance. The term deterministic reflects total chaos.

The complexity theory, in the form of deterministic chaos, teaches us to deal with disorder. It teaches us that small things can amount to mishaps, which is called 'sensitive dependence on initial conditions' or the 'butterfly effect'. It refers to change that is complex and not easy to understand.

The theory teaches us to use chaos as an opportunity to improve situations, as we should with regards to the formulation and implementation of the policy on African traditional medicine.

With regard to the traditional medicine draft policy, we are experiencing a societal and human complexity. Human complexity hinges on internally self-generated sources and has an unpredictable future. Societal complexity is not an unusual chaos, it is actually part of reality and gives rise to a structure. It allows a higher level of order.

7.5 POLICY ISSUES

Policy problems are describes as, "unrealised needs, values or opportunities for improvement" (Dunn 2007:72). Policy issues involve potential courses of action, and it reflects competing views of the nature of problems. Policy issues are considered by different organisational levels, and are classified by different hierarchies. Issues are classified by major, secondary, functional and minor issues. Major issues exist at the level of state and federal. Secondary issues exist at the level of local levels, while functional issues exist at project level. Finally minor issues are found within a specific project. As one moves up the hierarchy, then policy issues become interdependent. It is imperative to remember that complexities and chaos increase as one move up the hierarchy of policy issues. (Dunn 2007:81). With regard to the draft policy of traditional medicine, we are monitoring and evaluating the issues in and around the policy. The policy is in the draft form and needs a public opinion, and it is important to note that issues have been extracted after the research was conducted. Recommended solutions will be presented.

7.6 RECOMMENDATIONS

- Practitioners should only practice and train over the age of 21, because it gives them enough time for proper training or an internship, and they are more mature in dealing with ancestral spirits. They must be prohibited from certain procedures, for example: drawing blood, treating cancers, and treating AIDS/HIV. They may, however, practice midwifery if they have had suitable training.
- Traditional healers can be used as home caregivers, spiritual healers and traditional advice counselling entities in the communities.
- Traditional healers must be prevented from referring to themselves as 'doctors' or 'professors'. Traditional health practitioners must realise that they are holistic healers and must be addressed as such. They must not be allowed to mislead people into believing that they are allopathic doctors.
- Traditional health practitioners can be renamed as 'Spiritual Practitioners'.
- It must be imperative that every practicing traditional health practitioner be registered annually with the relevant board.
- A formal training course must be attended under an experienced herbalist and documented on paper.
- A written record of the THP's location of practice and specialty must also be documented.
- Policies on health and safety, hygiene and sterility need to be implemented and practiced.
- Training on patient confidentiality must to be taught and implemented.
- Co-operative relationships between modern medical doctors and traditional practitioners need to be developed, the use of exchange workshops between the two professionals can be implemented.

- To make scientific information and technology available to traditional healers.
- To implement a continued professional development (CPD) programme, which is a mandatory requirement for all other health care professionals.
- Traditional healers can be used as a means of communication towards patients, to comply with medical requirements.
- The development of traditional hospitals in which a scope of practice is defined. Traditional hospitals can be used as a recovery ward and for spiritual guidance.
- A code of ethics and a standard of professional ethics should be implemented.
- Health and safety regulations pertaining to the profession and the citizens must be listed and implemented.
- Protecting the environment, by prescribing only certain areas of land for herb cultivation for traditional medicine and putting restrictions on sourcing herbs from certain other areas.
- Dispelling myths and making people aware. Thereby filtering out the positive side of traditional medicine (i.e. medical benefits with some herbs), and rooting out the 'quack' practices (e.g. using amulets around a patient's body to cure diseases).

7.7 A RECOMMENDED FRAMEWORK: THE DEVELOPMENT OF TRADITIONAL MEDICINE VS. THE DEVELOPMENT OF A COUNTRY

'The Development of Traditional Medicine VS. The Development of a Country' model, is a practical recommendation and is linked to the 'Rostovian Take-off Model'. The model is described in stages, as is the Rostovian model, and illustrates the growth of a country as well as the maturity of public health and medicine in terms of western and traditional medicine. The reason for using this model is that modernisation can further health care, because, as discussed above, the reality is that 80% of the population still uses the traditional method.

