

## TABLE OF CONTENTS

<b>CHAPTER 1. INTRODUCTION .....</b>	<b>4</b>
1.1 STATEMENT OF THE PROBLEM .....	4
1.2 OBJECTIVES .....	6
1.3 METHODS .....	7
1.4 CHAPTER LAYOUT .....	14
<b>CHAPTER 2. GLOBAL PERSPECTIVES ON TRADITIONAL HEALTH CARE SYSTEMS ....</b>	<b>17</b>
2.1 INTRODUCTION.....	17
2.2 MEDICAL PLURALISM.....	17
2.3 SALIENT FEATURES OF TRADITIONAL AND MODERN MEDICINE.....	20
2.4 ASIAN PERSPECTIVES .....	22
2.4.1 TRADITIONAL MEDICINE IN CHINA.....	22
2.4.2 SOUTH-EAST ASIAN PERSPECTIVES .....	26
2.5 EUROPEAN PERSPECTIVES .....	28
2.5.1 ALTERNATIVE MEDICINE.....	29
2.6 AFRICAN PERSPECTIVES .....	33
2.6.1 HISTORICAL BACKGROUND.....	33
2.6.2 THE CONTINUED EXISTENCE OF TRADITIONAL MEDICINE.....	34
2.6.3 THE REVIVAL OF TRADITIONAL MEDICINE.....	36
2.7 APPROACHES TO MEDICAL PLURALISM.....	36
2.8 LEGAL ISSUES .....	41
2.8.1 INTRODUCTION.....	41
2.8.2 THE STATUS OF THE AFRICAN TRADITIONAL HEALTH CARE SYSTEM .....	42
2.8.3 THE “LIBERALISATION” OF TRADITIONAL MEDICINE.....	43
2.8.3.1 Traditional medicine in Botswana.....	46
2.8.3.2 Traditional medicine in Ghana.....	50
2.8.3.3 Traditional medicine in Nigeria .....	54
2.8.3.4 Traditional medicine in Swaziland.....	61
2.8.3.5 Traditional medicine in Zimbabwe .....	65
2.8.4 LEGAL OPTIONS FOR TRADITIONAL MEDICINE.....	76
2.9 CONCLUSION.....	78
<b>CHAPTER 3. AN OUTLINE OF THE SOUTH AFRICAN HEALTH CARE SYSTEM.....</b>	<b>81</b>
3.1 INTRODUCTION .....	81
3.2 THE OFFICIAL HEALTH CARE SYSTEM .....	81
3.2.1 THE PUBLIC AND PRIVATE SECTORS OF THE NATIONAL HEALTH SYSTEM (NHS).....	87
3.2.2 LEGAL ASPECTS OF THE SOUTH AFRICAN OFFICIAL HEALTH CARE SYSTEM.....	93
3.3 HEALTH CARE PROVISION OUTSIDE THE OFFICIAL HEALTH CARE .....	103
SYSTEM .....	103
3.3.1 SELF-CARE .....	103
3.3.2 THE SECTOR OF THE ALLIED HEALTH PROFESSIONS .....	106
3.3.3 THE TRADITIONAL MEDICAL SECTOR.....	110
3.3.3.1 Historical and legal development .....	111
3.3.3.2 Political changes since 1994 .....	113
3.4 CONCLUSION.....	121

**CHAPTER 4. TRADITIONAL HEALING IN SOUTH AFRICA ..... 125**

4.1	INTRODUCTION .....	125
4.2	SOME BASIC AFRICAN CONCEPTS OF HEALTH AND ILLNESS .....	125
4.3	CAUSES OF ILLNESS AND CLASSIFICATION OF DISEASES .....	127
4.4	THE HEALING PROCESS AND AIM OF HEALING .....	129
4.5	AFRICAN TRADITIONAL HEALERS .....	131
4.5.1	THE CATEGORISATION OF TRADITIONAL HEALERS .....	131
4.5.2	THE DIVINER .....	132
4.5.3	THE HERBALIST.....	134
4.5.4	SPIRITUAL OR FAITH HEALERS .....	136
4.5.5	TRADITIONAL BIRTH ATTENDANTS .....	137
4.5.6	SPECIALISTS .....	140
4.5.7	GENERAL FEATURES COMMON TO ALL CATEGORIES .....	141
4.6	THE HEALER'S FEE.....	143
4.7	THE TRADITIONAL HEALER'S MEDICINES .....	144
4.7.1	CATEGORIES OF MEDICINES.....	144
4.7.2	METHODS OF TREATMENT.....	146
4.7.3	ROUTES OF ADMINISTRATION OF MEDICINES .....	147
4.7.4	THE IMPORTANCE OF PREVENTION.....	148
4.7.5	THE TRADITIONAL PHARMAPOEIA .....	149
4.7.5.1	General .....	149
4.7.5.2	Herbal medicines in a broader context .....	150
4.7.6	TWO POINTS OF PARTICULAR SIGNIFICANCE.....	153
4.8	THE TRADITIONAL HEALER'S CLIENT .....	153
4.8.1	THE CLIENT'S TREATMENT OPTIONS.....	154
4.8.2	THE HEALER-CLIENT RELATIONSHIP .....	155
4.8.3	HEALTH CARE PREFERENCES.....	156
4.9	THE HEALER'S ROLE AND STANDING .....	157
4.10	THE SPECIAL ROLE OF THE HEALER IN MENTAL HEALTH CARE.....	158
4.11	HEALERS IN TRANSITION.....	162
4.12	THE CONTROL OF TRADITIONAL PRACTICE.....	163
4.13	CONCLUSION .....	164

**CHAPTER 5. THE HEALER'S ROLE IN WITCHCRAFT AND SORCERY IN A LEGAL CONTEXT ..... 167**

5.1	INTRODUCTION.....	167
5.2	THE WITCHCRAFT SUPPRESSION ACT OF ZIMBABWE, 1889.....	173
5.3	WITCHCRAFT AND WITCHCRAFT SUPPRESSION IN BOTSWANA.....	176
5.4	ANTI-WITCHCRAFT LEGISLATION IN SOUTH AFRICA .....	177
5.5	WITCHCRAFT SUPPRESSION IN CAMEROON.....	182
5.6	CONCLUSION.....	184

**CHAPTER 6. THE TRADITIONAL HEALTH CARE SYSTEM AND THE SOUTH AFRICAN BILL OF RIGHTS ..... 187**

6.1	INTRODUCTION.....	187
6.2	FUNDAMENTAL HUMAN RIGHTS IN AN AFRICAN CONTEXT .....	187
6.3	THE RIGHT TO CULTURE.....	190
6.3.1	SECTION 31 .....	192
6.3.2	SECTION 30 .....	193
6.4	THE RIGHT TO HEALTH CARE.....	195

6.4.1	THE RIGHT TO HEALTH CARE AS A SECOND-GENERATION RIGHT.....	195
6.4.2	THE INFLUENCE OF INTERNATIONAL LAW ON SOCIO -ECONOMIC RIGHTS.....	199
6.4.3	THE SIGNIFICANCE OF THE RIGHT TO HEALTH CARE AND THE TRADITIONAL HEALTH CARE SYSTEM	200
6.5	CHILDREN'S RIGHTS .....	200
6.5.1	CHILDREN'S RIGHTS IN INTERNATIONAL LAW.....	201
6.5.2	CHILDREN'S RIGHTS IN SOUTH AFRICA.....	204
6.5.3	CULTURAL VALUES VERSUS CHILDREN'S RIGHTS .....	205
6.5.4	CONCLUSION.....	207
6.6	THE RIGHTS TO EQUALITY, DIGNITY, LIFE, PRIVACY, RELIGION, ECONOMIC ACTIVITY, ENVIRONMENT AND THE TRADITIONAL HEALTH CARESYSTEM.....	208
6.7	THE QUESTION OF THE SICK CERTIFICATE.....	216
6.8	CONCLUSION.....	218
 <b><u>CHAPTER 7. DISCUSSION AND RECOMMENDATIONS .....</u></b>		<b><u>221</u></b>
7.1	INTRODUCTION.....	221
7.2	NECESSITY FOR STATUTORY REGULATIOIN OF TRADITIONAL.....	224
	MEDICINE.....	224
7.2.1	THE PROFESSIONALISATION OF TRADITIONAL MEDICINE.....	228
7.2.2	THE ADVANTAGES OF STATUTORY REGULATION.....	231
7.3	THE PRACTICAL IMPLEMENTATION OF OFFICAL RECOGNITION AND STATUTORY REGULATION .....	231
7.4	THE ENVISAGED POSITION OF TRADITIOMNAL MEDICINE IN THE OFFICIAL HEALTH CARE SYSTEM.....	233
7.5	THE POTENTIAL DIFFICULTIES REGARDING OFFICIAL RECOGNITION AND STATUTORY REGULATION .....	235
7.6	CONCLUSION.....	237
 <b><u>BIBLIOGRAPHY .....</u></b>		<b><u>239</u></b>
 <b><u>TABLE OF STATUTES .....</u></b>		<b><u>258</u></b>
 <b><u>TABLE OF CASES .....</u></b>		<b><u>262</u></b>

## CHAPTER 1. INTRODUCTION

### 1.1 STATEMENT OF THE PROBLEM

South Africa, like many African countries and, indeed, most contemporary societies, has a pluralistic system of health care. A highly institutionalised First World medical system based on modern scientific medicine, coexists with a variety of non-conventional therapies, including a multiplicity of local indigenous systems founded on traditional beliefs and practices.

African traditional healing is part of African culture, and today traditional healers remain essential for the health and well-being of a great part of the black population. Several surveys have shown that between 70 and 80 percent of South African Blacks use the services of traditional practitioners (*South African Medical Journal* 1997:268), while approximately 60 percent of all babies born in South Africa are delivered by traditional birth attendants (Karim, Ziqubu-Page & Arendse 1994:3). Thus, the introduction of biomedicine has never replaced the indigenous healing system, and traditional healers continue to be consulted for a variety of reasons by the black population. Consequently, dual treatment regularly takes place (Freeman & Motsei 1992:1185).

In addition, the modern health care system has several shortcomings. Apart from a general shortage of personnel, there are wide geographical discrepancies in the access to health care facilities. Furthermore, modern services are often not affordable and/or culturally irrelevant and ill-suited to handle the range of illnesses occurring in the African population.

In legal terms, however, there is a serious discrepancy between the law and reality. South Africa's official health care system is a monopolistic one, in which only modern scientific medicine is recognised as lawful. Health care is dispensed by professionals with formal training who are licensed by the state. According to present legislation, therefore, any

medical act not backed by a licence is illegal and unlawful, - including traditional healing practices. *De facto*, on the other hand, healers practise widely and are largely unmolested and informally tolerated by the authorities. Like those of most other African countries, the South African government adopts a policy of non-intervention, leaving its traditional practitioners alone and concerning itself with the task of making modern health care increasingly available and accessible.

This stance, however, must be criticised on various grounds. First of all, it officially ignores an activity which is shown to be vital to the life and well-being of the majority of its citizens. It creates legal uncertainty between the healer and the healed. It also neglects the traditional sector's positive contributions to health care, and hampers cooperation between the two sectors. Most notably, however, traditional practice remains essentially unregulated, and in certain circumstances, harmful or even fatal.

In the context of the South African Bill of Rights, the government's attitude may even be challenged on constitutional grounds, since Chapter 2 of the 1996 Constitution guarantees the right to culture as well as to health care, equal treatment for different cultural groups, and, by implication, free choice in health care provision. At the same time, the right to bodily integrity as well as the rights of women and children must be protected against offensive, dangerous and even fatal traditional practices. The member states of the World Health Organisation (WHO), including South Africa, are currently engaged in strategies for the attainment of a level of health that will permit them to lead a socially and economically productive life (Bannerman, Burton & Wen-Chieh 1983:7). 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief and economic or social condition (WHO 1947 in Jansen 1973:1). Benatar and van Rensburg (1995:18) define access to a reasonable standard of health care as a universal right, at the level of care that each society can afford.

However, to turn the principle of a right to health and health care into practical action is a daunting task for most African countries where the seeds of ill-health are to be found in the prevailing politico-socio-economic conditions.

South Africa is facing the very same problem. Access to health care must be broadened to the multitude of hitherto marginalised people within affordable limits while at the same time ensuring and improving the quality of services. Effective health care, in addition, must meet the needs felt by the people, including those of a socio-cultural and psychological dimension which the modern Western model with its mechanistic and reductionist approach is largely unable to address.

A traditional health care system exists, legally or illegally, in virtually all African countries, including South Africa. In transforming the country's health care system it appears sensible, therefore, to fully utilise and develop the vast human resources existing in the traditional sector, and to finally take official cognisance of an activity which plays a major role in people's life. It is, therefore, to be recommended that the traditional sector be recognised and in the process reformed. Traditional healers as part of the health care team could meet needs currently not met by the official health care system, and bridge the cultural gap in the conceptual appreciation of health and illness.

From the point of view of the consumer, the two medical systems are complementary. What is needed is a legal framework to facilitate cooperation as a political choice. With this strategy, a valuable cultural heritage could be preserved while at the same time guaranteeing quality care for all, with health care activities in whatever sector provided in a safe and competent manner.

## **1.2 OBJECTIVES**

The general objective of this study is to understand the continued significance of traditional medicine as a major component of the global phenomenon of medical pluralism, and to illustrate how other countries in Europe, Asia and Africa legally approach the existence of non-conventional therapies which, by definition, fall outside the official health care as provided for by modern scientific medicine.

The specific objective is the meaningful accommodation of the traditional medical sector in the South African health care system.

The point of departure is the fact that traditional medicine, although extensively used for a variety of reasons, has at best an unofficial status with the resulting largely unregulated state of traditional practice and legal uncertainty in the practitioner-client relationship. While the Bill of Rights contained in the 1996 Constitution of the Republic of South Africa - notably the rights to culture and health care - seem, at first glance to support the recognition and development of traditional medicine, it will also be shown that rights such as those of women and children need to be protected against traditional practices that clash with human rights standards.

The ultimate aim, therefore, is to demonstrate how legal reform measures might assist in regulating traditional practice, and help to establish the traditional sector as a recognised part of South Africa's official health care system. Through statutory regulation it is hoped to preserve an invaluable cultural heritage while at the same time safeguarding the health and well-being of the people.

### **1.3 METHODS**

The present study is based on a comprehensive literature review (books, journal articles, theses, reports). Acts and other legal documents; court cases and newspaper reports and presentations on scientific, social, political, cultural and legal aspects of traditional medicine and traditional health care, going back to the early 1970's, and in some cases even further, were researched. Data so obtained was supplemented by observational visits to a random sample of twenty-two traditional healers in the former Transkei between 1986 and 1998.

The sources were divided into the following categories:

### **(1) Medical aspects**

In this category the researcher studied material dealing with traditional medicine as practised by traditional healers in South Africa and neighbouring African countries. The first focal point was the traditional practitioner himself, his demographic background, professional training and way of entry into the profession. Secondly, the researcher focused on traditional activities such as methods of diagnosis and treatment, and the traditional pharmacopoeia. Thirdly, the practitioner-client relationship was examined, including the factors influencing the utilisation pattern as followed by the health care consumers. Finally, the adaptation of the traditional healer to changing socio-political circumstances, i.e. “the healer in transition”, was investigated.

Medical aspects were gathered from books and journal articles. Another important source of information were interviews with twenty-two practising healers in the former Transkei, conducted between 1986 and 1998. Most of these practitioners resided in remote villages, while some had more ‘modern’ practices in Umtata, Port St.Johns, Flagstaff and Lusikisiki. One healer agreed to see the researcher at his local government office in Umtata, while two practitioners visited her regularly at her own office at the University of Transkei.

The interviews were conducted in the form of open-ended conversations, with healers’ junior assistants often acting as interpreters when language was a communication barrier. The initial questions asked usually related to age, formal education, religious affiliation and the category of healer into which the practitioner felt he belonged. Next, interviewees were encouraged to talk about their way of entry into the profession, type of training and qualifications acquired, years in practice and whether in full- or part-time practice.

Further questions were aimed at gathering information about preventative activities as well as the types of conditions treated, fields of specialisation, instruments used in diagnosis and therapy, and the average length of consultations. Healers were also invited to tell how and where they obtained their roots, barks and herbs, and whether they made use of modern tools such as stethoscopes, injections and over-the-counter products bought in pharmacies. The last set of questions always related to membership of professional associations, attitudes

towards cooperation with the modern health care sector, and whether/when patients were referred to a clinic or hospital.

Departing from indigenous African medicine, the researcher then concentrated on literature dealing with traditional medicine in China and the South Eastern region of Asia, as well as folk medicine in Europe.

## **(2) Legal aspects**

The first legal documents studied were the following South African statutes dealing with the regulation of modern and complementary/traditional medicine, respectively:

Health Professions Act 56 of 1974

Medical, Dental and Supplementary Health Service Professions Amendment Act 89 of 1997

Nursing Act 50 of 1978

Nursing Amendment Act 19 of 1997

Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982

Chiropractors, Homeopaths and Allied Health Service Professions Second Amendment Act, 2000

Medical Schemes Act 72 of 1967

Medical Schemes Act 131 of 1998

Pharmacy Act of 1974

Pharmacy Amendment Bill of 1997

White Paper for the Transformation of the Health System in South Africa, Government Gazette No 17910, Notice 667 of 1997

National Health Bill of 2001

Further, the researcher studied legal texts, books and journal articles relating to the legal status of the traditional healer in South Africa, such as the KwaZulu Act on the Code of

Zulu Law 6 of 1981; KwaZulu Act on the Code of Zulu Law 16 of 1985, and Application of Health Standards in Traditional Circumcision Act of 2001 (Eastern Cape).

The following were significant with regard to traditional medicines:

Medicines and Related Substances Control Act 101 of 1965

Medicines and Related Substances Control Amendment Act 90 of 1997

South African Medicines and Medical Devices Regulatory Authority Bill of 1998.

Within the African region, the researcher reviewed the health laws of Botswana, Ghana, Kenya, Lesotho, Nigeria, Sierra Leone, Swaziland, Tanzania, Uganda and Zimbabwe, which usually either exempt the practice of traditional medicine from prohibited medical activities or, in some instances, even authorise it.

The research was then extended to cover the legal rules pertaining to traditional medicine in China, South East Asia (India and Nepal) and several European countries (notably Germany and the United Kingdom), some of them specifically regulating the practice of certain traditional or other non-conventional healing activities (e.g. the German law of 1939 with regard to the *heilpraktiker*).

Next the South African Interim Constitution (Constitution of the Republic of South Africa Act 200 of 1993) and the final Constitution, Constitution of the Republic of South Africa, Act 108 of 1996, with their respective Bill of Rights, were examined, with special attention to provisions guaranteeing the rights to health care, culture, privacy, equality, dignity and the rights of the child. Also studied were the Basic Conditions of Employment Act 75 of 1997 and the Basic Conditions of Employment Amendment Act 11 of 2002 with regard to rights of employees concerning sick leave.

South African constitutional case law relating to those rights was traced back to 1994, while comparative studies included relevant cases from Botswana, Canada, Germany and Japan.

International law instruments applicable in this context included:

Universal Declaration of Human Rights, 1948

European Convention for the Protection of Human Rights and Fundamental Freedoms, 1961

International Covenant on Civil and Political Rights, 1966

International Covenant on Economic, Social and Cultural Rights, 1966

African Charter on Human and Peoples' Rights, 1981

United Nations Convention on the Rights of the Child, 1989

Convention on Indigenous and Tribal Peoples, No 107, 1989

African Charter on the Rights and Welfare of the Child, 1990 and

UN Declaration on the Rights of Persons Belonging to National or Ethnic, Religious or Linguistic Minorities, 1992.

The last topic covered was the association between anti-witchcraft legislation and the practice of traditional medicine. In this context the researcher studied in particular the South African Witchcraft Suppression Act 3 of 1957 as amended by the Witchcraft Suppression Amendment Act 50 of 1970; the Witchcraft Suppression Act of Zimbabwe, 1889 and the Bechuanaland Protectorate Witchcraft Proclamation, 1927.

Fisiy and Geschiere's (1990) article provided an insight into a development regarding the relationship between traditional healer and witchcraft in the East Province of Cameroon.

### **(3) Policy aspects**

In this context a rich variety of sources was available, all dealing with various government approaches to traditional health care delivered outside the official modern health care system, and subject only to customary control and a certain degree of regulation by traditional healers' associations.

Guided by the recommendations set out in 1978 by the World Health Organisation (WHO) in the Alma-Ata Declaration on Primary Health Care and the Promotion and Development of Traditional Medicine, the researcher proceeded to study policy suggestions on the status

of traditional healing in Africa in general and South Africa in particular, such as the exclusive (monopolistic), tolerant and inclusive approach. African countries researched in this context included Botswana, Ghana, Lesotho, Nigeria, Swaziland, Uganda, Zimbabwe and Zaire.

For South Africa itself, various sources were consulted, emanating from the Department of Health, modern medicine represented by the South African Medical Association (the then Medical Association of South Africa), individual researchers, traditional healers in their capacity as chair-persons of traditional healers' associations, as well as practitioners and consumers in public hearings. Among these sources were an article by Dr D Hackland, Secretary of Health, KwaZulu-Natal: "The traditional healer in modern society" (in *South African Family Practice* September 1987:372-3), the National Health Plan presented by the African National Congress (ANC) in 1994, the White Paper for the Transformation of Health Care in South Africa (*Government Gazette* no 17910, vol 382, 1997), recommendations by Dr Confidence Moloko, Chairperson of the ANC's National Health Committee (12 August 1998); ethical guidelines on the relationship between doctors and practitioners of alternative medicine, drawn up by the Medical Association of South Africa and approved by the Interim Medical and Dental Council in December 1995 (*SAMJ* 86, 3 March 1996), and recommendations published by the Centre for Health Policy of the University of the Witwatersrand (1991). The researcher also had personal communications with Richard Haigh, the Social Plant Use Coordinator from Valley Trust (1997), Professor GA Louw, psychologist (1997), Mr Tholene Sodi from the Department of Psychology, University of Venda (1997), and Dr Schalk Loots, Director of the School of Primary Health Care at the Medical Faculty of the University of Pretoria (1997).

The researcher attended a Public Hearing arranged by the Standing Committee on Health and Welfare of the Eastern Cape Province in conjunction with the National Portfolio and NCOP Committees on Health on 23 May 1997 in Umtata, the primary focus of which was to investigate the desirability of the establishment of a statutory council to "regulate traditional healers and faith healers." Further points of discussion were

- (a) whether or not medical certificates issued by traditional and faith healers should be officially recognised and
- (b) whether medical aid schemes should provide coverage for consultations with traditional and faith healers.

To gauge the attitudes of traditional healers towards official recognition and registration, the researcher conducted interviews with Mr N Dlakela, President of the Transkei Traditional Healers' Association, who was a regular visitor at the University of Transkei between 1986 and 1989; Mr Solly Nduku, a traditional practitioner and local government employee, elected in 1994 as Chairperson of the Eastern Cape Traditional Medical Practitioners' Association, and in 1995 as Chairperson of the National Interim Committee for Traditional Medical Practitioners on Policy and Legislation (29 May 1997); Mr SJ Mhlongo, President of the Inyangas National Association and Chairman of the Examination Committee, a school teacher and traditional healer himself (1997); and traditional doctor Sobantu Phillip Kubukeli, founder of the Western Cape Traditional Healers, Herbalists and Spiritual Healers Association in 1991 and elected President in 1992 (1997).

Comparative research extending beyond the African continent covered the integrated medical system in China, as well as the official coexistence of modern medicine with indigenous medical systems in India and Nepal. In the study of the status of folk-, and by extension alternative/complementary medicine in Europe, the researcher concentrated mainly on Germany and the United Kingdom, while at the same time taking note of the wide variations between various European countries.

#### **(4) Statistical information**

For statistical data on modern health care workers in South Africa, their numbers and geographical distribution, the researcher relied to a great extent on findings published by the Health Systems Trust in the *South African Health Review* 1997 to 2001.

In addition, the researcher received valuable assistance from Dr LE Makubalo, Directorate: Health Systems Research. Further data was provided by the National Department of Health,

the Health Professions Council of South Africa, as well as the Pharmacy Council, the Nursing Council and the Allied Health Professions Council, all of South Africa.

To gain information on the number of traditional healers, the various categories, and their professional associations, the researcher studied research publications on conditions in South Africa as well as neighbouring African countries, and traced global figures on the use of non-conventional therapies, mainly in Europe and the United States of America.

### **(5) Research aspects**

In this context the researcher consulted a large number of research publications on the efficacy as well as the potential harm and toxicity of traditional medicines, with the focus mainly on the effects of traditional healing as a whole, and its special benefits in mental health care. Some of the findings were based on the researcher's own ongoing research project entitled, "Common Causes of Poisoning in Transkei", which includes incidents of toxicity and even fatality due to traditional medicines.

At the Department of Pharmacology of the University of Cape Town the researcher had the privilege of speaking with two researchers who were practising traditional healers at the same time, traditional Dr Isaac Maeng (BSc), and Mr Calvin Ntutela (MSc Traditional Medicine). Maeng was involved in the compilation of the *South African Traditional Healers' Handbook* (Kagiso, 1997), a product of the Medical Research Council's Traditional Medicines Research Group of the University of Cape Town and the University of the Western Cape.

## **1.4 CHAPTER LAYOUT**

Chapter 2 deals with global perspectives on traditional health care systems. It describes the phenomenon of medical pluralism in Asia, Europe and Africa, as well as legal options for health care services delivered outside the respective official health care systems. More extensively discussed are the approaches of those African governments where health care

legislation either exempts or expressly authorises the practice of traditional healers (e.g. Botswana, Ghana, Lesotho, Nigeria, Sierra Leone, Swaziland, Uganda and Zimbabwe).

Chapter 3 focuses on the South African health care system. The official health care sector as regulated by extensive health laws is outlined, followed by a discussion of health care provision outside the national health system, such as self-care, and care through the allied health professions and the traditional medical sector. Where possible, statistical data is supplied on specific shortcomings of the current situation. Attention is drawn to the latest political efforts to recognise the significance of the traditional system, while at the same time acknowledging the need for stricter control.

Chapter 4 is devoted to traditional healing in South Africa. The points of departure are basic African concepts of health and illness, disease causation and the aim of healing. The various categories of healers, their way of entry into the profession and their respective methods of diagnosis and treatment are described. The traditional pharmacopoeia is placed in an economic and environmental context. The discussion of the healer's client illustrates the intricacy of the decision-making process in health care utilisation and the importance of the shared world view in the clinical encounter, notably in mental disorders. Special emphasis is placed on the healer's standing and his accountability to the respective community, as well as the more recent control exercised via traditional healers' associations. The challenge facing traditional practitioners with regard to modernisation and increased competition under changing socio-economic circumstances is also discussed.

Chapter 5 looks at the healer's role in the context of witchcraft and sorcery. Although the phenomenon has significant social functions in the traditional African setting, anti-witchcraft legislation has severely impinged on witch-finding and curing in cases of bewitchment. The pros and cons of legislative control are discussed with special emphasis on the relevant legislation in South Africa, Botswana, Zimbabwe and Cameroon.

Chapter 6 concentrates on the traditional health care system within the context of the rights contained in the Bill of Rights of the 1996 Constitution of the Republic of South Africa.

While notably the rights to health care and culture seem to support the official recognition of the traditional sector, it will also be shown that traditional values and practices may clash with human rights norms, particularly with regard to women and children.

Chapter 7 concludes the study and makes recommendations for the reform of the traditional health care system. It is shown that through statutory regulation of the traditional sector, traditional medicine can be preserved and promoted, at the same time delivering health care services in a safe and competent manner, with minimum standards of quality being guaranteed. In the researcher's view only in this manner will official cooperation between the two medical systems be facilitated and finally realised.

## **CHAPTER 2. GLOBAL PERSPECTIVES ON TRADITIONAL HEALTH CARE SYSTEMS**

### **2.1 INTRODUCTION**

There is a growing notion worldwide that the so-called modern biomedical approach to health care does not meet and address people's health needs adequately, especially, but not exclusively in the non-Western world. Consequently, non-conventional therapies are increasingly in demand.

This chapter describes medical pluralism all over the world, the various approaches taken by governments to non-conventional therapies, and the legal implications of such approaches.

### **2.2 MEDICAL PLURALISM**

Bannerman 1982 (in Wolfers 1990:6) describes medical pluralism as "a medical system incorporating two or more medical traditions". According to Kleinman (1976:568), medical pluralism is found in most contemporary societies where there are different, coexisting, complementary or competing medical systems arising from different traditions, practices and bodies of knowledge.

Pluralistic medical configurations are in no sense limited to the technologically less developed countries (Good 1987:7). According to Lee (1982:629), it is a normal rather than an abnormal phenomenon that several medical traditions - each with its distinct system of concepts, skills and organisations - exist side by side in one country. Unschuld (1980:15) points out that the issue of coexisting medical traditions is not limited to either non-Western societies into which Western-style medicine was introduced earlier as an alien cultural entity, or to pluralistic societies, such as the USA, with groups of different ethnic, cultural

and historical origins. He goes on to say that in contemporary East and West Germany, health planners and legislators are found to take cognisance of persistent alternative therapeutic systems. Wilkinson and Sussman (1987:4) state that there is still a strong belief in the efficacy of self-treatment and folk medicine.

Medical pluralism can thus be regarded as a global phenomenon. It usually involves a modern biomedical health care system as a dominant player in coexistence with “alternative medicine”, which the World Health Organisation (WHO) 1993:5 defines as all forms of health care provision which “usually lie outside the official health care sector”. This description embraces formalised traditional systems of medicine e.g. Ayurvedic and traditional Chinese, the activities of traditional healers, as well as chiropractic, naturopathy, osteopathy and homeopathy, among others. According to the British Medical Association (*BMA* 1993:5), the practices, loosely grouped together under the umbrella of non-conventional therapies, have little in common beyond the fact that they “treat patients”.

Although the terminology may sometimes be confusing, the modern, biomedical system is variously identified as Western, modern, biomedical, orthodox, allopathic, scientific, conventional or cosmopolitan medicine. The terms largely overlap, and all relate to their origin in medical science as received from Western Europe. Berliner (1984:30) states that scientific medicine is the generic term for a specific mode of healing therapies characterised by

- the assumption that disease is materially generated by specific aetiological agents such as bacteria, viruses, parasites, genetic malformation or internal chemic imbalances;
- a passive patient; and
- the use of invasive manipulation to restore/maintain the human organism at a statistically derived equilibrium point (health).

In this study the terms “modern”, “scientific”, “allopathic”, “Western”, “orthodox” and “biomedicine” will be used interchangeably.

Non-conventional or unorthodox therapies include traditional and complementary/alternative medicine, the latter usually comprising chiropractic, homeopathy, naturopathy and similar disciplines.

The local health care systems, are variously referred to as “traditional”, “indigenous”, “folk” or “ethnomedicine”. Folk systems comprise folk health care practices that have evolved in particular cultural settings and have, until recently, provided the sole source of health care for most of the world's population (Stoner 1986:44). Neumann and Lauro (1982:1818) define Ethnomedicine as the practice of traditional healers who rely on indigenous medicines and/or rituals to treat the sick, while Foster (in Bannerman et al 1983:17) states that the term embraces those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine. Akerele (1984:76) cites the WHO's (1976) definition of traditional medicine as the sum of all knowledge and practices - whether they can be explained or not - used in the prevention, diagnosis and elimination of physical, mental or social imbalances, and relying exclusively on past experiences and observations handed down from generation to generation, whether orally or in writing.

The WHO (1978) (cited in de Jong 1991:1) defines the “traditional healer” as “a person who is recognised by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and other methods based on the social, cultural and religious background, as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability”.

Cosminsky (1983:142-143) points out that the term “traditional birth attendant (TBA)” is used by the WHO to indicate “a person who assists the mother at child birth and who initially acquired her skills delivering babies by herself or by working with other traditional birth attendants”, whereas the term “midwife” is used to refer to a person with formal medical education who is officially registered or licensed.

The terms “traditional and indigenous medicine or healer” will be used interchangeably in this study.

In conclusion, traditional medicine has always been an integral part of all human culture. Bannerman (in Kirkland et al 1992:1) points out that traditional medical systems have been found in all societies throughout history, and predate the rise of modern scientific medicine at the beginning of the nineteenth century. At the same time it must be kept in mind that this “dualistic model” of health seeking behaviour does not adequately consider other health care alternatives’ such as self-treatment, traditional family and community medical knowledge, and various other non-conventional therapeutic systems as indicated above.

### **2.3 SALIENT FEATURES OF TRADITIONAL AND MODERN MEDICINE**

Das (1996:24) states that traditional medicine is strongly embedded in the culture and beliefs of the local people and focuses on the patient as a whole human being and not only on the biological aspects of disease. It is understood by the people, is fairly inexpensive and is generally accessible.

Modern medicine, on the other hand, has several shortcomings for the African. Firstly, according to Harrison and Dunlop (1974:1), modern medical education and care in the less developed countries were closely copied from Western models and are often seriously irrelevant. Secondly, Brookbanks(1990:66) states that scientific medical systems that divide the human being into various sections such as physical body, soul and spirit are ill-suited to take the meaning of illness into account or meet patients’ psychological needs. Thirdly, Freeman and Motsei(1992:1186) are of the opinion that the technological advances in Western medicine have resulted in the erosion of the human quality of care. The biomechanical reductionism and technological “fixes” in health care are inadequate to understand most problems in health care and in particular, modern medicine is presently unequipped to handle the rapidly growing caseload of mental and sociopathic disorders (Kleinman 1980:381).

Another negative aspect has been the inability of the Western medical system to meet even basic health care requirements. MacCormack (1986:151) states that governments in some developing countries (parts of Southern Africa, for example), having enacted legislation to make the practice of traditional medicine illegal, were not able to provide official health services that adequately covered the population, were reliably supplied with drugs, or were appropriately responding to the health needs as people perceive them.

Yoder (1982:1851) identifies poor access, especially in rural areas; emphasis on curative rather than preventive services; and the inappropriate training given to medical personnel among the limitations of biomedical care in developing countries.

In general, numerous factors have led to the widespread and increasing appeal of traditional and complementary/alternative medicine throughout the world, particularly since the 1980's (WHO 2001:3). In some regions, they are more accessible; in fact, one third of the world's population and over half of the people in the poorest parts of Asia and Africa do not have regular access to modern facilities and essential drugs. The most commonly reported reasons for using traditional and complementary/alternative medicine are that they are more affordable, more closely respond to the patient's ideology, and are less paternalistic than allopathic medicine.

Hence, Bannerman et al (1983:11) points out modern medicine has not been able to replace traditional medicine, and in many countries of the world 80 percent or more of the population living in rural areas are still cared for by traditional practitioners and traditional birth attendants. In addition, the so-called orthodox health services devised for Third World populations remain culturally unacceptable and economically unobtainable. Barriers to accessibility are not only geographical but also linguistic and cultural in nature. In this sense, then, equitable distribution of highly professionalised, physician-dominated, hospital-based health services is not feasible, sustainable or even desirable.

One of the reasons for the resurgence of interest in traditional medicine has, therefore, been the fact that there are inadequate health care resources to meet existing needs. However, the

revival of traditional and other unorthodox systems of health care is by no means confined to the so-called developing countries. In urban societies in all parts of the world, health care is being sought from and provided by official and unofficial practitioners, and in some wealthy countries self-care has become a major public health issue (Bannerman et al 1983:12).

## **2.4 ASIAN PERSPECTIVES**

### **2.4.1 Traditional medicine in China**

From the beginning of the Christian era until very recently, traditional Chinese medicine was the most advanced therapeutic system in the world (Bannerman et al 1983:68-75).

Traditional Chinese medicine comprises a range of practices including acupuncture, moxibustion, herbal medicines, manual therapies, exercises, breathing techniques and diets (WHO 2001:2). Some original non-medicinal methods, such as acupuncture, moxibustion and massage, were introduced over three thousand years ago. Acupuncture is a technique whereby needles are inserted into specific sites of the body surface to improve the flow of energy around the body, thereby preventing and treating disease and disability (Fulder 1988:xv). Moxibustion refers to the burning of rolled cones of dried *Artemisia* (mugwort) over acupuncture points in order to affect the flow of energy at those points (Fulder 1988:xvii). Bannerman et al (1983:70) indicate that China has vast experience in the use of natural herbal medicines, and a large store of books on pharmacology.

The earliest recorded history of traditional medicine in China dates back to 1 800 BC. The *Book of Rites*, a manual of ceremonies written in the Zhou dynasty (1 100 to 800 BC), records that there are very specialised doctors in four fields, namely nutrition, internal medicine, surgery and veterinary medicine. The oldest and most comprehensive work of medicine still extant, *Internal Classic*, appeared around 300 BC and is a combination of medical theory and clinical practice. It has remained an essential textbook in the colleges and schools of traditional Chinese medicine (Bannerman et al 1983:69).

As early as the second century BC, traditional Chinese medicine combined systematic theories with practical experience. By the fifth and sixth century AD it had begun spreading to foreign countries. According to Jingfeng (1988:521), the nineteenth - century propagation of Western medicine in China served political ends. In his view the opening of Western-style hospitals, clinics and medical schools, was a weapon of economical and political domination. China's indigenous medicine was discriminated against at the same time and the traditional system became "non-scientific" and "backward".

Bannerman et al (1983:71) points out that in time, two different attitudes developed: to eliminate the traditional system and replace it with modern medicine while perhaps preserving its effective drugs and prescriptions; or to accept this precious legacy and develop it with modern scientific knowledge and methods into a unique medicine and pharmacology with the characteristic style of China. Furthermore, according to Bannerman et al (1988:71), in 1929 the Central Government of Kuomintang passed a bill "to ban traditional medicine in order to clear the way for developing medical work", but did not succeed in banning and replacing it. In the first place, people in the vast rural areas and in many cities earnestly believed in traditional medicine. Secondly, the use of traditional Chinese medicine yielded satisfactory results in many diseases. Moreover, medicinal herbs were readily available at low cost, were convenient and simple to use, and had very few side effects. Thirdly, traditional medicine had a unique theoretical system which could neither be replaced nor explained by modern science. Thus, traditional Chinese medicine has survived and not been eliminated in spite of the persecution it suffered before the liberation in 1949.

However, it was only after the founding of the People's Republic of China in 1949 that traditional Chinese medicine entered a new period of development. The new government attached great importance to it, giving energetic support to it and taking effective measures to speed up its modernisation. To "foster unity between Chinese and Western-trained doctors" became one of the principal policies for health work laid down by the government and formulated according to the actual needs of the country (Bannerman et al 1983:71).The

main objectives of the new strategy were, *inter alia* to develop, systematise and raise the level of traditional Chinese medicine; to organise ways for Western-trained doctors to learn and study traditional medicine; and to gradually modernise traditional medicine and pharmacology (Bannerman et al 1983:72).

A special policy provided that no discrimination against the old medical system was to be allowed. An article of the State's Constitution stipulated that “the nation in developing health care and hygiene programs shall develop both modern and traditional medicine” (Jingfeng 1988:525). Whereas before the liberation traditional Chinese medicine had been regarded as illegal, after 1949, it gained a new legal status, and an integrated medical system eventually evolved (Jingfeng 1988:525). Accordingly, Bannerman et al (1983:72) report Chinese medicine and Chinese *materia medica* have become a part of free medical care. Pharmacies and wards of traditional medicine have been accommodated in the hospitals of Western medicine departments.

At the same time, fundamental changes in both the social status and the academic position of traditional doctors occurred. Many doctors specialised in both Western and traditional medicine, so that currently there are three types of doctors in China, namely traditional, Western-trained, and Western-trained with qualifications in traditional medicine. In many conditions, the effect of the combined treatment is much better than that of either system applied alone (Bannerman et al 1983:73-74).

In order to enable traditional doctors to master some modern science and technology, many provinces and municipalities have organised various types of training and orientation courses for teachers of traditional medicine, as well as advanced courses for traditional doctors (Bannerman et al 1983:72). At present, there are twenty-three institutions of higher learning in traditional medicine, while students in the Western medical colleges are obliged to pursue some courses in the traditional system. Furthermore, China has five hundred and twenty-two hospitals of traditional medicine, and almost all hospitals of Western medicine have set up traditional medicine departments. The so-called “barefoot doctors” who work in

the rural areas have all received appropriate training in both Western and traditional methods of treatment, but most of them mainly apply acupuncture and herbal treatment.

According to Jingfeng (1988:526), China's integrated medical policy is based on the conviction that both schools are aiming at a common target, the curing of disease, and that only their approach to and interpretations of the mechanism of disease pathogenesis differ. By combining the two systems, the overall clinical result will be improved. In this context it is important, however, that both traditional Chinese and Western medicine should be placed on an equal footing. Jingfeng (1988:528) states that both systems “should cooperate with each other, and learn from each other's merits to make up for their respective shortcomings”. Bannerman et al (1983:74) concur, stating that the two schools of medicine should be mutually supporting and complementary, and there should be no strife.

The Government of China has indicated its commitment to the integration of traditional and allopathic medicine on a number of occasions. Article 21 of the Constitution of the People's Republic of China, adopted in 1982, promotes both allopathic and traditional Chinese medicine. In 1988, the Central Secretariat of the Chinese Communist Party stated that both systems of medicine should be attributed equal importance. In 1997, the Government reiterated that traditional and allopathic medicine should be practised alongside each other at all levels of the health care system.

Bannerman et al (1983:73) state that the unique features of traditional Chinese medicine were formed and passed down through several thousand years, and to date traditional Chinese medicine has generated over 10 000 medical books, 5 000 kinds of herbal drugs, and a wide range of clinical therapy. At the same time, the production of Chinese herbal medicines has increased and gradually developed into an industrial system over the last thirty years. According to the WHO (2001:149), there are 800 manufacturers of herbal products in China, with a total annual output worth US \$ 1800 million; over 600 manufacturing bases, 13 000 central farms specialising in the production of materials for traditional medicines, and 340 000 farmers who cultivate medicinal plants, on a total planting area for medicinal herbs of 348 000 acres. There are 170 research institutions

across the country, one of the most prestigious being the Academy of Traditional Medicine in Beijing. Traditional Chinese medicine and pharmacology have not only contributed to the development and prosperity of the Chinese people, but have also had a significant influence on the development of medical science in general (Bannerman et al 1983:70).

However, Stepan (1983:307) points out that it should be borne in mind that the revival of the old Chinese medical system that occurred in the People's Republic of China resulted in a truly integrated system of health care, the procedures and structures of which were determined by party policies and implemented by representative political agencies. Thus, the successes of China's health care system are not likely to be repeated by other governments simply by imitating the methods employed. The system works in China as it does owing to the Chinese political system, and more particularly, its economic policy. Consequently, other countries can scarcely hope to adopt China's system of health care while not at the same time adopting its economic system.

#### **2.4.2 South-East Asian Perspectives**

The major systems of traditional medicine being practised in the south-east region can be classified as (a) formalised systems of indigenous medicine, which include Ayurveda, Siddha, Unani-Tibbi, the Chinese system of medicine, the *amchi* (Tibetan) system of medicine and Burmese medicine; and (b) non-formalised traditional systems of medicine practised by herbalists, bonesetters, practitioners of *thaad* (element system), and spiritualists. In addition, yoga, nature cure and homeopathy are being practised in some countries including Bangladesh and India (Bannerman et al 1983:236). Almost all the countries in the Region (e.g. Bangladesh, Burma, India, Indonesia, Maldives, Nepal, Sri Lanka and Thailand) officially recognise one or more of the traditional systems of medicine and are making efforts to utilise the respective practitioners in their national health care delivery programmes. Recognition usually involves the establishment of a board or council responsible for registration, maintaining the standard of the teaching institutions and promoting research. A general feature is the existence of registered traditional practitioners

side by side with unregistered healers. Only a small percentage of registered traditional practitioners are institutionally qualified.

In India, for example, the traditional systems practised include Ayurveda, Siddha, Unani, yoga, naturopathy and the Tibetan systems of medicine (Bannerman et al 1983:237). These systems are recognised by the government for the purpose of national health services. A statutory Council regulates the practice of these systems of medicine, and maintains minimum standards of education in all undergraduate colleges throughout the country. In order to promote research, the Government has also set up four independent Central Research Councils, one each for Ayurveda and Siddha, Unani, homeopathy and yoga, and naturopathy. The practitioners of traditional medicine are actively involved in the official health care delivery programme, and the Government has drawn up a list of traditional remedies for purposes of providing primary health care. There are also a number of traditional hospitals and dispensaries in the country.

In Nepal, Ayurveda is practised as a traditional form of medicine. There are 82 ayurvedic clinics and a 50-bed ayurvedic hospital. About 75 percent of the population resort to ayurvedic treatment. Facilities are available for intensive education in this system, for example a three-year certificate course. There are 200 institutionally qualified practitioners and about 1 000 traditionally trained healers (Bannerman et al 1983:238). The Ayurvedic Medical Council was established in terms of the Ordinance of 1988 with the mandate to register suitably qualified physicians to practise ayurvedic medicine (WHO 2001:137-138). The Ordinance makes provision for four categories of practitioners according to qualifications and experience in ayurvedic science, registered ayurvedic practitioners to issue birth and death certificates as well as certificates of patients' physical and mental fitness, and the range of ayurvedic medicines that a practitioner is permitted to prescribe. In terms of government policy there is a system of integrated health services in which both allopathic and ayurvedic medicine are practised.