Stage 1: *Traditional society.*

This stage occurs in underdeveloped countries. The majority of the population still uses traditional medicine and is part of a traditional society. Modern medicine has been introduced into the country, however, the majority of the population does not trust it.

Stage 2: *Pre-conditions for take-off.*

At this stage, modernisation has begun where both modalities are acceptable. However, the population is still confused as to what modality is best. There is a need for integration of traditional medicine into the National Health System and western doctors need to accept the legitimisation of TM. Society is overcoming the traditional way and there is a western invasion.

Stage 3: *Take-off.*

In this stage: there is an introduction of western technology, traditional medicine has been trialled and tested, and policies are put into place. Both modalities are safe, effective and acceptable to use. Over time, access to western medicine will expand and result in the decline of negative manifestations of traditional medicine.

After a policy is put into place, communities will become more accepting of both modalities and both modalities will be safe and effective to use. There will be freedom of choice amongst people and neither modality will be able to criticise the other, because they will both be fair, ethical and regulated.

The model will prove to be progressive, using traditional knowledge in a manner which is safe for communities too and acceptable ethically.

STAGES OF TRADITIONAL MEDICINE

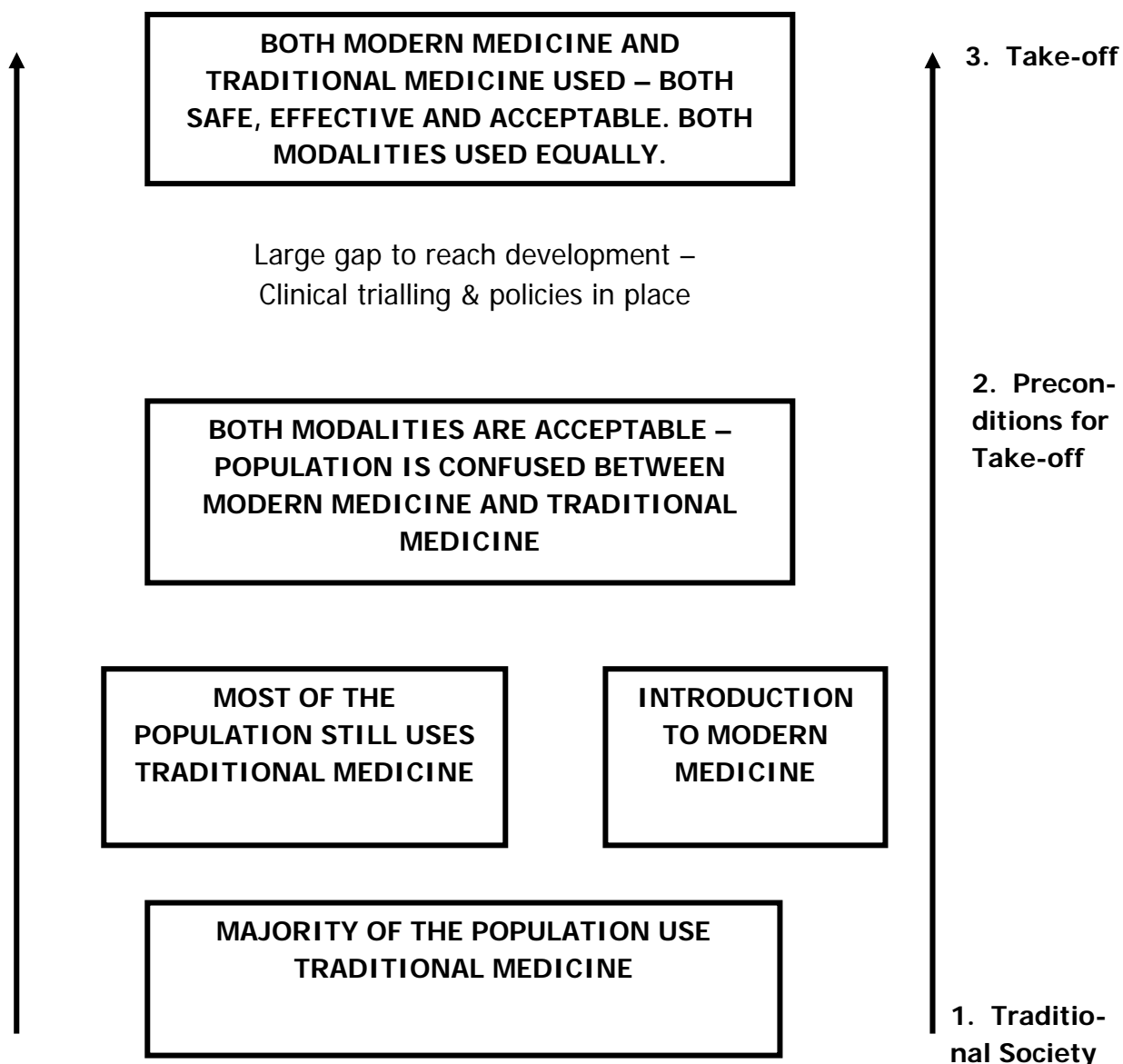


FIGURE 6: A Recommended Framework. The Development of Traditional Medicine VS. The Development of a Country Model.

In summary, after having reviewed the necessary data, extracted the objectives of the research, furnished recommendations and a proposed framework, we can justify that in the limitations faced both legally and practically there is a way forward towards the development in recognition of traditional medicine within the democratic South Africa. Irrespective of all the pitfalls and obstacles of apartheid, South Africa has proven that it can move towards a progressive and inspired nation,

which opens doors towards a more inspired, educated, prosperous and progressive nation.

7.8 CONCLUSION