In Bangladesh, the Unani and Ayurvedic Practitioners Ordinance of 1972 established the Board of Unani and Ayurvedic Systems of Medicine which is responsible for maintaining

educational standards and the registration of duly qualified persons. The Ordinance of 1983 prohibits the practice of Unani and ayurvedic medicine by unregistered persons (WHO 2001:138).

Bannerman et al (1983:235) maintain that, given the number of practitioners of traditional medicine in some countries of this region, and the population they serve, various aspects of the practice of traditional medicine as well as the treatment by traditional medicines of certain diseases for which modern medicine has no cure, should be scientifically researched. Most significantly, however, in an attempt to meet the basic health needs of the maximum number of people in the shortest possible time, the best approach in utilising traditional healers in the provision of primary health care should be investigated while at the same time promoting cooperation between traditional practitioners and physicians.

## **2.5 EUROPEAN PERSPECTIVES**

In a review of the health care systems in Europe, the British Medical Association (BMA) (1993:9) found a vast number of both official and unofficial healing methods in use, and a revival of a variety of non-conventional and traditional forms of medicine throughout Europe. According to Bannerman et al (1983:241), many Continental therapeutic practices are not really traditional, since the traditional elements have been diluted over the centuries by official medicine. The term “folk medicine” is therefore more appropriate in this context. In addition, the survival of true folk medicine in Europe no longer belongs to a genuine medical “system”. Independent manifestations can be found in individual households all over the Continent, mostly in rural areas. The more popular traditional therapeutic practices include herbalism, balneotherapy, the use of mud and clay, as well as cupping and bleeding. Balneotherapy refers to the healing powers of medicinal springs, and spas that were already in use in Roman times, are still popular today. Although the spiritual aspect is still strong in folk medicine, magic has generally been replaced by mysticism or religion. Christianity, for example, brought faith in saints with special healing powers (Bannerman et al 1983:241).

Side by side with folk medicine, manifestations of “popular medicine” (home remedies and practices of ancient or more recent origin) and “alternative medicine” are found. According to the WHO (BMA 1993:5) alternative medicine comprises all forms of health care provision which “usually lie outside the official health sector”. The BMA (1993:5,7) states that alternative medicine is a global description which embraces formalised traditional systems of medicine (e.g. Ayurvedic, traditional Chinese); traditional healers and medicine men; chiropractic, naturopathy, osteopathy, homeopathy and even “Christian science”. The practices are loosely grouped together under the umbrella of non-conventional therapies, while conventional medicine is treatment delivered by a registered medical practitioner. Bannerman et al (1983:240) explain that folk medicine, popular medicine and alternative medicine in Europe are classified together as unofficial medicine as opposed to scientific Western medicine. They (1983:241) also draw attention to the fact that not all the traditional therapeutic methods practised in Europe are of European origin; next to true folk medicine there are manifestations of imported traditional medicine, such as acupuncture as practised in China, and Asian traditional medicine as practised by the practitioners of the Unani system. In addition there are over 5000 acupuncturists in Europe who are either tolerated or partly accepted by official medicine. In most European countries there is ongoing discussion on whether the authority to practise acupuncture, for example, should be limited to physicians.

In recent years Asian traditional medicine has gained ground particularly in Britain due to the large number of immigrants from Bangladesh, Pakistan and India. Not all the clients of the traditional practitioners are of Asian origin, but also include white patients, mainly young people dissatisfied with modern medicine or patients with chronic diseases (Bannerman et al 1983:242).

### **2.5.1 Alternative medicine**

Bannerman et al (1983:243) indicate that many factors, including growing disillusionment with and unfulfilled expectations of “bureaucratic” medicine, have led to the increasing

popularity of the alternative sector. In Germany, for example, 75 percent of allopathic physicians use complementary/alternative medicine, and 77 percent of pain clinics provide acupuncture treatment (WHO 2001:95). In the Netherlands, likewise, a survey carried out in 1999 revealed that about 80 percent of the population would like to have complete freedom of choice over their medical treatment; specifically, they would like health insurance schemes to recognise complementary/alternative medicine.

Alternative medicine includes a variety of methods.

(1) **Naturopathy.** *Heilpraktikers* or healing practitioners or naturopaths are found all over Europe (Bannerman et al 1983:243). These healers study and practice neural therapy, iris diagnosis, acupuncture, homeopathy, chiropractic, phytotherapy, psychotherapy, and ozone therapy. Most practitioners, however, concentrate on only a few of these methods. In the Federal Republic of Germany the practice of the *heilpraktiker* is regulated by legislation authorising them to practise on condition that they pass an examination conducted by a local public health officer. However, they may not call themselves physicians. Healing practitioners are also not authorised to attend a birth, to dispense prescription medicines or to issue death certificates. Only a few private health insurance agencies cover the costs of this type of treatment. Associations of healing practitioners have been formed to establish teaching institutions, inform the public, issue journals and give courses in various techniques among other things. In 1994, for example, there were between 10 000 and 13 000 *heilpraktikers* in Germany, 8 000 of whom were members of professional associations (WHO 2001:95).

It should be noted that substantial numbers of academically trained physicians are making use of the methods of healing practitioners.

(2) **Herbalism.** In Europe herbs have been used for centuries by people themselves and by lay practitioners. They are currently a consistent part of alternative medicine.

In many industrialised countries, medicinal plants have become industrial products through methodical cultivation, import and export, industrial processing, packaging and marketing.

Plant remedies are now sold in pharmacies and drugstores and, according to the regulation in each country, in supermarkets and health-food stores (Bannerman et al 1983:244).

In some European countries, herbalists are not officially authorised to practise but are tolerated; in others they have the approval of the health administration and have some legal recognition. The *heilpraktiker* in the Federal Republic of Germany includes herbalism in his repertoire.

**(3) Osteopathy and chiropractic.** Osteopathy and chiropractic were both brought to Europe from the USA. Chiropractic was founded at the end of the nineteenth century by Daniel David Palmer, a magnetic therapist practising in Iowa, USA. Chiropractic is currently practised in every region of the world (WHO 2001:3).

As techniques, osteopathy and chiropractic overlap considerably. Chiropractic uses joint-adjusting procedures, manipulation, massage and other techniques to treat musculo-skeletal complaints (BMA 1993:x). Osteopathy is a system of diagnosis and treatment whose main emphasis is on conditions affecting the musculo-skeletal system. It uses predominantly gentle manual and manipulative methods of treatment to restore and maintain proper biomedical function (BMA 1993:xi).

So far, only a few European countries officially recognise chiropractic (e.g. the Federal Republic of Germany and Switzerland). In other countries, pressure is exerted by physicians and occasionally by politicians to bring osteopaths and chiropractors into the official health service, and to make registration and proper training compulsory in order to protect patients from unqualified practitioners (Bannerman et al 1983:246). In the UK, there are several institutions for training, and the British Chiropractors Association has a register of all qualified practitioners, limited to graduates from approved chiropractic colleges.

**(4) Homeopathy.** Bannerman et al (1983:247) point out that homeopathy is not uniformly considered as a “system” of medicine. The BMA (1993:x) describes homeopathy as the treatment of patients by administering highly diluted forms of natural substances which in a healthy person would bring on symptoms similar to those that the medicine is intended to treat.

Vithoukias (cited in RH Banneerman et al 1983:110) states that homeopathy takes a holistic approach to the sick and treats their disturbances on the physical, emotional and mental levels simultaneously in order to bring back the patient’s lost equilibrium by stimulating and strengthening their defence mechanisms.

Samuel Hahnemann, a German physician, founded homeopathy and introduced it to the Western world in his work, “Organon of the Art of Healing”, published in 1810. By the 1870s, the UK had about 300 homeopathic doctors and homeopathic hospitals in several cities. Because of the lack of medically qualified homeopaths to meet the demand, patients often turn to unqualified practitioners who have adopted homeopathy as one of their therapeutic methods (Bannerman et al 1983:247). In the Federal Republic of Germany homeopathy is taught at the training colleges for *heilpraktikers*. Qualified physicians frequently take supplementary courses in order to incorporate homeopathic methods into their healing repertoire. Health insurance agencies reimburse homeopathic treatment. In general, throughout Europe, whether the practice of homeopathy should be restricted to physicians is still debated (Bannerman et al 1983:248).

**(5) Balneotherapy** Bannerman et al (1983:245) state that balneotherapy, the use of medicinal springs, has always been integrated into official medicine in Europe. It is not considered an alternative but a complementary, curative method.

The role of laypersons (mothers, grandmothers, other family members, neighbours and colleagues) as the first providers of health care in preference to professional health workers remains an important component of the European health care system. While self-care is

becoming increasingly popular, health authorities are beginning to appreciate self-help as a means to relieve official medicine of some of the demands on health care and as a tool for health education (Bannerman et al 1983:249). At the same time, there is a revival of non-conventional and especially traditional forms of medicine currently throughout Europe (BMA 1993:9). Wilkinson and Sussman (1987:3 – 4) point out that in highly complex societies with medically advanced technologies substitute healing strategies flourish and the use of alternative medicines and the beliefs accompanying them have no social boundaries. Practitioners of alternative medicine continue to press for official recognition. At the same time health authorities, realise the need for careful scrutiny and appraisal of all medical methods and therapies, and for quality control of drugs, including herbal medicines. In addition, they seek assurance on the cost-effectiveness of traditional compared to official health care before taking action (Bannerman et al 1983:250). South Africa can learn lessons from them in its own efforts to regulate the traditional health care system.

## **2.6 AFRICAN PERSPECTIVES**

Traditional medicine is part of African culture and intricately linked with the African world view. The WHO (1976:3-4) defines traditional medicine as the sum of the practices, measures, ingredients and procedures which, from time immemorial, have enabled the African to guard against disease, to alleviate his suffering and to cure himself. Healing practices between African countries vary widely according to their particular socio-cultural heritage. Although it is not possible, therefore, to speak of a single African traditional health care system, differences between cultures south of the Sahara are sufficiently small for generalisations to be made within certain limits (Karim et al 1994:4).

### **2.6.1 Historical background**

The modern health care system based on Western science and technology is of recent origin in the greater part of the Third World (Pretorius, de Klerk & van Rensburg 1993:12). In Africa, its use dates back to the late nineteenth century, the period of colonialism and

christianisation, and the rise of capitalism. With the advent of the early missionaries in Africa, it was believed that the African could be won by demonstrating that Western medicine was superior to traditional medicine. Traditional healers were regarded as “witchdoctors who exploit the ignorance and superstitiousness of the unenlightened local people” (Rappaport 1980:81). On the whole, the colonial administrations prohibited traditional medical practices and condemned them as “heathen” and “primitive” (Ulin & Segal 1980:1). At the same time, official health care activities were limited to looking after the interests of the local European sectors and their indigenous labour force (Sanders 1989:526). Only after independence, that is from 1975 onwards were conscious efforts made to spread orthodox medicine to indigenous populations through health centres and hospitals. Similarly, it is only since the 1960s that orthodox medical education has taken root in Africa, as a replica of the erstwhile colonial masters' education, namely that of Britain, France and Portugal (Adekunle 1995:454). And not until the 1980s were efforts made to adapt the content and scope of training to local imperatives in order to make medical education relevant to the needs of the societies that the graduating doctors would serve.

According to Sohl and Bassford (1986:1175), Western-trained practitioners established formal centres of education, training and research throughout Africa. They organised themselves into national and regional societies suited to represent the profession in negotiations with the governments, to assist members with legal support and to enforce discipline among them. They also developed codes of conduct and criteria for certification and licensure. Professional codes became a quality assurance guarantee to society as well as a check-list for the initiated members of the profession on the standards and limits of practice.

### **2.6.2 The continued existence of traditional medicine**

Modern medicine has been established not so much by displacing traditional medicine as by increasing medical options. Nchinda (1976:134) maintains that traditional African medical systems survive because they satisfy four basic user requirements: accessibility, availability,

acceptability and dependability. Even where biomedical health care facilities are physically present, actual utilisation patterns indicate that biomedicine is not preferred for many illnesses nor for common events such as childbirth.

Although the use of traditional healers tends to diminish as people become urbanised, their influence runs very deep, and in times of stress even the most Westernised of African people might consult them (Sheriffs 1996:64). Warren (1979:250) found that students and hospital workers in Ghana maintain a belief in the spiritual causation of certain illnesses, and how they are best treated by traditional priests/priestesses or in Christian spiritual churches. Similarly, de Jong (1991:6) reports that educated people living in urban areas continue to consult traditional practitioners. Demands for these services may even increase with modernisation since healers are skilled in helping people to cope with the psychological and social stresses that often accompany rapid social and economic change.

Nonetheless, according to Bourdillon (1989:36), while the limits of modern medicine and the efficacy of traditional healing have, to some extent, been accepted in academic circles, the modern Western system with science and progress, and the indigenous system is still associated with ignorance and backwardness. Green (1988:1127) states that African governments tend to regard indigenous practitioners as an embarrassing anachronism, because they project an image of the backward, the primitive, the heathen, even the illegal. Western planners are inclined to think of traditional systems as archaic, dysfunctional, as a way of life to be overcome if there is to be progress.

Kikhela, Bibeau and Corin (1979:217) point out that in Zaire and the rest of Africa, two medical systems, in fact, exist, the first imported and the second an extension of autochthonous medical traditions. From the consumers point of view, the two systems are complementary. Nowhere in Africa, however, has this complementarity yet resulted in effective cooperation or integration into a single structure which acknowledges the fundamental legitimacy of both. In a study in Kenya, Good (1987:9) found that the plural medical systems of the technologically less developed countries remain inequitably distributed and poorly interconnected.

### **2.6.3 The revival of traditional medicine**

The revival of traditional medicine is due to several factors. Firstly, Anyinam (1987:807) points out that since the collapse of colonialism, Africans have witnessed a gradual revival of their self-image and socio-cultural identity. He goes on to say that in countries where scientific medicine was imported by colonial administration, independence brought about a reactive revival of indigenous health beliefs and practices, due as well to the four attributes of African ethno-medicine (viz. availability, accessibility, acceptability and adaptability). Secondly, the revival occurred in independent African states confronted with serious health problems, and accompanied the primary health care strategy initiated by the Alma-Ata Declaration of 1978 (Hours 1986:45). Traditional medicine was considered a possible means of avoiding or curbing the spiralling costs of modern health care services. Thirdly, the efficacy of many traditional practices in the local setting was reassessed (Bannerman et al 1983:12). Finally a reawakening of interest in the emotional, spiritual and irrational aspects of medicine today in those societies with a long experience with scientific medicine indicates that many of the psychosocial needs addressed in the traditional system remain unmet in the biomedical sphere (Kirkland et al 1992:10).

## **2.7 APPROACHES TO MEDICAL PLURALISM**

Stepan (1983:292-308) identifies four broad approaches to medical pluralism: exclusive, tolerant, inclusive and integrated.

### **(1) The exclusive (monopolistic) approach**

This approach recognises only the practice of modern scientific medicine as lawful, with the exclusion of and sanctions against all other forms of healing. The actual enforcement of such strict legislation varies from country to country. This approach applies to most of the countries of Europe and the Americas (as well as to their then colonies). Health laws of the 1800s up to 1950 were formulated as diverse modifications of a monopolistic system under which health care was dispensed by university-educated physicians and a few other

professionals with formal training, such as dentists, pharmacists and nurses. Thus, only duly trained and registered persons were authorised to practise medicine, midwifery, dentistry or pharmacy. This implied a prohibition on healing activities by persons who were not members of the “medical profession”. The prohibitions were sometimes declared expressly, and penal sanctions were laid down in the case of violations.

## **(2) The tolerant approach**

In this approach, only scientific medicine is officially recognised while the practice of various forms of traditional medicine is tolerated by law, at least to some extent. This legislative model applies notably to some developed countries with particularly advanced health care systems which do not prohibit healing by individuals without a formal degree or healing by non-scientific methods. Here, legislation permits and regulates the practice of some specific non-orthodox methods, such as chiropractic and osteopathy; and more recently, acupuncture has come under regulation.

In the Federal Republic of Germany and the United Kingdom (UK), for example, “official” medical care is based on scientific medicine and provided by professionals with formal degrees and qualifications. However, neither country prevents non-physicians from providing non-orthodox health care. Thus, the legal position in **Germany** is as follows (WHO 2001:95-96): There is no monopoly on the practice of medicine. Licensed non-allopathic practitioners may practise medicine, and all licensed allopathic practitioners are allowed to use complementary/alternative medicine. There are, however, some restrictions on the performance of particular medical acts, for example only allopathic physicians and dentists may practise dentistry and only allopathic doctors are allowed to treat sexual, communicable and epidemic diseases; deliver specific medications; give or provide anaesthetics and narcotics; practise obstetrics and gynaecology; take X-rays; perform autopsies; and issue death certificates. Infringement may result in penal punishment. In order to obtain the title of allopathic physician, a person must have an academic degree in medicine, practical experience, a licence from a public authority, and a medical certificate confirming that there are no indications of physical or mental disability or addiction to drugs.

A law passed in 1939 and amended in 1974 regulates the occupation of lay health practitioners (*heilpraktikers*). Licensed practitioners may practise medicine with the exclusion of the above-mentioned medical acts. To qualify for a licence, candidates must be at least 25 years old, have German or European Union citizenship, have completed primary school, have a good reputation, be in possession of a medical certificate confirming that there are no indications of physical or mental disability or addiction to drugs, and pass an examination before a health commission proving that they have sufficient knowledge and ability to practise and that their treatments will not negatively affect public health. The examination verifies candidates basic knowledge of anatomy, physiology, hygiene, pathology, sterilisation, disinfection, diagnosis and health regulations. Most notably, however, there is no standardised training for *heilpraktiker* candidates, which has resulted in a wide variety of teaching methods as well as variations in the length and quality of training. However, as part of the standard curriculum, allopathic medical schools are required to test students on their knowledge of complementary/alternative medicine. Students may also select a postgraduate specialisation in complementary/alternative medicine. The title “homeopathic physician” is legally protected and is obtained through a three-year training programme. Chiropractors must apply for a *heilpraktiker* licence; those holding a degree from a regionally accredited institution may use the title “doctor of chiropractic”. Public and private insurance schemes in Germany provide the same kind of coverage. Both currently reimburse some complementary/alternative treatments and are moving towards broadening this coverage. Phytotherapeutic and homeopathic medications are reimbursed (WHO 2001:96).

The regulatory situation in the **United Kingdom** is as follows (WHO 2110:125-126):

Although complementary/alternative medical practitioners without an allopathic medical degree are tolerated by law, only medical providers holding a university degree in allopathic medicine are officially recognised. To obtain full registration, candidates must obtain their qualification from the faculty of medicine of a university and complete one year of general clinical training. Being a registered medical practitioner confers privileges and responsibilities, including the right to a protected title, to hold specific posts, to provide

general medical services in the National Health Service, and to issue certain statutory certificates. The General Medical Council is a statutory body that regulates the medical profession and maintains a register of qualified allopathic doctors. Non-allopathic providers may practise medicine with the exception of medical activities specifically prohibited by an Act of Parliament, and provided they do not breach the Medical Act of 1983. Allopathic physicians referring patients to non-allopathic practitioners retain clinical responsibility for their clients. They themselves may use complementary/alternative therapies provided they have the requisite skills and/or qualifications.

In 1950, the government gave official recognition to homeopathy in the Faculty of Homeopathy Act, while osteopathy and chiropractic are regulated through the Osteopaths and Chiropractors Acts of 1993 and 1994, respectively. Regulation is based on a register, and registration depends on having recognised qualifications. Under the Code of Professional Ethics, the principal criteria for disciplinary action are professional incompetence, conduct that falls short of the standards required of a registered practitioner, conviction of a criminal offence, and serious impairment of health affecting the ability to practise.

Although registered practitioners of these two professions have special rights, including title protection, they – like other non-allopathic practitioners – are not recognised as official health care providers, and may not work in National Health Service hospitals.

Stepan (1983:298) also gives as examples of “tolerant” legislation, some Latin American countries where the established health care system is still firmly based on the concepts and organisational structures of modern scientific medicine, but certain forms of traditional medicine are tolerated by law, typically the activities of herbal practitioners and traditional birth attendants. In these countries, legislation makes provision for certain special exemptions from the prohibition of unauthorised practice of the healing arts - as opposed to permitting the practice of indigenous healing in general.

### **(3) The inclusive approach**

In this approach, systems other than scientific medicine are recognised as legal and official. Their practitioners may practise their form of healing legally, provided they conform to certain standards. Thus, two (or possibly more) systems of health care coexist.

This is the present state of both statutory law and its implementation in practice in large parts of South Asia. In several countries in this region, systems of traditional medicine are not merely tolerated, but recognised as part of the state-regulated structure of health care, and supported as such by government. Stepan (1983:301) states that, such organisational inclusion is facilitated where traditional systems, as a consequence of long historic development, are formalised to a considerable degree. For instance, it is characteristic of the professional level of the ayurvedic system that strong emphasis is placed on the necessity to combat quacks and charlatans.

In India, for example, a Central Council for Indian Medicine, established by an Act of Parliament, is responsible for teaching and controlling the practice of Ayurveda, Siddha and Unani. A Central Council of Homeopathy was established in 1973. The Drugs and Cosmetics Act 1940, as amended in 1966, and the Drugs and Cosmetic Rules of 1945, as amended in 1964 and 1970, regulate ayurvedic and Unani drugs and homeopathic medicines. However, Leslie (1983:303) stresses that “indigenous and cosmopolitan medicine are not officially integrated in India as they are in China in a state-sponsored hierarchy of medical institution”.

In summary, in the inclusive system, practitioners of traditional systems of medicine are officially recognised and their activities are fully legalised and regulated by law. Practitioners may be employed in public health institutions and perform certain official medical functions. Nevertheless, the traditional system remains separate from the main structure of health care based on modern scientific medicine. The two systems are not integrated in the sense that professionals trained in different systems work together as members of a single national health care network.

#### **(4) The integrated approach**

This approach entails official promotion of the integration of two or more medical systems within a single recognised health care service. Integrated training of health practitioners is the official policy. According to Stepan (1983:307), so far only two countries seem to have so far integrated traditional medicine in their official health care system in the real sense of the word, namely China and Nepal. Stepan points out that the lack of adequate information and the absence of the normal statutory regulation of medicine make it difficult to analyse the legal aspects of health care in these two countries. Moreover, "the system works in China as it does owing to the Chinese political system, and more particularly to its economic policy. Consequently, other countries can scarcely hope to adopt China's system of health care while not adopting its economic policies" (Stepan 1983: 307).

## **2.8 LEGAL ISSUES**

### **2.8.1 Introduction**

Today mainstream medicine is one of the most highly regulated of all social and economic activities (Stone & Matthews 1996:5). The practice of modern scientific medicine is universally legislated. Legislation was originally designed to regulate the delivery of health care as a monopoly of formally educated physicians and a few other professionals. Subsequently, even the practice of the allied and auxiliary health professionals was limited to licensed persons (Stepan 1983:290).

Akerele (1984:81) states that, in reality, however, most people relied and still rely on various forms of traditional medicine. In advanced and affluent societies these forms of healing are sought in addition to scientific medicine; in vast areas of the poor world, traditional medicine still is, and will no doubt continue to be, the only form of health care available to hundreds of millions of people. Nevertheless, relatively few governments have introduced

legislation to promote traditional medicine and in many developing countries the law lags behind the practice. According to the BMA (1993:27), at present there is great diversity in the practice and control of unofficial or informal (including traditional) medicine throughout the world. What complicates the situation further is that even in countries where the practice of non-conventional therapies is restricted by law, the use of such therapies is, in fact, widespread.

Besides the call for greater cooperation with the official medical sector, there is a widespread demand for greater regulation of non-conventional medicine. Stone and Matthews (1996:2) stress that the largely unregulated state of therapies outside the official health care system is an undesirable state of affairs. Consumer protectionists deplore the lack of uniform standards of training and practice, inadequate disciplinary procedures, and the fact that patients harmed by incompetent or negligent practitioners are often left with no effective form of redress save that provided by common law. At the same time, non-conventional providers whose political ambitions are for recognition, strive likewise towards effective regulation.

### **2.8.2 The status of the African traditional health care system**

Traditional healing systems exist in virtually all African countries. In most, however, their position is ambiguous. According to Last (1986:2), it is generally one of more or less benign official neglect, and can be summarised as follows:

- Indigenous healers are unregulated and unfunded by government and largely unaccountable in law for malpractice, manslaughter or fraud.
- Even where regulations for licensure exist, the nation wide effect is minimal.
- Academic medicine uses specific healers on an *ad hoc* basis for referrals, for giving medical students an insight into traditional medicine, and for carrying out scientific studies mainly of the traditional pharmacopoeia.

De Jong (1991:9) concurs, pointing out that in most sub-Saharan African countries healers are typically unrecognised and legally unprotected. Their patients, likewise, have no legal recourse in the case of malpractice. In this context MacCormack (1981:425) states that the main difference in status between traditional and biomedicine is that most indigenous healers in Africa enjoy traditional legitimacy, which develops over time. “Uncoerced obedience” arises from personal loyalty to those recognised as the heirs and bearers of legitimacy. Biomedicine, on the other hand, has acquired a legal-rational authority in the society, based on formal training and examination leading to legal entitlements (MacCormack 1986:154).

It is only since the 1970s that a number of African countries have taken steps to officially recognise and regulate traditional medicine through appropriate health legislation.

### **2.8.3 The “liberalisation” of traditional medicine**

Stepan (1983:298-301) states that in those African countries under the preliberation influence of French legal traditions - a strict, total and enforced monopoly of orthodox medicine - the trend towards the liberalisation of traditional medicine was cautious and hesitant. For example, in Mali, the first step was the establishment in 1973 of a National Institute for Research on the Traditional Pharmacopoeia and Traditional Medicine; some traditional practices were legalised, and a first draft regulation of traditional healing was compiled.

In the former British colonies, on the other hand - in line with the political principle of minimal interference - the official attitude towards traditional medicine was more liberal, and they seem to follow a tolerant model. A typical legislative technique in these countries was to include provisions in the basic medical law which exempt all or some forms of traditional medicine from the general prohibition on the practice of medicine by non-professionals. In some cases this was then followed by legislation expressly authorising and extensively regulating the practice of traditional medicine, usually in the mould of health

laws applicable to modern scientific medicine. “Natural therapeutics” is often subject to similar regulations – in a number of instances even before laws relating to traditional medicine are passed.

In **Sierra Leone**, the Medical Practitioners and Dental Surgeons Act of 1966 provides that nothing in the Act is to be construed as prohibiting the practice of customary systems of therapeutics, provided that such systems are not dangerous to life or health. The Medical Practitioners and Dental Surgeons Decree of 1994 repeals the 1966 Act (WHO 2001:32). However, it retains exemptions for traditional medical practitioners. Section 43 reads as follows:

Nothing in this Decree shall be construed to prohibit or prevent the practice of customary systems of therapeutics or the practice of druggists authorised by any law; but nothing in this Decree shall be construed to authorise the practice of any customary system of therapeutics which is dangerous to life or health.

The Traditional Medicine Act of 1996 regulates the profession of traditional medicine and controls the supply, manufacture, storage and transportation of herbal medicines. The Act establishes the Scientific and Technical Board on Traditional Medicine and two committees under it, namely the Disciplinary Committee to advise the Board on matters relating to the professional conduct of traditional medical practitioners, and the Drugs Committee to advise the Board on the classification and standardisation of traditional medicines. The Scientific and Technical Board is charged with securing the highest practicable standards in the provision of traditional medicine by promoting the proper training and examination of students of traditional medicine, controlling the registration of traditional health practitioners, and regulating the premises where traditional medicine is practised. In terms of the Act, the Board shall have a registrar in charge of the register of traditional medical practitioners. Restriction on use of the title “traditional medical practitioner” and the provision of medical aid are also covered by law. Part IV of the Act contains a list of the diseases for which traditional health care providers may not advertise treatments.

In **Uganda**, the Medical Practitioners and Dental Surgeons Act, 1968 prohibits unlicensed persons from practising medicine, dentistry or surgery. However, section 36 of the Act allows the practice of any system of therapeutics by a person recognised by the community to which he belongs to be duly trained in such practice, provided that the latter is limited to that person and community only.

At present, the Ugandan Government is in the process of developing a health policy emphasising primary health care. The Health Review Commission recommended that the Ministry of Health work closely together with traditional medical practitioners to achieve the WHO's objective of "Health for All by the year 2000". The Commission specifically advocated including traditional health practitioners as members of community health teams and welcoming them to participate in primary health care. Traditional and Modern Health Practitioners Together against AIDS and other diseases (THETA) is a non-governmental organisation dedicated to improving mutually respectful cooperation between traditional and allopathic health care providers in Uganda (WHO 2001:36-37). Its objectives are education, counselling and better clinical care for people with sexually transmitted diseases, including HIV/AIDS.

In **Lesotho**, the Natural Therapeutic Practitioners Act of 1976 regulates the practice of natural therapeutics and limits such practice to registered practitioners. Section 2 of the Act defines natural therapeutics as the provision of services for the purpose of preventing, healing or alleviating sickness or disease, or alleviating, preventing or curing pain "by any means other than those normally recognised by the medical profession" (WHO 2001:19). Natural therapeutics includes methods commonly employed by homeopaths, naturopaths, osteopaths, chiropractors and acupuncturists. Section 3 prohibits non-registered persons from practising as natural therapeutic practitioners. Applicants for registration must be at least 21 years of age, be citizens of Lesotho, and be recommended as qualified by the Natural Therapeutic Practitioners Association of Lesotho. Authorised persons under the Act are prohibited from carrying out certain medical procedures, including performing operations or administering injections, practising midwifery, withdrawing blood, and

treating or offering to treat cancer. The Act also prohibits preventing any person from being treated by an allopathic physician or improperly influencing any person to abstain from such treatment. The Lesotho Universal Medicinemen and Herbalists Council Act of 1978 followed the 1976 Act. It provides for the establishment of the Universal Medicinemen and Herbalists Council. Section 5 states the objectives of the Council (WHO 2001:20) to promote and control the activities of traditional medical practitioners, to provide facilities for the improvement of their skills, and to bring together all traditional health care providers into one associated group. Every practitioner must have a valid licence to practise, and the Council must keep a register of its members. Membership is open to every traditional healer who pays the prescribed fee.

The standing of traditional medicine within the official health care system in Botswana, Ghana, Nigeria, Swaziland and Zimbabwe together with the respective historical development of relevant health legislation, are discussed below. The situation in South Africa will be reviewed in detail in chapter 3.

It may be noted at this stage that, even when a form or forms of traditional medicine have been exempted from the monopoly of modern medicine and thus legalised in particular countries, this does not necessarily signify the automatic removal of all obstacles to cooperation between the modern and traditional sectors. Stepan (1983:301) points out that the usual prohibitions against cooperation with non-physicians, included in codes of medical ethics and other laws regulating professional conduct in allopathic medicine, have usually not been formally repealed.

#### 2.8.3.1 Traditional medicine in Botswana

In a study on the improvement of Botswana's health care system through the introduction of a comprehensive, promotive and holistic approach, Frants Staugard (1989:21), a medical doctor working in Botswana, focused on the relationship between the traditional and the modern health care sectors, and on possible future modifications of the official government

policy on the former. Staugard (1985:21-22) states that the laws passed by the chiefs in the Bechuanaland Protectorate from 1889 onwards aimed at limiting the number of traditional healers and bringing their activities under closer control by the chief. The colonial administration, on the other hand, wished to severely curtail traditional healing in the Tswana society. The Witchcraft Proclamation of 1927, was aimed directly at the witchdoctor (diviner), and his supernatural manipulations and mystical healing techniques. Herbalists, in contrast, were accepted as “honest persons who mix medicines for the purpose of curing their fellows”. He (1985:22-23) goes on to say that Proclamation No 62, 1934, from the Bechuanaland Protectorate’s High Commission, section 2 stipulated that no person “shall practise in the territory as a medical practitioner, dentist, chemist, nurse or midwife unless he is registered as such in accordance with the provisions of this Proclamation”. Furthermore, in terms of section 8.5, “the provisions of the preceding sections shall not apply to native herbalists prescribing according to their customs”.

Staugard (1985:23) explains that this proclamation thus exempted “native herbalists” from the obligatory registration of medical personnel: “Native herbalists were tolerated as long as they did not enter into the sphere of Western medicine, for example, by supplying their patients with patent medicines or mixtures of these with herbs”.

An Advisory Council discussed the question of a special register of “native herbalists”, but no decisions were made and the question was left open.

In the 1960s the control over the traditional healer, *dingaka*, was transferred from the central to the local level. The District Councils were given authority to issue licences to healers. Initially, no distinction was made between herbalists and bone-throwers in this respect (Staugard 1985:25). However, with independence from colonial rule in 1966, the attitude adopted by the new government again reflected the heritage of the colonial administration: bone-throwers (diviners), associated with the supernatural, had to be eliminated, whereas the herbalist was to be granted the stamp of legitimacy through the possession of a licence issued by the District Council (Staugard 1986:65).

According to Staugard (1985:25), “the ensuing formation of professional associations should be seen as a political move by the healers themselves to achieve social acceptability in accordance with European criteria”. Dunlop (1979:194) points out that the government was envisaged to empower these healers’ associations “to regulate the practice of traditional healing by issuing licences to those whom its officers judge to be competent”. In reality, however, these associations never gained any real influence vis-a-vis the government, and were soon subject to “personal cultism and factionism” (Staugard 1986:65). Thus, there was no common forum or body which could promote healers’ interests in the official arena. In this context, many practitioners became wary of contact with the official health system as the interchange between modern and traditional doctors was not one between equals in terms of power and privilege (Staugard 1989:130).

The government’s first reference to an official policy on traditional healers in Botswana was the National Development Plan of 1976-1981 (Staugard 1985:25-26):

Although not part of the modern health care system the traditional healer (*ngaka*) performs a significant role in Botswana especially in the rural areas...The policy of the Ministry is to evaluate further the contribution of traditional healers to the health care system of the country and possibly then to seek ways of closer cooperation and consultation.

Chapter 13, section 13.28 of the National Development Plan of 1979-1984 developed the constructive attitude further (Staugard 1985:26):

There are a large number of traditional practitioners of various types who are frequently consulted on health and personal matters. The Ministry of Health will continue its policy of gradually strengthening links with traditional practitioners – both diviners/herbalists and faith healers. The emphasis will be put on improving mutual understanding, especially about the practices and techniques of the traditional practitioners. No full-scale integration is envisaged, but referrals between modern health care services and traditional practitioners will be encouraged where appropriate.

Thus, according to Staugard (1989:91), active repression and repressive tolerance finally led to more or less active encouragement of traditional medicine, and there are approximately 3100 traditional healers in Botswana, 95 percent of whom reside in rural areas. They are generally well respected and influential, and remain central figures in the everyday lives of the majority of the rural population. In addition, there are chiropractors, osteopaths, naturopaths acupuncturists and other complementary/alternative medical professionals in Botswana whose registration requirements are outlined in the Medical, Dental and Pharmacy Amendment Act of 1987 (WHO 2001:7).

Staugard (1989:126) points out that modern scientific medicine has established a country-wide network of facilities where care and cure is offered by qualified registered practitioners. A crucial question is whether the high prevalence of traditional healers, especially in the rural areas of Botswana, and the widespread use of their services by their fellow villagers is a temporary phenomenon which will change fairly rapidly in the near future together with changes in the economic and social development of the country, or whether traditional medicine in Botswana provides services, remedies and cures which ought to be seen as complementary or even superior to those offered by the modern medical sector and thus as persisting. Staugard (1989) maintains that traditional medicine has a contribution to make to the concept of comprehensive and promotive health care. Furthermore, health planners and politicians alike seem to agree that a successful implementation of the primary health care strategy in a developing country like Botswana requires the active participation of the traditional health care sector. Such participation may be proposed in terms of integration, professionalisation or cooperation/complementary coexistence (Staugard 1989:130). However, in Staugard's (1985:201) view, an integration of the two systems would be a bad choice and probably the "kiss of death" to traditional medicine. Professionalisation implies official control of healers' activities by means of laws and regulations, which is bound to disrupt the socio-cultural context of the traditional health worker. It might also impose some of the analytical and biomechanical concepts of modern medicine on the healer and bias him towards curative care (Staugard 1985:202). Thus, cooperation between two independent sectors, not intending to control and to regulate but to respect the unique character of each other, would be the preferred solution (Staugard

1985:202). Consequently, Staugard (1986:70) recommended that existing legislation, which is of a decidedly colonial nature and shows little understanding of important features in Tswana culture, be abolished.

According to Staugard (1985:201), the existing mechanisms of social control by the local community appear to be effective in regulating and eliminating any excessive power of a particular member of the community when this power is used for purposes other than beneficial to the community as a whole, perhaps with the exception of the so-called neo-herbalists who often practise their healing skills on an ambulatory basis and thus necessitate official regulation of their activities to avoid charlatanry and commercialism. In Staugard's (1989:129) view, Botswana needs both health care systems, and the two need each other.

### 2.8.3.2 Traditional medicine in Ghana

Twumasi and Warren (1986:117-125) state that in Ghana, under the colonial government it was an offence to practise indigenous healing, or for clients to use the services of healers. However, only when a practitioner used medicine to kill a person would a case be brought to the law courts. The government's aim was to liquidate "native practices of traditional medicine". Traditional healers were thought "to be insincere, to be quacks who lived on the neuroses of their illiterate folks" (Twumasi & Warren 1986:122). Healers were also looked down upon by the Christians. Thus, indigenous healing lost its prestige and was stigmatised, and practitioners were forced to practise in secrecy.

After Ghana's independence in 1957, the nationalist government gradually created a new awareness of Ghanaian culture. The late President Kwame Nkrumah initiated a revival of African arts, culture and medicine, and took the first steps towards altering the official status of indigenous healers in Ghana.

In 1963 his government appointed Mensah Dapaah, an MSc graduate from McGill's University, to organise traditional healers. In the same year Ghana's Psychic and Traditional

Healing Association was founded (Warren 1986:73-86). Spiritual and faith healers were grouped under the psychic wing, traditional herbalists and traditional birth attendants under the traditional herbalist wing of the Association. Formal inauguration followed in 1969. In 1973, yielding to an appeal by a large number of healers in the country, membership was extended to include priests and priestesses. The objectives of the Association (Warren 1986:76-77) include the following:

- to promote and encourage the study of herbalism and psychism in Ghana and Africa as a whole;
- to support and protect the conduct, status and interests of the healers, to repress malpractices, and to decide all questions of a vocational nature affecting healers for the common good;
- to affect changes of law regarding the members;
- to provide a central organisation in Ghana for research into traditional medicine;
- to establish clinics in all the regions for the treatment of those diseases and ailments which orthodox medicine has not found cures for, and to treat common diseases alongside orthodox practitioners.

In general, the intentions and resolutions of the Association seek a common ground where indigenous and Western medicine can work together. In line with this development, the Medical and Dental Decree of 1972, and the Nurses and Midwives Decree of 1979 authorise indigenous forms of treatment provided that the practitioner is an indigenous inhabitant of Ghana, and provided further that no act is performed which is dangerous to life. Folk therapists obtain their licences to practise from the Ghana Psychic and Traditional Healers Association as an officially recognised body (Sanders 1989:528). Substances listed in the Poisons Ordinance of 1952 may be used by practitioners of scientific medicine only.

After the fall of Nkrumah, the organisational structure of the Association fell to pieces, and it was not until Acheampong's military government that it was revived (Twumasi & Warren 1986:123). In 1974 a Centre for Scientific Research into Plant Medicine was opened at Mampong. A physician was appointed as head of the centre, and steady progress was made in convincing healers to cooperate with him and bring their herbs for scientific

analysis. Some practitioners, however, did not want to expose their medications to scientific testing for various reasons. Spiritualists/diviners and faith healers, in particular, were often reluctant to join the Association, to be controlled by an outside power, and to subject their preparations to public scrutiny. The healers who cooperated were usually herbalists (Twumasi & Warren 1986: 124).

Besides the Research Centre, several large-scale health projects were initiated in the 1970s with donor assistance and designed to improve the skills particularly of traditional birth attendants (Warren 1986:78). The Primary Health Training for Indigenous Healers (PRHETIH) Programme, initiated by Warren and others in 1979 in the Brong-Ahafo Region, served to upgrade the knowledge and skills of traditional healers in Techiman District. Twumasi and Warren (1986:133) describe the PRHETIH Programme as an important step towards collaboration between indigenous and modern health practitioners with the aim of providing basic health care coverage to rural areas. According to Bannerman et al (1983:324), the approval of the Programme by the central government authorities and especially the Ministry of Health, the collaboration between local leaders, healers and modern health personnel, as well as the active community participation all contributed to satisfactory results: the care, particularly of sick children, improved, healers gained new primary health skills, and the relationship between Western health workers and healers benefited. The PRHETIH Programme operated effectively from 1979 to 1983. However, between 1983 and 1985 conflicts between some of the healers and modern health workers resulted in a breakdown in the programme.

Warren, Bova, Tregoning and Kliewer (1982:1879) point out that the Techiman healers showed an openness to expanding their knowledge and increasing their primary health care activities. However, the most striking achievement to emerge from the Programme was the exchange of ideas and information among indigenous and modern practitioners: the PRHETIH Programme is an experiment to map out and apply the guidelines along which medical science and traditional healing should work together.

In 1999, the Government brought all the traditional medical practitioners' associations together under one umbrella organisation, the Ghana Federation of Traditional Medical Practitioners' Associations (WHO 2001:16). The Traditional Medicine Practice Act of 2000 makes provision for a council to regulate the practice of traditional medicine, register practitioners and license them to practise. It also regulates the preparation and sale of herbal medicines (WHO 2001:17). The Act defines traditional medicine as "practice based on beliefs and ideas recognised by the community to provide health care by using herbs and other naturally occurring substances", and herbal medicines as "any finished labelled medicinal products that contain as active ingredients aerial or underground parts of plants or other plant materials or the combination of them whether in crude state or plant preparation".

The Act is divided into four parts. Part I concerns the Medicine Practice Council, including its establishment, functions and membership. Part II covers the registration of traditional medical practitioners. In terms of Clause 9 no person shall operate or own a practice or produce herbal medicines for sale unless registered under the Act. The qualifications for registration are set out in Clause 10. Clause 13 makes provision for the Minister of Health, on the recommendation of the Council and in consultation with healers' associations, to regulate the titles used by traditional medical practitioners based on the types of services rendered and the qualifications of the healers. Part III covers matters concerning the licensing of practices. Part IV deals with staff for the Traditional Medicine Practice Council and contains financial and miscellaneous provisions, such as the appointment of a registrar, the keeping of a register, and offences.

The Traditional Medicine Unit under Ghana's Ministry of Health was created in 1991 and upgraded to a directorate in 1998 (WHO 2001:17). The Ministry, in consultation with the Ghana Federation of Traditional Medical Practitioners' Associations and other stakeholders, developed a five-year strategic plan for traditional medicine from 2000 to 2004. It proposes the development of a comprehensive training programme in traditional medicine from basic to tertiary levels, amongst other things.

Volume I of the Ghana Herbal Pharmacopoeia contains scientific information on fifty medicinal plants. A second volume is currently in preparation. Efforts are being made to integrate traditional medicine into the official public health system. The Ministry of Health is working towards including traditional medicine in the curricula of medical schools as well as introducing a diploma course in traditional medicine at the postgraduate level.

### 2.8.3.3 Traditional medicine in Nigeria

Nigeria is a culturally pluralistic society, and the medical sector is a complex, pluralistic system composed of indigenous therapeutic activities, orthodox Western medicine, Islamic healing approaches, as well as practices which synthesise aspects of these various methods (Afonja & Pearce 1986:8). Ajai (1990:685) stresses that alternative and traditional medicine are distinct concepts, with only the latter being indigenous to a country.

Nigeria became independent on 1 October 1960. A civilian government was followed by military rule, until an elected government came to power in 1979. One of its priorities was the provision of health care (Oyebola 1986:226-227).

As in other underdeveloped nations of Africa, Asia and Latin America, the medical system which the Nigerian government inherited from the colonial administration was hospital-based and urban-centred, preventing adequate coverage of the rural population (Pearce 1986:165). At the same time, the indigenous belief system did not relinquish its hold on the people, and scientific and traditional medicine continued to coexist (Oyebola 1981:87). Hence, in exploring alternative sources of health personnel, the move to use traditional healers gained momentum (Oyebola 1986:227). Odebiyi (1990:341) states that the formal recognition of and cooperation with traditional healers were expected to improve health care in two main ways: enhancement of quality of care and supply of low-cost primary health care. Consumers would also benefit from a smooth referral system.

In 1966, the Ministry of Health authorised the University of Ibadan to conduct research into the medicinal properties of local herbs. Efforts to promote traditional medicine continued throughout the 1970s in the form of conferences and training programmes. In 1979 the establishment of a Traditional Medical Conference of Nigeria to control the practice of indigenous medicine and develop a syllabus for training practitioners was proposed (Pearce 1982:1613). Oyebola (1986:230) points out that a major theme of the Nigeria Medical Association (NMA) Conference in April 1980 was “the place of traditional medicine in basic health care delivery”.

In 1981, the possible adoption of a national policy on the utilisation of traditional medicine was discussed by the National Council on Health (NCH). Oyebola (1986:227) reports that the Council unanimously agreed that a national traditional healers’ board with representatives of the Federal and State governments (mostly traditional healers) should be established. Each state was urged to pass a traditional healers’ bill and set up a traditional healers’ board. The state boards were to work closely with the national healers’ board. The NCH also appointed a committee to work out the details of implementing these decisions. The first and perhaps the most critical issue was the adoption of a suitable common language, since most practitioners speak solely their local language and are furthermore illiterate (Oyebola 1986: 228).

According to Oyebola (1986:228), another indicator of the government’s commitment to the promotion of traditional medicine was a decision in the Senate to establish a Senate Committee to solve the problems of the health care delivery system in Nigeria. In pursuance of its assigned duties, this Committee called on members of the public to submit memoranda on traditional medicine that would assist in defining the role of traditional healers in health care provision. Thus, the Federal as well as the State governments in Nigeria actively pursued the legalisation of practitioners of the traditional sector and their utilisation as partners in the official health care team. The Nigerian Medical and Dental Practitioners Act of 1988 forbids the practice of medicine by unregistered practitioners, specifically the issuance of death certificates, the performance of post-mortems, or certification of leprosy

and mental disability. However, traditional medical activities are protected by a provision in section 17(6), which reads as follows (WHO 2001:29; Ajai 1990:686):

Where any person is acknowledged by the members generally of the community to which he belongs as having been trained in a system of therapeutics traditionally in use in that community, nothing ... shall be construed as making it an offence for that person to practise that system; but the exemption conferred by this subsection shall not extend to any activity (other than circumcision) involving an incision in human tissue or to administering, supplying or recommending the use of any dangerous drug within the meaning of part IV of the Dangerous Drugs Act.

As Ajai (1990:686, 692) explains, the phrase “system of therapeutics traditionally in use in that community’ refers to Nigerian traditional medicine, which is thereby exempted from the prohibition of unauthorised medical practice. However, only a qualified and registered physician is empowered to issue certificates of death, to perform post-mortem examinations, to certify that a person is a leper or a lunatic, or to issue sick certificates.

At the same time, some state governments in Nigeria have gone much further in their strategy regarding the status of traditional medicine. Lagos State was the first to pass the Traditional Medicine Bill and to officially recognise traditional healers. In 1980 the Lagos State government established a Traditional Medicine Board and empowered it to regulate the practice of traditional healing in that state (Ajai 1990:688). The members of the Board are largely traditional practitioners with Chief J Lambo, a traditional healer, as chairman. The main functions of the Board include the following (Ajai 1990:688):

- to prepare the criteria for registration and to maintain a register of all traditional practitioners;
- to formulate plans for the development of traditional clinics, health centres and hospitals;
- to standardise training in traditional medicine and define the type of medical services to be rendered;
- to set up a code of conduct and thus regulate the practice of traditional healers.

The administration of the Board is principally carried out by civil servants with state funds. At a Senate hearing in Lagos in 1983 it was suggested that the Federal Government should set up a National Council for traditional healers and allow them to practise alongside orthodox medical doctors; establish trado-medical departments in all colleges of medicine, and form a national research centre (Oyebola 1986:234). In addition, the Lagos Ministry of Health initiated official ongoing collaborative programmes involving traditional healers (Green 1986:137). In particular, the Lagos Ministry of Health and the Lagos branch of the Planned Parenthood Federation of Nigeria (PPFN) have trained Yoruba herbalists in modern family planning technology since 1984 (Green 1988:1128).

Ojanuga (1980:86) points out that, despite support for the integration of the traditional and scientific medical systems, there was little research on the feasibility of such policy in Nigeria. Thus, the National Council of Health (NCH) in 1981 considered it appropriate to gauge the reaction of Western-trained doctors to the plan of utilising traditional healers as official health care providers. Consequently, the Nigeria Medical Association and the Nigerian Medical Council, the two bodies that control the practice of Western medicine in Nigeria, were asked for comments. According to Pearce (1986:240), although many members of the Association felt that healers could be useful in health care delivery, there was general agreement that the available information on several aspects of traditional medicine was too scanty to allow for a meaningful decision on government level. In general, doctors insisted that the recognition of indigenous practitioners should depend on whether or not the healer's work can be submitted to scientific analysis. Odebiyi (1990:334, 340) states that most physicians were therefore only interested in the scientific and quantifiable aspects of traditional medicine. Consequently, the possibility of collaboration appears most promising in regard to traditional birth attendants, herbalists and traditional psychiatrists who have often been found to be effective. Pearce (1986:169) considers it important that the various categories of traditional healers should not be lumped together, and Oyebola (1986:231) maintains that the criteria for the classification and functions of each category should be clearly enunciated. On the whole, however, Western-trained physicians appeared unwilling to refer patients to the traditional sector (Ojanuga 1980:87), and did not want healers included as health personnel in the official system of medical care (Pearce

1986:239). According to Oyebola (1986:230), the majority were of the opinion “that recognising traditional healers at this time was like licensing killers”.

The requirements for collaboration stipulated by the Nigeria Medical Association (NMA) include the following (Oyebola 1986:231):

- New entrants into the profession should have a pass in at least three subjects, one of them a scientific one.
- Before a traditional healer is certified, he must practise for five years, be able to read and write, and keep records.
- Traditional healers must attend regular refresher courses and workshops.
- State and federal governments should establish an Institute of Traditional Medicine to ensure a minimum of 5 years’ training for trado-medical students.
- Traditional healers should also not be allowed to issue sick and death certificates.

The NMA further recommended the establishment of a research institute of traditional medicine and encouraged research projects on traditional medicine in universities. Oyeneye (1985:69) stresses the importance and necessity of mechanisms for the evaluation of the technologies, knowledge and competence of the practitioners, and assessing the effectiveness of the herbs and other organic matter used in traditional practice.

Recognition should entail the certification of practitioners by their local governments through the respective Ministry of Health to enable them to practise in their local government area. Traditional birth attendants, bone-setters, mental health therapists and circumcision “surgeons” should be registered following recommendations by their village heads (Oyebola 1986:230). Herbalists, like conventional doctors, should be subject to annual inspection and renewal of registration certificates by the appropriate authorities. Odebiyi (1990:341) indicates that registration should be the basis for formal recognition of healers.

With regard to the traditional sector, healers' associations called for government recognition and support. Associations of traditional healers are common in Nigeria. According to Braitto and Asuni (1979:188), all the practitioners they interviewed belonged to a healers' association. Likewise, Oyebola (1981:87) found a proliferation of Yoruba herbalists' associations, and that it was particularly the herbalists who became politically conscious and sought recognition. Moreover, associations were charged with the responsibility of drawing up guidelines of practice and codes of conduct, and to establish disciplinary committees to deal with deviant behaviour. Associations also provided a forum for practitioners to meet, to continuously improve their knowledge through the exchange of ideas, and to identify specialists in specified areas and refer relevant cases to such persons (Oyebola 1981: 91).

Oyebola (1986:232-233) points out that there usually are several associations in the various states, with a lot of competition for leadership, while at the national level the formation of a single umbrella association is fraught with obstacles, including rivalry, ethnic loyalty, language problems and differences in opinion on how national officers should be elected. Thus, although the existence of numerous associations makes a central control of traditional practice more problematic and furthermore weakens the healers' bargaining power, the difficulties involved in forming a national association of practitioners are often underestimated.

Braitto and Asuni (1979:188) report that in order to join, 73 percent of healers took an oath only; 4 out of 30 took an oath and paid dues; one took an oath and a test, while one healer paid his fees only. According to Vontress (1991:247-248), the Association for Nigerian Doctors requires that healers take an examination before being granted a certificate of membership. Furthermore, candidates must take an oath that they will use their powers to benefit people, never to harm them. Some healers' associations now issue certificates to their members to serve as accreditation of professional competence. Although the recipients of these certificates must have undergone a defined period of apprenticeship, there is still no way of testing professional skills (Oyebola 1986:232).

The relationship between the two healing systems in Nigeria differs from state to state, and at the national level there has been no official recognition before the 1990s. In 1992 the National Primary Health Care Development Agency was established with a broad mandate on health matters, including the endorsement of traditional birth attendants (WHO 2001:30). In 1994 all state health ministries were requested to set up boards of traditional medicine in order to enhance the contribution of traditional practitioners to the nation's official health care system. The National Traditional Medicine Development Programme was established in 1997. Since then the Federal Ministry of Health has instituted measures to formally recognise the practice of traditional medicine, amongst them policy documents on a national code of ethics and minimum standards for traditional practice. In 2000, the Traditional Medicine Council of Nigeria Act was proposed (WHO 2001:30). The functions of the Council include facilitating the practice and development of traditional medicine; establishing guidelines for the regulation of traditional medical practice in order to protect the consumers from quackery, fraud and incompetence; and liaising with state boards of traditional medicine to ensure adherence to the policies and guidelines outlined in the Federal Traditional Medicine Board Act. Odebiyi (1990:334) maintains that "before one can focus on the integration of the two medical systems, one should be convinced of the utility of the systems, especially the traditional one". This supports the statement of the President of the NMA (Oyebola 1986:230) that, while the Association appreciates the services of traditional healers, herbs and other medications need to be subject to rigorous scientific analysis to identify their specific medicinal potential and potency.

In his discussion of the legal implications and complications of a possible integration of traditional medicine into the Nigerian health care delivery system, Ajai (1990:685-696) maintains that freedom of conscience is a fundamental right in Nigeria. The State is precluded from adopting a state religion or from preferring one religion above others. Since traditional medicine is inextricably connected with traditional religion and traditional religious practices, the integration of the traditional sector into the national health care system poses difficult questions of law. A review of the constitutional implications of government sponsorship and involvement in the practice of traditional healing leads to the conclusion that it is unconstitutional for the government to pursue integration.

#### 2.8.3.4 Traditional medicine in Swaziland

As elsewhere in Africa, the Swaziland Government “has had an ambiguous policy or non-policy towards traditional healers” (Green & Makhubu 1984:1071). There was an attempt in 1945/46, during the colonial administration, to pass legislation that would provide for the registration and taxation of healers, and would seek to control their activities. While prior to that time, and dating back to 1894, all ‘witch-doctoring’ was considered illegal in Swaziland, the proposed legislation would have amounted to official recognition of the traditional sector by the government. However, due to vigorous opposition from the then Director of Medical Services, the legislation was not implemented (Green & Makhubu 1984:1071).

The late King Sobhuza II was generally supportive of traditional healing. He envisioned the development of a health care system that would combine the best of both traditional and modern medicine and maintained that a scientific study of indigenous practices should be undertaken before attempting to intervene in healing activities. In 1954, the King issued an executive Order-in-Council which represented the further development of the earlier proposed legislation (Green & Makhubu 1984: 1071). The Order dealt with the registration of healers, misconduct and malpractice, a standardised fee-schedule, and referral of patients to clinics. Registration and taxation of traditional practitioners started in the same year, and the relevant records were kept by the Swazi National Council. In addition, the Control of Natural Therapeutic Practitioners Regulations were published in 1978 (WHO 2001:35), which defined “natural therapeutic practitioners” as persons practising chiropractic, homeopathy, naturopathy and electropathy.

Some years before his death in 1982, King Sobhuza II also began to call for the formation of a professional association of traditional healers, in particular to re-establish social control mechanisms that could operate in a modernising society (Green & Makhubu 1984:1076). Green and Makhubu point out that healers’ associations should be viewed as a way of

promoting rather than directly controlling traditional healing practices. They also enable practitioners to run their own affairs in an organised manner.

In response to the King's call there were various attempts on the part of the healers to organise themselves into local associations. An important motivational factor was the desire to dissociate themselves from the frauds, charlatans and ritual murderers often associated in the public mind with traditional healers. The difficulty in this context was that formal associations and even cooperation amongst practitioners were a *novum* for traditional medicine in Swaziland (Green & Makhubu 1984:1071).

By 1979, lecturers at the University of Swaziland were asked to assist practitioners in forming their own associations, and to study the medicinal qualities of Swazi herbs (Gort 1987:74). At the same time there followed a directive to the Ministry of Health to look into ways of finally organising traditional healers. The Minister subsequently formed a Commission for Traditional Medicine whose function was to recommend ways of regulating indigenous practice (Green & Makhubu 1984:1071). The Commission drafted revised legislation that dealt with issues such as registration, payment of fees and the formation of a national association. Although the King's death in 1982 interrupted the development of the Commission's activities, the Swaziland Traditional Healers' Society was founded in 1983. One year later it was given office space in Ministry of Health headquarters in Mbabane in order to facilitate communication and to symbolise the new working relationship between organised healers and the Minister (Green 1986:130). Workshops were initiated in cooperation with the Health Education Centre to foster collaboration between the two sectors (Hoff & Maseko 1986:412). The sessions were designed to encourage informal dialogue with the aim of developing mutual respect and understanding.

The government of Swaziland realised that modern health care personnel would not easily displace traditional medicine, and that the latter could not be ignored. Green (1985:283) emphasises that primary health care provision and health education strategies must begin with an acknowledgement that traditional medical beliefs are tenacious, and that traditional

practitioners are opinion leaders in matters pertaining to health. Thus, based on research findings and recommendations mainly by Green and Makhubu (1984), Green (1985) and Gort (1987), the Minister of Health adopted a policy of seeking cooperation with traditional healers. Within this strategy, the registration of healers represented a first step towards recognition and control over their activities. In addition, it provided tax revenue (Green & Makhubu 1984:1076).

The registration of traditional healers began during the late colonial period. After independence in 1968 the Swazi National Council continued to register healers and to collect taxes from them. However, the Control of Natural Therapeutic Practitioners Regulations of 1978 limit the definition of “natural therapeutic practitioners” to persons practising chiropractic, homeopathy, naturopathy and electropathy. Consequently, traditional healers were not officially recognised or controlled (Stepan 1983:300).

With regard to the government, Gort (1987:76-77) states that health officials in general were concerned that there was not enough information about traditional healing practices, that healers were known to resist sharing knowledge, and that some traditional procedures did more harm than good. Accordingly, the Ministry of Health requested research (funded by USAID) to assess the areas and extent of cooperation possible between traditional healers and modern health care personnel (Green & Makhubu 1984:1071-1079).

Indigenous practitioners, for their part, were generally interested in gaining respect and recognition from the government. They were also favourably inclined towards registration which they felt should be carried out at local level where the examination of healers' qualifications could be conducted by those familiar with them, such as chiefs, assistant chiefs and fellow healers (Green & Makhubu 1984:1076). According to Green and Makhubu (1984), 30 percent of the practitioners believed that the law would support them in collecting overdue patient fees, and protect them against complaints by clients or their families. Registration was also regarded as conferring legitimacy, respectability and authority on healers, and allowing them to travel and practise freely throughout Swaziland and neighbouring countries. In addition, 98 percent of the healers wished for better

cooperation between themselves and doctors or nurses. The healers were generally also keen to learn more about modern medicine; 91 percent were enthusiastic about undergoing some sort of training in order to improve their healing skills (Green 1986:125). Others, however, asserted that they did not want to be trained (Gort 1987:77). There was also a certain amount of suspicion on the part of the healers regarding the motives of the Ministry of Health (Green 1986:126). Green and Makhubu (1984:1075) point out that it is important to appreciate that most practitioners do not need the relatively low salaries that government employment would provide. On the whole, particularly those who are most successful in their practice may show little interest in cooperation with the modern sector (Gort 1989:1100).

According to Green (1986:126), there was a great deal of suspicion and outright negative bias towards traditional healers on the part of most modern practitioners. This attitude resulted from, *inter alia*, a failure to understand the healer's role in Swazi society, the nature of scientific medical education, a certain amount of professional jealousy, the "bad press" practitioners often receive by local sensation-seeking media, and the fact that healers often engage in practices deemed unacceptable by public health standards (Green & Makhubu 1984:1077). Gort (1987:80) found that some Swazi physicians viewed any interaction with traditional medicine as inappropriate, and stated that much of their own work was devoted to correcting the mistakes made by traditional practitioners.

As for referral, Campbell (1998:159) found that modern doctors are usually reluctant to refer patients to the traditional sector since they do not know what the standard of care will be.

The Ministry of Health in Swaziland has adopted a policy of cooperation with traditional healers. The strategy implies a better working relationship between the two health care sectors whereby appropriate referrals become more routine, certain of the healers' skills are upgraded, and the cultural sensitivity of modern health care workers is increased. The option of cooperation avoids the dangers of integration where the traditional healers' role might be fundamentally altered, and they may become second-rate paramedical workers or what Gort (1987:207) calls a poorly paid, low-status, government –regulated mini-nurse. At present,

Gort (1987:25-26) states that the incorporation of traditional healers into the official health care system is, at best, premature and based on inconclusive evidence or, at worst, dangerous to both traditional and modern medicine. Bias against healers on the part of doctors and nurses as well as suspicion on the part of practitioners regarding the motives of the Ministry of Health need to be overcome to enhance the cooperation strategy (Green & Makhubu 1984:1077).

With regard to policy, Green and Makhubu (1984:1077) recommend establishing a basis for ongoing collaboration with training seminars for healers. Since cooperation has to be two-sided, plans will have to be developed to educate modern health care personnel about indigenous healing methods and to resolve communication difficulties. For its part, the government needs to encourage and support the formation of professional associations of healers in order to ensure a continuing dialogue between healers and health officials. Associations will also help to disseminate information among practitioners and assist in improving the quality of healing practices (Green & Makhubu 1984:1075).

According to Campbell (1998:153), Dr Qhing Qhing Dlamini, the Minister of Health of Swaziland, is of the opinion that the two systems of health care delivery are different and should stay that way. "The best option is for patients to use their own discretion and decide for themselves when to go to a healer and when to use the medical sector. There is definitely a place for both."

#### 2.8.3.5 Traditional medicine in Zimbabwe

In Zimbabwe, as in other developing countries of Africa, traditional medicine is a genuine health care alternative. However, Cavender (1991:362) points out that the two major cities in Zimbabwe, Harare and Bulawayo, offer health care choices beyond orthodox and indigenous medicine, including chiropractic, reflexology, homeopathy, acupuncture and ayurvedic medicine. Together they embrace the complexity of medical pluralism in Zimbabwe today.

In his study on the role and work of the African traditional healer in modern Zimbabwe, Chavunduka (1994) interviewed altogether 7810 traditional practitioners and some of their patients. According to Chavunduka (1986:32-34), traditional healers in Zimbabwe can be placed into eight main categories: spirit mediums, herbalists, spirit mediums who are also herbalists, diviners, diviners who also treat their patients, midwives, midwives who are also herbalists, and faith healers. Reynolds (1986:182) points out that the boundaries between categories are often blurred. Traditionally, the members of a community as a whole were responsible for monitoring the activities of practising healers and for disciplining those who committed anti-social acts. In addition, healers themselves often organised feasts or rituals which could be regarded as professional conferences. Chavunduka (1994:2) explains that such meetings controlled and disciplined practitioners in much the same way that churches control their priests.

During the country's early colonial period, the Rhodesian government and early Christian missionaries made considerable efforts to discredit the traditional healer's role for a variety of reasons (Chavunduka 1986:30). Firstly, many did not realise that traditional medicines were effective in curing a variety of illnesses. Secondly, they felt that healers encouraged the belief in witchcraft and led people to worship their ancestors instead of God. Consequently, in 1889 the Witchcraft Suppression Act was passed. The Medical Council also took part in these attempts to suppress the activities of healers. Modern medical doctors were not allowed to refer patients to traditional health care providers or work with them in any way. If they did, they committed a breach of ethics and were liable to penalties through the Medical Council (Chavunduka 1986:31).

It was only in the 1950s and 1960s that traditional healers in parts of Central and Southern Africa actively started promoting the value of traditional medicine. This was done largely through healers' associations (Cavender 1988:252). Chavunduka (1994:10) reports that in Zimbabwe healers were beginning to organise themselves in an attempt to regain public recognition for their contribution to society. At the same time public debate started,

particularly among the intellectuals, about the role of traditional healers and traditional medicine in modern Zimbabwe (Chavunduka 1994:12).

In 1980 Zimbabwe became independent (Arkovitz 1990:109). At independence the government of Zimbabwe, through the policy of the Ministry of Health, adopted the global conception of primary health care (Mutambirwa 1989:931). This also meant providing modern health care in areas that had been ignored by the previous Rhodesian government. The political party which won the general election in 1980 – the Zimbabwe African National Union (Zanu-PF) – expressed a favourable attitude towards indigenous medicine and assisted its development (Chavunduka 1994:11). In 1981, the Natural Therapists Act and the Traditional Medical Practitioners Act were passed. The Natural Therapists Act of 1981 regulates the organisation and registration of natural therapists, a term that includes homeopaths, naturopaths and osteopaths. In terms of this Act, it is an offence for an unregistered person to engage in the practice of these professions for gain. Licensing provisions deal with educational standards and required qualifications. The Traditional Medical Practitioners Act of 1981 made provision for the formal legal recognition of traditional healers in Zimbabwe and created the framework for the organisation of healers in the mould of the Western medical system. According to the WHO (2001:40), it is the most comprehensive piece of legislation on the practice of traditional medicine that has been enacted anywhere in the world. Sanders (1989:528) points out that the Act defines “practice of traditional medical practitioners” as “every act, the objective of which is to treat, identify, analyse or diagnose, without the application of operative surgery, an illness of body or mind by traditional methods” and makes it an offence for anyone not registered as a folk practitioner to practise folk therapy for gain.

Chavunduka (1986:63) reports that it was not easy to secure the enactment of the Bill. There was a lot of opposition particularly from Western-trained Zimbabweans, missionaries and the leaders of some Christian churches – less against traditional midwives and herbalists, and more against spiritual healers. Chavunduka (1994:18) states that the Traditional Medical Practitioners Act of 1981 assisted the development of traditional medicine in Zimbabwe in two main ways. Firstly, it recognised the Zimbabwe National Traditional Healers’

Association (ZINATHA) as the official association of traditional healers in the country. Secondly, it provided for the formation of a traditional medical council. Chavunduka (1986:35) points out that in terms of Section 3 (2) of the Act, the function and purpose of the Council shall be

- (a) to supervise and control the practice of traditional medical practitioners;
- (b) to promote the practice of traditional medical practitioners and to foster research into, and develop the knowledge of such practice;
- (c) to hold inquiries for the purpose of this Act;
- (d) to make grants or loans to associations or persons where the Council considers this necessary or desirable for, or incidental to, the attainment of the purposes of the Council.

The Council consists of twelve members, seven of whom, including the chairman and vice-chairman, are appointed by the Minister of Health after consultation with ZINATHA; the remainder are elected by registered folk therapists (Dauskardt 1990:355). Chavunduka (194:34) claims that members appointed or elected are registered traditional medical practitioners who have practised as healers for not less than five years. Chavunduka was appointed the first Chairman of the Council by the Minister of Health.

The Registrar of the Council is appointed by the Minister of Health in consultation with the Council. It is the duty of the Registrar to enter a registered healer's name, address, date of first registration and other such particulars as the Council may from time to time determine in the register (Chavunduka 1986:36). Applications for registration are submitted to the Registrar and then referred to the Council, which has the authority to grant registration if satisfied that the applicant possesses sufficient skills and ability to practise as a traditional medical practitioner and is of good character (Chavunduka 1994:36). Where appropriate, the Council may allow the applicant to practise as a qualified spirit medium. Furthermore, the Minister of Health may grant registration as an honorary traditional medical practitioner, with or without qualification as a spirit medium, to applicants of special standing. Registered healers may use the title "registered medical practitioner" or "registered spirit medium".

Registration of a traditional medical practitioner is now a legal requirement, and it is an offence for any person who is not registered as such to practise traditional medicine. In this context, section 31 (2) of the Act states that the person who, not being registered as a traditional medical practitioner

- (a) for gain practises or carries on business as a traditional medical practitioner, whether or not purporting to be registered; or
- (b) pretends, or by any means whatsoever holds himself out, to be a registered medical practitioner; or
- (c) uses the title 'Registered Traditional Medical Practitioner' or any name, title, description or symbol indicating or calculated to lead persons to infer that he or she is registered as a traditional medical practitioner

shall be guilty of an offence and liable to a fine not exceeding two thousand dollars or to imprisonment for a period not exceeding two years or to both such fine and imprisonment (Chavunduka 1986:36). Falsely claiming to be a registered spirit medium constitutes a similar offence.

The disciplinary powers of the Council are stated in Part IV of the Act (Chavunduka 1994:39). The Council may hold inquiries into an allegation that a registered practitioner has been guilty of improper or disgraceful conduct, or is grossly incompetent, or has performed any act appertaining to the practice of a traditional medical practitioner in a grossly incompetent manner. A registered practitioner who is found guilty of such conduct or who is grossly incompetent is liable to disciplinary measures which include cancellation or temporary suspension of registration (WHO 2001:40). Any person who is aggrieved by the decision of the Council may appeal against such decision to the Minister of Health. Funds of the Council consist of all fees and other moneys payable to the Council. The three main sources of funds are registration fees, court fees and fines (Chavunduka 1994:35).

The Traditional Medical Practitioners Act of 1981 recognised ZINATHA as the official association for traditional medical practitioners (Chavunduka 1994:13). Prior to the Act there were a number of small associations of healers in various parts of the country. Previous attempts to unite them had been unsuccessful. According to Chavunduka

(1986:37), some of the reasons why these associations remained weak, poorly organised and small were poor leadership, lack of government support and encouragement, and intense rivalry between the various groupings.

The present national body, ZINATHA, was founded on 12 July 1980. Its basic organ is a branch. Between the branches and the national leadership is the District Executive Committee (Chavunduka 1994:26). ZINATHA also has a central department of research and education (Chavunduka 1986:38). Chavunduka was elected the first President of ZINATHA. He was at the same time Head of the Department of Sociology and Dean of the Faculty of Social Studies at the University of Zimbabwe (Chavunduka 1994:11-12). Although not a practising traditional healer but an outsider, he was acceptable to all parties. He had worked among traditional healers as a researcher for twelve years. He had also been used by various smaller associations as an adviser in legal, political and administrative matters. As an educated leader, he was expected to fight the political battle for legal recognition more effectively. He was also regarded as a good administrator and a person who could be trusted in financial matters.

In order to join the Association, an application form is completed. People who cannot read or write are assisted. The first part of the application deals with personal details, the second with the applicant's professional background, e.g. training and area of specialisation. When joining, the individual pays a joining fee and thereafter an annual subscription fee (Chavunduka 1994:23).

ZINATHA's goals include (Cavender 1988:252):

- to promote traditional medicine and practice;
- to encourage research into traditional medicine and methods of healing;
- to promote training in the art of herbal and spiritual healing; and
- to cooperate with the Ministry of Health and establish better working relations between traditional and conventional medical practitioners.

The Association maintains practising standards and controls incompetence (Dauskardt 1990:355). The main mechanism of control is the register of traditional medical practitioners which is published from time to time. Copies of the register are sent to community leaders all over the country, and are also sold to members of the public (Chavunduka 1994:24).

In 1981, the Association published a list of what a healer may or may not do, including the following (Chavunduka 1986:38-39):

- If a patient shows no signs of improvement he must be advised to seek another opinion.
- Diseases which are more effectively treated by the conventional medical profession must be referred to a hospital or clinic without delay.

Practitioners who are believed to have doubtful qualifications have to appear before the National Disciplinary Committee which has the power to cancel an individual's membership and remove his name from the register of the Association (Chavunduka 1994:24). The National Executive Committee is the highest disciplinary body (Chavunduka 1994:31).

Since 1981, two health care systems have been officially recognised by the Government of Zimbabwe: (1) a traditional system with its origin in spiritual and herbal healing and (2) a Western, technologically-oriented system (Arkovitz 1990:109). Although the State is principally concerned only with the modern sector, it allows the traditional partner to develop on its own, without much government control and interference. Through their Association and Council, traditional healers were given the main power in the control of traditional activities. The official recognition made cooperation between the two medical systems possible and facilitated research into traditional medicine.

Chavunduka (1986:38) reports that ZINATHA's department of education has been active since 1981. By 1983 it had established two medical schools and four clinics. At the schools, students were taught the various uses of plants and other medicines, together with hygiene and simple book keeping (Chavunduka 1994:30). The teachers and examiners were members of ZINATHA who had a teaching background. One lecturer from the Medical

School of the University of Zimbabwe gave occasional lectures (Chavunduka 1994:30). After the two-year course in medicine, students serve a three-year apprenticeship in one of the clinics run by the Association (Chavunduka 1986:38). Spiritual healing, however, was never formally taught (Bourdillon 1989:31). As mentioned, cooperation between the two medical systems is now possible and encouraged. Consequently, attempts are also made to teach aspects of traditional medicine in schools, universities and training hospitals – although university authorities rejected the proposal to introduce a course on traditional medicine at the Medical School of the University of Zimbabwe (Chavunduka 1994:31).

Furthermore, seminars and workshops attended by both traditional healers and modern medical practitioners have been held since 1982. The first national workshop on traditional medicine and its role in the delivery of primary health care in Zimbabwe was held in 1985. Delegates from both sectors attended. The objectives of the workshop included the following (Chavunduka 1994:18-19):

- to investigate the role of traditional medicine in the primary health care programme;
- to establish a sound dialogue between practitioners of traditional and modern medicine;
- to investigate the impact traditional medicine can make on the national economy;
- to identify priority diseases;
- to develop mechanisms for patient referral;
- to stimulate research and development of traditional medicine; and
- to promote conservation and initiate cultivation of medicinal plants, flora and fauna.

The following were among the resolutions adopted at the end of the workshop (Chavunduka 1994:20-21):

- to compile a traditional medical pharmacopoeia;
- the government to establish a scientific research institute on traditional medicine;
- to cultivate/propagate traditional medicines of proven therapeutic value;
- to set up a pharmaceutical processing plant to manufacture pharmaceuticals from traditional medicines; and
- to teach traditional medicine in the Medical School of the University of Zimbabwe.

However, Chavunduka (1994:21) states that by 1994 many of the workshop resolutions had not yet been implemented .

Chavunduka (1994:40-41) states that although Zimbabwe opted for cooperation with traditional healers as official policy, the integration of the two medical sectors and full professionalisation of traditional healers were rejected (temporarily) for the following reasons:

Integration was likely to undermine the traditional medical system. The degree of formal subordination required was unacceptable and impracticable for certain types of healers. Another problem would be the remuneration of healers by the government. Full professionalisation would mean government control of the activities of traditional healers by means of laws and regulations. This could disrupt the healers' socio-cultural integration. It also implies a substantial risk of imposing some of the analytical, biomechanical concepts of modern medicine on the healer, thus forcing them to abandon those elements of traditional healing which cannot be easily accommodated within the framework of modern medical thinking. In addition, there is the likelihood of imposing the curatively-biased approach of the modern health care sector on the traditional one. Reynolds (1986:186) maintains that while professionalisation could facilitate the exchange of ideas, the formulation of a traditional pharmacopoeia, the monitoring of abuse, and a smooth system of referrals, there is a danger that the role that healers fulfil in their communities might be trivialised in the process.

However, following official recognition, there was a lack of progress in the further development of this policy option. Chavunduka (1994:37) points out that there were several obstacles. For example, registering all traditional healers is difficult when some are illiterate; many practitioners are old men or women who live in remote rural areas and are unable or unwilling to travel long distances to register; some spirit mediums argue that the spirit they inherited does not allow them to register, and policing the traditional sector is difficult, since many have no reliable postal addresses, and the Council has to rely on the few licence inspectors that have been appointed by ZINATHA.

Thus, by 1992, there were still a number of unregistered individuals who were carrying on business as traditional doctors, even though it is now an offence for any person who is not registered in terms of the Act to engage in the practice of traditional medicine for gain. Another difficulty in registration is differentiating between genuine healers and those who pass themselves off as such. Chavunduka (1986:65) explains that it is possible for someone with very little knowledge of traditional medicine to complete the required application form. It is useful, therefore, to ask officials of the Association's local branch to comment on the application received from the respective area. This procedure is time-consuming and expensive, however. Consequently, the Association invites and relies heavily on reports received from community members.

A further problem is that many healers are inexperienced in committee procedures and administration in general. Lastly, people who stand for and are elected to positions of authority tend to be herbalists, although herbalists are in a minority in the traditional sector in Zimbabwe, while today spirit mediums still form the elite group in the profession. Likewise, traditional midwives and faith healers have not been very active in the affairs of the Association. Although they are members, they are not considered qualified traditional medical practitioners by either spirit mediums or herbalists (Chavunduka 1986:66). Herbalists are more prominent in Association proceedings than members of all the other categories for a number of reasons (Chavunduka 1994:28-29), namely their desire to improve their status, that they have more formal education, receive some form of medical instruction and have to serve some kind of apprenticeship. The Witchcraft Suppression Act of 1889 also played a part in the promotion of herbalism, because it was more oppressive of spirit mediums. Other forces which favour empirical rather than spiritual medicine are Christianity, Western education and the attitude of some political leaders. In addition, tribalism and the desire for money and power have stood in the way of progress (Chavunduka 1994:280), together with both formal and informal opposition from modern as well as traditional practitioners. It should be pointed out that healers, although generally in favour of cooperation with the modern sector, often dislike the idea of working alongside doctors in hospitals and clinics, and usually prefer working in their own homes (Chavunduka 1986:41). On the other hand, many specifically African professionals see the

indigenous practitioners as a threat to their professionalism and thus militate against collaboration (Freeman & Motsei 1992:1189).

Furthermore, Kale (1995:549) points out that the Traditional Medical Council has not met since 1989 and referrals which do occur are mostly from the traditional to the modern sector. Research projects have not been carried out because of a shortage of funds and qualified research workers (Chavunduka 1986:38).

Another unresolved issue remains the reluctance on the part of medical aid societies to include traditional healers in their schemes. According to Chavunduka (1986:70), the main obstacles in this context are that many healers would find it difficult to complete the required medical forms; there may be no banking facilities in rural areas, and many practitioners live far from post offices.

According to Cavender (1988:252), a related problem is the issuing of sick certificates by traditional healers because “the ultimate objective of most indigenous healers in Zimbabwe is to enjoy the same legal status as conventional medical practitioners. Legal status here is interpreted to mean that the services of healers would be compensated by government and private medical aid programs, and that healers would have the same authority to justify a patient’s temporary or permanent leave from work”.

The two schools of traditional medicine established by ZINATHA, one in Harare and one in Bulawayo, closed down in 1983 and 1984, respectively.

Cavender (1988:253) considers the Association’s failure with regard to traditional medical schools as instructive in the sense that it is attributable, at least in part, to the fundamental problem of converting an essentially informal process of education into a formal one. In his view, the reason is that as long as the society (and government) perceive the informal process of becoming a healer as legitimate, there is no need or incentive to obtain formal training in the traditional art of healing. And as long as traditional medical knowledge remains highly idiosyncratic and protected by healers as

personal knowledge not to be shared with others, it will be almost impossible to establish a standard curriculum in, for example, the identification and application of the traditional *materia medica*.

As for ZINATHA itself, many members feel that they are not benefiting from their membership (Cavender 1988:252). Poor relations exist between the central office in Harare and some of the district committees. ZINATHA's goal of setting up education and research programmes in traditional medicine has not yet been achieved. On the positive side, dialogue between the two medical sectors has been established in many districts, and attempts have been made by the Association to cultivate certain plants of proven therapeutic value. The Ministry of Health has initiated a number of training programmes, although mainly for traditional midwives, and in 1990 ZINATHA set up its own department of AIDS prevention (Chavunduka 1994:22).

Chavunduka (1994:20) states that Zimbabwe recognises the important role played by traditional medical practitioners, and Cavender (1991:362) points out that the parties involved are essentially "comfortable with the current policy of cooperative coexistence". However, as part of the general thrust of cultural and socio-economic development, traditional medicine has yet to be methodically updated. Furthermore, to achieve a fruitful cooperation between the two sectors, there necessarily needs to be mutually beneficial two-way communication.

#### **2.8.4 Legal options for traditional medicine**

Kikhela, Bibeau and Corin (1981:96-99) state that there are four options for traditional medicine in African countries:

- traditional medicine is illegal (but the law is seldom enforced);
- traditional medicine is unofficially recognised (the state simply ignores it);
- traditional medicine is regulated by law (some healers receive official authorisation to practise);

- traditional medicine is “integrated” into primary health care (the option recommended by the World Health Organisation).

Legal prohibitions on traditional medicine are unrealistic. The effect of prohibitive legislation, where it exists, is minimal or non-existent (Stepan 1983:295). At the same time, legislation provides for the registration of folk therapists and the regulation of their practice in Ghana, Lesotho, Nigeria, Sierra Leone, Zimbabwe, Senegal, Burkina Faso and Namibia (WHO 2001: 31; 8; 28).

Countries like Botswana, Kenya, Zimbabwe, Tanzania and Uganda define areas such as community-based care, counselling and some forms of symptomatic treatment as appropriate areas for the involvement of traditional practitioners. Staugard (1991:22) points out that in some countries traditional healers and traditional birth attendants are identified as the missing link between the government health service and the majority of the population. In their role as community leaders and guardians of social norms, they may play an important role in channelling educational messages to the local communities and act as teachers and “change agents”. For example, a number of African governments use cooperation with traditional health practitioners in their national AIDS programmes.

Good(1987:302) points out, however, that published information about projects in Africa with healer involvement sanctioned at the national level is scarce and mainly related to Nigeria, Ghana, Swaziland and Zimbabwe. Most of the programmes involving traditional healers tend to single out herbalists and related specialists rather than spiritual healers and diviners. Opong (1989:611) cites the important PRHETIH (Primary Health Care Training for Indigenous Healers) Programme in Techiman, Ghana (see section 2.8.3.2).

In many instances and for a long time African countries engaged in a policy of non-intervention. Dunlop (1975:585) states that they implicitly recognise that the traditional system is widespread, that people demand such services, and that traditional practice is complementary to that provided by the modern health care sector. It is also acknowledged

that the biomedical model is inadequate or at best only partially equipped for treating the whole range of illnesses to be found in Africa (Last 1986:3).

From a politico-legal point of view, African countries have generally left their healers alone, legislating neither for nor against them (Fulder 1988:197). In practice this means that the state is officially concerned only with the modern medical sector, leaving the traditional one to develop on its own without state control. It also means that traditional health care is usually not included in the curricula of most medical schools – although there may be exceptions (de Jong 1991:8).

The reasons for African governments adopting a hesitant approach when it comes to acknowledging folk therapists as equals of medical doctors are that most feel that they should withhold full recognition until it becomes possible to formulate precise rules regarding their practice, and fear of charlatanism. Sanders (1989:529) points out that, in addition, to identify *bona fide* folk healers, classify them according to levels of training and expertise, specify qualification requirements for registration, and devise an appropriate code of ethics is a mammoth task. Moreover, governments also want to await the outcome of current research into the curative value of folk therapeutic techniques and substances. Anyinam (1987:807) contends that governments continue to drag their feet since recognition would mean full acceptance of responsibility for the activities of traditional healers.

## **2.9 CONCLUSION**

Medical pluralism is a global phenomenon. All medical systems can be conceived as pluralistic structures in which modern scientific medicine is just one component in competitive or complementary relationship to numerous alternative therapies (Leslie 1980:191). The argument is especially strong for developing countries where local medical systems are largely composed of indigenous systems, and where the emulation of costly models from industrialised nations is not only culturally but also economically inappropriate. Part of the renewed interest in traditional healing is therefore due to the fact

that there are inadequate health care resources to meet existing needs. It is increasingly recognised at both national and international levels that in order to achieve “Health for All” all available resources need to be utilised effectively (Oppong 1989:605). Accordingly, the WHO encourages its member states to accord priority to the development of primary health care within a policy of self-sufficiency and self-development using mostly local resources (Bibeau 1979:184).

The most important local resource is the vast human resources represented by the traditional medical sector. Thus, the most cogent reason for the radical development and promotion of traditional medicine is that it is one of the surest means to achieve total health care coverage of the world's population, using acceptable and economically feasible methods (WHO 1978:413). In the process, the positive aspects of the traditional health care system would be preserved, while the shortcomings should be corrected and eliminated (Lee 1983:1438).

Furthermore, apart from economic considerations, the cultural satisfaction derived from the utilisation of traditional health care plays an equally significant role. In addition, as has been shown worldwide, the exclusive systems, which give scientific medicine a legal monopoly of health care, have not abolished or displaced other practices, and many forms of alternative care satisfy demands which are not met by the official medical system (Leslie 1983:315). In particular, the biomedical model has proved inadequate or at best only partially equipped to treat the whole range of illnesses found in Africa. Traditional healers are ubiquitous and play a crucial role in providing services to the majority of the African population (Hess 1998:6). They represent an untapped resource which has enormous potential to treat many prevailing diseases and to educate people in all aspects of preventable conditions.

A satisfactory accommodation of the traditional health care system within the official sector is the main challenge. However, Freeman and Motsei (1992:1188) points out that the utilisation of traditional healers and their inclusion in the official health care system is a complex process, and has not been fully achieved anywhere in the world, although attempts

to train and utilise healers have been made in many developing countries, notably with regard to midwifery and mental health care. There is a long history of fear, suspicion, misunderstanding and mistrust fostered by different philosophies as well as language and communication difficulties between the two sectors. Moreover, there is the major obstacle of the largely “unregulated” state of traditional medicine and the lack of legal control.

The most basic and extensively applied approach to traditional medical systems available to governments is that of tacit recognition. The main problem here is that the state cannot regulate traditional practice nor can it include the traditional sector in official health care programmes, consequently depriving itself of an important health care resource. By adopting a legislation strategy, a government accords traditional healers a certain status and legitimacy (Dauskardt 1990:353). According to the Centre for Health Policy (1991:4), most importantly, however, it provides for some control over their organisation, registration and activities which will improve the standard of care. In this context it has also been shown that the global community faces similar regulatory problems as regards the status of non-conventional therapies which fall outside the official health care system of the respective countries and enjoy ever-increasing utilisation and popularity.

Chapter 3 examines the South African health care system and its various components, including the traditional health care sector.

## **CHAPTER 3. AN OUTLINE OF THE SOUTH AFRICAN HEALTH CARE SYSTEM**

### **3.1 INTRODUCTION**

The South African health care system may be regarded as embracing an official health care system, an informal health care sector that includes, *inter alia*, self-care and African traditional medicine, and alternative/complementary medicine as represented by the allied health professions. This chapter discusses the three components in a historical and legal context. At the same time particular emphasis will be placed on the respective socio-economic aspects of each sector, such as their accessibility and affordability. In this regard, frequent reference is made to the *South African Health Review (SAHR)*, 1998 to 2001.

### **3.2 THE OFFICIAL HEALTH CARE SYSTEM**

The health services which the government inherited in 1994 were a highly dubious legacy. Like the country, they had been fragmented into National, Coloured and White “own affairs”, four provincial and ten homeland health departments (*SAHR* 2000 chapter 2 p 3). There was an appalling inequity in access to services across the country, centred on urban-rural differences, racial groupings and economic power/poverty. Table 3.1 illustrates the inequity.

**TABLE 3.1 ACCESS TO PRIMARY HEALTH CARE IN 1995**  
 (% households with medical care less than 5 km away)

Eastern Cape	61,2
Free State	63,0
Gauteng	70,0
KwaZulu-Natal	54,3
Mpumalanga	64,3
Northern Cape	63,5
Northern Province	46,4
North West	60,3
Western Cape	72,9
African	
African urban	77,0
African rural	40,4
White	
White	72,2
Coloured	71,2
Indian	71,1
South Africa	62,2

Source: *SAHR* (1998, ch 2 pp 7-8)

From table 3.1 it is clear that Africans in rural areas have the least access to health care; the majority of this group are more than 5 km away from care facilities.

In addition, notwithstanding the inequities between provinces, far greater inequalities exist within provinces, and there are wide differences in the range and quality of services offered. The most marked difference is that between rich and poor, which still exists. According to the *SAHR* (1998 chapter 1), “South Africa, in 1998, remains a land of stark contrasts between those that have and those that have not. A land where some people have the best standards of living, good health and access to health care, while some have very poor living standards, a great deal of ill health and poor access to health care”.

Many of the problems such as the urban-rural divide, still exist in spite of progress made since 1994. For example, the district health expenditure per capita is significantly higher in urban than in rural districts (see *SAHR* 2000, chapter 6, p 5). Another indicator is the primary health care (PHC) utilisation rate – the average number of visits per person per year, which is heavily dependent on access to PHC facilities, their staffing, their drug supply and the perceived quality of care. According to the *SAHR* (2000, chapter 6 p 6), the following was found:

	Mount Frere	Mount Currie	Uitenhage
PHC utilisation rate	0,48	0,88	3,5

The data suggests that urban districts experience an overall utilisation rate about three times higher than their rural counterparts.

Table 3.2 below illustrates the problem of the remaining difference between provinces (personal communication with the Department of Health).