The study was undertaken to explore the extent and effectiveness of traditional healing and the integration of the field into the national health care system of Southern Africa, using the Limpopo Province as the area for research. The challenges and truths of the field were exposed and the effectiveness evaluated. The findings are from a relatively small sample of practitioners and users, however, it is hoped that the findings may create an insight into the field of traditional healing. The analysis and findings must be seen in context of the nature and scope of the study, it is believed that the findings will aid towards improving the relevant draft policy and adding quality towards the policy.

The aim of the research was to try and understand how traditional medicine can be integrated within the western medicine practices and add value to the draft policy. The goal was to attempt to understand and explore traditional medicine, which is still practiced with varying degrees across various parts of South Africa. Traditional healing still exists as the dominant form of health care in rural areas. Therefore it needs to be critically analysed to protect the communities and practitioners against malpractice and find a way to bring safety and regulation to protect its benefits, but at the same time continue to have some scope for its survival and growth. The study has revealed that most medical doctors, who were interviewed for this research, seem to support the integration of traditional health practitioners in the health care field, if a system can be designed which allows the THPs to be regulated and create a scope of practice which is on par with the western system of medicine. That is to say it must: have a scope for research, comply with health and safety regulations, and fulfil requirements of regulatory authorities, which must be applicable to all traditional health practitioners.

Another response that was noted, was that rural people are moving towards using national health care, as long as it is provided within rural areas. They are developing more trust towards allopathic doctors, however, they feel that clinics are

still difficult to reach, which is the reasoning why they consult traditional practitioners instead. People in rural and urban areas, make use of traditional health practitioners more often for benevolent purposes than for health care. People who wish to get rid of bad omens and bad luck seek traditional healers, rather than doctors, however, they would prefer to make use of clinics and hospitals to solve their health care problems.

When the attitude responses of the traditional healers were noted it was observed that traditional healers do not want to work within hospitals due to the nature of work involved. They believe that they are holistic healers, who care about their patients. Most of them wish to 'treat' their patients at a specific location. When questioned about their rates, THPs believe that their fees depend on the herbs that they may use and that every case is different, and must be done as the ancestors directed them to do. Therefore the prices of medications cannot be regulated. It was found that the majority of THPs are against scientific testing and trialling of their herbs, in fear of the pharmaceutical companies commercialising their remedies without compensating them monetarily for it.

The South African government is forced to legitimise traditional healing, because of practitioners' democratic rights. The government, however, also has a duty to protect the rights of the general public. The heritage of the country must be maintained, but there are challenges, because the protection, health and safety of South Africans must also be fulfilled. There is a high prevalence of people who make use of traditional healers, but in the same light they must be aware of what traditional healers cannot treat. The users have a right to be told about practice limitations and know about other forms of health care, even if they are based in rural areas.

When it came to questioning nurses and other caregivers in the health profession, it was noted that people are in confusion as to what the best health care for them is and therefore utilise both modalities. The policy makers need to make both modalities safe and effective to use and must have full confidence as to the wellbeing of the communities. This is a complex situation and needs to be evaluated and dealt with properly. Laws and regulations needs to be put into place,

in order to reach a position where the health care in South Africa is secure and efficient and each professional is held accountable in their particular field. If the health care in South Africa is distributed evenly and effectively in all rural and urban areas and all health care professionals, including traditional health practitioners are held accountable and are transparent towards the profession, this will move South Africa towards modernisation and ultimately towards a better, more effective and healthier lifestyle. This will improve the lives of people of the country and create a better position and a safer environment.

The research is likely to raise questions that are difficult to answer, however, we are all aiming for a safer and democratic South Africa. The field of traditional medicine has proven to be widely used and the field of medicine in the country is improving. Whether the two disciplines can be integrated successfully is up to the policy makers to set out a well written and effective policy that creates a safe environment, accountability and transparency aimed at improving the national health care system for all, where both traditional and allopathic medicine co-exist in harmony.

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APPENDIXES

A APPENDIX A: QUESTIONNAIRE ASKED TO THE TRADITIONAL HEALTH PRACTITIONERS:

- What type of traditional healer are you?
- Would you prefer to be integrated into a government hospital?
- Would you prefer to be registered under a board to protect your scope of practice and field?
- What is the difference between spiritual healers and traditional healers? Do they have different treatments?
- Would you prefer to have your prices regulated? Do you have a fixed fee? Does your consultation include dispensing medicine?
- Do you ever refer clients to the local hospital, general practitioner or medical doctor?
- Do you ever prescribe medication from the chemist?
- Would you prefer to be educated about health issues by the government and regulated in your scope of practice and field?
- Would you like your medication to be scientifically tested, so that it can be utilised in hospitals? If no, why is it not possible?
- If there is integration, would you be prepared to work hand in hand with medical doctors to the patients preferred method of treatment?
- How do you feel about the referral system?
- How do you feel about registration?
- Will you refer patients that you are not permitted to treat?
- Why do some THPs practice secretly?
- Will you study at university? Will the ancestors allow this? Why should this profession be legitimised?
- Do you make your own medicine? Or do you have it made? Do all THPs have the same medicine?
- How do you differentiate between diseases? Who trains you? Do you treat all diseases?
- Can you tell me some success stories, and some difficult cases where patients did not recover well?
- Who in your community is seen as a 'hoax' and who is for real?

- Do THPs work together?
- Is ritual killing part of the profession of a THP?
- If you were sick, where would you go? Do THPs make use of western doctors?
- Who is your client base? How many educated people consult with you? What are their main reasons?

B APPENDIX B: QUESTIONNAIRE ASKED TO SERVICE USERS OF THPs WITHIN RURAL COMMUNITIES AND URBAN AREAS WITHIN THE LIMPOPO PROVINCE:

Section 1: Exploring the extent of the use of traditional medicine:

- Do you make use of a traditional healer? Answer 'Yes', 'No' or 'Sometimes'. If 'yes', how often do you consult a traditional healer?
- Do you prefer a traditional healer over a medical doctor and why?
- What type of traditional healer do you make use of more often?