**TABLE 3.2 PROVINCIAL DISTRIBUTION OF IDENTIFIED OCCUPATIONAL GROUPS**

- filled posts as at 28 February 2001

	Professional nurses	Medical practitioners	Medical specialists	Dental practitioners	Pharmacists
EC	6 170	792	172	47	111
FS	2 907	559	235	27	80
Gau	8 016	1 750	1 480	224	293
KZN	9 223	1 837	523	64	303
Mpu	2 273	429	24	48	90
NC	845	199	16	11	21
NP	5 043	658	47	37	128
NW	2 885	395	47	42	66
WC	4 133	1 123	1 162	108	214
Total	4 1511	7 676	3 706	608	1 354

Source: Personal communication with the Department of Health

If expressed per 10 000 of the population, the distribution of health personnel per province is as follows (personal communication, DOH):

**TABLE 3.3 HEALTH PERSONNEL PER 10 000 AS AT NOVEMBER, 2001**

	Professional nurses	Medical practitioners	Medical specialists	Pharmacists
Eastern Cape	16,61	2,04	0,72	1,18
Free State	24,69	3,96	1,59	1,62
Gauteng	33,67	8,31	4,61	5,29
KwaZulu-Natal	19,08	3,85	1,47	1,90
Mpumalanga	12,71	2,64	0,59	1,24
Northern Cape	19,60	3,73	0,60	1,32
Northern Province	10,81	1,22	0,24	0,47
North West	16,58	1,86	0,52	1,27
Western Cape	30,21	9,69	5,44	4,03
National	21,05	4,35	1,99	2,29

Source: Personal communication with the Department of Health

The major difference in access to health services is still between people who predominantly use the private sector through membership of medical aids and those who rely mainly on the public sector. Nevertheless, great strides in access to essential health care have been made through the White Paper for the Transformation of the Health System in South Africa (Government *Gazette* No 17910, Notice 667 of 1997) and the National Health Bill of 2001. The White Paper represents the new national health policy. The aim of Government (Preface) is to develop a unified health system capable of delivering quality health care to all citizens, “efficiently and in a caring environment”, through a primary health care (PHC) approach and based on a district health system (DHS). The PHC team acts at the community level. It is envisaged to consist of a mix of health personnel with appropriate skills to deal with common conditions, and to execute prompt referrals to the next level of care where necessary (White Paper section 4.1.2). A PHC team should include community health nurses, midwives, doctors, PHC nurses, enrolled nurses and nursing auxiliaries, oral hygienists/therapists, clerical and support staff and rehabilitation personnel. The existing PHC team: population ratio of 1: 30 000 should be reduced to 1: 15 000 over a five-year period (White Paper section 4.1.2).

The legal framework for this transformed health system is established in the National Health Bill of 2001, which is expected to replace the 1977 Health Act. The passage of the Bill was complicated by the complex constitutional environment, that is the division of powers between the different spheres of government. Of particular significance therefore, are the sections providing for the creation of a district health system (DHS) and outlining its functions. Related are the processes for the demarcation of local government boundaries and the establishment of fully accountable municipal governance structures (SAHR 1999, chapter 2 p 11).

The National Health Bill is based on the principles of accessibility and affordability of essential health care. Its purpose is to establish a national health system which

- i) encompasses public, private and non-governmental providers of health services; and

- ii) provides the population of the Republic with the best possible health services that available resources can afford (section 3 (a)).

### 3.2.1 The public and private sectors of the National Health System (NHS)

This aspect relates to the accessibility and affordability of health care services. As stated above, the major difference in access occurs between those who can afford medical aid and those who cannot, who rely on public services, including the non-insured population. Thus, while approximately 18%, nearly one in five South Africans, belong to a medical aid scheme, this group has access to 85% of the pharmacists and 60% of the medical specialists working in South Africa, and has about four times as much spent on their health care than people who do not belong (SAHR, 1998, chapter 1 p 1). Likewise, nearly 60% of health spending occurs within the private sector but benefits less than a quarter of the population (SAHR, 2000, chapter 7 p 3). The group belonging to medical schemes comprises mainly people who live in towns and cities and who are employed, often earning high incomes.

Table 3.4 depicts the distribution of health personnel between the two sectors for the years 1989/90 and 1998.

**TABLE 3.4 PROPORTION OF HEALTH PERSONNEL IN THE PRIVATE SECTOR**

	1989/90	1998
General practitioners	53%	62%
Specialists	66%	77%
All categories of nurses	21%	43%
Pharmacists	89%	88%
Dentists	93%	89%

Source: SAHR (1999, ch 6, p 3)

Table 2.4 indicates that in 1998, 62% of general practitioners, 77% of specialists, 88% of pharmacists and 89% of dentists worked for the private sector – meeting the needs of approximately one- fifth of the population. In 1989/90 nurses were the only category of staff with a greater number working in the public sector, while the 1998 data suggests that this is now changing – nearly half of all nurses are now employed in the private sector.

Table 3.5 depicts the same trend in favour of the private sector.

**TABLE 3.5 THE PUBLIC/PRIVATE DIVIDE IN SOUTH AFRICAN HEALTH, MID-1999**

Category	Total	Public sector	Private sector	Public:private ratio
GPs	19 729	27,4 %	72,6 %	1: 2,65
Specialists	7 826	24,8 %	75,8 %	1: 3,04
Dentists	4 269	7,4 %	92,6 %	1: 12,51
Pharmacists	4 410	23,7 %	76,3%	1: 3,21

Source: *SAHR* (1999, ch 16, p 15)

Figures provided by the Department of Health and the respective Councils (personal communication) for 2001 show only a slight improvement as far as staffing in the public sector is concerned (see table 3.6).

**TABLE 3.6 HEALTH PERSONNEL IN THE PUBLIC SECTOR, 2001**

Category	Posts filled in public sector	Total registered with Council	% in public sector
General practitioners	7 676	30 149	25,5
Medical specialists	3 706	8 713	42,5
Dental practitioners	608	4 522	13,4
Pharmacists	1 354	5 976	22,7

Source: Personal communication with the Department of Health

However, while the two sectors are often perceived as two distinct entities – a public sector providing care for the majority of the population, and a private sector caring for the wealthy who are able to afford medical scheme coverage – the Government’s goal is to build constructive public-private partnerships from which both should benefit. According to section 2.4 of the White Paper (1997), “the activities of the two sectors should be integrated in a manner that makes optimal use of all available health care resources; the public-private mix of health care should promote equity in service provision”.

This policy is confirmed by the National Health Bill of 2001. In terms of section 57 the Minister must prescribe mechanisms to enable a coordinated relationship between public and private health establishments in the delivery of health services. Similarly, section 29 provides that the National Health Authority must function in an advisory capacity to the Minister, for example on policy concerning any matter that will protect, promote, improve and maintain the health of the population, including the designing and implementation of programmes to provide for effective referral of patients, or to enable integration of public and private health establishments.

Goudge (*SAHR*, 1999, chapter 6 p 1) contends that the public sector can benefit from interaction with the private sector as long as the Government is successful in its attempts to adequately regulate the latter. Private sector behaviour should be influenced both through legislation and through a framework of incentives (financial and non-financial).

One of the major steps taken by the Government to reduce inequity amongst those who belong and those who wish to belong to medical aid schemes was the passing of the Medical Schemes Act 131 of 1998, which was finally implemented in January 2000, and repealed the Medical Schemes Act, 1967. Its purpose includes the achievement of the following objectives: to consolidate the laws relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes and the appointment of a Registrar; to make provision for the registration and control of certain activities of medical schemes, and to protect the interests of members.

Section 1 provides the following definitions:

“Medical scheme” means any medical scheme registered under section 24 (1).

The “business of a medical scheme” means the business of undertaking liability in return for a premium or contribution-

- (a) to make provision for the obtaining of any relevant health service;
- (b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service.

“Relevant health service” means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object-

- (a) the physical or mental examination of that person;
- (b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
- (c) the giving of advice in relation to any such defect, illness or deficiency;
- (d) the giving of advice in relation to, or treatment of, any condition arising out of pregnancy, including the termination thereof;

- (e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof.

Section 20 (1) provides that no person shall carry on the business of a medical scheme unless that person is registered under section 24.

Any medical scheme registered under this Act shall assume liability for and guarantee the benefits offered to its members and their dependants in terms of its rules (section 26(1) (b)).

In terms of section 29, the Registrar shall not register a medical scheme, and no medical scheme shall carry on any business, unless provision is made in its rules for a number of matters, one of which is contained in subsection (n):

the terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and shall not provide for any other grounds, including age, sex, past or present state of health, of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants other than for the provisions as prescribed.

A further relevant matter for which provision has to be made in the rules is referred to in subsection (o), namely "the scope and level of minimum benefits that are to be available to members and dependants as may be prescribed".

Section 29 and the rules for which it makes provision before a medical scheme may be registered by the Registrar are of the utmost significance. Firstly, they provide for a compulsory minimum benefits package which all schemes are obliged to offer, and which the Department of Health is to review every two years in consultation with the Council for Medical Schemes, provincial health departments and consumer representatives

(SAHR, 1999, chapter 2 p 2). Secondly, they disallow “risk-rating” on the basis of age, sex, current health status and medical history, factors which previously made medical schemes extremely expensive for those who needed care the most. The result was an increasing number of elderly and critically ill people falling back into the public hospital system at the point when they required the most extensive levels of health care (SAHR, 2000, chapter 8 p 3). At the same time, the potential for cross-subsidisation not only of the elderly and ailing by the young and healthy, but also of low by high-income earners is created.

Furthermore, the Act provides for a number of requirements aimed at ensuring improved governance, financial administration and accountability of medical schemes. The Council of Medical Schemes will gain corporate status and be funded in part by levies on medical schemes, while remaining ultimately accountable to the Minister of Health. In terms of section 25 of the National Health Bill 2001, one of the functions of the National Department of Health as listed in Schedule 1 is to regulate medical aid schemes.

Cumulatively, the amendments will reform the financing of private health care, improve equity of access to private medical insurance and lead to greater efficiency in the use of resources in this sector.

Another aspect is that overall, public health services are still heavily dependent on general tax revenue. In recent years, user fees and social health insurance (SHI) have received attention as alternative sources of financing. The regulations to the Medical Schemes Act which were finally published on 22 October 1999 and came into effect on 1 January 2000 could confer significant advantages on the public sector which has virtually obtained a preferred provider status. “If public hospitals and structures market their services appropriately, they have the potential to attract many more private patients and thereby a greater share of revenue from the private medical aid market” (SAHR, 1999, chapter 2 p 2).

### 3.2.2 Legal aspects of the South African official health care system

The Health Professions Act 56 of 1974 is the “charter” of the medical practitioner in South Africa (Strauss & Mare 1992:15). Apart from medicine, it also governs the practice of dentistry and psychology, as well as the supplementary health services with the exception of nursing, midwifery and pharmacy which are regulated by their own laws. Examples of those who supply such supplementary services include: occupational therapists, physiotherapists, medical technologists, optometrists, radiographers, speech therapists and audiologists, dietitians, medical physicists, masseurs, oral hygienists, food inspectors, biomedical engineers, medical scientists, clinical biochemists and orthopaedic footwear technicians. The Act replaced the South African Medical and Dental Council as established by Act 13 of 1928 with the Interim National Medical and Dental Council (INMDC) of South Africa.

The Medical, Dental and Supplementary Health Service Professions Amendment Act 89 of 1997 effected some major changes in the principal Act of 1974. Its purpose is, *inter alia*, to provide for the establishment of the Health Professions Council of South Africa and professional boards for the various health professions; to abolish the INMDC; and to provide for control over the education, training, registration and practices of health professionals.

Section 3 states the objects of the council which include the following -

- (a) to co-ordinate the activities of the professional boards established in terms of this Act and to act as an advisory and communicatory body for such professional boards;
- (b) to promote and to regulate inter-professional liaison between registered professions in the interest of the public;
- (c) to determine strategic policy and to make decisions in terms thereof, with regard to the professional boards and the registered professions, for matters such as finance, education, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, interprofessional matters and maintenance of professional competence;

- (d) to consult and to liaise with relevant authorities on matters affecting the professional boards in general;
- (e) to assist in the promotion of the health of the population of the Republic.

In terms of section 4 (d), the council may make rules on all matters which it considers necessary or expedient in order that the objects of this Act may be achieved. Section 5 (1) provides for a more representative council which shall consist of the following members, namely -

- (a) not more than 25 persons designated by the professional boards;
- (b) one person in the employment of the Department of Health, appointed by the Minister;
- (c) one person in the employment of the Department of Education, appointed by the Minister of Education;
- (d) nine persons registered in terms of this Act, appointed by the Minister;
- (e) one person from the South African Medical Services, appointed by the Minister of Defence;
- (f) three persons appointed by the Committee of University Principals;
- (g) two persons appointed by the Committee of Technikon Principals;
- (h) nine public representatives, one from each province, appointed by the Member of the Executive Council responsible for health in each province;
- (i) one person versed in law, appointed by the Minister.

Section 15 (1) deals with the establishment of professional boards which the Minister shall, on the recommendation of the council, establish in regard to any profession in respect of which a register is kept in terms of this Act.

Section 15A includes amongst the objects of the professional boards

- to consult and liaise with other professional boards and relevant authorities on matters affecting professional boards;
- to assist in the promotion of the health of the population of the Republic on a national basis;

to control and to exercise authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with, any profession falling within the ambit of the professional board;

to promote the standards of training;

to maintain and enhance the dignity of the profession and the integrity of the persons practising the profession; and

to guide the profession and to protect the public.

The general powers of professional boards are contained in section 15B. In terms of this section a professional board may, *inter alia*,

remove any name from a register in such circumstances as may be prescribed, or, upon payment of the prescribed fee, restore thereto, or suspend a registered person from practising his or her profession pending the institution of a formal inquiry in terms of section 41;

appoint examiners and moderators, conduct examinations and grant certificates, and charge such fees in respect of such examinations or certificates as may be prescribed;

subject to prescribed conditions, approve training schools; and

upon application by any person, recognise any qualification held by him or her.

Chapter II (sections 16-35) deals with control over training and registration. In terms of section 16 (1), no person or educational institution, excluding a university or a technikon, may offer or provide any training having as its object to qualify any person for the practising of any profession to which the provisions of this Act apply or for the carrying on of any other activity directed to the mental or physical examining of any person or to the diagnosis, treatment or prevention of any mental or physical defect, illness or deficiency in man, unless such training has been approved by the professional board concerned.

Any person or educational institution wishing to offer such training has to apply in writing to the professional board concerned for its approval (section 16 (2)).

Section 17 makes registration a prerequisite for practising and provides, *inter alia*:

Section 17 (1) No person shall be entitled to practise within the Republic-

- (a) the profession of a medical practitioner, dentist, psychologist or as an intern or an intern psychologist or any profession registrable in terms of this Act; or
- (b) except in so far as it is authorised by the provisions of the Nursing Act, 1978, the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982, the Pharmacy Act, 1974, and sections 33, 34 and 39 of this Act, for gain any other profession the practice of which mainly consists of-
  - (i) the physical or mental examination of persons;
  - (ii) the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in man;
  - (iii) the giving of advice in regard to such defects, illnesses or deficiencies; or
  - (iv) the prescribing or providing of medicine in connection with such defects, illnesses or deficiencies,

unless he is registered in terms of this Act.

Every person desiring to be registered in terms of this Act shall apply to the registrar and shall submit the relevant qualifications together with such proof of identity and good character as may be required by the professional board concerned (section 17 (2)).

If the registrar is satisfied that the qualifications and the other supporting documents satisfy the requirements of this Act, he shall, upon payment by the applicant of the prescribed registration fee, issue a registration certificate authorizing the applicant to practise the profession within the Republic (section 17 (3)).

Section 18 requires the registrar to keep separate registers in respect of medical practitioners, dentists, interns, student interns, medical students, dental students, psychologists, intern-psychologists and psychology students or any other health professionals as determined by the council and persons doing community service in terms of section 24A.

The professional board concerned may direct the registrar to remove from or restore to the register the name of any person on stipulated grounds (section 19).

Any person who is aggrieved by any decision of the council, a professional board or a disciplinary appeal committee, may appeal to the appropriate High Court against such decision (section 20 (1)).

The registers shall be kept at the office of the council (section 21).

Section 24 deals with the qualifications for registration which the Minister may, on the recommendations of the council, prescribe, and which shall entitle any holder thereof to registration in terms of this Act.

Section 24A obliges any person registering for the first time for a profession listed in the regulations in terms of this Act to perform remunerated medical community service for a period of one year. (NB. Compulsory community service commenced on 1 July 1998 for doctors and in 1999 for dentists.)

Section 26 makes compliance with certain conditions relating to continuing education and training a prerequisite for continued registration.

Section 31 (1) provides that every university, technikon and other educational institution at which the relevant qualifications can be obtained shall furnish the council on its request with full particulars as to -

- (a) the minimum age and standard of general education required of students;
- (b) the course of study, training and examinations required of a student before such qualification is granted;
- (c) the results of any examinations conducted by it.

The Minister may, on the recommendation of the council, by regulation define the scope of any other health profession registrable in terms of this Act by specifying the acts which shall be deemed to be acts pertaining to that profession (section 33 (1)). In terms of

subsection (2), a professional board, established under section 15 in respect of any other health profession, shall register entitled persons under this Act.

Registration is a prerequisite for practising a profession in respect of which a professional board has been instituted (section 34).

Chapter III deals with offences committed by unregistered persons for practising while unregistered:

medical practitioners and interns (section 36);

psychologists and intern-psychologists (section 37);

dentists (section 38);

as well as with the prohibition of performance for gain of certain acts deemed to pertain to other health professions by unregistered persons registrable in terms of this Act (section 39).

Chapter IV sets out the disciplinary powers of professional boards that were previously vested in the council. In terms of section 41 (1) a professional board shall have power to institute an inquiry into any complaint, charge or allegation of unprofessional conduct against any person registered under this Act, and, on finding such person guilty of such conduct, to impose any of the penalties prescribed in section 42 (1).

Section 52 regulates the dispensing of medicines by medical practitioners, dentists or other persons registered in terms of this Act.

Nurses and pharmacists are regulated by the Nursing Act 50 of 1978, as amended by the Nursing Amendment Act 19 of 1997, and the Pharmacy Amendment Act 1 of 2000, respectively.

The Nursing Amendment Act, 1997, has as its purpose to consolidate the laws relating to the professions of registered or enrolled nurses, nursing auxiliaries and midwives. It establishes the South African Nursing Council (section 2), which – like the Health Professions Council discussed above – has become more representative of the community. Amongst the objects of the council is to control and to exercise authority in

respect of all matters affecting the education and training of, and the manner of the exercise of the practices pursued by registered nurses, midwives, enrolled nurses and nursing assistants (section 3 (b)). Chapter 2 deals in detail with education, training, registration and enrolment (sections 15-27).

The Pharmacy Amendment Act 1 of 2000 establishes the new South African Pharmacy Council and contains provisions relating to the licensing of pharmacies as well as the education, training, registration and practice of pharmacists. Significantly, the Act removes the former restrictions that only pharmacists may own pharmacies. Pharmacies must, however, still be conducted under the continuous personal supervision of a pharmacist. The opening up of pharmacy ownership to non-pharmacists may be regarded as an important measure to ensure the more adequate distribution of pharmacies in rural and other under-served areas (*SAHR*, 1998, chapter 3 p 3). The Act also provides for the performance of remunerated community service in a state institution by all pharmacists applying for registration with the Pharmacy Council. This brings the profession in line with those governed by the Medical, Dental and Supplementary Health Service Professions Amendment Act, 1997. As mentioned, doctors and dentists started community service in 1998 and 1999, respectively.

Further Acts of relevance to the health professions are the Medicines and Related Substances Control Amendment Act 90 of 1997, the South African Medicines and Medical Devices Regulatory Authority Act 132 of 1998 and the Medical Schemes Act 131 of 1998.

They all regulate certain aspects of medical practice and are therefore briefly discussed in the following paragraphs – with the exception of the Medical Schemes Act which has been scrutinised above (see 3.2.2).

The Medicines and Related Substances Control Act 101 of 1965 provided for the registration of medicines intended for human and animal use, for the registration of medical devices, for the control of medicines, scheduled substances and medical devices,

and for the establishment of a Medicines Control Council. The purpose of the Amendment Act of 1997 includes the following:

to provide that the council shall be a juristic person;

to make provisions for the constitution of the council;

to provide for -

the prohibition on the sales of medicines which are subject to registration and are not registered;

procedures that will expedite the registration of essential medicines, and for the re-evaluation of all medicines after five years;

measures for the supply of more affordable medicines in certain circumstances;

the licensing of certain persons to compound, dispense or manufacture medicines;

the generic substitution of medicines;

the establishment of a pricing committee;

the regulation of purchase and sale of medicines by wholesalers; and

to regulate anew the Minister's powers to make regulations.

Notably, it is the provisions for international tendering and for "parallel importation" of medicines into South Africa; the promotion of generic substitution, and the establishment of a pricing committee to effect single exit prices that were obviously introduced as measures to bring down the costs of medicines, thereby making health care more accessible and affordable (*SAHR*, 1998, chapter 3 p 3). However, the Act has been put on hold following an action brought in the Pretoria High Court by the Pharmaceutical Manufacturers' Association (PMA) whose main objection relates to the provision for parallel importation, the circumvention of statutory patent protection in some circumstances, and the increased power of the Minister vis-à-vis the Medicines Control Council. The Association is seeking an interdict against the commencement of the Act until its legal validity has been clarified.

In the wake of the Medicines and Related Substances Control Amendment Act, 1997, followed the South African Medicines and Medical Devices Regulatory Authority Act 132 of 1998. The relevant Bill was passed towards the end of 1998, following the appointment by the Minister of Health in January 1998 of a Review Team to review the existing process for the regulation of medicines in South Africa, and the subsequent appointment of a Medicines Regulatory Authority Transformation Task Team which was to investigate mechanisms for the implementation of the Review Team's recommendations (SAHR, 1998, chapter 3 p 5).

The Act provides for the establishment of the South African Medicines and Medical Devices Regulatory Authority (SAMMDRA) to replace the Medicines Control Council. The management of the Authority is to be the responsibility of a board appointed by the Minister for that purpose. The primary object of the Authority is to provide for the monitoring, evaluation, regulation, investigation, inspection, registration and control of medicines, complementary medicines, veterinary medicines, clinical trials and medical devices as well as related matters in the public interest (section 5). It should be noted that for the first time in South Africa, provision is made for an effective process to register and regulate complementary medicines.

Section 1 defines "medicine" and "complementary medicine". It stipulates:

"orthodox medicine" or "medicine" means any substance or mixture of substances intended to be used by, or administered to, human beings for any of the following therapeutic purposes:

- (a) treating, preventing or alleviating symptoms of disease, abnormal physical or mental state or the symptoms thereof;
- (b) diagnosing disease or ascertaining the existence, degree or extent of a physiological condition;
- (c) otherwise preventing or interfering with the normal operation of physiological function, whether permanently or temporarily and whether by way of terminating, reducing, postponing or increasing or accelerating the operation of that function.

The definition of “complementary medicine” is stated and discussed below (see section 3.3.2).

Chapter IV of the Act deals with the registration of medicines, complementary medicines, veterinary medicines and medical devices. In terms of section 24 (4) the Authority may determine different processes or guidelines for the evaluation of orthodox medicines, complementary medicines, and veterinary medicines or devices. Any registration under this section must, in the public interest and so as to ensure the quality, safety and efficacy of medicines or devices, be valid for such period as may be determined by the Authority and may be subject to stipulated conditions (section 24 (9)).

Significant portions of the Medicines and Related Substances Control Amendment Act, 1997, are also repealed by this Act, with the result that the 1997 Amendment Act now deals mainly with measures specifically aimed at ensuring that affordable medicines are made available to the public.

The Act provides for the continuation of Regulations and Schedules of Substances which in terms of the Medicines and Related Substances Control Act, 1965, had been in existence, subject to their consistency with the Act and any repeal or amendment of them by a competent authority.

On 30 April 1999 the President issued Proclamation R49 of 1999, Government Gazette No 6519, to the effect that the Act would come into operation on that day. However, the promulgation was precipitate since it occurred without the necessary regulations or schedules being in place, thus rendering the entire medicines regulatory system inoperative (*SAHR*, 2000, chapter 3 p 11). An initial application for the reversal of the promulgation notice was refused by the Pretoria High Court. On appeal by one of the applicants, the Pharmaceutical Manufacturers’ Association (PMA), a full bench of the High Court found that the original notice of promulgation was, indeed, invalid. This decision was, in turn, subjected to review by the Constitutional Court and upheld, albeit

for different reasons. The result of the Constitutional Court's decision means that the Medicines and Related Substances Control Act 101 of 1965, is still in place.

### **3.3 HEALTH CARE PROVISION OUTSIDE THE OFFICIAL HEALTH CARE SYSTEM**

Health care outside the official sector is principally provided through self-care, African traditional medicine and “alternative/complementary medicine” in the form of the allied health professions.

#### **3.3.1 Self-care**

Self-care – or the lay sector – represents an important part of every health care system. Cavender (1991:362) points out that it is culturally universal that every adult individual possesses some knowledge of self-healing, and part of this knowledge is shared with other members of the family and local community.

Self-treatment is generally the first therapeutic intervention resorted to by most people across a whole range of cultures (Kleinman 1980:81), including the people of South Africa, before a traditional, orthodox or alternative practitioner is sought for medical assistance. Thus, self-care is at the basis of what Schwartz (in Cavender 1991:367) refers to as the “hierarchy of resort in curative practice”. Notably, the various layers of this “hierarchy” then interact with each other since patients pass freely from one to the other.

In the US and Taiwan, for example, it has been established that roughly 70 to 90 percent of all illness episodes are managed within the lay sector (Kleinman 1980:367). In general, however, although the lay sphere of care is the largest component of any health care system, it is the least studied and no recent data is available. Similarly, Joubert, Sebata and van Reenen (1984:129) report that little is known about the nature and extent of self-medication in African communities. In a study of 600 households in Ga-Rankuwa,

Joubert et al found that various medicines were present in 67% of the homes. Of these, 9,4% were African traditional medicines and 89,2% Western medications (78,5% over-the-counter medicines; 5,3% patent medicines and 5,3% prescription medicines). The major source of the medicines found were pharmacies. Westaway (1990:34) studied a peri-urban black community near Pretoria with regard to health complaints and type of medical assistance sought, and found a paucity of information on the subject of self-care. The current researcher found no other figures in the literature review.

Self-care is gaining more and more official recognition, and recent health policies stress the importance of individual responsibility for their own health, as well as of community participation in health care. For example, in chapter 2, section 2.5.1 the White Paper for the Transformation of the Health System in South Africa, 1997, provides that

All South Africans should be equipped with the information and the means for identifying behavioural change conducive to improvement in their health.

Much of the progress made in improving the health status of individuals depends on the existence of healthy environments and lifestyles. It is crucial, therefore, to involve individuals, families and communities in this process.

And section 2.5.2 develops this idea:

People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services.

Likewise, “the essential health care package should be negotiated between the providers and the communities, to ensure that priorities perceived by the communities are addressed and that communities have a clear understanding of their entitlements” (section 2.5.2).

Similarly, section 8 of the National Health Bill 2001 provides for the right of health care users to participate in any decision affecting his or her personal health and treatment.

The promotion of community participation in the planning, provision and evaluation of health services is listed in Schedule 1 (national functions); Schedule 2 (provincial functions) and Schedule 3 (district functions) of the same Bill.

In addition, community participation in legislative processes was encouraged through public hearings organised by the National Assembly Portfolio Committee on Health on all health bills which were passed by Parliament in 1998, with the exception of the Sterilisation Bill.

Osibogun (2001:11) confirms that it is crucial that individuals and families assume responsibility for their own health and welfare and that of all others in the community, and develop the capacity to contribute to their own and the community's development. "The sooner self-help is taken into account as one of the basic concepts of primary health care in all countries, the likelier it will be that we shall move towards achieving health for all" (Osibogun 2001:12). Osibogun (2001:13) goes on to say, "People must chip in their own contribution and assume responsibility for their own health, while administrators must discharge their responsibilities equitably. Such partnerships will ensure that health programmes have a better chance of success, because health services will be consistent with local perceptions of health needs and managed with the support of local people".

According to Robinson (1980:415- 420), people have always banded together to solve their common difficulties and promote their mutual interests. While governments have a responsibility for the health of their people, so the people of any country have the right and duty to participate individually and collectively in the planning and implementation of their health care. Self-care is a feature of nation-building projects which has a direct effect on the health of the people.

### 3.3.2 The sector of the allied health professions

“Alternative” or “complementary” medicine in South Africa received new legal status as well as statutory definition through the Chiropractors, Homeopaths and Allied Health Service Professions Second Amendment Act 2000, which defines “allied health service profession” as embracing the profession of ayurveda, Chinese medicine and acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, phytotherapy, therapeutic aromatherapy, therapeutic massage therapy or therapeutic reflexology, or any other profession contemplated in section 16 (1) to which this Act applies (section 1). The respective practitioners are those registered in terms of this Act. The purpose of the Act includes the following: to amend the Chiropractors, Homeopaths and Allied Health Service Professions Act 1982; to establish the Allied Health Professions Council of South Africa; to provide for the establishment of professional boards; to regulate the relationship between the new Council and the professional boards; and to make provision for matters relating to the responsibility, accountability, democratisation and transparency of the Council and professional boards.

The establishment of the Allied Health Professions Council of South Africa is provided for in section 2; its objects are stated in section 3 and include the following:

- to assist in the promotion and protection of the health of the population of the Republic;
- to govern, administer and set policy relating to the professions registered with the council;
- to control the practice of the professions and to investigate in accordance with the provisions of this Act complaints relating to the affairs of practitioners and students;
- to control the registration of persons in respect of any profession and to set standards for the training of intending practitioners.

The general powers and constitution of the council are dealt with in sections 4 and 5, respectively. Section 10A provides for the establishment of professional boards, section 10B for their constitution. The objects of professional boards are outlined in section 10C, their powers in section 10D. The appointment of the registrar is dealt with in section 11.

In terms of section 16, the Minister may, at the request of the council, by notice in the Gazette declare the provisions of the Act to be applicable to any profession which has as its object the promotion of health, or the treatment, prevention or relief of physical or mental defects, illnesses or deficiencies in humans. Excluded are the professions of

- (a) Ayurveda, chiropractic and homeopathy;
- (b) naturopathy, osteopathy and phytotherapy, for which professional registers shall be re-established with effect from the date of commencement of this Act;
- (c) Chinese medicine and acupuncture, therapeutic aromatherapy, therapeutic massage therapy and therapeutic reflexology, for which professional registers shall be established with effect from the date of commencement of this Act.

Section 16 (3) provides that the Minister may, subject to the Medicines and Related Substances Control Act, 1965 and to the approval of the Medicines Control Council, on the recommendation of the council, by regulation prescribe access to and availability of medicines relative to the professions registered in terms of this Act.

Section 16A deals with control over training and states that no person or educational institution shall offer or provide any education or training in any allied health profession to which the provisions of this Act apply, unless such education or training has been considered by the relevant professional board and approved by the council after considering a recommendation by the relevant board.

The prescribing of qualifications is provided for in section 16B: the Minister may from time to time, on the recommendation of the council, prescribe the qualifications obtained by virtue of examinations conducted by an educational institution or examining authority which entitle any holder thereof to registration under this Act; provided that the council

must first consult the relevant professional board before making a recommendation to the Minister relating to a qualification to be prescribed.

Section 23 (1) provides that the council may, in respect of a practitioner registered in any allied health profession in terms of this Act, institute an inquiry into any written complaint, charge or allegation of unprofessional conduct against such practitioner.

Section 24 deals with penalties for unprofessional conduct.

In section 31 provision is made for offences and penalties incurred by unregistered persons practising for gain.

The South African Medicines and Medical Devices Regulatory Authority Act 132 of 1998 is further of major importance for practitioners of the allied health professions. As stated above, its primary object is to provide for the regulation, registration and control of orthodox medicines, complementary medicines, scheduled substances, veterinary medicines and medical devices. For the first time in South Africa, the Act includes provisions with regard to complementary medicines whose definition is given in section 1:

“complementary medicine” means any substance or mixture of substances, which -

- (a) originates from a plant, mineral, or animal, and which may be, but is not limited to, being classified as herbal, homeopathic, ayurvedic or nutritional; and
- (b) is used or intended to be used for, or manufactured or sold for use in, or purported to be useful in, complementing the healing power of a human or animal body or for which there is a claim regarding its effect in complementing the healing power of a human or animal body in the treatment, modification, alleviation or prevention of disease, abnormal physical or mental state or the symptoms thereof in a human being or animal; and
- (c) is used in, but not limited to, the disciplines of Western herbal, African traditional, traditional Chinese, Homeopathy, Ayurveda, Unani, Antroposophy, Aromatherapy and Nutritional supplementation; or

(d) because of its origin, intended use or use in a discipline, is determined by the Authority, by notice in the Gazette, to be a complementary medicine.

Chapter IV of the Act deals with the registration of medicines and complementary medicines. In terms of section 24 (4), the Authority may determine different processes or guidelines for the evaluation of orthodox and complementary medicines. Although this provision is to be welcomed, the wording ‘different processes or guidelines’ may be regarded as vague and leaving room for legal uncertainty. Following public hearings, the National Assembly Portfolio Committee on Health compiled a report containing recommendations to the effect that dual (or indeed multiple) registration of practitioners should be permitted. Through personal contact with the Allied Health Professions Council in November 2001, the researcher confirmed that this proposal had, in fact, indeed been followed through, and the subsequent information was obtained (see table 3.7).

**TABLE 3.7 PRACTITIONERS REGISTERED PER MODALITY**

<b>‘Modality’</b>	<b>Total number of practitioners registered</b>
Ayurveda	78
Chinese medicine and acupuncture	493
Chiropractic	335
Homeopathy	335
Naturopathy	335
Osteopathy	63
Phytotherapy	21
Therapeutic aromatherapy	368
Therapeutic massage therapy	132
Therapeutic reflexology	1 152

Source: Personal communication with the Allied Health Professions Council

The following numbers of practitioners were registered for one to five “modalities” (see table 3.8).

**TABLE 3.8 PRACTITIONERS FOR 1 TO 5 MODALITIES**

<b>Number of modalities (concurrent)</b>	<b>Number of registered practitioners</b>
1	2400
2	702
3	246
4	24
5	20

However, while the number of practitioners registered with the Allied Health Professions Council is known and easily obtainable, no exact data is available to indicate the extent to which these ‘modalities’ are actually utilised by health care consumers.

### **3.3.3 The traditional medical sector**

Traditional healers are firmly established health care providers in their respective communities. Several surveys have shown that between 70 to 80 percent of the African population use the traditional medical sector as their first contact for advice and/or treatment of health concerns (Chipfakacha 1994:860-862; *Sowetan* 1994:4).

Karim et al (1994:2) found that when an African patient consults a biomedical doctor, the traditional practitioner has already been consulted and will subsequently be sought in an

estimated 80 percent of cases. According to them (1994:3), approximately 60 percent of all babies born in South Africa are delivered by traditional birth attendants.

Foster, Freeman and Pillay (1997:189) state that there are currently about 350 000 traditional healers in South Africa. According to Karim et al (1994:2), there are approximately 200 000 traditional healers practising in South Africa and adjacent territories, i.e. one healer to every 200 or 300 of the population served. Pretorius, de Klerk and van Rensburg (1993:15) estimated a ratio between 1:108 and 1:847.

### 3.3.3.1 Historical and legal development

In the early twentieth century, administrators and missionaries generally dismissed indigenous healing practices as superstitious and practitioners as charlatans (Bourdillon 1989:35). Alternatively, traditional healers were regarded as “witchdoctors who exploited the ignorance and superstitiousness of the unenlightened natives” (Rappaport 1980:81). Traditional medical activities were condemned as “heathen” and “primitive”, and there was a tendency to view the healer as a “relic” whose practices provided Western observers with an opportunity to study “primitive” healing (Ulin & Segall 1980:81). At the same time the health laws regulating modern scientific medicine usually rendered traditional medical practices illegal.

In South Africa, the Health Professions Act 56 of 1974 barred those not registered with the South African Medical and Dental Council from practising or performing any procedure pertaining to medical practice. The Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982 made provision for the legal practice of chiropractors, homeopaths and allied health service professionals registered with the Chiropractors, Homeopaths and Allied Health Service Professions Interim Council.

In KwaZulu-Natal, however, a different dispensation applies: the licensing and control of traditional practitioners and traditional midwives is covered by the KwaZulu Act on the Code of Zulu Law 1981 (Act 6 of 1981). The relevant sections are quoted here:

- 87 (1) Black medicine men, herbalists and midwives...may practise as such if duly licensed but not otherwise.
- 87 (2) Notwithstanding anything to the contrary in any other law contained a licence to practise as a Black medicine man, herbalist or midwife shall not be issued unless the authority of the Minister of Health and Welfare for the issue thereof has first been had and obtained.
- 89 (1) A duly licensed medicine man, herbalist or midwife may claim a fee for services rendered.
- 90 Gross or culpable blunders or negligence entailing bad results renders a medicine man, herbalist or midwife liable to a civil action for damages apart from any criminal charge which may be laid against him.
- 91 Any Black who practises or purports to practise as a medicine man, herbalist or midwife in contravention of the provisions of section 87 shall be guilty of an offence.
- 92 (1) A Black licensed as a medicine man or herbalist may not assume the title of 'doctor' or 'chemist' or any other designation mentioned in the Medical, Dental and Supplementary Health Services Professions Act, 1974 (Act 56 of 1974).
- 92 (2) A Black licensed as a medicine man or herbalist may prescribe, deal in or sell only medicines known as '*imithi yesintu*' and only to a person who is his *bona fide* patient and on whom he is in personal attendance.

In the context of this legislation, Gumede (1990:91) draws attention to the fact that only "medicine men and herbalists" may practise for gain with the exclusion of other categories such as diviners, for example. As for the rest of the country, the present legal standing of traditional healers is uncertain. According to current legislation, healers' activities are illegal and unlawful.

Based on the views of the people acknowledging the practices as part of their culture they might be called informal. The term “unregulated” is best avoided. In line with users’ perspectives, traditional activities are regulated primarily by various cultural norms and values, and nowadays also to some extent by healers’ associations – although a single regulatory body does not exist.

Traditional healers are organised and licensed by approximately 100 organisations which are officially registered under the Companies Act and not as health care providers. Notwithstanding the fact that their members subscribe to a certain code of ethics, these associations do not have the mechanisms to enforce this code, thus leaving the door wide open for quacks and charlatans.

In practice, however, the healers’ position differs from their actual legal standing. *De facto*, the traditional sector exists and is in strong demand; thus, healers continue to practise and are generally not harassed by the authorities (Freeman & Motsei 1992:64).

### 3.3.3.2 Political changes since 1994

In 1994 Government accepted the National Health Plan (African National Congress 1994). One very important aspect of the new dispensation in health care is the Government’s commitment to involve traditional healers in the official health service. Consumers would henceforth be allowed to choose whom to consult for their health care, and legislation is to be changed “to facilitate the controlled use of traditional practitioners” (ANC 1994).

In November 1995 the National Minister of Health and the Provincial Members of the Executive Council (MECs) for Health called upon provincial governments to conduct public hearings on the viability of the traditional health care sector. The hearings were subsequently held in May and June of 1997. They resulted in a report at the end of that year, compiled by the National Council of Provinces and presented to the National

Assembly's Portfolio Committee on Health. According to the report, all the provinces were in favour of a statutory council for traditional healers which should consist of local representatives rather than persons appointed by the respective MECs for Health. Further recommendations included that traditional healers should be registered; traditional practices should be standardised; and healers should also be recognised by and have access to medical aid schemes.

Subsequently, in February 1998, the Portfolio Committee on Health conducted public hearings on the issues raised by the report of the National Council of Provinces, that is a council for traditional healers, their training, ethics and a code of conduct. Numerous role players submitted proposals, including the National Health Committee of the ANC, the Inkatha Freedom Party, the National Education, Health and Allied Workers' Union (NEHAWU), the National Progressive Primary Health Care Network and Doctors for Life.

With the exception of Doctors for Life, all the parties were in favour of the incorporation of traditional healers into the formal national health care system.

The Portfolio Committee subsequently compiled a report on the future status of African traditional health care which was presented to the Minister of Health in July 1998. The main recommendations contained in the report were that traditional healers should be legally recognised and registered within three years. In the meantime, an Interim Co-ordinating Committee (ICC), nominated by the provinces, has been established to advise on a statutory council for traditional healers. The council as proposed by the ICC consists of 34 members, constituted as follows:

- two traditional healers from each province,
- one legal representative,
- one representative from the Department of Health,
- one community member for each province (not a healer),
- one representative each from any of the existing councils for medical and allied health professions, and

three representatives from the current ICC.

An Interim Traditional Medical Practitioners Council was to be inaugurated in November 1999. Its task was to pave the way for a fully-fledged council within three years. The whole process was to be executed in close collaboration with the Department of Health. At the time of writing, the ICC had apparently disbanded and an interim statutory council was not yet in existence.

However, progress has been made on various fronts:

(1) The official attitude of the modern medical sector has changed.

Until 1994, physicians were prevented by a code of ethics from referring patients to traditional healers. In 1994 the Interim National Medical and Dental Council (INMDC) accepted a proposal from the Medical and Dental Association of South Africa (MASA) to scrap Ethical Rule 9(2), which prohibits doctors from communicating with alternative practitioners. The Council also agreed that MASA should draft guidelines on future relations regarding issues such as referral, formal and informal education, and closer cooperation. The guidelines were endorsed by the Executive Committee of the INMDC in December 1995. They include the following (*SAMJ* 1996:226):

1. With any referral the doctor must decide whether the proposed therapy is likely to benefit the patient. Doctors are reminded that there exists no duty on them to refer patients to these practitioners. However, the interests of the patient should always be borne in mind when decisions on whether to refer or not are taken.
2. As a general rule, it is inadvisable for a doctor to refer a patient to any practitioner who is not subject to a registering and disciplinary body. However, in South Africa, many practitioners of alternative medicine are not registered with any statutory council or similar body. In cases where the doctor has been asked to refer to an unregistered practitioner, the doctor may use his/her own discretion. It is understood that patients accept co-responsibility for their health, and are also responsible for exercising discretion when requesting a referral to an alternative practitioner.

3. Doctors will not be held accountable for mismanagement on the part of a practitioner of alternative medicine if they have referred the patient to a particular practitioner.
4. Medical practitioners may assist with the training of alternative practitioners when so requested.
5. It is admissible that doctors obtain knowledge of or familiarise themselves with the methods and therapies used by alternative practitioners. Attention should be given to including an overview of these therapies and methods into medical education.

In these guidelines, “alternative medicine” includes the practitioners of the allied health service professions as well as African traditional healers.

- (2) The traditional medical sector is mentioned in policy and legal documents.
  - (a) In section 4.1.2, the White Paper on the Transformation of the Health System in South Africa, 1997 provides as follows:
 

Traditional practitioners and traditional midwives should not, at this stage, form part of the public health service, but should be recognised as an important component of the broader primary health care team. The regulation and control of traditional healers should be investigated for their legal empowerment.
  - (b) The National Health Bill 2001 lists as one of the district functions in Schedule 3, Part D (Planning and Human Resources), the provision of cooperation between all health care providers in the district, including general, traditional and complementary practitioners.
- (3) Provision is made for traditional medicines. As far as traditional medicines are concerned, the South African Medicines and Medical Devices Regulatory Authority Act, 1998 makes provision for the control of orthodox as well as complementary medicines, and the regulation of persons who may compound and dispense orthodox and complementary medicines. Relevant provisions of the Act are repeated here for easy reference.

“Complementary medicine” (section 1) means any substance or mixture of substances which –

- (a) originates from a plant, mineral or animal, and which may be but is not limited to, being classified as herbal , homeopathic, ayurvedic or nutritional; and
- (b) is used or intended to be used for, or manufactured or sold for use in, or purported to be useful in, complementing the healing power of a human or animal body or for which there is a claim regarding its effect in complementing the healing power of a human or animal body in the treatment, modification, alleviation or prevention of disease, abnormal physical or mental state or the symptoms thereof in a human being or animal; and
- (c) is used in, but not limited to, the disciplines of Western herbal, *African traditional* (own italics) medicine, traditional Chinese medicine, Homeopathy, Ayurveda, Unani, Antroposophy, Aromatherapy and Nutritional supplementation; or
- (d) because of its origin, intended use or use in a discipline, is determined by the Authority, by notice in the Gazette, to be a complementary medicine.

For the purposes of registration, the Regulatory Authority may determine different processes or guidelines for the evaluation of orthodox and complementary medicines (section 24(4)). This will be done by setting up separate expert committees which, in the case of the latter, consist of persons representing skills or experience in complementary medicines, toxicology and clinical pharmacology (section 21(1) (b)).

Gray (1998:10) points out that in the context of traditional medicines, issues of safety and quality will take precedence over proof of efficacy. The aim is to regulate, not to prevent access to what many people use in preference to orthodox medicines.

#### (4) Research.

A Research Group on Traditional Medicines has been established, based at the University of Cape Town and co-directed by Professor Peter Folb of the Department of

Pharmacology at UCT and Professor Peter Eagles of the School of Pharmacy at the University of the Western Cape (*SAMJ* 1997:268). The Traditional Medicines Programme (TRAMED) is founded on a collaborative agreement entered into by the Medical Research Council, the two Universities mentioned, and several traditional healers. Its object is to document traditional medicines derived from indigenous medicinal plants, identify and isolate therapeutically active ingredients, and establish a national database. The ultimate goal is to set up a herbal formulary that will be available and accessible to all those concerned with health care delivery, including traditional practitioners. The Group has also compiled a comprehensive manual on primary health care, the *South African Traditional Healers' Primary Health Care Handbook*.