Section 2: Reasons why traditional healers are preferred:

- What are your reasons for preferring a traditional healer if you consult one?
- Are they more cost effective than medical doctors or less cost effective?
- Do you think you should have to pay for medical services or should the government subsidise this?
- Are they more accessible (i.e. nearer to your home)?
- Have you ever been cheated by a traditional healer?
- Do you trust a traditional healer?
- Are you influenced by family members to seek traditional healing?
- Is it part of your religion to visit a traditional healer?
- Would your community be unsupportive if you were to visit a doctor at a clinic?
- How often do you visit the doctor at the local clinic or district hospital?
- Are you satisfied with the service, treatment, medication and healing at hospitals?

Section 3: The integration of traditional medicine into the health management system:

- Would you utilise traditional healers, if they were integrated in the health care system?
- Would you consult a traditional healer at a hospital?
- Will you go to a medical doctor if you were sick?
- What illnesses would you usually ask a traditional healer to heal?

- If traditional healers' services were for free, would you consult them?
- If a child is ill, do you go to a traditional healer first or to a hospital?
- How do you choose a healer? Is it because of spiritual guidance or because the community recommends it?
- How quickly will a traditional healer help you compared to a medical doctor at a hospital?
- If you see that the traditional medicine is not working, will you go to another traditional healer or will you go to the hospital?
- Do you follow hospital treatment?
- Do you have anything against hospital treatment? If so then what do you have against it?
- Do you prefer your healer to be a woman or a man?

C APPENDIX C: QUESTIONNAIRE ASKED TO WESTERN DOCTORS:

- Have you been exposed to traditional healers in your medical career? What was it?
- How would you feel about getting referrals from traditional healers?
- Will you treat a patient that was referred to by a traditional healer?
- Do you feel any different to patients who have sought traditional medicine?
- What percentage of patients that come to you have initially sought traditional healers?
- Have you received any complaints from patients about their traditional healers when they seek modern medicine?
- Do you believe traditional medicine must be trialled?
- How do you feel about traditional healers, and merging the scope of practice and integrating them into the health care system?
- How do you feel about combined management of diseases?
- Would you feel comfortable working hand in hand with traditional healers?
- Do you believe that traditional medicine hampers the health and overall medical care in the province?
- What challenges do you think we will face by merging the two disciplines?
- Have you found anything positive approaching a *sangoma* (THP)?
- What methods would you propose to try to educate traditional healers, and up to what level?
- Is the Public Health care trying to escape its responsibilities?

D APPENDIX D: QUESTIONNAIRE ASKED TO NURSES AND THOSE WHO WORK WITHIN AND AROUND THE PROCESSES:

1. Do you find that doctors that see patients who have been treated by THPs give the patients the same services as every other patient?
2. What is your opinion of traditional healing versus doctors' treatments?
3. Can you give me some examples where patients have come in after being treated by a THP to a) their detriment, b) to their benefit?
4. Do you think people who have medical aid are more likely to use mainstream medicine health care than those who do not have medical aid?
Do you think that traditional medicine must be incorporated into hospitals and why?
5. Give me your general view on THPs?
6. Is there a sense that, health wise, THPs are for the poor and the doctors are for the rich?
7. Have you ever consulted a THP?
8. Do people consult with THPs, because they are more accessible?

E APPENDIX E: QUESTIONNAIRE ASKED TO HOSPITAL MANAGERS AND TO A PROVINCIAL HEALTH DEPARTMENT MANAGER:

- What is the current status regarding a traditional healing policy parallel to mainstream public health?
- Do you think the policy needs to be re-visited or amended?
- How far has it been implemented?
- What have been the main challenges?
- Do you think the integration is based on a commitment to ATM techniques or simply to attempt to draw more people into public health care system? Or are we escaping public health responsibilities?