(5) Traditional circumcision

The Legislature of the Eastern Cape has passed the Application of Health Standards in Traditional Circumcision Act, 2001 (EC). The background to the Act is stated in the Explanatory Memorandum:

Taking note of the fact that no legislative framework exists at national, provincial or local level for governing the performance of traditional circumcision and the holding of circumcision schools or treating of initiates, and the fact that deaths and mutilations of initiates occur continuously as a result of negligence on the part of traditional surgeons and traditional nurses, the Department of Health in the Province of the Eastern Cape has embarked on a process where workshops amongst the stakeholders have been held and a need has been expressed for the enactment of a law governing traditional circumcision in order to fill that gap.

This Act is intended to deal with and control hygienic standards which must be observed in carrying out the ritual of circumcision as well as the conduct of all those involved therein including the traditional surgeons, traditional nurses, initiates, other persons visiting the circumcision school or who come into contact with the initiates.

Under the heading “policy context” the need for the recognition of the custom of circumcision is realised.

The Act provides for the designation by the MEC for Health of medical officers (section 2), whose powers and functions are stated in section 3:

- (a) Issuing of permission to circumcise or treat an initiate;
- (b) Keeping of records and statistics pertaining to circumcision and reporting thereon as prescribed, to the department; and
- (c) A right of access to any occasion or instance where circumcision is performed or an initiate is treated.

In terms of section 4 (1) no person, except a medical practitioner, may perform any circumcision in the Province without the written permission of the medical officer designated for the area in which the circumcision is to be performed.

A person may apply as prescribed for permission to perform circumcision and such permission may not be given unless all the conditions set out in Annexure A of the Schedule have been complied with (section 4 (2) (a)).

The conditions have to be presented in the official language understood by the applicant (section 4 (3) (a)).

Amongst the conditions set out in Annexure A are the following:

- A prospective initiate must undergo a pre-circumcision medical examination by a medical doctor. The medical certificate must indicate whether the prospective initiate is fit to undergo circumcision.
- An instrument used to perform a circumcision on one initiate must not be used again to perform a circumcision on another initiate.
- The traditional surgeon must keep instruments to be used by him to perform circumcision clean at all times, and shall use any substance prescribed by a medical officer for the sterilisation of the instruments.

Section 5 deals with the permission to hold a circumcision school or treat any initiate which must be given in writing by the medical officer designated for the area.

The conditions for obtaining permission include *inter alia*:

- The medical officer concerned must be allowed to visit the circumcision school at any time.
- The initiate must, at least within the first eight days of the circumcision, be allowed by the traditional nurse to have a reasonable amount of water to avoid dehydration.
- The traditional nurse must report any sign of illness of the initiate, as soon as possible.
- The traditional nurse must stay with the initiate at the circumcision school 24 hours a day during the first eight days of the initiation process.

In terms of section 6 (2), the treatment of initiates is restricted to the traditional nurse, the medical practitioner, the medical officer or any other person authorized by the medical officer.

Section 7 provides for the consent form necessary in respect of a prospective initiate below the age of 21 years; the consent form has to be completed and signed by the parent or guardian in the prescribed format.

The responsibility of the parent or guardian is also emphasised by further conditions contained in Annexure A which state:

- There must be proof in the form of a birth certificate or an identity document that the prospective initiate is at least 18 years old, or if the parents so specifically request, at least 16 years old.
- Parental consent must be obtained in respect of a prospective initiate who is under 21 years of age or who has not acquired adulthood.
- The traditional surgeon must be known to the parents of the prospective initiate, and must use instruments approved by such parents.

Any person who contravenes the provisions of sections 4, 5, 6 and 7, or fails to comply with any conditions imposed by a medical officer is guilty of an offence and liable on conviction to certain penalties as stipulated by the Act (section 9).

The essence of the Act was published in the *Daily Dispatch* of 26 October 2001. According to an article in the *Daily Dispatch* of 27 October:

The Eastern Cape House of Traditional Leaders rejects with contempt the newly passed legislation. According to Chairperson Chief Mwelo Nonkonyana the Leaders are very disappointed that the Bill had been passed by the Bisho Legislature. It is a load of rubbish and we reject it with the contempt it deserves.

### **3.4 CONCLUSION**

Since 1994 the official health care system in South Africa has achieved some major progress in addressing the imbalances of the past. Fragmented, racially-divided, urban/hospital-centred services have been transformed into an integrated, comprehensive national system geared to provide essential health care to the whole population. Health care has become more equitable and accessible, although disparities still exist across the country and the provinces to a varying degree.

The official health care sector remains strictly regulated, and a number of new health laws have been promulgated, especially from 1997 onwards, providing for the control of the various health professions as well as the medicines used. The private sector has become more tightly controlled through the Medical Schemes Act of 1998, and efforts are being made to ease the financing of the public sector through a more favourable “public-private mix.”

Outside the official health care system, the allied health professions embrace a wide spectrum of “alternative/complementary” medicine, each category with its own

professional board, and all ultimately regulated by the Allied Health Professions Council. Registers have been opened for the practitioners of Ayurveda, Chinese medicine and acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, phytotherapy, therapeutic aromatherapy, therapeutic massage therapy and therapeutic reflexology. For the first time, provision is made for the control and regulation of complementary medicines by the South African Medicines and Medical Devices Regulatory Authority Act of 1998.

As part of the informal health care sector, the lay sector has gained in significance. Self-care by individuals, families and communities is actively encouraged. All South Africans are urged to take responsibility for their own health, and to participate in various aspects of planning and provision of health services, while the health authorities are to ensure the promotion of community involvement in the planning, provision and evaluation of health services.

As far as the traditional medical sector is concerned, it remains widely used but largely “unregulated”. Little has changed on the ground: the healer has no statutory position, and the Government does not financially support his services. At the same time, however, some real progress has been made towards officially recognising and legitimising traditional medicine. The Government, for example, has committed itself to involve healers in the official health services. Thus, the National Health Bill of 2001 provides for the cooperation between all health care providers, including general practitioners and traditional healers (Schedule B, Part D).

On a more practical level, provincial departments of health have for years now been actively engaged in providing traditional healers and traditional birth attendants with primary health care training, notably in respect of HIV/AIDS, sexually transmitted diseases (STDs) in general, and tuberculosis. In June 1995 the Medical Association of South Africa formulated guidelines for cooperation between modern and African traditional medical practitioners – although referrals have largely remained a one-way procedure, from the traditional to the Western sector.

While the access of traditional healers to medical aid schemes is still under debate, several private sector companies have started to partially acknowledge the services delivered by the traditional sector (*SAHR*, 1999, chapter 18 p 5). Medscheme, for instance, South Africa's largest medical aid administrator, has introduced limited traditional practitioner benefits, while Eskom has allowed employees to claim a certain number of visits to traditional healers on the company's medical plan since 1994. The Medical and Burial Savings Scheme has screened and recognised more than forty healers that clients may consult should they so wish. The Chamber of Mines and the National Union of Mineworkers have also allowed a panel of traditional healers at mines, and have granted their employees three days' leave to consult such healers (*Sowetan*, 1 November 1994; *Beeld*, 15 December 1994; *Business Day*, 6 February 1999).

What has not been achieved yet is the "controlled use" of traditional practitioners as proposed in the ANC's National Health Plan of 1994, and progress in legally regulating the sector has been slow. The Interim Co-ordinating Committee for Traditional Medicine, nominated by the provinces, has disbanded, while the Interim Statutory Council has yet to be established. The problems involved in implementing a policy on traditional health care are multifaceted. Budgetary, personnel and time allocations have to be made at the central, regional and local levels. Mechanisms are necessary to register healers, monitor their practices, provide standardised training and assess traditional knowledge. The sheer size of the sector is one complicating factor, the existence of various categories of healers another. In addition, historical disharmony within the ranks of traditional practitioners interferes with attempts to unite the numerous healers' associations for the purpose of registration and thus control of the profession. Once recognised and legally regulated, the ideal place for the traditional healer appears to be the primary health care team where people's basic needs are met at the district level.

In conclusion, while the allied health professions have managed to bring their house legally in order, a similar process could be followed by traditional healers in order to oust quacks and charlatans who tarnish the image of this kind of health care provider and

cause potential harm to the consumer. The Application of Health Standards in Traditional Circumcision Act 2001 (EC) should not serve as an example of how to regulate traditional practice since it appears to subject the traditional surgeon to the powers of the medical officer. Its rationale can best be explained by the absence of qualified and accredited traditional practitioners to oversee the initiation process. Once accredited healers exist, they themselves should be allowed to regulate their activities, subject to the powers and functions of the statutory healers' council.

Chapter 4 describes the various facets of traditional healing in South Africa.

## **CHAPTER 4. TRADITIONAL HEALING IN SOUTH AFRICA**

### **4.1 INTRODUCTION**

This chapter describes African traditional healers, their concepts of health and illness, ways of diagnosis, methods of healing, the traditional pharmacopoeia, and the client who makes use of the traditional medical sector. The description covers the categorisation of healers, and the various ways to become a practitioner, and the dimensions of traditional healing, which range from medical to spiritual and moral aspects. Most importantly, however, it will become clear that the logical point of departure must at least be an attempt to understand African religion, culture and beliefs on which the concepts of health, disease and illness causation are based. Only by discussing traditional medicine in the context of the African world view is it possible to gain insight into the multifaceted role of traditional healers and the significance of traditional medicine in the everyday life of Africans. And only in this way can suggestions be made for the development, professionalisation and regulation of the traditional medical sector.

Much of the data presented here was gathered in personal interviews with practising healers, while additional information was found in the literature review. In this context it should be stressed that, while healing practices between African countries vary in keeping with their particular socio-cultural heritage, differences between cultures south of the Sahara are sufficiently small for generalisations to be made within certain limits (Karim et al 1994:4).

### **4.2 SOME BASIC AFRICAN CONCEPTS OF HEALTH AND ILLNESS**

It is not possible to understand the traditional healing system without first looking at the African world view which still dominates the African in both urban and rural areas (Karim et al 1994:6), and which determines his concepts of health and ill health. The African world view denotes a belief system which encompasses the physical world and

the sociological environment; it expresses a continuity between the living and the dead; and lastly it comprises the metaphysical forces of the universe (Good, Hunter and Katz 1979:143). The “wholeness” of the person is the interdependence of parts of a system which includes the individual’s family, the community in which he lives, as well as the influence of the ancestral spirits over him. At the same time the individual is seen as a mind-body-spirit continuum, and at any given time the state of one is reflected in the others (Karim et al 1994:4). These fundamental principles have to be considered in order to understand the importance of pleasing the ancestors as well as adhering to taboos.

Good health and ill health are regarded as the net result of a delicate and intricate balance between a person and his relationship with the ancestral spirits. While good health and good fortune are a reward for good behaviour and constant sacrifice to the ancestors, ill health may be a punishment for sins of omission or commission (Gumede 1990:41). Of equal importance to the African are taboos. Taboos are a “system of avoidances which regulate human conduct in order to ensure a healthy whole - physically, spiritually and morally” (Gumede 1990:128). They are unwritten laws handed down from generation to generation, through which parents teach their children a code of living. Observance of taboos from early childhood inculcates the correct public health behaviour pattern.

According to traditional beliefs, the well-being of the individual depends primarily not on the person himself but on his relationship with others (Staugard 1985:67). This is in keeping with the WHO’s definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Bannerman et al 1983:12). Harmonious relationships with members of the family, the community and the environment promote health and well-being, while illness is regarded as the material sign of a lack of harmony between the individual and his social environment (Karim et al 1994:5). Ill health is brought about by an imbalance or disequilibrium of man in his total ecological system (WHO 1978:13). At the same time illness is a misfortune that involves the whole person. Ellis (1996:127) states that the patient is suffering in a different dimension, beyond the biomedical framework of Western medicine which divides him

into mind and body, the spiritual and the physical. And it is precisely here that the main difference between modern and traditional thinking, between disease and illness, occurs.

Disease in the Western model is doctor-orientated and mechanistic; it is the malfunctioning or maladaptation of biological and psycho-physiological processes in the individual; it is understandable in the sense that a 'broken machine' is to be mended (Ellis 1996:127). Illness, on the other hand, is an expression of the traditional model. It is the perception and interpretation that the patient gives to his condition. It represents personal and interpersonal reactions to disease. It is shaped by cultural factors that govern the labeling, explanation and value attached to the experience. Illness is culturally constructed and socially created (Ellis 1996:129). Likewise, there is a difference between curing and healing (Ellis 1996:129). Curing refers to practices which are efficacious from the point of view of medical science in either redressing, limiting or preventing disease. Healing refers to practices which are efficacious from the point of view of the patient and his/her perceptions and experiences.

### **4.3 CAUSES OF ILLNESS AND CLASSIFICATION OF DISEASES**

As far as the perception of illness is concerned, there is a basic distinction between theories of natural and supernatural causation (Karim et al 1994:6). "Natura" causation applies to illnesses which have a specific, recognisable and predictable course. "Supernatural" causation applies to those culture-bound illnesses that are perceived to be inexplicable by natural laws, that is their aetiology, diagnosis and treatment are all inextricably bound up with the African traditional world view of health and sickness. According to Chavunduka (1994:69), illnesses in this category have a cultural or social cause.

Afflictions such as coughs, colds, slight fever, stomach ache and headache are generally regarded as 'natural' since they occur from time to time as part of normal life, are usually of a fleeting nature, and resolve completely. They respond to either traditional or modern

medicines, although there is a readiness to use the curing techniques of biomedical origin. Only if the symptoms are severe and persist, i.e. when the illness fails to respond to ordinary treatment, is it regarded as deviant, and why a deviant case has occurred needs to be explained. Thus, while biomedicine asks what caused the condition and how did the patient fall ill, the traditional belief system requires answers to the questions of “who” and “why” (Karim et al 1994:6).

In this context, the significance of ancestors and taboos has to be appreciated. Karim, Ziqubu-Page and Arendse (1994:4) state that many if not most Africans believe that the ancestors sustain and look after their descendants. On the other hand, if they withdraw their protection, the descendant is left vulnerable to all sorts of misfortunes and diseases. The wrath of the ancestors is usually evoked by discord in the home, the flouting of certain customs and the transgression of societal norms. Thus, the main cause of cultural or social illnesses is believed to be displeased ancestral spirits or other angered spirits. Of major importance in this context is the non-observance of certain taboos, adherence to which ensures a physically, spiritually and morally healthy state.

Other forms of illness are believed to result from a state of impurity or uncleanness, for example, those associated with menarche, childbirth, miscarriage and death. Non-observance of the required rituals may lead to illness.

Finally there are cases of spirit possession and bewitchment. Alternatively, sorcerers, witches or jealous people may deliberately place harmful objects in the path of an enemy resulting, for example, in stroke or a variety of other afflictions (Karim et al 1994:6).

Campbell (1998:77-150) interviewed healers and discuss the conditions they treat, ranging from diabetes, stroke and asthma to personal and emotional problems, trouble at work, and bad luck in relationships. Some practitioners deal with epileptic seizures, cases of nightmares, suicidal tendencies, infertility, unemployment and personal as well as economic misfortunes. As far as AIDS is concerned, many healers feel able to prolong and improve the quality of life through diet, exercise and herbal treatment.

#### **4.4 THE HEALING PROCESS AND AIM OF HEALING**

The traditional healer's approach to illness depends on how causation is perceived. Thus, the healing process follows different stages. Firstly, there is the identification of the cause of the affliction. According to Karim et al (1994:6), it is an essential part of the healing process that the "who" be ascertained. Secondly, the hostile source is removed. This may occur through seeking ancestral forgiveness with rituals and sacrifices, neutralising the sorcerer, or by prescribing certain medications. The treatment of symptoms via the biomedical approach may therefore be regarded as ineffective if not accompanied by rituals to deal with the "ultimate cause". Likewise, although traditional healers may advise their patients to purchase biomedical drugs, or may prescribe or dispense such remedies themselves, they often reinforce the curative power of these medicines "with verbal charms to fence off evil spirits or sacrificial rituals to restore the equilibrium of the elements" (Karim et al 1994:5).

Most importantly, however, healing involves the whole person, his physical, psychological, spiritual and social aspects. Gumede (1990:155) state that the healer treats the patient within his physical, spiritual and emotional environment, past and present. Only infrequently is the person treated in isolation. Family members are almost always involved, and the healing process is further facilitated by including members of the community.

In addition, the healer's hospital is his home where the physically and mentally ill live together as part of a therapeutic community (Karim et al 1994:4), where staff, patients and relatives share the same facilities. Thus, healing is group-orientated, and the concept of the family as the "extended patient" stands in contrast to the isolation of the sick individual from his social environment often imposed by the modern medical system (Good et al 1979:143).

The aim of healing is the removal of anxiety in the individual, of tension between family or community members, and the re-establishment of social order, i.e. the settling of antagonistic feelings between people (Karim et al 1994:9). Rituals, in particular, seek to restore balance and harmony in terms of cultural beliefs and values. The completion of rituals often has a calming effect on the patient and relieves his feelings of guilt. Thus, many of the practices of traditional medicine are designed not only to preserve cultural institutions, but also to help the individual to live at peace with family, clan, village, tribe and inner self (Freeman & Motsei 1992:1186).

In conclusion, healing seeks to provide a meaningful explanation of illness. It responds to the surrounding personal, family and community issues (Ellis 1996:144). Illness has to be explained in order to be overcome, and a patient with a deviance has to be reintegrated in the community. Therapeutic strategy, therefore, is also social strategy. Healing methods promote group harmony, thereby decreasing individual vulnerability. In this way, healing meets psychological and emotional needs and leads to successful recovery on various levels. And it is here that the main difference between modern and traditional approach becomes apparent. Gumede (1990:154) points out that the traditional approach is holistic; it addresses the human experience of disease, while the modern doctor attempts to heal the “affected part”. In addition, traditional healing has a dichotomous role: it is designed to promote the well-being of the individual and to maintain the continuity of the way in which society functions (Karim et al 1994:5).

Appreciating this essential difference also helps to understand why treatment given without explanation might confuse the patient and render the therapy less effective or even unacceptable. It might also explain why an African patient will go to a biomedical practitioner for the relief of symptoms and to the traditional healer to discover the cause of the illness.

## **4.5 AFRICAN TRADITIONAL HEALERS**

### **4.5.1 The categorisation of traditional healers**

“Traditional healer” is a generic term (Ellis 1996:144). It describes a person who is recognised 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 on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability (WHO 1978:9)

Various categories of healers can be identified. Although each category has its own distinctive features and functions, these may often overlap so that boundaries become blurred. In addition, there are grades within each category ranging from novices to specialists and consultants (Karim et al 1994:7).

In the literature, practitioners in the various categories are often referred to by the names given to them by their respective ethnic group, e.g. Zulu, Xhosa, Sotho, Tswana, Nguni, Tsonga, Shona, Swahili (Last & Chavunduka 1986:34).

The categories most commonly described are the diviners, herbalists, faith healers , traditional birth attendants, traditional surgeons, bonestters, and specialists (Karim et al 1994:7; Ulin & /Segall 1980:15-16; Gumede 1990:51; Good et al 1979:143; Last & Chavunduka 1986:32-33).

In contrast to the sometimes marked specialisation and part-time characteristic of rural healers, urban healers tend to be full-time “general practitioners” who often serve an ethnically heterogeneous clientele. Thus, 80 percent of healers interviewed in a study in Kenya (Ulin & Segall 1980:39) identified themselves as diviners and herbalists, while the

remaining 20 percent combined these skills with midwifery. Staugard (1985:55) also describes diviner-herbalists who are able to make a diagnosis, for example, by means of bones, and at the same time treat the diagnosed illness with herbal preparations. Last and Chavunduka (1986:33) and Freeman and Motsei (1992:1183) found the same. Likewise, there are traditional midwives who are also herbalists (Last & Chavunduka 1986:33).

Ulin and Segall (1980:39) found that few healers can survive in the city unless they both diagnose and treat a client. In addition, traditional practices have undergone change in response to modern technological advancements (Freeman & Motsei 1992:1184).

#### **4.5.2 The diviner**

The diviner is in the first place a diagnostician; in other words, he is an expert at carrying out a diagnosis (Last & Chavunduka 1986:33). He not only defines the illness but also its ultimate cause in terms of the African belief system (Karim et al 1994:7). Thus, a diviner may be consulted to find out “why the cows are barren, why the fields are not producing plenty of crops, why the young bride is not having a baby after two years of married life, why the child is ill, why ill-luck dogs the family, why the cow died – in fact why anything has gone wrong” (Gumede 1990:69). The diviner is a person able to communicate with the spirits when in a state of possession (Chavunduka 1994:63). Karim et al (1994:7) points out that his speciality is divination within a supernatural context through culturally accepted mediumship with the ancestral spirits. In addition, he may have knowledge of medicinal herbs.

In general, diviners differ from each other in the methods they use in the diagnostic process. While the majority carry out the diagnosis while in a state of possession (Chavunduka 1994:72), others may use possession and the casting of bones. For this purpose, bones of animals, birds and humans are used. The ancestral spirits then talk to the diviner through the way the bones lie. Less common methods include the use of the shell of a tortoise, pieces of polished wood or stones, a mirror, a needle, a calabash or

dreams and smells (Chavunduka 1994:72; Staugard 1985:80). In some instances the ancestors may reply directly by whistling out words from the rafters (Ellis 1996:144). Chavunduka (1994:72) found that some healers are able to inform their patients of the reason for their visit and the social cause of their illness without having been told anything by their client. Once a certain spirit has been identified as the cause of an illness or misfortune, the practitioner advises the patient on the procedure necessary to propitiate the spirit, and may also prescribe a herbal remedy to cure the physical damage already sustained by the individual.

According to traditional beliefs, a person does not choose to become a diviner; only a person “called” or “chosen” by the ancestors can become one (Karim et al 1994:10). Chavunduka (1994:48) speaks of “spirit mediums” who have inherited or are believed to have inherited their healing spirit from a deceased healer in the family or from an alien spirit. Another way of becoming a diviner or spirit medium is by living in a riverbed or pool, usually for a couple of days (Chavunduka 1994:48). In some instances, the art of divination may be conferred through a dream (Staugard 1985:44).

Symptomatically, the chosen individual becomes ill or behaves like a mentally disturbed person (Karim et al 1994:10). Gumede (1990:70-73) states that he is prone to excessive dreaming, is riddled with sharp pains in the chest, headache and general body pains, loses weight and becomes restless. The illness may be regarded as a natural one at first, and attempts are made to cure it with ordinary medicines. In the process all home remedies are being exhausted while the symptoms remain. It is usually at this stage that a practising diviner of repute is consulted and only he/she is able to differentiate between the “call” and mental illness (Karim et al 1994:10). If it is thus established that a spirit wishes to confer its powers upon the individual, a ritual ceremony is held at which the spirit is honored and accepted (Chavunduka 1994:63). The novice then leaves his/her home to live with and be tutored by a master sangoma of repute. The apprenticeship is of an informal nature, and often requires much discipline of body and mind. It includes physical training such as dancing as well as mental exercises, e.g. meditation, dreams and

communication with the ancestral spirits. Many novices live in self-imposed celibacy (Gumede 1990:75).

During apprenticeship, the candidate has to pass a number of tests. The tests may take place over a number of years (Chavunduka 1994:75). When the tutor is satisfied that his charge is ready, the relatives are informed and a ceremony is arranged, the diviner's graduation (Gumede 1990:75). The ceremony is a celebration, together with a solemn prayer that the ancestral spirits may guard and guide the new mediator between the living and the spirit world. A sacrificial beast is slaughtered, and the flow of blood is an essential part of the ceremony. When the goat has been skinned and opened up, the diviner takes out the gall bladder and sprinkles the student from head to toe with the gall. According to Gumede (1990:76), this festivity is followed by the hairdo and the homegoing ceremony. Only then does the tutor collect his tuition fee, which may be two head of cattle. Staugard (1985:57) states that initiation ceremonies are still performed following the original pattern among the Basotho and other tribes in Southern Africa, but have become rare among the Batswana, for example.

In the majority of cases diviners are female (Staugard 1985:57), and are usually considered the elite group among the healers (Chavunduka 1994:65). As described above, their activities are part spiritual, part medical.

### **4.5.3 The herbalist**

The herbalist practises the art of healing. Gumede (1990:85) regards the herbalist as "equivalent to the general medical practitioner". Herbalists are usually men and are often chosen for their profession by an established practitioner (Wessels 1985:284). The art of healing tends to run in families but is not necessarily hereditary. The point here is that to become a herbalist is the individual's choice, and thus the profession is freely accessible (Karim et al 1994:7).

The novice is apprenticed to a practising herbalist of repute for a number of years (Last & Chavunduka 1986:34; Chavunduka 1994:48). His business is to act as messenger, herb-gatherer and general helper to his master, accompanying him on his excursions as medicine-bearer, all the time learning by observation and instruction (Karim et al 1994:10). Thus, the student learns to identify and name the relevant herbs, plants, animals, insects, birds and snakes. He is also taught how to select the best; that is, the most powerful specimens. Later he is sent to go and dig alone, but to bring the exhibits to the master for checking and approval. Next he learns how to mix the various ingredients and prepare a mixture. Further, the novice assists the herbalist in the administration of medicines and is allowed to treat some patients according to the master's instructions. After a few more years, the student is introduced to the management of progressively more severe illnesses and problems. Thereafter he may begin to treat patients on his own (Chavunduka 1994:50).

The period of apprenticeship varies in standard and format from one area to another. Thus, training is not standardised and is principally based on hands-on experience (Karim et al 1994:10). Nowadays, however, it is also possible for individuals to acquire the necessary knowledge through formal training at a school of traditional medicine, although the number of such schools is still small (Chavunduka 1994:48). Furthermore, according to Chavunduka (1994:51), there are herbalists who have entered the profession through dreams in which the candidate sees the correct medicine to cure a sick person and is also shown the place in the woods where the medicine is to be found. In Zimbabwe, healers who discover remedies in this way, may obtain a licence to practise traditional medicine, but are usually limited to the management of the particular illness.

The herbalist specialises in the retail or wholesale of herbal drugs, most often gathered by himself. He has a small shop or stand at the urban market place where his preparations are sold to the customers, or he may travel around in his district to distribute his medicines to clients or, in some cases, to other healers (Staugard 1985:54). Patients may be referred to them by spirit mediums, while others consult them directly (Last & Chavunduka 1986:33).

In general, herbalists possess an extensive knowledge of the traditional pharmacopoeia. However, they also apply rituals and symbolism. Karim et al (1994:7) point out that their service is comprehensive and their expertise includes curative, preventive and prophylactic treatment, as well as preparations for luck and fidelity, for example. Some may specialise in a particular disease and become renowned experts in their field.

#### **4.5.4 Spiritual or faith healers**

Faith healers are usually professed Christians who belong to one of the Independent African churches (Karim et al 1994:7). The origin of these can be traced back to the rise of the Independent African church movement which broke away from the more Western-oriented missionary churches (Freeman & Motsei 1992:1183). Although faith healers are not “traditional” in the usual sense of the word in that they did not exist before the development of Western medicine, they are nonetheless “traditional healers” as they share a common theory of health and disease, and treat by integrating Christian rituals and traditional practices (Freeman & Motsei 1992:1183).

According to Karim et al (1994:7), “faith healers believe their healing power comes directly from God, through ecstatic states or trance-contact with spirits, or sometimes a combination of both ancestral spirit and Christian Holy Spirit possession”. They often claim to have been chosen by God through a revelation in a dream (Staugard 1985:54). Thus, since faith healing is a calling from God, and since the power of diagnosis and treatment flow from him, a period of training is usually regarded as unnecessary.

The services provided by the faith healer are essentially diagnostic and curative in nature. Staugard (1985:74) states that the faith healer may use a simple procedure of asking the patient to “open the bible”, following which the practitioner is able to “read the diagnosis” from the respective page. In other cases, the healer himself may open the bible in front of the client or make the diagnosis by laying his hands on the holy book. Healing

often occurs through prayer, by laying hands on the patient or through holy water, ashes or herbs (Karim et al 1994:7). Sometimes rhythmic movements or dances may be performed. In certain instances the afflicted may live for months or even years at the practitioner's residence. Here they are prayed for, go through purification rites, and are in close contact with the healer (Karim et al 1994:7).

Faith healing, then, integrates both Christian and traditional African beliefs, and faith healers are therefore still regarded as "traditional healers". They share the patient's world view and perceptions of health and disease. Like diviners, they are "called" to the profession. Their treatment has the same basic features, and their approach is holistic. Like other traditional practitioners, they occupy the role of a leader amongst the local community.

Staugard (1985:64) points out that to classify them as "traditional healers" may therefore not only be a pragmatic choice, adopted to facilitate policy considerations of future cooperation, but also a theoretically valid one, based on shared basic features.

#### **4.5.5 Traditional birth attendants**

Traditional birth attendants are usually elderly women. Karim et al (1994:8) points out that women aspiring to be traditional birth attendants are required to satisfy certain criteria, such as that they should have had at least two children themselves in order to be able to appreciate the joys and agonies of childbirth.

The majority (72,1%) of birth attendants interviewed by Chavunduka (1994:66) were influenced by their grandmothers in their choice of profession. Apprenticeship to another midwife is the common pattern of training. The novice acquires knowledge informally by watching and doing. For example, she learns about washing hands with soap and keeping surfaces dirt-free. Chavunduka (1994:66) states that the period of apprenticeship may be

short since many of those who go into midwifery are already qualified herbalists. In other cases, training may stretch over 15 to 20 years (Karim et al 1994:8).

The traditional birth attendant acts as midwife, gives advice and performs rituals associated with pregnancy and childbirth (Ellis 1996:144). In addition, she is often involved in maternal and childcare. The traditional birth attendant usually attends to a pregnant woman from the fifth to the seventh month onwards. She visits her client regularly for physical examination and to give the expectant mother confidence. She also teaches behavioural avoidance during the antenatal period and assists with a medicine that will make the birth easier. The midwife is then summoned as soon as labour begins. In case of complications she makes the necessary referrals (Chavunduka 1994:66).

After delivery she performs the ritual bathing and massage of the mother and sees to the prescribed disposal of the placenta. She also gives advice on post-partum and cord care and assists the mother in breast-feeding. In many cases she continues to be consulted at every stage of the child's growth.

Often the traditional birth attendant also deals with other problems besides the health of mother and child. For example, she may assist in solving marital problems. A few midwives provide birth control medicines and advice, while others are consulted in cases of infertility in men and women. Aphrodisiacs may be recommended to clients who wish to increase their sexual drive (Chavunduka 1994:67).

According to Karim et al (1994:8), traditional birth attendants do not charge for their services but gifts or donations in kind are usually given. In addition, they may be invited to be guest of honour when the baby is named.

The relationship between the traditional midwife and her client is usually personal and holistic (Gumede 1990:210). Visits are made in an atmosphere of confidence and trust. Care is centred on the client and her family. Overall, the traditional birth attendant is highly respected for her obstetric and ritual expertise by the women she serves. She is

part of the cultural and social life. As mentioned above, many midwives are also qualified “general medical practitioners” (Chavunduka 1994:66).

The role of the traditional birth attendant is and has remained extremely important. Over two thirds of the babies in the world are delivered by traditional midwives who are trained in the traditional medical system (Gumede 1990:203). In South East Asia, for example, 80 to 90 percent of domiciliary deliveries are performed by traditional birth attendants. In some areas they are the only source of assistance. Traditional birth attendants are found in almost every village in Africa, Asia and Latin America, and are creditable sources of communication regarding planned parenthood, maternal and childcare, and sexual behaviour. The WHO (1978:23) reported that in countries where traditional birth attendants are officially recognised considerable numbers have been trained and are used in basic health service delivery. The relevant countries include Ghana, Indonesia, Malaysia, Pakistan, the Philippines, Sudan and Thailand, where their use is considered part of the national health development plan.

In her study of traditional birth attendants among the Annang of Nigeria, Brink (1982, in Karim et al 1994:8) found that the methods and standards of practice were quite good given the circumstances under which they operate; a few areas such as hygiene and asepsis needed to be targeted. Ityavyar (1984) in Karim et al (1994:8) confirmed that traditional maternal and childcare and the methods of delivery applied by traditional birth attendants in Nigeria were as effective as the biomedical approach, and that such services may even have lower maternal and infant mortality rates. However, a recent study of traditional birth attendants in rural Bangladesh (id21, Health Highlights, December 2001) reveals less favourable results, for example, by declaring their current training ineffective in preventing post-natal infections. Thus, to improve maternal and child health, recommendations are made to review their current training and above all support their activities by a strong referral system. The major issue in this regard is the necessity of a change in attitude, and this applies to both the traditional birth attendants themselves as well as to the modern professional health workers with whom they have to cooperate in a

comprehensive health care system. The same considerations are regarded as relevant for the situation in South Africa.

#### **4.5.6 Specialists**

Within each category of traditional healers there are specialists, for example, herbalists who specialise in the treatment of children's diseases, women's illnesses or in the management of epilepsy (Last & Chavunduka 1986:34). Some of them may become experts in their particular field and are often in great demand beyond their local communities (Gumede 1990:108).

Other specialists may be skyherds who are able to protect against lightning, hail, thunder and storm. According to Gumede (1990:99), the Zulus fear lightning; they believe that there are people who have learnt to control the heavens and to use lightning in order to harm or destroy their enemies. The skyherd is fearless and bold. He has chosen a hazardous profession. Anyone courageous enough may join the ranks of these specialists. He could be a practising herbalist or an ordinary novice (Gumede 1990:101). Whoever has the inclination to become a skyherd undergoes training by a skilled professional. The training itself is fairly short and simple. It ends in an initiation ceremony, according to Gumede (1990:104): the anointing with medicine, the incision making and the licking of hot medicine from the fingertips. During the subsequent graduation ceremony the novice is commended to the ancestral spirits for guidance and protection. A sacrificial beast, a goat, is slaughtered. The master gives the novice his doctor's bag. The young graduate then takes an oath which represents the skyherd's code of professional conduct.

When the occasion of thunder and lightning arises, the skyherd fortifies himself with strong medicine, the ingredients of which have been mixed and ground into a powder and fried in a hot receptacle over the fire. He dips his fingers into the hot brew and sucks

them. He then runs outside with his medicated sticks and shouts towards the sky, calling the heavens to stay away from the homestead and the fields.

Apart from the skyherds, there are also the rainmakers (Ellis 1996:144). Zulu kings, for example, were the chief rainmakers, believed able to cause rainfall or drought as they pleased. Another category of specialists, indicated by Staugard (1985:55), are the suckers who perform their task with hollow bones or simply by using the mouth to remove impurities from the client's body. In most cases they combine sucking with divination and herbalism.

Ellis (1996:144) points out that the definition and role of specialists vary greatly between geographical areas, and many functions may overlap.

#### **4.5.7 General features common to all categories**

Some healers are selected for medical training early in their lives, while the majority of practitioners begin their practice between the ages of twenty and forty years (Chavunduka 1994:52). Not infrequently the healer may pass on his skills to one of his sons who shows an interest in the profession (Karim et al 1994:10).

A person aspiring to be a traditional healer must first undergo an apprenticeship which varies in standard and format from one area to another. Learning and training do not occur in a "school" system but are based on hands-on experience (Karim et al 1994:10). In addition to the cleansing rituals that an apprentice has to undergo, certain strict rules and taboos need to be adhered to, such as abstinence from certain foods and sexual activity. According to Zungu (1992:24), training and apprenticeship are often extensive, rigorous and may be filled with suffering and sacrifices.

The length of training may vary a great deal, from a few months to about a decade, depending on a number of factors such as the age of the student, the branch of medicine,

the continuity of education and the attitude of the teacher (Chavunduka 1994:52). As mentioned, some healers are taught by their parents or grandparents, others by unrelated practitioners. A sizeable amount of knowledge may also be gained through revelations, dreams or flashes of intuition (Pearce 1986:244). Some healers may acquire information by falling into a well (Oppong 1989:609). Knowledge is gathered about herbal remedies and the details of ritualistic procedures, and how to interpret dreams. In addition, the personality of the novice must also be shaped (Buhrmann 1984:69).

The fee for training is not fixed, but Staugard (1985:54) provides some estimates. The apprenticeship is usually for a specified period of time at the end of which the neophyte is tested for competence, goes through the ritual of a graduation ceremony and becomes a qualified healer who then sets up his own medical practice (Karim et al 1994:10).

In her study of traditional healers in the suburbs of Johannesburg, Farrand (in Karim et al 1994:10) noted a trend towards a shorter and more condensed training compared to rural areas. Another more recent innovation are attempts to formalise and standardise the training of traditional healers through schools, such as the Academy of Traditional Healers in Zimbabwe, established in 1982 (Karim et al 1994:10).

In general, empirical medical knowledge has developed through trial and error over many generations, and the structures for information within the indigenous system have remained relatively small. One major disadvantage of storage in the oral tradition is attrition of information caused by memory loss or death (Pearce in Last and Chavunduka 1986:247).

In an investigation into the socio-demographic background of individual healers through interviews, the researcher found that two of the practitioners questioned were researchers at the Department of Pharmacology of the University of Cape Town. One had a BSc degree, the other an MSc in Traditional Medicine. A third practitioner was a local government employee, while a fourth was a female faith healer who visited the researcher regularly in her office at the University of Transkei in an effort to have her healing

techniques scientifically verified. The literature review revealed that some traditional healers are trained nurses, teachers, even lecturers (Sheriffs 1996:64). Among the practitioners interviewed by Campbell (1998:77) were a researcher in medicinal and advanced organic chemistry, a government AIDS counsellor, a policeman and a clinical psychologist. However, Mthembu (1990:92) found that most of the healers had only primary education.

#### **4.6 THE HEALER'S FEE**

Healers were formerly commonly paid in kind, and even today payment is often not exclusively monetary (Karim et al 1994:5). Usually a small retainer fee is paid initially, and the rest when treatment is complete or when the patient is healed.

In general, the fee schedule is neither fixed nor standardised. The fee charged varies from region to region, between healers, according to the type of illness and the nature of treatment (Karim et al 1994:5). Arrangements to pay later can easily be made if the patient is indigent. Chavunduka (1994:45-46) states that many urban healers nowadays receive their fee for herbs that they recommend to their clients straightaway instead of waiting to collect their dues after a cure has been effected and the patient's family is satisfied. In rural areas, however, most traditional healers continue the normal practice of not being paid until the patient is fully cured.

Chavunduka (1994:57) states that many practitioners, particularly in the rural areas, do not charge much and some do not charge any fee at all; they do not regard the practice of medicine as a source of wealth but as a service to the community. Such healers are rewarded by the status that accrues to them and their families from the ability to heal and the access to the world of spirits. However, although some practitioners do not receive any fees, they may expect the patient to give them gifts from time to time, and this method of payment may, in certain instances, become very expensive in the long run (Chavunduka 1994:57).

Staugard (1985:152) found that the majority of patients do not pay anything to the faith healer. Likewise, traditional birth attendants do not charge for their services, but donations in kind or gifts are usually given (Karim et al 1994:8). In addition, the traditional midwife is often invited to be the guest of honour when the baby is named.

In South Africa, payments for the services of traditional healers are currently not subsidised. Healers operate outside the formal health care system at the financial cost of the patient. Their payment occurs on a fee-for-service basis.

#### **4.7 THE TRADITIONAL HEALER'S MEDICINES**

Right at the outset it should be stressed that traditional healers do not generally make a clear distinction between a "medicine" in its modern medical and its broader sense which includes, for example, charms and amulets of various sorts. Chavunduka (1994:76) points out that a "medicine" is not only used to cure a physical disorder but "to achieve almost any end that requires for its success control over forces which would otherwise be uncontrollable". Accordingly, medicines may be used to protect against witchcraft, to pass an examination, to win the love of an unwilling woman, to see in the dark, to grow crops successfully, to create or cure a witch, and for many other purposes.

##### **4.7.1 Categories of medicines**

In principle, three categories of medicines exist (Karim et al 1994:8): preventive or prophylactic medicines; medicines to treat ailments; and medicines used to destroy the power in others. Medications in the first category play a particularly important role since a large part of the healer's practice is concerned with prescribing preventive remedies. They may be used for self-fortification or be sprinkled around the kraal to ward off lightning, or to cause discomfort to a witch. Other preventive medications have the aim of protecting a newborn baby from illness (Chavunduka 1994:77). In this case, the healer may soak different roots in water in which the child is bathed twice a day. After six days,

if the baby is strong and healthy, the roots are discarded, but if the baby is ailing the herbal baths are continued for another two months. When the child is about six months old, another medicine is prescribed to prevent convulsions. When it starts teething, the healer prepares yet another formulation to ensure good and healthy dentition.

Further types of preventive medicines are means of birth control. A number of techniques for contraception and abortion are known to the traditional healer, including herbal preparations, social methods and mechanical means (Chavunduka 1994:77). Social methods of birth control may consist of taboos against sex during lactation; prolonged breast-feeding; abstinence; and variations of intercourse, such as withdrawal or *coitus interruptus*. Mechanical means recommended by traditional practitioners may comprise pre-coital insertion of medicines; post-coital douching using a variety of substances; and the use of charms and amulets.

Medicines in the second category (i.e. for the treatment of ailments), are prepared in different forms such as hot and cold infusions or decoctions which can be used orally, as rectal enemas or for inhalation. Yet others are made into powders, poultices, lotions and a variety of ointments that comprise animal fat, clay and sometimes ashes (Karim et al 1994:8). The recipes for the various mixtures are usually kept secret and are part of the knowledge that the healer will pass on to his apprentice.

The third category of medicines (used to destroy the power in others), are usually targeted at particular individuals such as witches. In the case of an enemy, a concoction is placed in his/her path; when passing by he/she will contract a fatal disease (Karim et al 1994:9). If the cause of an illness is perceived to be bewitchment, a number of procedures and rituals may be performed in order to remove the spell. These may include the induction of vomiting, enemas, blood-letting, whistling or more elaborate methods, such as animal sacrifices.

Chavunduka (1994:77) expands the three categories. According to him, there are also medicines used as an instrument of law and order or for the preservation of morality, such

as the medication given to a husband who suspects his wife of being unfaithful. Others again may be employed to protect a person's property from would-be thieves. Chavunduka 1994:79) adds that there are also medicines which are used in the detection of crime and witchcraft or other anti-social behaviour. Thus, if a community leader believes that there is a witch amongst them he will hire a specialist so that a public ordeal to discover the guilty may be held. On the appointed day, all the adults in the village are brought together and each one has to drink the special mixture prepared by the healer. Those who vomit are declared innocent, while the culprit may develop diarrhoea and die.

In addition, medicines may be prepared with the intention of injuring a particular person. The most common preparations used by witches and sorcerers usually cause an illness characterised by severe pain in the legs which makes the victim unable to walk. Furthermore, there are medicines made up to change an individual's behaviour or life style, such as formulations used to force a person to give up smoking or drinking. Lastly, there are medications aimed at changing the behaviour of animals and snakes, for example to make a dog vicious or a snake harmless (Chavunduka 1994:80).

Apart from being categorised according to their aim, the healer's medicines may also be classified as simple or complex (Chavunduka 1994:76). Simple medicines may be administered to the sick individual by anyone who knows about them, such as herbs for treating headaches and the common cold. Complex medicines, on the other hand, are for curing disorders, such as severe abdominal pain. Here, a qualified healer is required to ensure that the right medicine is used and the correct procedure followed during administration. Thirdly there are medicines which must be provided during a ceremony. Again, only a qualified practitioner is able to fulfil all the necessary requirements.

#### **4.7.2 Methods of treatment**

The administration of herbal medications is the most common therapeutic method used by African traditional healers (Karim et al 1994:8). Other methods include simple surgical procedures, rituals as well as psychosocial counseling.

Surgical procedures may consist of scarification, blood-letting and cupping, and are frequently performed in full view of onlookers (Karim et al 1994:9). The letting of blood is sometimes used as a way of casting out the illness. Holes are made into the ground, and the patient's blood is poured into these holes to 'make the sickness go into the holes' (Asuni in Karim et al 1994:9). The cupping horn is frequently used in illnesses such as severe headache, rheumatism, painful abdominal conditions and other disorders in which severe and continuous pain is experienced (Chavunduka 1994:81). In other cases, for example, where a foreign body is believed to be in the patient's body, the healer may suck with his mouth or through a hollow bone and then spit out the culprit.

Besides herbal preparations, many social techniques may be used in the treatment process such as rituals and symbolism to restore balance and harmony (Karim et al 1994:9). As mentioned above, the faith healer in particular makes use of prayers, the laying on of hands, singing, dancing, as well as holy water and holy ashes (Staugard 1985:89-91).

#### **4.7.3 Routes of administration of medicines**

As far as the routes of administration of traditional medicines are concerned, a variety of techniques are employed. Mixtures may be taken by mouth, e.g. drunk, sucked or licked from fingertips. In other cases medicines are inhaled: the patient, covered with a large skin or blanket, crouches over a boiling pot. The steam induces perspiration and reduces fever (Karim et al 1994:9), acts against eruptions on the face such as acne (Gumede 1990:87-90), and is used for respiratory disorders such as asthma, or to drive away evil spirits (Chavunduka 1994:80). Some practitioners prefer using the powdered ingredients directly over the fire, and the patient inhales the fumes rising from the burning embers. Furthermore, powder may also be sniffed or smoked in the form of a cigarette. For

headaches, for example, certain leaves are crushed and rubbed between the two palms, and the patient sniffs the volatile oil (Gumede 1990:87-90). Other powders may be used to induce vomiting with the aim of cleansing oneself or simply for good luck. According to Gumede (1990:89), emesis is the treatment of choice employed by certain healers in cases of pulmonary tuberculosis.

Where children are concerned, the researcher's own experience and the literature review indicate that a lot of medicines are administered through enemas (Gumede 1990:89). They are, however, also used for adults, especially for stomach complaints (Karim et al 1994:9). Further ways of applying medicines are bathing in a medicated bath or smearing the medication on the body. Gumede (1990:90) states that a special medicine is rubbed over the eyebrows to enhance dignity and personality. If the client is an accused, he uses this method just before the court hearing. The magistrate then will not see the correct file clearly and the case will be repeatedly remanded until it is finally dismissed. Medicines may also be rubbed into incisions which are made in the skin over the painful area (Chavunduka 1994:80). Fomenting treatment is particularly used for aching feet, sprains, swollen joints, boils, abscesses and carbuncles (Gumede 1990:87-90). Burning incense is said to appease the ancestors (Karim et al 1994:9), while "smoking out" may be employed to protect the newborn which is passed a few times over the fumes to facilitate adaptation to all the dangerous elements of the world and to prevent allergic reactions at a later age (Gumede 1990:87-90).

#### **4.7.4 The importance of prevention**

The prevention of disease and bad luck occupies a substantial part of the traditional practice, and is probably the most common reason for a contact between healer and client (Staugard 1985:91). Prevention may be sought against witchcraft, bad luck, burglary, lightning, infertility among humans as well as cattle, and fire. The objects of protection are the individual, his property, the family and the community (Chalmers 1990:10). For example, protective medicines are sprinkled in the yard to protect the homestead against

witchcraft, while the skyherd uses the same technique against lightning (Gumede 1990:90).

Further methods are provided by amulets, bracelets, charms and necklaces (Staugard 1985:91). According to Chavunduka (1994:79), there are many examples of goodluck charms, such as the love potion, charms to make one's business prosper, to grow crops successfully, to win the love of an unwilling woman, to ward off evil spirits, to win an election or when gambling, and to keep one's job. Court cases have shown that human flesh may be used as medicine or charm, but cases of this nature are getting fewer (Chavunduka 1994:79).

#### **4.7.5 The traditional pharmacopoeia**

##### 4.7.5.1 General

Traditional healers use herbs and plants, animal fats and skins, blood, birds, insects, snakes, fish and mineral matter (Chavunduka 1994:56). Plants provide roots, leaves, bark, fruits, bulbs, seeds, stems, fibres, twigs, branches, pods, flowers, sap, wood and grain. The terms "traditional" and "herbal" medicines are sometimes used interchangeably since most of the healer's preparations are based on plant/herb material.

While some medicines are used as placebo and others for magic, many are of definite medicinal value. For example, according to Gumede (1990:116-124), there are medications

- to expel worms
- to improve sexual performance
- to ensure an easy and uncomplicated child birth
- to relieve dysmenorrhoea
- to cure chest complaints and diseases of the gastro-intestinal tract
- to induce vomiting
- to treat skin conditions such as sores, burns, wounds and ulcers.

Over time, healers have accumulated an extensive knowledge of natural material for medicinal and nutritional purposes. This includes the very relevant awareness of the fact that, for example, the concentration of active ingredients in medicinal plants may vary according to season and location (Karim et al 1994:9).

While many preparations have known therapeutic properties, it is important to remember that the curative strength of a medicine is often believed to originate in a combination of the medicine's intrinsic qualities and the healer's spiritual power (Reynolds 1986:183). Thus, the ritual and symbolic context may play a crucial role (Hufford 1992:26). It is partly these last-mentioned considerations which are usually disregarded by the scientific researcher and lead to negative results in the evaluation of efficacy.

#### 4.7.5.2 Herbal medicines in a broader context

Some very topical issues with regard to herbal medicines relate to their general characteristics, healing values, economic potential and potential risk to both consumers and environment.

##### (1) General characteristics and healing value

Healing medicines are often ample preparations composed of vegetable substances in association with animal and mineral compounds (Attisso in Bannerman et al 1983:192-206). Many plants are used for a variety of different complaints in different countries, and even in one country by different healers. On the other hand, as observed by Karim et al (1994:9), there exists a remarkable uniformity in the herbs used within a region, and African healers usually work cooperatively and not competitively with one another. Nevertheless, recipes for mixtures are generally kept secret. Furthermore, healers do not normally use any definite measurements (Chavunduka 1994:81), and preparations often require a certain ritual and symbolic context to exert their effects. As indicated above, all

these factors, together with variations in the concentration of active ingredients according to season and location make it difficult to scientifically assess therapeutic value, and may pose a risk to the consumer.

## (2) Economic potential

Herbal medicines are the most commonly used therapeutic method in many developing countries, and thus have an enormous economic potential (Karim et al 1994:8). Fulder (1988:184) reports that there are half a million plants on this planet, and only about five percent have been scientifically investigated. Van Wyk, van Oudtshoorn and Gericke (1997:7) list and illustrate over 30 000 species of higher plants. In South Africa, approximately 3 000 species of plants are used as medicines, and of these 350 are the most commonly used and traded medicinal plants. Although there are no accurate figures available, the unregulated trade in crude medicinal roots, barks, bulbs and leaves is estimated to be worth R 1 billion annually (Campbell 1998:78). Clarke (1998:5) states that the traditional medicine industry is worth up to R 2,3 billion per year, and that in Durban alone 1 500 tons of traditional medicines are sold annually in medicine markets. The herbal trade in KwaZulu-Natal is estimated at between R15 and R20 million a year (*City Press*, October 4, 1998).

## (3) Environmental risk

Another important issue is the risk which traditional medicines may pose for the environment. According to Ayensu (in Bannerman et al 1983:175), it was in the wake of initiatives from various quarters towards the promotion of traditional herbal medicines that the world's forests were – and still are - being depleted at an alarming rate by business concerns that see no harm in human mismanagement of the environment. However, every part of natural vegetation that is indiscriminately destroyed before it is

explored, may rob mankind of a medicinal plant that could cure some or other as yet untreatable ailment. Efforts, therefore, have to be intensified on the proper conservation of endangered plants used in traditional medicine. So far, people have taken medicinal plants for granted and therefore failed to develop measures of conservation and protection. Recommendations by the WHO (1996:14) stress that changes in health sector policies should include, *inter alia*, increasing concern for the environment and global ecosystems.

According to an article in the *Daily Dispatch* (October 4, 1998), experts who carried out a study on the trade in endangered species for the World Wide Fund for Nature (WWF) and IUCN, the World Conservation Union, found that traditional African medicines represent a threat to many species of fauna and flora in Eastern and Southern Africa. The study – “In Search of a Universal Cure: Protection for the Medicines of Eastern and Southern Africa” – lists 102 medicinal plants and 29 animal species from 17 African countries which the researchers believe should be placed under observation and protection. As the findings emphasise, the aim is not to deprive people of their traditional medicines, but to assist them in making use of nature without destroying it in the process. In order to protect African natural medicines, the report calls for improved cooperation between health and nature conservation authorities and traditional healers, preservation programmes targeted at specific species, and also projects for plant breeding.

Herbal medicines may be regarded as valuable in a therapeutic as well as economic context. It is therefore not surprising that in many African countries research institutes have been established to scientifically assess their healing properties. In South Africa, traditional medicine and its pharmacopoeia form the focus of a new research group set up by the Medical Research Council (MRC) and the Universities of Cape Town (UCT) and the Western Cape (UWC). The Research Group on Traditional Medicines (TRAMED) is based at UCT, and is co-directed by Professor Peter Folb of the Department of Pharmacology at UCT and Professor Peter Eagles of the School of Pharmacy at UWC (*SAMJ* 1997:268). It is a project to document traditional medicines derived from indigenous medicinal plants, identify and isolate their therapeutically active ingredients,

and establish a national database of high-quality essential traditional medicines. The ultimate goal is to compile a herbal formulary that will be available and accessible to all concerned with health care delivery, including traditional healers. It may be added here that the same Research Group has produced the *South African Traditional Healers' Primary Health Care Handbook*, first published in 1997.

#### **4.7.6 Two points of particular significance**

Before concluding the topic of the traditional healer's medicines, two points should be stressed here:

- (1) Herbal medicines are not inherently safe. They may have potentially serious and even fatal side-effects, and may also interact with conventional medicines with deleterious results (CME 1999:249-251).
- (2) While academic researchers tend to reduce African traditional medicine to herbalism, it is crucial to remember that the traditional healer's approach is not limited to the use of herbs and plants. Matthews (in Kirkland 1992:70) points out that the traditional African medicine man cures not only with herbs but also acts as an intermediary with various divinities and as a manipulator of magical forces. Thus, as described above, many social techniques may be used in the treatment process, such as rituals and symbolism to restore balance and harmony, and herbal treatment is commonly combined with individual or group therapy. The faith healer in particular makes use of prayers, the laying on of hands, singing and dancing, holy water and holy ashes. In this way, herbal practice is inseparable from the art of human healing, which includes healer-client interdependence and the paraphernalia which enhance the power of curing agents (Good et al 1979:144).

#### **4.8. THE TRADITIONAL HEALER'S CLIENT**

#### **4.8.1 The client's treatment options**

In general, the person falling ill has four alternatives for care (Staugard 1985:83). Firstly, there is self-care, such as treating oneself by using one of the numerous methods for cure which are transmitted from generation to generation. This may include the use of simple herbal concoctions or of patent medicines obtained from the general dealer. Secondly, there is the option of communal care. This entails seeking advice and treatment within the extended family, and particularly among the elders who are experienced in the treatment of common ailments. The third and fourth alternatives are consulting a modern or traditional health practitioner.

Healers are consulted for a wide range of physical, psychological and social problems, including getting a promotion, passing an examination, winning a soccer game, falling pregnant, or persuading one's spouse to be faithful (Vontress 1991:243). Physical disorders, on the other hand, may range from infertility and epilepsy to hypertension, diabetes and asthma (Campbell 1998:77-150). In addition, the significance of prevention is important. Chavunduka (1994:70) points out that many Africans believe that especially social illnesses may, to a certain extent, be avoided by wearing charms, presenting the necessary offerings to the ancestors, behaving in such a way as not to make enemies, and avoiding places where witches and sorcerers may attack one.

A decisive factor in illness behaviour and health seeking preference is the perceived cause of illness. Thus, in the case of culture-bound syndromes (i.e. illnesses with supernatural causation), the biomedical approach is seldom satisfactory to the client's beliefs and expectations, and a traditional healer will usually be consulted to perform the necessary rituals (Karim et al 1994:6). Where witches and sorcerers are the assumed culprit, curative measures in the form of medicines may be of use to correct the bodily condition, while rituals are required to remove the ultimate cause (Chavunduka 1994:70).

Overall, therapy selection is a complex issue. Where different types of medical care are available, the choice may be influenced by the nature of the illness, beliefs about its

aetiology, geographical and psychological accessibility of care facilities, economic constraints, and previous experience with institutions of either origin (Yoder 1982:1855; Durkin-Longley 1984:867; Chalmers 1990:11-12). In addition, Ellis (1996:145) found that degree of Westernisation, level of education and socio-economic position of the client play a role, as well as the possible stigma attached to consulting a traditional healer. However, Anyinam (1987:808) points out that the psycho-religious services of healers continue to be elicited by even highly educated men and women who are fearful of witchcraft and bad omen. The researcher found that this applies today.

A significant group of patients could be described as double-consumers of health care in the sense that they utilise both modern and traditional health care services for the same condition, although for different reasons (Staugard 1985:171; Chalmers 1990:11).

#### **4.8.2 The healer-client relationship**

Traditional healer and client share the same world view. In most cases, both subscribe to the same culture and beliefs (Karim et al 1994:5). Healers commonly share the patient's language, dialect, idioms and other communication symbols, both verbal and non-verbal. They understand the client's needs and expectations. The healer is usually known to the patient and works in familiar settings. His ministrations depend on the perceived aetiology of the illness and accord with the prevailing beliefs of the community. His prescriptions are culturally meaningful and psychologically effective (Gumede 1990:203). The healer's approach is patient-centred. While the modern doctor treats the disease, the healer treats the person who happens to be ill (Karim et al 1994:4).

The relationship between practitioner and client is characterised by mutual respect, by the confidence of the patient in the capability of the healer, and by a relaxed and serene atmosphere where the individual patient and his various complaints are afforded the necessary care and concentration (Staugard 1985:123). The confidence of the healer in

his own healing potential is conveyed to the client and relieves his anxiety, while the client's faith in the practitioner is an equally important factor for the therapeutic outcome.

### **4.8.3 Health care preferences**

Broadly speaking, the traditional practitioner is consulted to explain the cause of illness through traditional techniques, while the modern doctor is sought to effect a relief of symptoms by means of Western medicine (Ellis 1996:145). Thus, the two operate in different dimensions, the main shortcoming of the biomedical approach being a lack of explanation which may often be related to lack of time, poor language skills, the inability of the modern doctor to "connect" with the patient's frame of reference, and his/her insensitivity to the client's socio-cultural context (Ellis 1996:130). In this sense, biomedical concepts of illness and disregard of the African patient's beliefs may pose a threat to the patient, resulting in biomedical therapeutic techniques in certain circumstances being ineffective and possibly unacceptable (Karim et al 1994:6). In this context it has been observed that "patients gravitate towards the therapist who shares their world view", accepts their health beliefs and thus demonstrates a patient-centred approach (Jorsh 1993 in Ellis 1996:147).

In conclusion, an analysis of illness behaviour and health care preferences shows that people prefer to have choices. In addition, it becomes obvious that consumers are able to see health care options as complementary rather than conflicting. As observed by Wolffers (1990:14), the wisdom of the people makes them look for what they need from the right source, and only absence, unaffordability or unobtainability of desired facilities can frustrate the choice. Thus, in South Africa as well, "dual" treatment regularly takes place (Freeman et al 1992:1185), i.e. both sectors may be used interchangeably, consecutively or even concurrently for the same ailment. Boonzaier (1985:237) states that patients attempt to get "the best of both worlds" and are perfectly happy to commute freely between traditional and Western treatment.

#### **4.9 THE HEALER'S ROLE AND STANDING**

The traditional healer plays an important role in the traditional African society. The term “role” may be defined as a set of behavioural expectations, rights and duties appropriate to a person who occupies a certain position (Ramogkopa 1993:20).

The healer's role was central in tribal life. He was personal adviser to the chief, and the only person in the village capable of mediating between the villagers and the ancestral spirits, able to interpret the symptoms of disease and prescribe the correct treatment (Staugard 1985:51). Today his role remains, multifaceted, comprising a wealth of knowledge, power and ability to serve in a variety of medico-religious parts (Zungu 1992:24). Thus, the traditional healer performs many functions. He is a spiritual guide, diviner, priest, physician, psychologist, judge, prophet, pharmacist and protector of moral values (Brookbanks 1990:82). He may also act as legal and political adviser, marriage counselor and social worker, and has a potentially critical contribution to make in counselling patients with terminal illnesses (De Jong 1991:4; 13). Another large part of his practice is devoted to counseling individuals whose personal problems are often the consequence of rapid social and economic change (Karim et al 1994:9).

At the local level the healer's influence and importance in the everyday life of the majority of the local population have remained almost unaffected by the official changes in society. Consequently, healers should be considered as contemporary unofficial community leaders and organisers (Staugard 1985:52), chosen and accepted by the community in which they live. According to Chalmers (1990:9), the African traditional healer continues to play a dominant social role in the community, serving as a centre of social, cultural and religious order. He assists in the resolution of conflicts, and helps to restore and maintain the balance between individuals, families and the community. He gives insight to patients, and is instrumental in re-establishing a sense of identity, self-esteem and confidence by regaining lost cultural values and preserving cultural institutions (Ellis 1996:144).

The inclusion of traditional healers who would spread curative as well as preventive and promotive health care was first suggested at the World Health Conference at Alma-Ata in 1978 as part of a primary health care approach. It has remained a valuable tool just as traditional healers have retained their availability and influence in the community. By virtue of their standing, they can bring about changes in the behaviour of individuals, families, neighbourhoods and communities (Karim et al 1994:8). In this context, healers may play a critical role between the traditional and modern environments, a “bridge to the modern world” (De Jong 1991:6), acting as teachers and “change agents”, and channelling educational messages to the local population. Realising their significance, a number of African governments have made cooperation with traditional health practitioners one of the strategies of their national AIDS programmes. In South Africa, for example, a study by investigators of the Medical Research Council (MRC) recommended that health care authorities should attempt integrating healers into health care activities such as voluntary counselling and testing for HIV, and for using them in home-based care for people with AIDS (Colvin, Gumede, Grimwade and Wilkinson 2002: 20-21). Likewise, Directly Observed Therapy for Tuberculosis (DOTS) programmes should consider recruiting healers as DOTS supervisors.

In conclusion, the African traditional healer remains a constituent part of African everyday life. Karim et al (1994:2) regard him as an integral part of African culture, fulfilling functions which go far beyond those that biomedically trained health care workers regard as appropriate to their profession. Furthermore, healers remain influential people who have credibility as well as prestige in the local African community.

#### **4.10 THE SPECIAL ROLE OF THE HEALER IN MENTAL HEALTH CARE**

Mental health care in Africa is believed to pose a special challenge to modern scientific medicine and a very definite field for traditional medicine. In the first instance, it is the culture-bound syndromes or “African disorders” that have plagued the psychiatric

fraternity for many years. They are regarded as peculiar to African people, and embrace mental and other illnesses caused by “social agencies” such as ancestral spirits, angry spirits, witches and sorcerers (Chavunduka 1994:82). An angry spirit, for example, is the spirit of someone who was wronged during life, such as an ill-treated parent, a neglected spouse or a victim of murder either by witchcraft or by physical means.

Secondly, a case of mental disorder may occur when an individual is about to inherit a healing spirit (Chavunduka 1994:82). The person chosen or “called” usually becomes ill. At times the restlessness may take the form of mental confusion. A proper diagnosis by an experienced healer will then reveal that the victim is troubled by a spirit wishing to confer its healing powers upon the patient. In such an instance no ordinary remedies are effective, and a ritual ceremony is required at which the spirit is accepted and honored.

Cases of this nature do not fit into the standard psychiatric classification of Western medicine (Wessels 1985:55). In addition, however, a third factor comes into play: mental ill health today represents a big slice of the diseases occurring in the Third World where communities are in a state of transition (Gumede 1990:196). Urbanisation, acculturation and commercialisation require social, economic, political and religious adjustments which may cause worry, strain, tension and anxiety. Many disturbances therefore reflect coping difficulties that then manifest themselves as inability to secure employment or a marital partner; strained or broken kin relations; alcoholism and job failure (Good et al 1979:146).

The appropriate treatment for mental ill health as provided by the traditional healer is tailored to the respective causative factors. Where the illness is due to natural causes herbal medicines may be administered. In addition, a ritual or even the simple contact with the diviner often helps to resolve social problems experienced by the patient and members of his group. During the ritual, the individual and community members are encouraged to confess and discuss shortcomings such as neglect of family or kinsmen (Chavunduka 1994:85).

Where a “social agent” is believed to be responsible for mental illness, it may be necessary to drive away an evil spirit. This may be done by the healer inducing a trance in the patient and instructing him to fight and overcome the spirit that is troubling him (Chavunduka 1994:82). Otherwise, a spirit medium may be hired to conduct direct negotiations with an angry spirit at a ritual while the diviner is in a state of possession. In some cases the diviner may recommend that the spirit worrying his client be transferred to another person or an animal (Chavunduka 1994:83).

In general, Ulin and Segall (1980:53) point out that modern scientific medicine is unequipped to handle the rapidly growing case load of mental and sociopathic disorders in Africa. Brookbanks (1990:1) concurs, stating that Western psychology is not able to address the mental health issues of African societies. The problem persists today. The main factor is the importance of a shared world view which applies to the traditional healer and lacks in regard to the modern medical practitioner. A common belief conveys to the patient that someone understands. And since his problem can be understood, it can also be cured. Without this understanding, the therapist is ineffective, his treatment is irrelevant, his best intentions are doomed to fail. And here exactly lies the root cause of an unsuccessful handling of the cross-cultural encounter: the modern doctor meets patients whose norms and values differ substantially from his own. Without a knowledge and understanding of the client’s belief system he can easily fall prey to errors of diagnosis, resulting in inappropriate management and poor patient compliance.

The application of a Western explanatory model to black patients poses a threat to the patient’s own interpretation, and this confrontation must be regarded as a major factor adversely affecting the credibility of the treatment and its outcome (Gillis, Koch and Joyi 1989:207). Louw (1993:1) cites Holdstock (1982), who states that we “ fail to realise the extent to which we impose a psychology developed in the Western world on Africa...We fail dismally in adapting and applying our psychology to life in Africa. Like the missionaries of old, we are trying to convert Africa to psychological reasoning along the lines of Western thought. And by doing so we naturally fail to acknowledge the psychological dimensions of Africa”. According to Allwood (1986), “mental health

professionals need to learn that in their work with African people their world view must be considered, and spiritual values must play a part in the healing-counselling process” (Allwood in Louw 1993:25).

Thus, modern mental health professionals and those most committed to a more appropriate bio-psycho-socio-cultural approach to primary health care are urgently calling for greater collaboration with indigenous practitioners (Edwards 1986:1273).

Foster et al (1997:191) quote the resolution adopted by delegates of the South African Regional Conference on Mental Health Policy, 4 October 1995:

It is affirmed that the authentic practice of traditional African forms of healing is vital to the mental health in Africa; its holistic approach to healing has much value for all to learn.

One culture has no right to impose its concepts of causation or classification upon another. Both systems should admit their inherent imperfections and work hard to correct them (Thabede 1991:13). The continuation of a solely Western health care model is one-sided and unacceptable (Louw 1993:35).

To summarise, much difficulty has been reported by Western psychiatrists who attempt psychotherapy with Africans or for that matter, by any psychiatrist seeking to treat ethnically different patients by using standard therapeutic approaches (Ilechukwu 1989:420). In all psychotherapy, the cultural factor is so important that Madura (in Buhrmann 1984:93) wrote that unwillingness “to consider patients’ culture is tantamount to treating them as a fragment rather than a whole person; this attitude is anti-therapeutic.” Counselling and psychotherapy are most effective when there is the greatest cultural and personal similarity between healer and the healed. Therapeutic effectiveness is directly related to the extent to which the counselor’s value system coincides with that of the client (Holdstock 1979:119). According to Holdstock (1979, Western techniques are, with few exceptions, culturally too different to offer a psychological approach to healing that would be meaningful for the majority of Africans.

Traditional healers who treat psychiatric ailments are an important health care resource for two reasons: firstly, they provide a service which is generally given low priority in the official health care sector. Secondly, psychiatric symptomatology is deeply embedded in culturally specific systems of meaning which are shared by clients and healers. Mental health problems cannot be solved exclusively through relying on Western modalities of treatment, nor can they be solved through sole reliance on traditional healers. But they can be alleviated through a balanced combination of both scientific and traditional approaches to therapy (Thabede 1991:13).

#### **4.11 HEALERS IN TRANSITION**

Like any other cultural system, indigenous medical systems have undergone change as African countries experience alterations in their ecological structures, socio-economic activities, political and cultural life. These changes have had an impact on the practice of traditional medicine in many parts of Africa, including South Africa (Anyinam 1987:809).

According to Edgerton (1977:480), the survival of the healer's role is heavily dependent on his ability to increment his power through adoption of what might be termed 'Western magic'. Increasingly, therefore, healers are displaying their flexibility by incorporating Western medical materials and methods into their practice (Simon 1991:677). In addition, they often include pharmaceutical products in their traditional repertoires (Simon & Lamla 1991:239). De Jong (1991:8), Oppong (1989:609), Anyinam (1987:809) and Campbell (1998:151-164) note the following changes: healers are dressed in white coats; operate from modern clinic facilities; use stethoscopes, hypodermic needles, clinical thermometers, bandages and X-rays; keep record cards – in some cases complete with diagnosis, treatment, referral and follow-up; bottle and label medicines; prescribe antibiotics; and have wheelchairs at their disposal. Others make capsules, test urine, and may have wards for patients as well as full-time students learning traditional practices,

while patients with minor ills may be seen by healers' assistants. Overall, settings often become more hygienic, and visiting cards and telephones may be used to manage the day-to-day workload.

At the same time, changing circumstances may confront practitioners with some special problems. Campbell (1998:91) states that healers may know little on the business side, how to organise a clean clinic or run a tidy traditional pharmacy. They need lessons in book-keeping and hygiene. They must be taught how to label medicines, keep detailed patient records and communicate with modern physicians in the case of referrals.

All in all, however, traditional medicine has kept in touch with changes in the society, and is willing to meet new expectations to become more attractive to clients.

#### **4.12 THE CONTROL OF TRADITIONAL PRACTICE**

In the traditional setting, the local community exercises social control over traditional practitioners. In addition, meetings of healers from time to time are not simple social gatherings but act in many ways as professional conferences and disciplinary or supervisory bodies, ensuring accountability to the public. Accountability, according to Coe (1978:413), signifies that "providers are responsible for assuring the quality of services rendered, both technically and organisationally, and for monitoring continually the competence and continuity of services provided". However, with modernisation circumstances have changed, and especially in the urban set-up the social control mechanism is no longer operative. An alternative form of control is now exercised by traditional healers' associations, many of whom are registered under the Companies Act. At present there are approximately 200 healers' associations in South Africa, among them the Inyanga's Association in KwaZulu-Natal which accepts members only after they have performed an oral examination in front of a select committee (Clarke 1998:5). Nhlayona Maseko is the head of the Traditional Healers Organisation (THO). In 1980 he placed 150 organisations, representing traditional healers in South Africa, under this

single umbrella body. It currently embraces more than 180 000 practitioners from South Africa and a number of neighbouring countries including Swaziland, Zambia and Zimbabwe (Hess 1998:6). The president of the National Traditional Healers Association of South Africa (NTHASA) is Patience Koloko. The Association represents 5 000 practitioners and is affiliated to the THO.

The various groupings are often split by historical, geographical and political factors. There is also disagreement as to who is a *bona fide* healer since the process of registering practitioners within these bodies is not uniform. Some associations are even alleged to confer simply notional professional qualifications upon their members. Other healers are wary that associations of traditional healers may be seen as embracing “weak junior professionals of low status” (MacCormack 1986:154).

Traditional doctor, Philip Kubukeli, President of the Western Cape Traditional Doctors, Herbalists and Spiritual Healers Association, acknowledges the disunity among the healers’ ranks. While he welcomes recommendations regarding the formation of an Interim Council for Traditional Healers in principle, he foresees difficulties in bringing all healers together into one single body. A better solution, according to him, might be to allow each of the 200 existing associations to conduct its own registration and regulation of traditional practice (*SAMJ* 1998:1057).

#### **4.13 CONCLUSION**

African traditional medicine is based on a special belief system, the African world view, which determines the concepts of health and illness, the causation of disease, the aims of healing and the dimensions of traditional medical practice.

African traditional healers are usually classified into various categories, although this process of categorisation must be seen as an over-simplified one due to a high degree of

overlapping and blurring of borders. Nevertheless, categories usually differ with regard to choice of profession, training and range of practice.

As far as traditional medicines are concerned, there is no clear distinction between a medicine in its narrow and broader sense. The healer's "medicines" thus comprise a wide range of approaches which may vary according to aim of treatment, technique and route of administration, as well as an extensive pharmacopoeia. An essential component of the latter are herbal medicines which themselves have therapeutic, economic and environmental potential. The healer's clientele include educated and uneducated alike, although Westernisation, education and socio-economic status appear to influence health care selection and decision-making process within the available options of self-care, family/community care, traditional healer or modern medical practitioner. Most important here is the fact that the two medical systems – modern and traditional medicine – are regarded as complementary and not exclusive, and that 'dual treatment' regularly takes place. An essential feature of the practitioner-client relationship is the fact that both parties share the same world view, values and explanatory models of illness. This is of particular significance in the provision of mental health care where modern medicine is to a large extent unable to deal with the socio-psychological dimensions of African disorders.

Overall, the healer's role is multi-faceted. Amongst others, he is the guardian of social rules, norms and values. As mediator between the people and the ancestral spirits he is indispensable for the attainment and maintenance of health as defined by traditional societies.

Healers in transition are faced with a variety of problems. The main challenge lies in adaptability - the traditional system's ability of accommodating changing political and socio-economic circumstances, especially in urban settings, and thus keeping its market share in an increasingly competitive environment.

In general, healers enjoy credibility, respect and a status of authority in their communities to whom they are also accountable. Besides this particular form of social control, healers' meetings and nowadays healers' associations exercise some control over traditional practice. Currently, there are approximately 200 traditional healers' associations in South Africa, unfortunately often split by historical, geographical and political factors.

In conclusion, traditional medicine has remained an expression of African culture. In this sense it has retained its accessibility, acceptability and relevance. It has the advantage of cultural, social, psychological and physical proximity, and meets spiritual and emotional needs not met by modern scientific medicine. It may be a great source of comfort to Africans undergoing cultural change by providing security and continuity in an unpredictable changing world (Green 1988:1128).

Traditional medicine has remained health- rather than disease-orientated and holistic in its approach. Health is viewed as a mind-body-spirit continuum but also refers to collective harmony. Collectively, traditional medicine encompasses a large body of indigenous knowledge and deals with a broad spectrum of physiological and mental ill health. Its regulation by modern law and evaluation by modern science will be a daunting though not insurmountable challenge.

Chapter 5 deals with the role of the African traditional healer in the context of witchcraft and sorcery, as well as the legal control of these phenomena in a variety of African countries, including South Africa.

## **CHAPTER 5. THE HEALER'S ROLE IN WITCHCRAFT AND SORCERY IN A LEGAL CONTEXT**

### **5.1 INTRODUCTION**

References to supernatural phenomena including magic or witchcraft, have been made in all cultures and at all times. It should be seen as a complex of traditional ideas, beliefs and rites which are handed down from generation to generation (Staugard 1985:94). According to Staugard (1985) in anthropological literature a generally accepted distinction is made between “white” and “black” magic. White magic is believed to have protective and productive functions in society, while black magic acts as a destructive force.

White magic is universally recognised in the form of rites and habits in the society which aim at shielding the individual or group against misfortune and evil. It is socially approved. It is prevalent in both traditional and modern medicine, and is often used for curing sickness (Staugard 1985:94). Black magic occurs in two principle forms: as witchcraft and as sorcery. Witchcraft is described as an innate quality and an involuntary personal trait. It is often a hereditary condition and provides a theory of failure, misfortune and death. Sorcery, in contrast, is the deliberate employment of malevolent magic. It is performed by an evil-minded person and involves the use of a spell or technical aid. Staugard (1985:95) explains that his own distinction was made on the basis of studies in the Azande culture in western Africa. However, it seems to apply to most African cultures as well as to Europe and North America.

In some cultures, supernatural forces are accorded such importance in the popular concepts of health and disease that religious rites, invocations, magical methods and even the invocation of witchcraft constitute an integral part of traditional healing, and can be used with beneficial results. However, the dangers of misuse or harmfulness of some of these techniques are evident (Bannerman et al 1983:311).

Under the “sociology of witchcraft and sorcery” Chavunduka (1994:87-102) makes a basic distinction between their cultural, social and psychological aspects on the one hand, and legal aspects on the other. According to him, when an individual accuses another person of witchcraft, the several meanings of such a charge have to be taken into account. Firstly, the accused is a bad person who ought to be helped to conform. He may be envious of others, he may go his own way despite the objections of his neighbours; he may commit anti-social acts, be a trouble-maker or be a person who fails to carry out the necessary rituals for his dead relatives. People who accuse others in this way are not seeking a legal ruling on the matter because the issues involved are not legal issues but cultural, social and psychological ones that nonetheless call for urgent action.

Traditional courts often handle cases of this nature successfully because they attempt to solve the underlying social problems. Their main aim is to reconcile disputing parties within the community and to restore social harmony. In this way, the individual is helped to conform to the accepted standards of social behaviour in the respective community, e.g. friendliness, good manners, hospitality and generosity.

Secondly, the idea of witchcraft may be invoked as a concept for explaining the deeper or indirect causation of events which seem unnatural. As Gluckman (in Chavunduka 1994:88) points out that “when the African says it is witchcraft that causes the death of a person, he is explaining the coincidence which science leaves unexplained.” The function of witchcraft accusation to explain otherwise inexplicable events is supplementary to its function of highlighting social tensions or reinforcing the moral code.

Thirdly, individuals who accuse others of witchcraft may be referring to sorcery. Chavunduka(1994:89) defines sorcery as a technique or tool employed by an individual in order to harm another person. Recourse to sorcery always occurs on a deliberate, conscious and voluntary basis. In Zimbabwe, Chavunduka (1994:90) points out that sorcery techniques fall into three broad categories:

(1) Those that involve the use of medicines or poison. Although modern courts often investigate this type of sorcery, these cases are not labeled as such, and many people have been sentenced for murder or attempted murder instead. On the other hand, many sorcerers escape conviction. One reason is that victims often do not die in hospital, and therefore no post-mortem examination is carried out before burial. Another explanation is that many accusations of sorcery are made long after the death of the victim and therefore remain unproven. Thirdly, many organic poisons are difficult to detect at a post-mortem examination.

(2) A poison or dangerous object planted by the sorcerer on a path or in the victim's home so that people coming into contact with it become sick.

(3) Techniques which are said to operate without actual physical contact. These are instances where persons become sick as a result of feeling convinced that they have been bewitched.

The last instance of witchcraft accusation involves "real" witches, that is, "those people who are said to eat corpses, dance naked in the fields at night, and cause sickness, death and other misfortune. This is the most controversial category in the broad context of witchcraft and sorcery" (Chavunduka 1994:91). The same distinction regarding the meaning of witchcraft accusations is also made by Staugard (1985:101-102) when he discusses the various "social functions" of witchcraft.

In accordance with modern thinking, many people hold that witchcraft is a myth; that witchcraft beliefs are based upon an essentially mistaken view of the world; that witches do not exist except in the mind of certain individuals (Chavunduka 1994:91). Academics, particularly from Europe, have accepted the doctrine of the unreality of witches which developed in Europe mainly because of the inhuman treatment inflicted upon persons

accused of witchcraft. However, Chavunduka (1994:102) states that “real witchcraft is possible, and witches of this last kind may cause sickness, death and other misfortune when practising their art”.

In his study of the situation in Zimbabwe, Chavunduka found that the subject of witchcraft continues to create controversy not only in that country but in many other parts of the world, and has, in fact, become the major area of conflict between traditional and modern practitioners: “Most traditional practitioners agree that witches exist and cause illness, while most modern practitioners say witches do not exist”. Thus, where witchcraft is believed to be involved, traditional healers see their task as one of identifying the witch if possible and then advising on the steps to deal with the evil (Chavunduka 1994:86).

Of particular interest in this context are the confessions made by “real witches” about their activities, either in church or in court or during the course of police investigations. Chavunduka (1994:98) reports that Advocate Crawford, who has examined many cases of such confessions in the formal courts of Zimbabwe, discovered a number of recurring features in these accounts which were confirmed by his own findings (Chavunduka 1994:98): witches tend to operate in groups; they use medicines to bewitch their victims; the statements of the various witnesses show a high degree of corroboration.

Studies tend to look for the reasons which might motivate a person to make a voluntary confession of witchcraft in a court of law, a type of evidence which according to Chavunduka (1994:98), is usually regarded as of doubtful relevance. Chavunduka advances three hypotheses in this context:

Firstly, people who confess to witchcraft are insane; they are emotionally unstable and attempt to vent their feelings of frustration by seeking to cause sensation.

Secondly, the individuals concerned confess to be witches in order to make others fear and obey them.

Thirdly, the confessors are often women who want to enhance their status in the community. However, Chavunduka (1994:99) states that neither explanation is

satisfactory and “one hypothesis which has not been adequately considered is that witchcraft, or at least certain types of it, is objectively valid and indeed existing”. Claims that witches sometimes use medicines or poison to harm people are correct. Others may confess to eating parts of their victims, which may later be confirmed by the police.

In summary, when an individual in an African community accuses another of witchcraft, he may well be right, bearing in mind the African definition of witchcraft as discussed under the above-mentioned four categories. It is important, therefore, to keep the cultural, social and psychological aspects of witchcraft separate from the legal aspect (Chavunduka 1994:103). The consequences to the person named as a witch or sorcerer can be serious, and it is the duty of the courts to protect individuals from violent reactions by their communities.

Due to the potentially fatal consequences that may arise in the context of witchcraft accusation witchcraft needs to be kept under control. However, Chavunduka (1994:105) maintains that “the suggestion that the only solution to the problem is the abandonment by the people of their beliefs in witches and sorcerers makes no sense”. Many people in Zimbabwe, as in other parts of Africa, do not see the solution in eliminating the ideas but in controlling and eradicating witches and sorcerers. There should be a law against witchcraft and sorcery because people do become sick or die as a result of the activities of certain other individuals (Chavunduka 1994:104).

The suppression of witchcraft has at all times been the aim of legislators in various parts of the world (Koyana 1992:48). In England, witchcraft was once so rife that it was made a capital offence. The last execution for witchcraft took place in 1776 in England and in 1772 in Scotland. As far as Africa is concerned, the belief in witchcraft is still rampant in many parts and opinions differ on the real answer to the problem (Koyana 1992:48). The Sudanese Penal Code, for example, lays down the severest penalties where the practice of witchcraft is involved. Thus, while legislative control of witchcraft is necessary, “intervention in this emotion-loaded field might be extremely difficult” (Bannerman et al 1983:311-312). Two problems arise: (a) to what extent legal prohibitions and sanctions

are justified if based on the probability of causing considerable social harm; and (b) what kind of legal regulations are actually enforceable in practice.

Colonial criminal laws against witchcraft, which are still on the statute books of many countries in various parts of the world, follow two broad patterns. Some, such as those of Malawi (1911), the United Republic of Tanzania (1928), and Uganda (1957), make the practice of witchcraft or the representation of oneself as a person possessing supernatural powers an offence *per se*, whatever the purpose for which the act may be committed. Others, such as the Penal Code of the former Belgian Congo, still in force in Zaire, or the 1925 Witchcraft Ordinance of Kenya, render witchcraft an offence only when it is used or threatened for a harmful purpose, that is “with the intent to injure” or “for the purpose of causing fear” (Bannerman et al 1983:311). While the excessively broad wording of the first type of criminal law makes such provisions almost unenforceable, laws of the second type may, depending on the dangerous nature of some customs or beliefs, be necessary and helpful (Stepan 1983:311).

Sanders (1989:527) states that in this context, colonial legislation – which has usually not been repealed following independence – has not succeeded in freeing the African community from witchcraft, and despite criminalisation the phenomenon continues to exist. Occasionally witches and sorcerers have their homes burnt or are killed. In the eyes of the state courts, to “burn out” or kill a witch or sorcerer constitutes a crime. While prepared to regard belief in witchcraft and sorcery as a factor mitigating sentence, they refuse to exculpate an accused who has acted deliberately against a witch or sorcerer.

Hence the belief in witchcraft remains. Aremu ( in Bannerman et al 1983:312) found that more than 90 percent of his undergraduate criminal law students believe firmly in witchcraft and other supernatural forces.

The role of the traditional healer in this context is of the utmost importance. Most traditional practitioners agree that witches exist and cause illness. Thus, where witchcraft is believed to be involved, they regard it as their job to identify the witch if possible and

then to advise on the steps necessary to deal with the evil and to cure the ensuing disease (Chavunduka 1994:86). At the same time, healers nowadays are extremely reluctant to name the witch or sorcerer because it is an offence to do so.

The term witch-doctor, however, should no longer be used because it is not correct. Although many traditional healers believe that some illnesses are caused by witchcraft, they also recognise other causative agents such as germs and bacteria and ancestral spirits, and deal with other health and social problems. Thus, witch-finding and dealing with witches is not a full-time occupation (Chavunduka 1994:8). Staugard (1985:102) confirms that it is incorrect to call a traditional healer a witch-doctor; the term is both derogatory and misleading. A healer may occasionally be employed as a witch-finder. In this role he acts as a guardian of social stability (Staugard 1985: 93).

Next anti-witchcraft legislation in Zimbabwe, Botswana, South Africa and Cameroon is discussed. Zimbabwe was chosen for Chavunduka's commentary, Botswana as a country closely following the legislative strategy employed by Zimbabwe, and South Africa in order to illustrate the historical evolution of the relevant legislation. The situation in the East Province of Cameroon is added because it indicates trend towards strengthening rather than combating belief in witchcraft.

## **5.2 THE WITCHCRAFT SUPPRESSION ACT OF ZIMBABWE, 1889**

The Witchcraft Suppression Act of Zimbabwe was passed in 1889. Chavunduka (1994:102) points out that it is aimed at five categories of people:

- (1) Any person who names or indicates any other person as being a witch is guilty of an offence.
- (2) People referred to as "witch-doctors": any person who names or indicates any other person as being a witch and is proved at his trial to be by habit and repute a witch-doctor or witch-finder faces a heavy sentence.

(3) It is an offence to employ or solicit any other person to name or indicate thieves and other wrong-doers by means of witchcraft; similarly, a person who employs someone to advise him how, by means of witchcraft, such thieves or wrong-doers may be identified, commits an offence.

(4) People who claim to have a knowledge of witchcraft or the use of charms: it is an offence to advise someone how to bewitch any person or animal or to supply someone with pretended means of witchcraft.

(5) Anyone who, on the advice of a witch-doctor or witch-finder ... uses or causes to be put into operation such means or processes ... calculated to injure any other person or any property, including animals, shall be guilty of an offence.

However, Chavunduka (1994:103-105) points out that the Witchcraft Suppression Act has a number of faults. The first relates to the definition of witchcraft in the Act as “the throwing of bones, the use of charms and any other means or devices adopted in the practice of sorcery”. According to Chavunduka (1994: 103) this definition is wrong because it says nothing about witches or witchcraft. The throwing of bones is a means of divination by which a diviner determines or attempts to determine who or what caused an illness or other misfortune, while another large part of the healer’s practice is concerned with prescribing preventive charms.

The second fault relates to the failure on the part of the legislature to make a distinction between the terms “witchcraft” and “sorcery” which are used interchangeably throughout the Act while, in reality, they represent two different concepts. The third fault is the neglect of the cultural, social and psychological dimensions of witchcraft as opposed to its legal aspects. While the consequences for a person identified as a witch or sorcerer can be serious, and while it is the duty of the courts to protect individuals from violent reactions by their fellow villagers, many people who accuse others of witchcraft or sorcery are not seeking a legal ruling on the matter, but are merely saying that the accused is a bad person, a trouble-maker, a deviant who needs to be helped to conform to the accepted standards of social behaviour of the respective community.

Finally, Chavunduka (1994:104) criticises the suggestion that the only solution to the problem of witchcraft and sorcery is the abandonment by the people of their beliefs in witches and witchcraft. Many people in Zimbabwe, as in other parts of Africa, do not see the answer in the denial of the witchcraft belief, but rather in a law appropriately controlling witches and sorcerers who may harm or even kill others through their activities.

Chavunduka (1994:104) concludes that the Witchcraft Suppression Act has undoubtedly removed the most dramatic dangers to life and liberty. Diviners and other practitioners are now more cautious about imputing witchcraft out of fear of prosecution. When faced with a case of witchcraft, they have become reluctant to name the witch, and rather point to a category of people among whom the culprit may be found; the patient then fixes on some definite person who he thinks has reason to wish him harm.

But the Act has also brought other problems in its wake. The main effect of severe sentences has been to drive the practice of witchcraft underground. Thus, while the use of techniques that were adopted in the past to identify witches or sorcerers is now forbidden by law, some healers may still be invited by members of the community to perform this task secretly.

Apart from identifying witches, there is the healing aspect. Many healers are able – or claim to be able – to cure witches. Hence, people who believe that they are witches or have been accused by other persons as being witches, still go to traditional healers for help. The healer then removes what he believes is an evil spirit in them. Chavunduka (1994:8) states that some churches perform this service as well.

The role of the traditional healer in the context of witchcraft and sorcery remains, together with the belief in these phenomena. According to Chavunduka (1994:105), traditional health practitioners are right in continuing to attend to illnesses caused or believed to have been caused by witchcraft, because they “often handle such cases effectively and many people are cured”.

### 5.3 WITCHCRAFT AND WITCHCRAFT SUPPRESSION IN BOTSWANA

Staugard (1985:101-102) states that witchcraft in the contemporary Tswana village seems to serve at least three major functions. Firstly, it provides a satisfying explanation for events which in other cultures are attributed to chance or bad luck. For the Tswana villager witchcraft, thus, is the logical answer to questions of “why me” and “why now”? Secondly, it acts as a force which buttresses the moral code of the traditional society. It is an instrument of moral reinforcement, serving the maintenance of social stability. Thirdly, it plays an important role in identifying tensions in social relationships, thus facilitating the provision of rational solutions to such tensions.

Staugard (1985:98) describes the healer’s role in the context of the various aspects of witchcraft as follows:

If a disease is diagnosed as having been caused by a foreign substance, the healer may prescribe purging treatment in order to remove the poison from the body. The treatment can be given in the form of emetics or enemas, or as external and internal ‘cleansing’ with large amounts of water. Steam baths and smoke from selected burning herbs may also be used.

If the poison is of a more serious nature, the appropriate method is sucking. In some cases the sucker may transfer the substance from the patient to an animal (for example, a goat), to a tree or to the earth through complicated rituals. In cases of domestic conflict such as marital infidelity, quarrels over the ownership of property, or general disagreement between individual members of the extended family, the Tswana healer may be employed to point out the person who has become a threat to the social balance and well-being of the group, and the culprit may be removed (e.g. advised to move to another village).

Effective methods of prevention against witchcraft are also available through the traditional healer in order to protect the individual, his household, domestic animals and

crops. However, if a sorcerer has been identified in a village as responsible for the disease or even death of another villager, he or she is usually brought to the tribal court. Staugard (1985:99) points out that the Chief alone has the right to prosecute and punish a sorcerer.

In general, Staugard (1985:102) found that, while the belief in the existence of “night witches” seems to be fading, the belief in the practices of “day witches” or sorcerers is both well defined and real to the majority of the Tswana villagers – notwithstanding anti-witchcraft legislation, like the Bechuanaland Protectorate Witchcraft Proclamation 17 of 1927 (Staugard 1985:227-228). It has almost the same wording as the Zimbabwe Witchcraft Suppression Act, but a sixth category of offenders is added: any person who for purposes of gain pretends to exercise or use any kind of supernatural power, witchcraft, sorcery, enchantment or conjuration, or undertakes to tell fortunes, or pretends from his skill or knowledge in any occult science to discover where or in what manner anything supposed to have been stolen or lost may be found shall be liable upon conviction to the punishments provided by section two.

Furthermore, Staugard (1985:99) points out that the customary courts of Botswana still hear cases of alleged contravention of the Witchcraft Proclamation, and continue to convict sorcerers. Thus, as observed in other African countries, legislation has not succeeded in eradicating either witchcraft or sorcery.

#### **5.4 ANTI-WITCHCRAFT LEGISLATION IN SOUTH AFRICA**

In his book *The influence of the Transkei Penal Code on South African Criminal Law* Koyana (1992) describes how Chapter 11 of the 1886 Transkei Penal Code finally developed into the Witchcraft Suppression Act 3 of 1957. Up to the middle of the nineteenth century the people of Transkei lived as totally independent chiefdoms with their own legal systems and constitutional as well as social organisations in the area between the Kei and Mtavuma Rivers, between Lesotho and the south-east coast of

Africa bordering the Indian Ocean. The country was small in size and had a population of less than one million people at the time. Criminal cases were heard and disposed of in the customary courts in accordance with customary law (Koyana 1992:18-19).

Between 1879 and 1894 Transkei was brought under British rule by a series of annexations, yet retained a separate status based, probably, on the fact that “the great bulk of the Transkeian population was black, and that these blacks lived not on white farms but on their own land” (Sanders in Koyana 1992:19). Nevertheless, as soon as annexation took place, the people of Transkei were automatically brought under colonial law, and the question of codifying the law in the Transkeian Territories immediately occupied the minds of the authorities (Koyana 1992: 23). As opposed to a civil code, a criminal code was urgently needed for two reasons, namely that the magistrates did not know which law to apply, while the people did not know which law they had to obey (Koyana 1992:27). The issue was between the colonial and the customary criminal law.

The Penal Code Bill was passed in the 1886 Cape Parliamentary Session, following the recommendations of the Cape Government Commission on Native Laws and Customs (1883). The Transkei Penal Code Act 24 of 1886 (Cape) finally came into force on 1 January 1887. It became the criminal code applicable to all people living in the Transkeian Territories regardless of race or colour (Koyana 1992: 36). Its significance lies in the fact that it is the oldest criminal code in Southern Africa, and the oldest type of criminal code of English law origin in Africa (Koyana 1992:18). At the same time it did not merely concern itself with the imposition of English law. Its drafters took what seemed worth taking from Roman-Dutch and Roman law as well, and the Code was thus successful in importing aspects of these legal systems into Transkeian and later South African jurisprudence (Koyana 1992:194). Most importantly, however, “such of the customary laws as are not opposed to universal principles of morality and humanity were left substantially unaltered” (Koyana 1992:45). Thus, the Code was a careful blend of Western and customary law principles. It was enacted by Western lawyers and meant to be applicable, for the most part at any rate, to a non-Westernised African community which so far had always had its life governed by the indigenous criminal law.

Koyana (1992:1) points out that the Transkei Penal Code exerted a great influence on South African criminal law, especially after the Union was formed. Of particular interest for the present study is Chapter 11 of the 1886 Code, which was devoted to the suppression of witchcraft, and which later formed the basis for the South African Witchcraft Suppression Act 3 of 1957, while the new Transkei Penal Code (Act 9 of 1983) virtually re-enacted the provisions of the 1957 Act.

Koyana (1992:50) discusses the relevant sections of the 1886 Code (Chapter 11). Section 171 prohibited the imputation of witchcraft, whereby a person names or indicates another to be a wizard or a witch. The maximum penalty was forty shillings. Where such imputation was made by a witch-doctor, the maximum penalty was two years imprisonment or a fine or flogging or any two or all three of these (section 172).

Section 173 made it an offence punishable by a fine of five pounds to employ a witch-doctor to name a person as a wizard or witch.

Section 174 laid down a maximum penalty of up to twelve months imprisonment with the option of a fine for witch-doctors who professed knowledge of witchcraft and supplied advice on how to bewitch or injure persons or property or cattle, or supplied by witchcraft material with intent that injury be caused thereby.

In terms of section 175, those who used witch-medicines with the intention of injuring any person or property were liable to periods of imprisonment of up to twelve months, with the option of a fine.

The Witchcraft Suppression Act 3 of 1957 reads as follows:

Aim: to provide for the suppression of the practice of witchcraft and similar practices.

1. Offences relating to the practice of witchcraft and similar practices.

Any person who-

- (a) imputes to any other person the causing, by supernatural means, of any disease in or injury or damage to any person or thing, or who names or indicates any other person as a wizard;
- (b) in circumstances indicating that he professes or pretends to use any supernatural power, witchcraft, sorcery, enchantment or conjuration, imputes the cause of death of, injury or grief to, disease in, damage to or disappearance of any person or thing to any other person;
- (c) employs or solicits any witch-doctor, witch-finder or any other person to name or indicate any person as a wizard;
- (d) professes a knowledge of witchcraft, or the use of charms, and advises any person how to bewitch, injure or damage any person or thing, or supplies any person with any pretended means of witchcraft;
- (e) on the advice of any witch-doctor, witch-finder or other person or on the ground of any pretended knowledge of witchcraft, uses or causes to be put into operation any means or process which, in accordance with such advice or his own belief, is calculated to injure or damage any person or thing;
- (f) for gain pretends to exercise or use any supernatural power, witchcraft, sorcery, enchantment or conjuration, or undertakes to tell fortunes, or pretends from his skill in or knowledge of any occult science to discover where and in what manner anything supposed to have been stolen or lost may be found,

shall be guilty of an offence and liable on conviction -

- (i) in the case of an offence referred to in paragraph (a) or (b) in consequence of which the person in respect of whom such offence was committed, has been killed, or where the accused has been proved to be by habit or repute a witch-doctor or witch-finder, to imprisonment for a period not exceeding twenty years or to a whipping not exceeding ten strokes or to both such imprisonment and such whipping;
- (ii) in the case of any other offence referred to in the said paragraphs, to one or more of the following penalties, namely, a fine not exceeding one thousand rand, imprisonment for a period not exceeding ten years and a whipping not exceeding ten strokes;

- (iii) in the case of an offence referred to in paragraph (c), (d) or (e), to a fine not exceeding five hundred rand or to imprisonment for a period not exceeding five years, or to both such fine and such imprisonment;
  - (iv) in the case of an offence referred to in paragraph (f), to a fine not exceeding two hundred rand or to imprisonment for a period not exceeding two years.
2. Presumption. – Where any person in respect of whom an offence referred to in paragraph (a) or (b) of section 1 was committed, is killed, it shall be presumed until the contrary is proved, that such person was killed in consequence of the commission of such offence.

This very detailed Act was followed by the Witchcraft Suppression Amendment Act 50 of 1970, which is of an extremely generalised nature and provides as follows:

ACT: to amend the Witchcraft Suppression Act 1957 so as to make it an offence for a person who pretends to exercise supernatural powers, to impute the cause of certain occurrences to another person; and to provide for incidental matters.

1 and 2. Substitute respectively sections 1 and 2 of the Witchcraft Suppression Act, No 3 of 1957.

3. Short title. – This Act shall be entitled the Witchcraft Suppression Amendment Act 1970.

As in other African countries, instances of witchcraft accusation continue to occur in South Africa with terrifying regularity. According to an article in the *Daily Dispatch*, October 18, 2002, more than 500 witchcraft-related cases were reported to the police in the Umtata region from January 2001, and the Umtata General Hospital conducts about 60 postmortems on witchcraft victims per year. Witchcraft targets are usually elderly women and widows. The brutal killing methods commonly employed are based on the myth that the person should be killed in such a way as to ensure she cannot return.

## 5.5 WITCHCRAFT SUPPRESSION IN CAMEROON

Fisiy and Geschiere (1990:135-156) discuss witchcraft suppression in Cameroon. The East Province of Cameroon is the most sparsely populated part of that country, and access is difficult because of the dense, marshy forests. To the people of Yaounde – the capital of Cameroon – the East Province is a remote corner where development has as yet barely penetrated. There is a notion that witchcraft flourishes in this region.

Since the end of the 1970s, the State Courts in the Province have regularly convicted “witches”, often without concrete proof of a physical attack and without confessions. This is a novelty. Witch-doctors play a crucial role in these prosecutions since only they have the expertise to prove the witches’ guilt.

The witch-doctor is regarded as the personification of witchcraft, and one can never be sure how he will use this dangerous tool. While witchcraft can be used constructively, there is always the risk that its potentially destructive tendency might get the upper hand. In the above latest development witch-doctors are no longer suspect persons for the Courts as they were in colonial times, but are now invited to come and testify as experts. They seem to act as a sort of pivot between the different parties involved, mediating between the alleged culprits, the village elite and the judges. In many cases they may even detect witches on their own initiative and drag them before the State Courts. Apparently, these changes correspond to the emergence of a new type of witch-doctor. The recent, now more or less formalised role of the witch-doctor in the Courts of the East Province can be seen as the confirmation of already existing forms of cooperation, a broader alliance between the new elite and the witch-doctors which has been emerging and developing since independence (Fisiy & Geschiere 1990: 150).

One of the reasons why cases of witchcraft are brought before the State Courts with increasing frequency seems to be a growing fear among the better-off elements in the villages of the jealousy of their poorer co-villagers, perhaps related to a deepening economic differentiation within the communities.

The more basic problem, however, appears to be that the state elite itself has hardly distanced itself sufficiently from the belief in witchcraft. While the national ideology may officially brand witchcraft as one of the main evils in the country, and while judges may unanimously condemn any form of witchcraft, many members of the now ruling class are personally still deeply involved with these occult forces. They seem to need access to this special kind of protection in order to fight off potential rivals or to demonstrate their apparent invulnerability. Under such circumstances, the effects of the new state offensive against witchcraft become naturally highly ambiguous (Fisiy & Geschiere 1990:154).

The issue of how modern judges should deal with witchcraft and sorcery, and particularly the question of sufficient evidence where either of these phenomena is alleged, has become a recurrent theme in many articles published by Africans in legal journals (Fisiy & Geschiere 1990:137). The example as provided by these more recent court proceedings in the East Province of Cameroon facilitates an insight into a more basic dichotomy: although the judges introduce modern elements, especially in the punishments which they impose (jail sentences and fines), they seem to be caught within local perceptions. Their collaboration with the witch-doctor automatically implies an official recognition of witchcraft with all its ambiguities. Thus, it seems that the state strengthens the very forces it is trying to combat. According to Fisiy and Geschiere (1990:154), one “can wonder whether the new persecutions do not confirm the belief in witchcraft instead of eradicating it”.

From the healers’ point of view, “witch-doctors” appear to expect that their collaboration with the Court will enhance their status. Their membership in the new official associations of traditional healers has the same objective. Recognition by the state is hoped to raise their general reputation of being able to heal and cure.

At the same time, however, the witch-doctor’s cooperation with the courts is difficult to reconcile with his role as healer. A witch-doctor is supposed to render someone’s witchcraft harmless; but how can he do so when he has the suspect convicted to jail?

Thus, Fisiy and Geschire (1990:153) point out that jail sentences are hardly conducive to cure a witch, and seem to interfere with the witch-doctor's role as healer.

## 5.6 CONCLUSION

The belief in witches and the power of witchcraft are universal (Buhrmann 1987:139). As far as Africa is concerned, witchcraft is still rife in many parts of the continent from Cape to Cairo (Koyana 1992:48). According to Neki, Joinet, Ndosu, Kilonzo, Hauli and Duvinage (1986:147), belief in witchcraft is found not only in the uneducated and semi-educated, but also in the well-educated people – even in doctors and scientists. Chavunduka (1994:103) points out that witchcraft and sorcery are separate concepts. Witchcraft may be regarded as a tool used to punish those who do wrong; it encourages people to be honest, polite and helpful. Hence, it contributes to social justice and order (Sebald 1986:269). Chavunduka (1994:87) also points out the cultural, social and psychological as opposed to the legal aspects of witchcraft. Most notably, however, Chavunduka (1994: 89-93) describes the “reality” of witchcraft and sorcery, and the ways in which witches and sorcerers may cause illness, death and other misfortunes. In the same context he seeks to explain the reason for voluntary confessions made by witches about their activities in church, in court, or during police investigations.

With black patients, witchcraft beliefs are the cultural norm. The witch image may attach itself to a person; this then leads to mental illness and inexplicable criminal behaviour (Buhrmann 1987:273). The patient's subjective experience is that of being in the power of the witch (Buhrmann 1987: 276).

Witchcraft is a belief deeply and firmly rooted in the African patient's cultural environment. The belief in witchcraft is therefore of significance in psychotherapy with

individuals from a culture that holds such beliefs (Neki et al 1986:145). Unfamiliarity with the nature of witchcraft concepts, their dynamic influence and their social functions may trouble the Western therapist. On the other hand, any attempt to dislodge this belief only leaves the patient confused, helpless and more anxious (Neki et al 1986:150). They go on to say that “non-confrontation” means going along with the client to the extent of “understanding” his beliefs, but no more than that. “Thus, the system can be utilized strategically, without entering into it and without reinforcing it” (Neki et al 1986:152). Empathy must not be with the patient alone, but also with his culture.

At the same time, the belief in witchcraft has medico-legal implications. Buhrmann (1987:275) emphasises that “to dispense justice with compassion, witchcraft and bewitchment must be understood”. The necessity of recognising a belief in witchcraft as a mitigating circumstance in the general African context is illustrated by the judicial experience in the Sudan where witchcraft is rife (Koyana 1992:51). As far as the Republic of South Africa is concerned, the courts have consistently taken the view that intentional killing based on the belief in witchcraft is murder, but the belief has been taken into account as an extenuating circumstance, and the judges have therefore always used their discretion in favour of the accused, and have avoided execution (Koyana 1992: 52). Accordingly, Buhrmann (1985:671) states that in cases of bewitchment it may be practical and feasible to assess an offender in his family, community and cultural setting.

Traditional healers, as indicated, have no problems in dealing with witchcraft. “Witch-doctors” are benevolent witches who can identify the malevolent witch responsible for a given act; they can also exorcise an evil spirit through their mystical power, ritual or medication (Neki et al 1986:147). Through oracles and divination they can find the cause of otherwise unexplained misfortune in either witchcraft, an evil spirit or a displeased ancestor. Once the cause has become known, suitable measures can be taken (Neki et al: 1986:150).

The issue has to some degree been complicated by anti-witchcraft legislation. Koyana (1992:48) points out that it has at all times been the effort of legislators in various parts of the world to suppress witchcraft through suitable legislation, - mainly because of inhuman treatment inflicted upon persons accused of witchcraft. However, in Africa, witchcraft suppression interferes with the practice of traditional healers. Diviners and other practitioners are now cautious about imputing witchcraft out of fear of prosecution, and court proceedings have consequently become infrequent (Chavunduka 1994:104). Nevertheless, healers try to indicate to the client who the witch is in a way which leaves no doubt in the victim's mind as to his/her identity; the patient then fixes on some definite person who he thinks has reason to wish him harm, and the suspect is pursued as a private enemy by his victim. In principle, however, the main effect of severe sentences in terms of anti-witchcraft legislation has been to drive the practice of witchcraft underground (Chavunduka 1994:105). Chavunduka (1994:105) states further that "traditional health practitioners are right in continuing to attend to illnesses caused or believed to have been caused by witchcraft". They handle such cases all the time, and many people are cured.

Chapter 6 deals with a legal issue of whether the traditional health care system and its activities are compatible with the Bill of Rights contained in the 1996 Constitution of the Republic of South Africa.

## **CHAPTER 6. THE TRADITIONAL HEALTH CARE SYSTEM AND THE SOUTH AFRICAN BILL OF RIGHTS**

### **6.1 INTRODUCTION**

The traditional health care system is part of African culture. It embraces health care as well as other cultural activities based on customary values and traditions.

An important characteristic of the Bill of Rights contained in the 1996 Constitution of the Republic of South Africa, Act 108 of 1996, is its recognition of cultural plurality. Respect for cultural diversity is protected in a number of provisions, such as section 9 (equality), section 10 (human dignity), section 11 (life), section 14 (privacy), section 15 (religion), sections 30 and 31 (language and culture; cultural, religious and linguistic communities). The right to health care is likewise protected within an extensive range of socio-economic rights.

Thus, it will be argued that the Bill of Rights provides a basis for the recognition and development of the traditional health care system. On the other hand, it will be shown that customary norms may clash with the values underpinning the Constitution. It is the protection of individuals, particularly of women and children, which poses the greatest challenge to those defending and embracing traditional customs as part of their daily life.

This chapter focuses on the importance of interpreting the Bill of Rights, particularly provisions embracing the rights to culture, health care and the rights of the child, in the relevant cultural context in order to either support or reject the traditional medical system.

### **6.2 FUNDAMENTAL HUMAN RIGHTS IN AN AFRICAN CONTEXT**

Fundamental rights are of a pre-constitutional nature. They are rights which already exist. They vest in people by nature of their common humanity (Van Wyk, Dugard, de Villiers

and Davis 1994:637). They are recognised and protected (not granted) by the state. The Constitution acknowledges these rights and affords them special protection through the device of constitutional supremacy. The state is required to create conditions and space for their enjoyment, and to provide for appropriate relief and remedies when they are threatened or infringed (Van Wyk et al 1994:640).

Fundamental rights are interrelated and interdependent (Chaskalson, Kentridge, Klaaren, Marcus, Spitz and Woolman 1996:ch 41-1). No fundamental right, however, is absolute and all rights are subject to the rights of others (Carpenter 1995:27). In the South African context, fundamental rights are contained in Chapter 2 of the 1996 Constitution of the Republic of South Africa, Act 108 of 1996.

Traditionally, a distinction is made between categories of rights, and only the so-called first-generation (civil and political) rights are regarded as justiciable rights, fit for inclusion in a human rights document since their guarantee requires negative state action only. However, while social and economical rights, for example, may increase the obligation of the state to act positively, the distinction has become theoretically and practically unsound. Van Wyk et al (1994:628) point out that all fundamental rights of individuals can and should be protected, not only those belonging to a particular class, category or generation. Consequently, the Bill of Rights is not just a negative enforcement mechanism shielding subjects against the abuse of government power, but it imposes a positive duty on the state to protect the entrenched rights (section 7).

Although it is often claimed that fundamental rights represent a universal and therefore culturally neutral value system, Bennett (1995:1) states that they betray their origin in Western law and philosophy at every turn. An evaluation within the African context is therefore indicated, while at the same time taking into account changing political and socio-economic circumstances over time.

Traditional African norms and values, like culture itself, must be seen in the context of the traditional community. At the heart of the African socio-political order was the family,

while the wider social support system embraced extended families, clans and tribes. Loyalty to the family was a cardinal value; individual interests were inevitably merged in the common weal, and the normative system tended to stress an individual's duties rather than his or her rights (Bennett 1995:4). The obligation to care for family members is a vital and fundamental value of the traditional African social system, as stressed, for example, in the African Charter on Human and Peoples' Rights (Bennett 1995:6).

In this way, African societies created an ethical system that served the goal of human dignity as effectively as any Western code. According to Bennett (1991:31), "the African conception of human rights was an essential aspect of African humanism sustained by religious doctrine and the principle of accountability to the ancestral spirits". However, Bekker (1994:442) stresses that there can be no denying that this support system has, to a large extent, disappeared. Modernisation and development have severed the individual from the supportive community. Furthermore, Christianity also radically changed the African support and value system. It was the missionaries who (misguidedly?) thought they had to convert the heathen and so "imposed" (Victorian) Western Christianity.

Consequently, the individual is now largely alone, isolated and confronted by the modern state, the modern economy and the modern city. According to Donnelly (1982) (cited in Bekker 1994:442), "in such circumstances, individual human rights appear as the natural response to changing conditions, a logical and necessary evolution of the means for realising human dignity".

Thus, those who contend that human rights are irrelevant to Africa because the continent has its own way of securing human dignity, all too often base their case on a conception of society that is rooted in pre-colonial times and no longer exists. Ejidike (1999:97) points out that in both traditional and modern perceptions, people's rights have meaning within a certain social unit. In the present age and time, the social unit and locality within which rights acquire meaning and content, is the state. Nevertheless, many traditional norms and values are still observed. This is by no means a rural phenomenon only. Many urban Africans continue to foster traditional practices, although it is difficult to quantify such a

statement (Bekker 1994:444). Bekker (1994:445) emphasises that many customs and usages are a social given, and the application of human rights norms will not make them disappear overnight.

In order to find a compromise between African and Western values, constitutionalists will have to find innovative ways to balance sometimes diametrically opposed ways of thinking within the framework of the Constitution. It must also be decided whether fundamental human rights should be applied vertically to relationships formed by traditional norms. If applicable, they will have to be interpreted in the light of cultural and social contexts (Hund 1997:390).

The most relevant fundamental rights in the context of the traditional health care activities will be discussed next.

### **6.3 THE RIGHT TO CULTURE**

From the outset it should be pointed out that the traditional health care system is regarded as a cultural institution, an essential part of African culture, and that culture, religion and language are tightly interwoven and cannot be separated from each other.

South Africa is a kaleidoscope of cultural, linguistic and religious heterogeneity, which is a source both of infinite richness and of intense potential conflict (Devenish 1999:202). Devenish (1999:209) points out that besides the inordinate variety of indigenous African traditions, it is characterised by the infusion and presence of both Western and Oriental cultures. Where manifestations of different cultures occur in any given society, very often a dominant culture emerges, resulting in the need for the protection of other prevailing cultures. The belief that a person's own culture is superior to all other cultures precipitates ethnocentrism, which, in turn, can result in political domination and cultural imperialism (Devenish 1999:204).

Historically, ethnic and linguistic division has been a typical feature of South African political life since colonial settlement (Chaskalson et al 1996:ch 35-1). Minority rule resulted in the white hegemony that characterised the political nature of South African society in both the era of imperialism and that of institutionalised segregation (Devenish 1999:202). It is only after 1994 that the country is emerging as a multi-cultural and multi-linguistic community provided for by the new constitutional and political dispensation. Venter (1998:444) points out that “all the provisions of the Constitution concerned with culture, language and religion are premised on plurality”. According to Devenish (1999:224), this requires a transformation from the predominantly bilingual, Calvinist and Eurocentric model of the apartheid era to cultural, religious and linguistic diversity.

The 1996 South African Constitution protects the right to culture, but does not define culture. Chaskalson et al (1996:ch 35-19) see culture as the particular way of life of an identifiable group of people and state that tradition, customs and folk-ways are synonymous for it. Culture is a complex social phenomenon which may include the practice of customs and traditions. According to Van Wyk et al (1994:573), culture denotes all those practices, institutions and beliefs of a group of people which uniquely identify the group.

According to Chaskalson et al (1996:ch 35-29), the significance of culture is the cultural heritage of individuals, their sense of belonging to a cultural structure and history, because it is an essential part of their conception of self, their orientation to reality, and further affiliation to culture and traditions is a vital aspect of what is meant to be human. Culture, language and religion are interwoven. Van Wyk et al (1994:598) point out that the relevant rights are particularly sensitive because their objects are closely connected with the emotions of the people.

Cultural pluralism is recognised formally and also by implication in various provisions of the 1996 Constitution. Chaskalson et al (1996:ch 35-5) state that two provisions have direct bearing on the protection of culture, namely sections 30 and 31.

### 6.3.1 Section 31

Section 31 of the 1996 Constitution accords individuals belonging to a cultural, religious or linguistic community the right to use their language, practise their religion and enjoy their culture in community with others (Chaskalson et al 1996:ch 35-12). Chaskalson et al (1996: ch 35-20) point out that the right also grants communities the freedom to establish and maintain their institutions without interference from any source in order to ensure their survival as a cultural entity. Devenish (1999:212) emphasises that section 31 introduces a collective dimension. Chaskalson et al (1996:ch 35-13, 14) concur, stating that culture, religion and language are essentially communal objects and section 31 protects both individual and group interests in cultural integrity. They (1996:ch 35-12) also state that the phrasing of section 31 is significant because rather than recognising rights of “minorities” with the accompanying connotations of a divided population, the Constitution prefers to emphasise that it is protecting connectedness. Thus, according to them (1996:ch 35- 16) “cultural community” replaces the “ethnic minority” referred to in Article 27 of the International Covenant on Civil and Political Rights, 1966, while the purpose of section 31 remains identical to that of Article 27, namely to protect cultural pluralism and tolerance. The right to culture applies both against the state and against individuals (Chaskalson 1996:ch 35-2). According to Devenish (1999:204), the right to culture establishes the right to be different.

The inclusion of section 31 in the Constitution indicates a commitment to the maintenance of cultural pluralism - even when this requires positive measures to be taken by the state to ensure the survival and development of minority cultures when they are threatened by disintegration. A state committed to cultural diversity, according to Chaskalson et al (1996:ch 35-18) “cannot simply remain neutral as its cultural patrimony fades into a dull uniformity”. In this context, the traditional health care system may be seen as a “minority cultural system” as opposed to the “dominant system” of biomedicine, and thus worthy of protection.

Cultural communities are also the focus in sections 185 and 235. Section 185 requires the establishment of a Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities, while section 235 is concerned with any community sharing a common culture, language and heritage (Venter 1998:439).

### **6.3.2 Section 30**

Section 30 protects the right to use the language and to participate in the cultural life of one's choice. It expresses an individual's right to non-interference in aspects of culture and language. Van Wyk et al (1994:579) maintain that it obliges the government to allow people to practise their culture. Chaskalson et al (1996:ch 35-23) stress that the exercise of individual and group rights may not be inconsistent with other fundamental rights.

Devenish (1999:218) emphasises that after the long and devastating years of apartheid South Africa needs a process of nation-building and national unity, while at the same time providing for recognition of cultural diversity. Cultural diversity requires cultural tolerance if there is to be mutual and peaceful coexistence (Van Wyk et al 1994:575). Devenish (1992:224) points out that what is required is a truly pluralistic society "which aims at uniting different ethnic groups in a relationship of mutual interdependence, respect and equality, while permitting them to maintain and cultivate their distinctive ways". In this process, South Africa can learn from the way other countries with heterogeneous communities have grappled with these potentially divisive issues (Devenish 1999:210). The fair and equitable treatment of minorities and their justifiable needs is an essential factor for peace, justice, stability and democracy, both within states and in international relations (Devenish 1999:215).

According to van Wyk et al (1994:580), cultural rights sometimes appear to conflict with other rights enshrined in the Constitution, for example, the right to equality, because certain cultural practices may allow or even promote inequality and discrimination. Other cultural activities may also be objectionable to outsiders as being harmful to health and hygiene (Van Wyk 1994:575). However, whether or not the traditional practices in question should

be rejected ought not to be determined arbitrarily or subjectively, but in accordance with human rights norms in order to avoid bias or unfairness in judging them (Van Wyk et al 1994:575). Venter (1998:448) maintains that in law, the values of the Constitution prevail over the values and content of culture where the latter are inconsistent with the Constitution. A case in point is Dow v Attorney-General (Chaskalson et al 1996:ch 36-28,29), in which the Botswana Court of Appeal confronted an argument that a law discriminatory in its effect was justified where its purpose was the preservation of a social practice. The majority of the judges took the view that the Constitution should be interpreted to be compatible with international law. Botswana had ratified the African Charter on Human and Peoples' Rights which provides for equal enjoyment of rights and freedoms without distinction of sex. After passage of the Constitution, the existing customs, traditions and cultures of Botswana society could not prevail over the constitutional provision designed to prevent discrimination. The Dow approach, according to Chaskalson et al (1996:ch 36-29), is likely to be attractive to a South African court when faced with similar issues.

Nhlapo (1995:41) points out that the South African debate over the protection of culture, and whether such culture is compatible with the fundamental rights enshrined in a modern Constitution, is truly underway, appearing to pit human rights activists against the “retrograde” forces of traditionalism. South Africa is a plural society, and the legal endorsement of cultural differences is the protection of cultural rights as contained in the Bill of Rights. The many problems of implementation are left to be solved by the courts (Bennett 1991:32-33) and obviously the legislature. According to Nhlapo (1995:41), our approach must be to avoid too reckless a push for cultural uniformity based on Western or international values. The guiding principle should be the guarantee of a life of dignity for every person. Cultural variations should be generally recognised and ousted only when they manifestly fail to protect human dignity.

## **6.4 THE RIGHT TO HEALTH CARE**

### **6.4.1 The right to health care as a second-generation right**

The right to health care belongs to the group of socio-economic rights. Its inclusion in the Bill of Rights is significant because it makes the redress of poverty and historical disadvantage a matter of fundamental concern.

Chaskalson et al (1996:ch 41-13) maintain that socio-economic rights aim to protect and advance access to basic human needs, and to improve people's quality of life. They must be interpreted in the light of the constitutional commitment to eliminate poverty and deprivation, and to promote substantive human dignity, equality and freedom.

Chaskalson et al (1996:ch 41-1) explain that by including socio-economic rights, one of the distinguishing features of the Constitution becomes apparent: its far-reaching commitment to the interdependency of all human rights, civil and political, as well as economic, social and cultural rights. The principle of interdependency embraces the notion that human rights should be treated holistically in order to promote human welfare and self-realisation. Values seen as directly related to the full development of personhood cannot be protected and nurtured in isolation. This reflects an appreciation of the intimate connection between the personal, political and socio-economic dimensions of human dignity and well-being.

Section 27 (1) (a) states that everyone has the right to have access to health care services. The state is required to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights (s 27 (2)). This latter provision touches on the sensitive issue of the justiciability of the so-called second-generation rights. Chaskalson et al (1996:ch 41-25) discuss this as follows: All human rights impose a combination of negative and positive duties on the state: to refrain from legislative or other actions which interfere in people's access to, or enjoyment of, the right in question, and the duty to take positive legislative and other measures to assist individuals and groups to obtain access to these rights.

The positive obligations can be broadly categorised into obligations of conduct and obligations of result (Chaskalson et al 1996:ch 41-34). The former oblige the state to take reasonable legislative or other measures to promote the realisation of the rights. These obligations are subject to a number of qualifications which limit their extent. The main limitations relate to resource constraints, and “progressive realisation” is applicable to promote and fulfil these rights (Chaskalson et al 1996:ch 41-28). Obligations of result, on the other hand, require the state to achieve a particular substantive standard. In the case of the right to health care, for example, it might involve the adoption and implementation of a plan of action to provide primary health care for all (Chaskalson et al 1996:41-25).

The phrase “access to” certain rights (s 27: health care, food, water and social security) has been used to resist an interpretation that the state is obliged to deliver the rights directly and without charge to everyone. Chaskalson et al (1996:ch 41-26) indicate that it limits the state's responsibility to those individuals and groups who encounter particular difficulties in gaining access to the various rights. This includes the adoption of enabling strategies to assist people to gain access to the rights “through their own endeavours and initiatives” (Chaskalson et al 1996:ch 41-33), as well as more direct forms of assistance. According to Chaskalson et al (1996:ch 41-36), the rights do not mean, for example, that fees or user charges are totally prohibited. However, any charges of this nature should not have the effect of depriving poor people of access to the rights. This implies that, when fees are charged, they should be affordable. At the very minimum, adequate provision must be made to allow impoverished individuals to apply for reductions or exemptions from standard charges. This understanding of the state's positive duties represents a departure from the commonly held perception of socio-economic rights as commodities to be dispensed by the state on demand and free of charge (Chaskalson et al 1996:ch 41-33).

In determining what is “adequate” housing (s 26) or access to health care through “reasonable measures” (s 27), regard must be had to, *inter alia*, what the state can afford (Chaskalson et al 1996:ch 41-37). Thus, the core content of the rights will vary according to the availability of the state's resources from time to time. It may also differ between

countries. In this context, Van Wyk et al (1994:611) state that it is difficult, if not impossible, to provide a universally acceptable definition of the practical content of some of these rights. However, while the qualifying adjectives in the phrases “adequate housing”, “sufficient food and water” and “appropriate social services” are clearly intended to import a qualitative dimension into the evaluation of the state's performance, the state is under a continuing obligation to improve not only the quantitative but also the qualitative dimensions of these rights (Chaskalson et al 1996:ch 41-39). The phrase “progressive realisation” (e.g. health care, housing) allows for the fact that the full realisation of social and economic rights will generally not be achieved in a short period of time (Chaskalson et al 1996:ch 41-39). However, the latitude provided for should not be interpreted as an invitation for the state to drag its feet. Section 237 requests that “all constitutional obligations must be performed diligently and without delay” (Chaskalson et al 1996:ch 41-40). Chaskalson et al (1996:ch 41-36) make a further important point in this context, namely the state has an ongoing duty to protect the respective rights. This includes relevant regulatory mechanisms in order to ensure that minimum standards are maintained and user charges controlled.

The main challenge facing the judiciary with regard to the enforcement of socio-economic rights is to develop the core content of the various rights. This will require an interpretation of concepts such as “basic education”, “sufficient food” and “adequate health care services”. Chaskalson et al (1996:ch 41-36) indicate that a purposive approach to interpretation is required. Sections 26 (housing) and 27 (health care) must be read to include a minimum core entitlement to a basic level of each of the enumerated rights. The state must ensure that groups in especially vulnerable and disadvantaged circumstances have access to a basic level of the respective socio-economic rights. This reading accords with a substantive interpretation of the Constitution's core values of human dignity, equality and freedom, and its commitment to social justice (Chaskalson et al 1996:ch 41-43).

As far as the availability of the state's resources is concerned, a court will, for example, be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters (Soobramoney v

MOH KZN, see Chaskalson et al 1996:ch 41-41). Chaskalson et al (1996:ch 41-33) point out that the court must prod the legislative and executive branches of government to take appropriate action while, at the same time, resisting the temptation to usurp their role or to dominate the constitutional dialogue. In B v Minister of Correctional Services it is stated (Chaskalson et al 1996:ch 41-37) that “what is adequate medical treatment cannot be determined in vacuo”.

A further important aspect is the horizontal in addition to the vertical application of socio-economic rights. One of the most profound changes introduced by the 1996 Constitution is related to the application of the Bill of Rights to private parties. Chaskalson et al (1996:ch 41-45) indicate that the relevant provisions of the Final Constitution are far more conducive to horizontal application than those of the Interim Constitution of 1993.

Section 8 (2) provides:

A provision of the Bill of Rights binds a natural or juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by that right.

Section 27 (3) requires that no one may be refused emergency medical treatment. Chaskalson et al (1996:ch 41-46) maintain that this formulation strongly suggests a horizontal application, for example, binding private clinics, hospitals or ambulance services.

The South African Human Rights Commission as provided for by section 184 has been given a special mandate in relation to socio-economic rights. Each year it must require relevant organs of state to furnish the Commission with information on the measures that they have taken towards the realisation of rights concerning housing, health care, food, water, social security, education and the environment (Chaskalson et al 1996:ch 41-55). Chaskalson et al (1996:ch 41-56) point out that the Commission can play a valuable complementary role to the judicial enforcement of socio-economic rights. This offers an opportunity to develop the normative content of socio-economic rights and to give greater definition to the obligations imposed on the state and private institutions.

### 6.4.2 The influence of international law on socio-economic rights

The 1996 Constitution requires a court, tribunal or forum to consider international law when interpreting the Bill of Rights. It is therefore imperative to consider relevant international legal instruments.

Socio-economic rights are recognised in the Universal Declaration of Human Rights (1948), and protected in a wide range of international and regional human rights conventions (Chaskalson et al 1996:ch 41-13), such as the International Convention on Economic, Social and Cultural Rights (1966). Van Wyk et al (1994:609) state that the European Social Charter was signed in 1961; it should be seen as complementary to the European Convention on Human Rights (1950).

The Organisation of African Unity (OAU) adopted the African Charter on Human and Peoples' Rights, which came into force in 1986. The Charter contains various provisions relating to socio-economic rights, *inter alia*:

- the right to enjoy the best attainable standard of health;
- the right to education, participation in cultural life, and the promotion and protection of morals and traditional values by the state.

Chaskalson et al (1996:ch 41-15) point out that the international community has consistently affirmed the equal status of social and economic rights, and called for their equal protection. However, in reality, the enforcement procedures for these rights have not been as effective as those available for civil and political rights. International law has not been able to develop sufficient remedies and enforcing mechanisms. The major strategies remain political rather than judicial in nature (Van Wyk et al 1994:611). The inadequacy of enforcement procedures for socio-economic rights has contributed to their normative underdevelopment and marginalisation from mainstream human rights agenda (Chaskalson et al 1996:ch 41-1).

### **6.4.3 The significance of the right to health care and the traditional health care system**

No court has yet been called upon to pronounce on whether access to health care services means access to “modern” or “traditional” health care, or both. If traditional care were included here, this would mean that the state should refrain from interfering with people's right to use the traditional health care system. In addition, it might impose a positive duty on the state to promote and develop the traditional sector, to provide financial assistance to its users, and to improve not only its quantitative but also its qualitative dimensions. Furthermore, it could be argued that the state has an obligation to provide for appropriate regulatory mechanisms to ensure that minimum standards are maintained and user charges controlled.

## **6.5 CHILDREN’S RIGHTS**

The question of the rights of the child is one of the most important issues in the contemporary world (Belembaogo 1994:202), and the notion that children have rights in both international and domestic law is today relatively well settled (Ncube 1998:1). However, children's rights, like all other fundamental human rights, must be interpreted within the relevant cultural context, and it is here that the best interests of the child might clash with cultural norms and practices as embraced by traditional societies. It is important, therefore, to place the role and status of the child in a historical perspective.

Alston (1994:85) states that the economic and social systems of pre-colonial Africa were characterised by three principles: the kinship system; the role of property in creating and maintaining kinship ties; and the dominant political role occupied by male elders in the community. An individual had status (as a parent, a child or a spouse, for example) as a member of the kinship group. To the respective status were attached certain responsibilities as well as entitlements or claims. Children were valued greatly as resources both for their

labour and for their role in ensuring lineage continuity (Ncube 1998:309). They performed important economic roles by directly engaging in production from a very early age. Their role tended to follow an existing gender-based division of labour. As they grew up they were assigned further tasks relative to their age (Alston 1994:90). As members of the group children were cared for by adults in return for future support (Alston 1994:91). The care of the child obviously included the provision of health care.

The family not only managed the training and socialisation of children into adulthood, but also had the authority to define the tasks, traditions and customs which had to be complied with before childhood could be determined to have come to an end (Ncube 1998:19). The attainment of adulthood was conceived of as a gradual process, often marked by initiation ceremonies and culminating in marriage (Ncube 1988:20). During the nineteenth century most of Africa south of the Sahara came under colonial rule. Christianity, industrialisation, urbanisation, Western education and capitalist influences resulted in a complex interaction between indigenous systems and those originating from outside the continent (Alston 1994:83). They all fundamentally affected the traditional, rural-based patriarchal and patrilocal African family and the African kinship system (Ncube 1998:22).

With the economic and social transformation of Africa came a push towards individualism tending to atomise the traditional family, and seriously impacting on the status and welfare of children (Alston 1994:110). The basis on which the relationship between the child and adults was founded was largely undermined (Ncube 1998:310). It is in this context that the state moved in to protect what is viewed to be the best interest of the child (Alston 1994:110).

### **6.5.1 Children's rights in international law**

Children's rights are recognised in a number of international instruments, most notably the UN Convention on the Rights of the Child, 1989 (henceforth the Convention), and the African Charter on the Rights and Welfare of the Child, 1990 (the Child Charter)

(Chaskalson et al 1996:33-1). International law regards children as independent beings, bearers of rights, notably the right to a certain degree of self-determination, relative to the evolving capacities of the child (Sloth-Nielsen 1995:404).

At the same time, however, it is recognised that the primary responsibility for the child rests with the family, and that the right to self-determination should be balanced by the child's inability to choose what is in fact his or her best interest (Sloth-Nielsen 1995:405). According to Article 2 of the Convention, the best interests of the child demand that all children should receive equal treatment (Sloth-Nielsen 1995:409). States are required to initiate programmes and policies aimed at eradicating discrimination and its consequences.

Article 3 makes the best interests of the child standard the primary consideration in all actions concerning children (Sloth-Nielsen 1995:408).

Article 12 grants children the right to say in matters affecting their lives; the view of the child must be given due weight in accordance with the age and maturity of the child (Sloth-Nielsen 1995:406). This right plays a role not merely in the realm of children's court proceedings, custody decisions and similar issues, but also in relation to questions such as the child's right to decide on medical treatment. Principal amongst the socio-economic and cultural rights enshrined in the Convention are the rights to health care, social security and education (Sloth-Nielsen 1995:415).

Article 24 obliges state parties to “recognise the right of the child to the enjoyment of the highest attainable standard of health; parties shall strive to ensure that no child is deprived of his/her right of access to health care services” (Sloth-Nielsen 1995: 415).

Article 27 recognises the right of the child to “a standard of living adequate for the child's physical, mental, spiritual, moral and social development”. At the same time the role of the family is emphasised. Ncube (1998:13) argues that the family constructs, defines and thus guards society's cultural values and norms. As provided for in Article 18 of the African

Charter on Human and Peoples' Rights, the family “is the custodian of moral and traditional values” of the respective community (Ncube 1998:14).

The underlying assumption of all international instruments on the rights of children is that international law is a significant tool in the improvement and development of the conditions under which children live throughout the world (Ncube 1998:3). International law obliges state parties to recognise, implement, expand, develop and enforce the recognised rights of individuals within their territories (Ncube 1998:3). The first implication for a state party signing the Convention is the obligation to refrain from acts which would defeat the object and purpose of the Convention. A state party should also review its legislation in order to ensure that domestic law is consistent with the provisions of the Convention (Sloth-Nielsen 1995:417).

The main problems and challenges in the implementation of children's rights arise from the respective cultural setting with its various traditional values and practices. Human rights, including children's rights, have to be interpreted and applied with sensitivity and due regard to the diversity of cultural norms and values (Ncube 1998:1). This body of opinion is based on the belief that, even though human rights norms and standards are universal in terms of their general formulation, their exact content and application have to take cognisance of cultural diversity. Ncube (1998:5) emphasises that behind the normative consensus of the international community as a whole lie the conceptual and substantive claims of cultural and contextual diversity. “The world community, being so diverse socially, economically and culturally, cannot understand the Convention in the same way” (Ncube 1998:289). According to Ncube (1998:2), international law gives rise to issues and problems in the constraints, demands and challenges of contemporary cultural values and traditional customs as regards the children of the African region (Ncube 1998:2). Ncube (1996:2) states that cultures often disagree on whether or not a particular custom or practice is in the best interest of the child. Most commonly, there is a conflict between the values of the modern world and the competing values of the older order (Alston 1994:105). Traditional ideas often appear to be inimical to modern, international notions of children's interests. While a rejection of traditional customs and values through law reform would result in the law being

very distant from reality, there are, on the other hand, many cultural practices which, by human rights standards, are difficult if not impossible to reconcile and accept (Belembaogo 1994:215). Alston (1994:20) points out that cultural arguments continue to be used to justify the denial of children's rights and to defend practices such as forced marriages of young girls and bonded child labour in parts of south Asia, or female circumcision and other cruel and dangerous rituals in Africa.

In its Preamble, the African Child Charter affirms that the African approach to children's rights takes cognisance of the African culture and heritage and the values of African civilisation which should inspire and characterise the content of the rights of the African child (Ncube 1998:14). The Convention, likewise, recognises the family and the rights of the family to bring up, socialise and develop children in a manner consistent with local values, customs and traditions. At the same time, however, the Convention also underscores the potential for conflict between the best interests of the child and the interests of the adult members of the family (Sloth-Nielsen 1995:405).

### **6.5.2 Children's rights in South Africa**

South Africa ratified the 1989 UN Convention on the Rights of the Child in 1995. Ratification established a legal framework for the recognition of children's rights and served as background to the development of a children's rights provision in the Interim Constitution Act 200 of 1993 (s 30) (Sloth-Nielsen 1995: 420).

Under the 1996 Constitution (section 28), children's rights include the right to basic nutrition, shelter, basic health care and social services; and the right to be protected from maltreatment, neglect, abuse or degradation. Chaskalson et al (1996:ch 33-15) point out that there is an obligation on the state to take positive steps to protect the child from harm.

The common law standard of the child's best interest has been constitutionalised (Chaskalson et al 1996:ch 33-19). Section 28 (2) provides that a child's best interests are of

paramount importance in every matter concerning the child. The interpretation of the “best interest”, however, remains a challenge. Chaskalson et al (1996:ch 33-1) state that the common law standard has been criticised as being open-ended and indeterminable. According to Sloth-Nielsen (1995:409), although used in domestic law in many countries, its precise meaning and content have been the subject of much debate and discussion. Likewise, Belembaogo (1994:203) indicates that the principle, while widely appearing in legislation and jurisprudence, has not been uniformly defined and is, in fact, susceptible to change and dependent on circumstances. In a South African context, the constitutional best interest standard has been interpreted in Hlope v Mahlalela, a custody case where it had to be decided whether common or customary law was applicable (Chaskalson et al 1996:ch 33-19).

### **6.5.3 Cultural values versus children's rights**

In law, the Constitution prevails, and cultural rights may not be exercised in a manner inconsistent with any provision of the Bill of Rights (s 30; s 31 (2)). Alston (1994:100) states that the African Child Charter stresses in Article 1 (3) that “any custom, tradition, culture or religious practice that is inconsistent with the rights, duties and obligations contained in the Charter shall to the extent of such inconsistency be null and void”. Ncube (1998:15) states that in terms of Article 21(1) of the same Charter, State parties shall take all appropriate measures to abolish customs and practices harmful to the welfare, normal growth and development of the child, and in particular

- a) those customs and practices prejudicial to the health or life of the child; and
- b) those customs and practices discriminatory to the child on the grounds of sex or other status.

Likewise, Article 24 (3) of the Convention requires state parties to “take effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children” (Ncube 1998:296). Discussing law reform in Burkina Faso, Belembaogo (1994:221-223) states that “customs which gravely contravene the principles of civilisation,

will not be applied”, while those that contribute to the child's full maturation and preserve his/her material interests deserve to be protected and preserved. At the same time, however, Belembaogo notes that the liveliness of customs and traditions represents a serious problem in enforcing the legislative norms effectively.

Bennett (1995:110-111) points out that until 1995 South African courts had not yet been called upon to balance the various constitutional rights and freedoms applicable in this context. However, he cites the Canadian case Thomas v Norris, in which the court carefully examined the relationship between individual rights and a group's rights to pursue its culture. It held that the plaintiff's experience (detained and forced to undergo an initiation ceremony of spirit dancing) was tantamount to assault, battery and unlawful imprisonment. All of these, the court stated, were opposed to a peaceful society committed to protecting the rights and freedoms of all. Aboriginal rights were not absolute; they were limited by criminal and civil law which have the function of ensuring that the exercise of one's freedom does not interfere with the rights of others. Bennett (1995:110) goes on to say that the right to culture in the Bill of Rights means that while all people have the right to participate in the cultural life of their choice, individuals are always free to opt out. It follows that no child may be forced to undergo initiation against his or her will. Bennett (1995:109) notes that initiation is “an occasion where parents submit their offspring to painful and humiliating rites that are intended to transform the children into adults”. Initiation is still widely practised in South Africa. Although no objection has been raised to the institution in principle, the courts readily invoke criminal liability if it entails the infliction of serious bodily harm; the victim's consent provides no defence in this regard. At the same time the potential harm of an initiation performed by an unqualified practitioner has been officially recognised and the legislature has sought to prevent this, for example, by the Application of Health Standards in Traditional Circumcision Act (EC) of 2001, which, while realising the need for the recognition and preservation of the custom of circumcision, seeks to fill a gap in the legislative framework of the Province by imposing the observation of hygienic standards by all those involved in the relevant procedures (see chapter 3, section 3.3.3.2 for details of the Act).

#### **6.5.4 Conclusion**

While the notion that children have rights in both national and international law is today relatively well settled, the concretisation and application of these rights in different historical, social and cultural contexts in individual countries is still highly contested. Local customs and certain cultural practices harmful to children's welfare present the most serious challenges to the children's rights agenda (Ncube 1998:295). Ncube (1998:306) points out that the tension between the underlying assumptions of the received law and those of local culture, customs and parental expectations is rampant in the African region. Belembaogo (1994:218) contends that the interests of the child should constitute a pertinent criterion for evaluating customary activities: customs that undermine the child's personality and physical integrity should be abolished, while only those that contribute to the child's full maturation and material interests deserve to be protected and preserved.

Alston (1994:vii) speaks about the importance of strengthening the hand of reformers and human rights activists seeking to change customs and traditional practices which are widely viewed as being detrimental for children and inconsistent with children's rights. Alston (1994:vii) goes on to say that, at the same time, however, there is a need for a culturally sensitive approach, and flexibility is required across diverse societies if the Convention is to be widely understood, respected and effectively implemented.

Children's rights have to be interpreted and applied with sensitivity and due regard to the diversity of cultural norms and values. They have to be approached and understood within the context of legal pluralism, cultural relativism and customary and traditional imperatives (Ncube 1998:1,9). According to Ncube (1998:15), the rights granted to children should in their localisation and implementation bear the local cultural fingerprint without, however, extinguishing the essential core of the respective right itself. In other words, the substantive rights granted are primary over cultural considerations which could negate the essence of the right.

Just as culture is not a factor which should be excluded from the human rights equation, so, too, must it not be accorded the status of a metanorm which trumps rights. It must be accepted that cultural considerations will have to yield whenever a clear conflict with human rights norms becomes apparent (Alston 1994:21).

Ncube (1998:320) maintains that if the vision of the Convention (and by implication, of the South African Constitution) is to be realised, we have to create ideal conditions under which family relations can be negotiated on the basis of recognising the individuality and human dignity of all family members irrespective of their gender and age. Parents have the responsibility to provide, protect and prepare the child to live an individual life in society. The child has to be brought up in the spirit of the ideals proclaimed in the Charter of the United Nations and, in particular, “the spirit of peace, dignity, tolerance, equality and solidarity” (Preamble). Within this context the states play a double role, namely to assist the families in discharging their responsibilities under the Convention, but also to act as the children's watchdog in order to ensure that such responsibility is discharged properly (Ncube 1998:317).

It is in this light that traditional health care practices must be carefully evaluated and balanced against children's rights and the best interests of children.

## **6.6 THE RIGHTS TO EQUALITY, DIGNITY, LIFE, PRIVACY, RELIGION, ECONOMIC ACTIVITY, ENVIRONMENT AND THE TRADITIONAL HEALTH CARE SYSTEM**

### **Equality (s 9)**

Equality is a core value of the 1996 Constitution. Within the context of the Bill of Rights, equality is the first substantive right to be mentioned. Section 9 (1) guarantees equal protection and benefit of the law. Chaskalson et al (1996:ch 14-61) emphasise that section 9 (1) extends the prohibition of discrimination to all persons. It also operates between private parties and not simply between the state and individuals. In this, the right differs from other

rights contained in Chapter 2 (Chaskalson et al 1996:ch 14-55). Du Plessis (1996:15) states that “the advancement of equality will give fuller effect to respect for human dignity”.

From the wording of the provision it may be argued that individuals practising or utilising traditional health care should be equal in status to those employing the modern sector, and deserving of the same protection.

### **Human dignity (s 10)**

Everyone has inherent dignity and the right to have their dignity respected and protected (s 10). The right to dignity has been recognised repeatedly as one of the most vital human rights contained in the Constitution (Schooling 1999:2). In National Coalition for Gay and Lesbian Equality v Minister of Justice, for example, the court stated that the right to dignity is a cornerstone of the South African Constitution. “Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings; human beings are entitled to be treated as worthy of respect and concern” (S v Makwanyana, in Chaskalson et al 1996:17-10). Alongside the right to life, the right to human dignity is described as the most important of all human rights, and as the source of all personal rights in the Bill of Rights (Makwanyana case, Chaskalson et al 1996:ch 17-6).

Section 10 provides no definition of the concept of dignity. Chaskalson et al (1996:ch 17-10) note that at its most basic the concept of dignity embraces subjective feelings of self-worth or self-respect, the freedom from contempt, ill-will or ridicule, and the protection of bodily integrity. However, the courts themselves have noted that dignity is a notoriously elusive concept (Schooling 1999:5). However, Chaskalson et al (1996:ch 17-6) maintain that it is neither possible nor desirable at this stage to predict the precise boundaries which the Constitutional Court will draw around the concept of dignity; the implications of the privileged status accorded to the protection of human dignity will become clearer through judicial development over time.

Very few cases so far have focused solely upon the right to dignity alone, and generally it has been considered in conjunction with the violation of other rights (Schooling 1999:2).

Schooling (1999:1) points out that central to the newly developed South African equality jurisprudence is the concept of unfair discrimination which the Court has characterised as being conduct which infringes upon the fundamental dignity of persons (President of the Republic of South Africa v Hugo; Prinsloo v Van der Linde; and Harksen v Lane). In so doing, the Court has elevated the notion of “dignity” to the status of a substantive legal criterion which lies at the heart of one of the most important rights in the Bill of Rights (Schooling 1999:1).

In the Hugo case, Goldstone J stated that the purpose of our new constitutional and democratic order is the establishment of a society in which all human beings will be accorded equal dignity and respect regardless of their membership in particular groups (Schooling 1999:3).

Seen together, these three seminal judgments by the Constitutional Court have greatly expanded the role of the concept of dignity. Schooling (1999:3) contends that it appears to have the greatest potential for contributing to the transformation and reconstruction of the South African society.

It is argued that the right to dignity requires respect for and tolerance of the traditional health care system - its providers and its clients and the cultural norms and practices which it embraces.

### **The right to life (s 11)**

Section 11 reads: everyone has the right to life. With the possible exception of human dignity, there can be no more basic value constitutionally protected than that of life itself (Chaskalson et al 1996:ch 15-1). In the absence of the right to life, no other right may be meaningfully held.

The Indian Supreme Court developed a broad right to life jurisprudence, holding that the right to life includes the right to a livelihood. Moreover, Chaskalson et al (1996:ch 15-3) maintain that it is likely that the Constitutional Court will be influenced by the factual context of social and economic deprivation in South Africa. Theoretically, then, it is possible to include claims as diverse as claims of dispossessed individuals to land, of the sickly to medical care, and of women to be free from violence under the right to life (Chaskalson et al 1996:ch 15-4). Inherent in a broader notion of life is the value judgment about what constitutes an acceptable quality of life. "So whilst life may be a value in and of itself, without water, food, livelihood, friendship, and recreation it may not be worth living" (Chaskalson et al 1996:ch 15-2). Similarly, Van Wyk et al (1994:605) argue that the right to life should be interpreted not only as a protection against being arbitrarily deprived of life, but should, for instance, also include the right to medical assistance, hospitalisation and nutrition. The law is a living organism and should reflect the needs, requirements and values of the society in which it functions. Chaskalson et al (1996:ch 15-4) add that it is difficult to justify a broad conception of the right to life without a simultaneous obligation on the state to alter or alleviate circumstances and thus to create a right, for example, to education or running water.

It is argued here that a meaningful life would include the right to health care of one's choice, as well as the enjoyment of cultural and traditional practices.

### **Privacy (s 14)**

Privacy is variously defined and described. as an amorphous and elusive concept. Chaskalson et al (1996:ch 18-1) indicate that at the very least the right to privacy includes the right to be free from intrusion and interference by the state and others in one's personal life.

Chaskalson et al (1996:ch 18-4) divide the new constitutional right to privacy into substantive and informational privacy rights; the former protect personal autonomy, while the latter deal with disclosure of and access to information. In this context, they (1996:ch 18-5) discuss the case of Jansen van Vuuren and another NNO v Kruger 1993 (4) SA 842 (A), where a doctor disclosed, without permission, that his patient was suffering from AIDS. This breach of the doctor-patient relationship gave rise to an action for defamation, but could also have been described as an invasion of privacy. Chaskalson et al (1996:ch 18-9) explain that privacy rights permit individuals to make important decisions about their lives without interference by the state. These rights are generally understood to give the person control over such matters as marriage, procreation, contraception, family relationships, child-rearing, and education.

The right to privacy undoubtedly includes the individual's autonomous choice of type of health care and healer. At the same time, the right plays a significant role in guaranteeing confidentiality within the context of the healer-client relationship.

### **Freedom of religion (s 15)**

The right to freedom of religion is discussed under the “right to culture see section 6.3 since culture and religion are inextricably linked. Nevertheless, a brief discussion of section 15 seems indicated here.

Section 15 (1) states: everyone has the right to freedom of conscience, religion, thought, belief and opinion. Chaskalson et al (1996:ch 19-1) interpret this to mean that, individuals ought to have the right to hold and express different views about the nature and management of the world. This also includes the right to propagate religious doctrine and to manifest religious beliefs in worship and practice (Chaskalson et al 1996:ch 19-2).

The concept of freedom of conscience, according to Chaskalson et al (1996:ch 19-7), was designed to protect ethical beliefs and practices not readily within traditional religious

systems. The term “conscience” can be taken to refer to a set of moral beliefs that are not grounded in religious faith.

Freedom of religion and statutes dealing with religious family law are most commonly challenged in terms of the equality provision (s 9). For example, polygamy might be regarded as unfair discrimination, and many religious organisations are founded on unjustified differentiation based on sex.

As stated above, the practice of religion is inextricably interwoven with aspects of culture and tradition, and thus with the beliefs and activities of the traditional health care sector which are, therefore, implicitly protected by the Constitution.

### **Economic activity (s 22)**

Section 22 stipulates: Every citizen has the right to choose their trade, occupation or profession freely. The practice of trade, occupation or profession may be regulated by law.

Chaskalson et al (1996:ch 29-15) emphasise that the right is granted to citizens. The purpose of that part of the provision which authorises regulation gives content to the right itself. Chaskalson et al (1996:ch 29-17) point out that while the right of choice of economic activity is safeguarded, the manner of practice may be regulated by law.

Article 12 (1) of the German Constitution is of interest in this context due to the similarity of the wording. It provides that all Germans have the right to freely choose their trade, occupation or profession, their place of work and their place of training. The practice of trades, occupations and professions may be regulated by statute. German courts have generally taken the view that the regulation of the manner in which a profession is practised is easier to justify than, for example, the limitation of entry into the profession itself (Chaskalson et al 1996:ch 29-16). The greater weight to be given to the protection of choice emerges from the German Pharmacy case (Chaskalson et al 1996:ch 29-17) where the following is stated:

The practice of an occupation may be restricted by reasonable regulation predicated on considerations of the common good. The freedom to choose an occupation, however, may be restricted only in so far as an especially important public interest compellingly requires.

Given the above-mentioned similarity of wording between Article 12 (1) of the German Constitution and section 26 of the 1996 South African Constitution, the approach of the German courts will doubtless have a measure of persuasive authority (Chaskalson et al 1996:ch 29-16).

In the Japanese Gypsy Taxi case, the court found that the law which granted, upon compliance with certain standards, a licence to operate a vehicle transport business, did not contravene the constitutional guarantee of freedom because it was a restriction designed to improve the existing state of traffic and road transportation in Japan (Chaskalson et al 1996:ch 29-17). Chaskalson et al (1996:ch 29-17) state that a South African court, when considering the merits of foreign case law, should test the regulation of the guaranteed right in terms of a rational connection between the regulatory statute and the objective sought to be achieved by the latter. The infringement of choice, on the other hand, should be examined rather as a limitation problem in terms of section 36 (limitation clause).

South African Post Office v Van Rensburg and another was the first case in which section 22 was considered by the courts. Relying, *inter alia*, on section 22 the respondent contended that section 7 of the Post Office Act contravened his constitutional right. Referring to section 90 of the Act, Lang AJ observed that the Minister, on application, could grant another party permission to run a postal service if he deemed it to be in the public interest. Thus, the respondent's right under section 22 had not been denied, but had rather been regulated by law. The Post Office Act did not impose an unjustified prohibition (Chaskalson et al 1996:ch 29-18).

Section 22 is of particular importance with regard to the traditional healing profession. While the choice to become a healer is guaranteed in principle, the manner of practising the relevant profession may be regulated by law.

### **Environment (s 24)**

Chaskalson et al (1996:ch 32:3) point out that “environment” is a broad and inclusive concept, and add that the discrete objectives of the right refer to actions against pollution, conservation, sustainable development and use of natural resources, while at the same time promoting economic and social development. Furthermore, section 24 adds an intergenerational dimension by explicitly mentioning present and future generations. Du Plessis (1996:19) states that the protection of the environment is dependent upon the adoption of reasonable legislative and other measures designed to promote certain policy objectives. In general, according to Chaskalson et al (1996:ch 32-8), environmental rights cover a relatively underdeveloped area in existing jurisprudence. Environmental rights are closely linked to the protection and advancement of health and well-being. They also play a significant role in the context of traditional health care.

Ayensu (cited in Bannerman et al 1983:175-183) state that initiatives from various quarters to promote traditional herbal medicines have led to a depletion of the world's forests at an alarming rate. According to an article in the *Daily Dispatch* (October 4, 1998), a study on the trade in endangered species for the World Wide Fund for Nature (WWF) and IUCN, the World Conservation Union, found that traditional African medicine represents a threat to many species of fauna and flora in Eastern and Southern Africa.

However, Chaskalson et al (1996:ch 32-5) state that there is another side to the story, pointing out that it “is the traditional knowledge that has governed environmental and ecological management over centuries”. It is only now, within the sphere of rediscovery of the “Rights of Indigenous and Tribal Peoples”, that the issue of environmental rights as acknowledged in traditional law and practice in Africa and elsewhere is gaining due recognition. The International Labour Organisation's Convention Concerning Indigenous

and Tribal Peoples in Independent Countries (Convention 169 of 1989) brought to light and solidified the often neglected reality that traditional practices are a repository of environmental protection (Chaskalson et al 1996:ch 32-5).

Furthermore, the ordinary masses need to be involved as core participants and beneficiaries in environmental management (New Plans for Africa's Parks, Skukuza Declaration in: *The Star*, October 17, 1994). According to Chaskalson et al (1996:ch 32-5), "re-incorporation of the people is vital in giving meaning to an environmental right which is relevant and meaningful to all.

## **6.7 THE QUESTION OF THE SICK CERTIFICATE**

While the discussion so far has been in favour of free choice in health care and reasonably unfettered enjoyment of cultural activities, a tension has arisen between constitutional rights on the one hand and the provisions of the Basic Conditions of Employment Act 75 of 1997, regarding, *inter alia*, sick leave, on the other (Aphane 1999:65-68). The Act requires that the medical certificate be issued and signed by a medical practitioner or any other person who is certified to diagnose and treat patients, and is registered with a professional council established by an Act of Parliament (s 23 (2)). Although many traditional healers belong to a professional association, these are voluntary, not statutory bodies. Thus, the Basic Conditions of Employment Act, on the face of it, seems to exclude practitioners of traditional medicine from the list of persons from whom a medical certificate may be obtained. This may have serious repercussions for members of the workforce, since an employee, treated by a traditional healer, could be regarded as having deserted his work, which in turn would enable an employer to dismiss the employee for misconduct (provided all the other requirements are met). Alternatively, the employer may refuse to pay the worker for the number of days that he has been absent from work.

It is submitted here that section 23 (2) of the Basic Conditions of Employment Act infringes upon a number of constitutional provisions. Firstly, the Constitution provides that

everyone is equal before the law and has the right to equal protection and benefits of the law (s 9 (1)). This includes the right not to be unfairly discriminated against on the basis of, *inter alia*, religion, conscience, belief and culture (s 9 (3) and (4)). Thus, employees who entrust their health to traditional healers do not enjoy equal protection and benefit of the law with employers who require the certificate to be issued by a registered medical practitioner.

A case in point is Nyathi v Wheeler (1999 8 CCMA 17.2 (unreported)), where Nyathi was absent from work for a period of about four months due to an illness which in his opinion required the ministrations of a traditional healer. When he wanted to resume work, he was told that he had been dismissed. The Commission for Mediation and Arbitration found Nyathi's dismissal to be fair, both substantively and procedurally. However, the Commission left open the question whether a medical certificate issued by a traditional practitioner is acceptable as proof of incapacity as required by section 23 (2) of the Basic Conditions of Employment Act.

In addition, section 23 (2) of the Act might also infringe on an employee's right to freedom of conscience, religion, thought, belief and opinion as enshrined in section 15 (1) of the Constitution. This right comes into operation, *inter alia*, in supernatural illnesses where the diagnosis may require divination and the treatment magico-religious interventions by a qualified traditional practitioner.

It is doubtful whether these two examples of a basic right violation of employees in South Africa could be justified in terms of section 36 of the Constitution which allows a limitation only to the extent that it is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.

However, while the constitutionality of the exclusion of traditional healers in terms of the Basic Conditions of Employment Act is yet to be determined, in practice it often occurs that agreements are entered into by employers and trade unions setting out the circumstances under which the certificate by a traditional healer registered with his professional association may be acceptable. It is now up to the legislature to expand the

provisions of section 23 (2) of the Basic Conditions of Employment Act in order to give effect to the employee's rights, thus officially acknowledging an already existing labour practice.

## **6.8 CONCLUSION**

The Bill of Rights of the 1996 Constitution of the Republic of South Africa entrenches a number of fundamental human rights. None of these rights is absolute. All are limited by the rights of others. Furthermore, all rights are based on the values underpinning the Constitution, namely democracy, human dignity, equality and freedom. The various provisions of the Bill of Rights relevant to the traditional health care system have been briefly discussed.

The rights to equality, dignity, life, privacy and religion may all be interpreted as guaranteeing a free choice in health care provision. The right to access to health care may arguably refer to either modern or traditional care.

Children's rights play a role in so far as certain traditional practices may be regarded as essential for the child's physical, mental, spiritual, moral and social development.

The right to environment deserves special mentioning and protection since the unregulated promotion of traditional herbal medicines may pose a significant threat to fauna and flora.

In the forefront, however, is the right to culture. The traditional health care system is essentially seen as a cultural institution and thus worthy of preservation. In this context, the most powerful argument in favour of sustaining customs and hence allowing a free pursuit of cultural rights is the fact that the traditional health care system, provided it is modified to take account of prevailing sentiment, endorses current social practice and therefore rests on a foundation of popular acceptance (Bennett 1991:32). Nhlapo (1995:38) points out that

what is unacceptable for many Africans is the notion that theirs is a delinquent culture which requires to be “sorted out” by a more advanced superior one.

Today, in the wake of the global process of decolonisation and the complete eclipse of imperialism, it is accepted that, in general, no one culture is superior to another (Devenish 1999:204). At the same time, in international law and politics, there is a move away from the assimilation of minorities towards the recognition of cultural pluralism as a desirable goal. Bennett (1995:9) states that a leitmotif of postmodernism, the philosophy that has come to dominate thinking in the late twentieth century, is tolerance of diversity. According to him, “a persistent feature of daily life is the fact that people who espouse radically different values and lifestyles, nevertheless manage to coexist and cooperate”. In the context of this movement, the indigenous people of Africa and Asia, *inter alia*, are perceived as having cultures worthy of protection. The underlying purpose of the various ensuing international conventions is to recognise the infinite richness of cultural diversity, and to prevent the cultural domination of minority, or less viable, indigenous cultures (Devenish 1999:207).

Cultural diversity allows for groups to protect what they regard as their own way of life while doing away with objectionable features which are universally or widely disapproved of (Van Wyk et al 1994:580). Here one thinks of cultural norms and health care activities which, in their communal aspects, may be in conflict with individual human rights, notably those of women and children. If challenged in law, the relevant practices would have to yield to the overarching values of the Constitution.

The concept of human rights derives its credibility from its function as a mechanism of protecting human dignity and ensuring the enjoyment of certain conditions necessary for a good life. Norms and principles may differ spatially but the variance is perceptible only in details since all the principles are aimed at preserving the dignity of man as perceived by the relevant society (Ejidike 1999:72). In discussing the African Charter on Human and Peoples’ Rights, Nhlapo (in Bekker 1994:446) pointed out that “Africa does need a human rights approach that cannot be dismissed as foreign and irrelevant. We need an

approach where African traditional values would be seen, not as a natural enemy of contemporary human rights, but as a standard for defining the content and scope of those rights. This may not be easy in all cases. Some traditional practices are incompatible with the spirit of the Charter. The attempt must, however, be made to seek out the positive aspects of African culture and apply them". Issues such as gender equality are particularly problematic in present-day Africa, where the tension between relativity and universality of human rights easily protrudes (Ejidike 1999:88).

In the South African context, the Constitution must be interpreted as respecting cultural institutions and practices only in so far as they are compatible with the Constitution's list of fundamental rights (Chaskalson et al 1996:ch 36-26). In effect then, in exercising the right to culture, one may not discriminate against either women or children. Chaskalson et al (1996:ch 36-24) state clearly that the constitutional protection of a community identity is not a licence to that community to violate the rights of its individual members.

Thus, the right to culture and therefore to traditional health care needs to be compatible with the provisions of the Bill of Rights. In order to achieve a compromise between African and Western values, constitutionalists will have to find innovative ways to balance sometimes diametrically opposed ways of thinking within the framework of the Constitution.

Human rights are a strategy, not an end in themselves. Nhlapo (1995:41) maintains that with this kind of vision we can use the Bill of Rights constructively as a point of departure in the negotiation of a new system which takes cultural diversity seriously, while at the same time protecting the rights of the individual. It is in this context that the issue of the sick certificate has been raised, and a change in the provisions of the Basic Conditions of Employment Act considered in order to allow employees a free choice in health care facilities.

Chapter 7 will argue that one way of preserving traditional values in a human rights culture is to professionalise and regulate the traditional health care system.

## CHAPTER 7. DISCUSSION AND RECOMMENDATIONS

### 7.1 INTRODUCTION

Since the 1970s health planners have come to realise that monopolistic systems of cosmopolitan medicine are ill-suited in developing countries. On the one hand, there are inadequate resources to provide modern health care to populations, and on the other hand, modern services are not able to meet all the needs felt by communities. Thus, modern medicine has not replaced traditional care, and data from a variety of African countries indicate that traditional healers make an enormous contribution, particularly but by no means exclusively in the field of psychosomatic medicine. The extent to which traditional medicine is practised is such that it cannot be ignored by those involved in the transformation and strategic planning of health care systems.

From a legal point of view, African governments essentially have two options: either official recognition and acceptance of traditional practitioners as health care providers, or a continuation of the *status quo*, namely ignoring the traditional sector in a laissez-faire approach. While the latter option maintains a state of legal uncertainty, the former, as will be argued, requires statutory regulation of the traditional health care system. In this context it will be pointed out that, if certain indigenous practices are, indeed, harmful and detrimental to public health, government has a responsibility to control rather than to ignore them (Green 1988:1127).

Including the traditional sector in the official health care system has several benefits. Firstly, by recruiting, training and linking the ubiquitous traditional practitioners to the biomedical system, part of the problem of providing primary health care to the underserved rural masses could be solved (Neumann & Lauro 1982:1817). As members of the primary health care team, traditional healers could help alleviate personnel shortages and increase coverage.

This solution would also imply a wider use of locally produced medicines. Secondly, the cultural heritage of newly independent nations would be preserved, and healing would become culturally more appropriate. Furthermore, by offering more freedom of choice with regard to other forms of healing beyond those provided by modern scientific medicine, “the right of the individual's autonomy” would be respected (Stepan 1983:297).

In addition, it has become evident that certain “African illnesses” may not respond to Western treatment, and that traditional medical systems may be well-suited to meet social and psychological needs not met by the Western style of care. Green (1988:1128) explains that they may be a source of comfort to Africans undergoing cultural change by providing security and continuity in an unpredictable, changing world.

The accommodation of traditional medicine in the national health care system, however, will become possible only if a number of requirements are fulfilled. In the first place it means that healers are accorded an identified place within the framework of organised health care, and that government undertakes to ensure that they practise in a safe and competent manner (Campbell 1998:2). Furthermore, native and modern doctors must treat each other with respect and honesty, and function in a partnership that reflects division of labour and unity of purpose, with each system recognising its own limitations of skills and competence. For official recognition of traditional healers to be effective requires recognition and appreciation of the foundations on which this medical system is built, which may not always be easy for the scientific mind (Bibeau 1982:1846).

For the purpose of inclusion in the official health care system, policy must be decided on with clear reasons and due consideration of opposing arguments, especially with regard to crucial issues such as proof of efficacy, safety and cost-effectiveness. Decisions must be based on the results of investigations into traditional medicine, and “more research on traditional healing is necessary before we can talk meaningfully about integration and collaboration” (Asuni 1979:176).

What is needed, firstly, is a clear definition of traditional medicine and the concept of

primary health care. According to Hammond-Tooke (1989:15-16), the focus should be on the possibility and desirability of accommodating two contrasting world views and the question of whether traditional healers can be incorporated meaningfully into the health care system of a modern state. Yet to answer this question requires an unambiguous understanding of what “traditional medicine” stands for in any particular region (Last 1986:2).

Secondly, knowledge is needed of the number, categories, geographical distribution and clientele of traditional practitioners.. In this context, it is important to be aware of the large variety of individuals who constitute the traditional sector personnel (Oppong 1989:605). Their backgrounds, education and methods of training have to be researched. Staugard (1985:2), points out that detailed information is also required on the specific practices within the traditional health care sector.

Policy-makers must also take into account the current pattern of decision-making by the people who are the users of a particular medical system, including the changes that socio-economic, political and cultural circumstances have effected in the ethno- as well as the biomedical system (Ulin & Segal 1980:57).

Finally, it is essential to find out whether traditional healers are, in fact, interested in the legal regulation of their activities. This issue has political, legal, cultural, social, administrative and economic dimensions.

Representatives of all types of health personnel, health ministry officials and traditional practitioners should be involved in all stages of planning and review. Respected community leaders and others knowledgeable about traditional medicine, health needs and disease patterns in the specific localities concerned should be part of the decision-making process.

In August 1998 the South African Government decided to enlist the help of traditional healers in achieving major goals in primary health care. In the first phase of this collaboration it was agreed to set up a statutory council to control their training, registration

and conduct of practice. Meetings are currently taking place between the Department of Health and traditional healers' associations to work out a framework for collaboration.

This chapter builds on these political developments and makes recommendations for the legal reform of traditional medicine in order to achieve culturally appropriate, accessible, more effective and quality health care. The two health care systems are envisaged in a parallel existence, each retaining its unique role and autonomy.

## **7.2 NECESSITY FOR STATUTORY REGULATION OF TRADITIONAL MEDICINE**

Mainstream medicine today is one of the most highly regulated of all social and economic activities (Stone & Matthews 1996:5). It is the epitome of a profession (Kottler 1988:10). To gain membership involves particular skills and prolonged training in specialised abstract knowledge. Student professionals go through an extensive learning process. The profession decides its own standards of education and training. Members provide skilled services. They can only practise if they are registered with the controlling body, the medical council. The profession is committed to the maintenance of health and the interests of patients.

Laws regulating the practice of medicine are universal. They are essential both to provide the medical practitioner with legal protection and to safeguard the public from unqualified medical treatment and malpractice (Owen 1983:292). Stepan (1983:290) points out that there has always been a genuine belief that every attempt at healing outside the framework of recognised medicine is likely to be ineffective, damaging and equivalent to quackery.

The legal regulation of modern scientific medicine has followed a similar if not uniform pattern first developed throughout continental Europe. During the nineteenth and first half of the twentieth century the health laws of most European countries and the

Americas (as well as many of their then colonies) were designed to regulate the delivery of health care as a monopoly of university-trained physicians and a few other professionals with formal training, such as dentists, pharmacists and nurses. Subsequently, even the practice of the allied and auxiliary health workers was limited to licensed persons (Stepan 1983:290). In time, the concept of health care regulated by law as a monopoly of licensed professionals was introduced by colonial legislation throughout the developing world.

Lee (1982:636) points out that long before the twentieth century both the great traditions of Western and Chinese medicine had developed not only a codified body of theoretical knowledge and practical skills, but also some forms of basic organisation, including control over entry into the profession, special institutions for training, and regulation of practice. The formation of professional associations was important mainly in the sense that, as a collective power and self-regulatory mechanism, it helped to facilitate the process of gaining recognition and support from the state.

Training is strictly standardised, takes place in formal institutions. There is a minimum time to complete training and a structured period for gaining practical experience (Freeman 1992:4). Knowledge is subject to formal evaluation. The lawful practice of medicine is reserved for individuals with the requisite qualifications. The profession is regulated by a code of ethics and disciplinary mechanisms.

With regard to traditional medicine, circumstances are vastly different from those described for modern scientific medicine. The most basic and extensively applied approach to traditional medical systems available to African governments is that of tacit recognition. Although in some instances more by default than by active policy, it suits those countries that choose not to engage themselves formally in the development and regulation of traditional medicine, yet recognise the practical role that the system plays. While the least costly to follow, it has the disadvantage of leaving traditional practitioners in an ambivalent and marginal position. In consequence, the legal status of the traditional medical sector in many sub-Saharan countries is vague. Healers are typically unrecognised and legally

unprotected. Their patients, likewise, have no proper legal recourse in the case of malpractice (De Jong 1991:9). As Kikhela (1981:97) puts it, the government permits itself to “ignore” an activity that is so basic to the life of its citizens. In addition, the state deprives itself of an important health manpower resource and of epidemiological information regarding the utilisation of health care in the traditional sector. Furthermore, this stance hampers the exchange of knowledge between the two medical sectors.

The “tacit recognition” option also applies to South Africa. With the exception of KwaZulu-Natal, traditional medicine is not covered by legislation and no provision for licensing is made. *De jure*, therefore, traditional medical practitioners are liable for infringing laws regulating the practice of Western scientific medicine by performing medical activities for gain while unregistered. In practice, however, the relative sparsity of such prosecutions in spite of the extensive use of traditional healing suggests that the government “tacitly accepts” the existence of the traditional sector.

At the same time, traditional medicine is largely unregulated. Compared to Western medicine with its clear guidelines, traditional practice does not have an official and universal mechanism to determine qualifications or inclusion/exclusion criteria that should be applied. In addition, the current existence of many registering bodies for traditional healers in South Africa only serves to complicate the issue. Consequently, the prevailing situation in the traditional sector is characterised by the following shortcomings:

- lack of standardised training and practice;
  - lack of uniform knowledge;
  - lack of a single professional accrediting body;
  - lack of uniformly applicable qualifications;
  - lack of mechanisms for the evaluation of therapeutic outcomes,
- all resulting in great variations in the quality of care.

Velimirovic as cited in Glasser (1988:1462) translated into clinical practice, these “variations” which may have serious implications in the sense that indigenous methods may have a wide spectrum from beneficial to outright dangerous or even fatal. Similarly, Karim

et al (1994:2) state that every doctor serving African patients sooner or later encounters diseases which have resulted from the ministrations of traditional healers. Traditional practitioners may also misdiagnose and/or mistreat a particular disease and persons with curable conditions may delay or miss out on effective treatment in the modern sector due to their misguided trust in traditional medicine (Dunlop 1975:582). Furthermore, incisions made in some forms of traditional healing may result in the transmission of, amongst others, HIV/AIDS and hepatitis as a consequence of poor hygiene. In addition, there is no truth in the commonly held view that because herbal preparations are 'natural' they must be safe (Moulds & McNeil 1988:573).

Lastly, one of the most recurring objections of modern medical personnel against traditional healers is their "failure to acknowledge the limits of their skills and competence, and an associated reluctance to refer their patients promptly" (Chiwuzie, Ukoli, Okajie, in Wolffers 1990:13). Healers may thus cause adverse effects by omission as well as commission (Moulds & McNeil 1988:573).

From the foregoing discussion it is clear that tacit recognition combined with non-regulation remains an unsatisfactory option.

A better choice, would be to legalise traditional medicine, while at the same time providing control over registration and practice. Although the most common manifestation of this approach has been the "simple licensing" of traditional healers (Dauskardt 1990:353), the present study advocates statutory regulation of the traditional sector similar to that which controls the practice of modern scientific medicine as well as that of the allied health professions, and which rests on the careful design of proficiency criteria, registration of qualified practitioners, and an enforceable code of ethics. Neumann and Lauro (1982:1819) state that the government should license only those healers who have completed a specified and recognised training period or apprenticeship, and who can demonstrate a predetermined level of competence in their work. Thus, legislation would go hand in hand with standardisation and regulation of healing activities.

In short, it would imply the “professionalisation” of traditional medicine as basis for official recognition.

The concept of professionalisation as envisaged in this context is examined next, although some aspects may have been touched on above under the regulation of modern scientific medicine.

### **7.2.1 The professionalisation of traditional medicine**

According to Last (1986:6), broadly speaking, there are two current definitions of a profession, one colloquial and the other technical. In both cases a distinct system of training and specialised skill and competence is implied, which together differentiate the profession from any other full-time occupation providing the main source of income.

The technical description of a profession lists four critical characteristics:

- autonomy: the profession retains a measure of independence through the right to regulate itself;
- monopoly: the professional has a statutory monopoly over a defined sphere of work; the monopoly is maintained by the profession’s control over licence to practise its particular kind of expertise;
- ideology of services: a code of ethics governing relations between a professional and the client and limiting competition between professionals is formally set out and can be enforced by the profession’s own institutions; and
- a body of esoteric knowledge.

A profession is also responsible for teaching and examining recruits to the profession, and for promoting research so that the profession can reproduce both its membership and its claims to expert knowledge. In return for social recognition of its special status, the profession is accountable to the public for providing the expected level and quality of service.

According to Whyte (1992:168), a medical profession may be defined as one which prescribes a specialised training to acquire knowledge, skills and values which form standards for performance. Expert knowledge is structured in such a way as to be susceptible to standardised instruction and use (Last 1986:7). The state certifies people as professionals on the basis of successful completion of training and examination, and grants professionals a monopoly on certain kinds of medical activities, including surgery and the dispensing of classified drugs.

As far as the professionalisation of traditional medicine is concerned, it is vital to note that the basis for standardised performance is, first of all, standardised training. A better choice will have to be made about the core content of training, the syllabus. The 1975 Working Paper of the World Health Organisation states that the syllabus should include, *inter alia*, an elementary knowledge of

- the various systems of the body;
- general hygiene and sanitation;
- nutrition;
- maternal and child health care;
- basic community health care; and
- first aid care.

Most notably, it is felt that traditional healers need the capability to identify and encourage existing beneficial traditional practices, and to eliminate harmful ones. They also require skills in certain modern methods of diagnosis, cure and prevention. They must be able to recognise signs of life-threatening illness, particularly in small children, and respond with prompt referral. Another crucial issue is the use of standardised dosages (Akerele 1984:78). The training of traditional birth attendants in modern delivery techniques and simple ante- and post-natal care is a good example for setting a specific course content.

In the context of training and education it is equally important to identify suitable teachers and the appropriate teaching methods. Teaching by working together does not require literacy skills or a curriculum based on abstract principles. However, literacy of the learners is advantageous since it allows a more concentrated form of communication (MacCormack 1981:427).

At the end of training then follows the assessment of knowledge. Good et al (1979:150) discuss a range of possible actions to establish procedures and criteria for the systematic evaluation of the basic knowledge of the various traditional specialists and their skills. Tests on the preparation, dosology and efficacy of herbal formulations should be included here. MacCormack (1981:427) points out that evaluation by examination is easier and cheaper than by on-the-job assessment.

The final step as far as training is concerned is the identification of criteria for licensing and registration, as well as the establishment and maintenance of a register of *bona fide* healers thus

- assuring patients that their healers have been well trained;
- giving practitioners legal protection in the performance of their stipulated functions;
- maintaining standards of practice.

A code of ethics ensures ongoing good conduct and performance.

Another important aspect in the professionalisation process is the formation of a professional association. Firstly, as an accredited professional body, it will help to separate quacks from genuine qualified practitioners. Secondly, as a collective power and self-regulatory mechanism it facilitates the process of gaining recognition and support from the state (Lee 1982:637).

### **7.2.2 The advantages of statutory regulation**

It is advocated here that professionalisation of traditional medicine should be ensured via statutory regulation. Statutory control is essential in order to safeguard minimum standards of education and training with consequent minimum standards of care, thus

- reducing the risk of harm;
- weeding out charlatans from the qualified practitioners;
- achieving limitation of practice commensurate with the applicable level of skills and competence; and
- protecting the healer and the healed.

At the same time, statutory regulation would be the correct approach to facilitate the accommodation of the traditional sector in the official health care system, with healers having to professionalise their activities along the lines described for the modern health care sector.

### **7.3 THE PRACTICAL IMPLEMENTATION OF OFFICIAL RECOGNITION AND STATUTORY REGULATION**

The envisaged professionalisation of traditional medicine has been outlined above as the “theoretical foundation” of official recognition and accompanying statutory control. What is described next is the practical implementation based on the relevant contributions by the various parties involved, as well as their ultimate cooperation in the accommodation of the traditional health care sector in the national health care system

The first requirement is a favourable government policy and supporting national legislation on the practice of healing, as well as commitment by officials from the Ministry of Health. It is also essential that the Government decide on the position which the traditional sector should occupy within the official health delivery system. Thus, in order to contribute

meaningfully, traditional healers need to be functionally integrated, preferably in the primary health care team.

Further support has to come from organised modern medicine, including a change in the medical university curriculum. Emphasis is to be placed on primary health care and its underlying philosophy of promotive and preventive care and community participation. Elements of traditional medicine need to be integrated into the syllabus. Consultations with healers should take place when required.

The role of the general public and health care consumers has to be acknowledged, taking into consideration the impact that modernisation, education and socio-political changes have had and continue to have on health-seeking behaviour, as well as recognising the freedom of choice in health care as guaranteed by the Constitution.

The main responsibility, however, lies with the traditional healers themselves. A statutory body similar to the Health Professions Council of South Africa should be established. Its functions would include the following:

- control over training, registration and practice;
- specification of entry requirements into the profession;
- maintenance of a register of *bona fide* healers;
- establishment of a code of conduct; and
- provision of penalties for practising while unregistered.

Registration would have to take into account the various categories of healers. The council would also have to be vested with disciplinary powers in cases of complaints, charges or allegations of improper or disgraceful conduct.

The formation of professional associations is to be encouraged to protect the interests of the traditional sector, make recommendations to the regulating authorities, and meet with representatives of the modern health care sector.

#### **7.4 THE ENVISAGED POSITION OF TRADITIONNAL MEDICINE IN THE OFFICIAL HEALTH CARE SYSTEM**

The inclusion of traditional healers in a national health care system can take various forms (Chavunduka 1994:40-41):

- incorporation of identified healers as village health workers into the primary health care programme;
- cooperation between two independent systems at appropriate levels;
- integration of the two systems of medicine into a single state-run health service.

Freeman and Motsei (1992:1184-1185) discuss these options under incorporation, cooperation/collaboration and total integration. Although the present study advocates the cooperation option, all three approaches are briefly discussed and evaluated.

In the incorporation option, identified healers are included into the official health care system as “first-line” health practitioners who function in a way similar to that of village health workers. Programmes of this nature have begun in South Africa, for example, at the Madadeni Hospital in Kwazulu-Natal (Freeman & Motsei 1992:1184). The incorporation strategy is not supported here. It is a piece-meal operation which does not appear to do justice to the traditional medical sector as a whole.

Total integration, on the other hand, would imply the evolution of a “new” healing system through the blending of the two sectors. People seeking help would thus not receive either a pure Western or traditional treatment, but a combination of the two. A small example of such integration is the practice of certain traditional birth attendants in a number of countries. The researcher is of the opinion that, as far as South Africa is concerned, however, such an approach is unlikely to be welcomed by either the modern or the traditional sector or the health care consumers.

What is advocated, therefore, is the official recognition of the institutions of traditional medicine in the form of a co-existence, a dualism of health care systems, where both remain essentially autonomous, and each retains its own methods of operation and explanation. Practitioners from the two systems cooperate through the recognition of the importance and the health value of the other. Cooperation may take the form of mutual referral. Alternatively, it may be felt that either treatment is insufficient on its own and that the particular illness requires a combined approach.

In this way, cooperation would be a solution which maintains both traditional and Western sector in a symbiotic relationship where the two are loosely linked and neither controls the other (MacCormack 1981:428). The one continues its emphasis on science and technological methods, the other the traditional way of healing and restoring a sense of well-being to “whole people” in a social context. It is important here to stress that this type of cooperation between two independent systems must be characterised by mutual respect, understanding and interest in learning and modifying one’s conceptions and practices, when necessary.

In this model, an argument could be made for the state to finance or at least subsidise care provided by traditional practitioners so as not to prejudice those patients choosing traditional medicine. However, it must also be pointed out that at a time when modern health care services are already hard pressed to provide even basic care in an adequate fashion, the drain which could occur through financing traditional healers could have detrimental and unacceptable effects on the modern sector ( Centre for Health Policy 1999:4).

The envisaged benefits of the cooperation option would include the following:

- increase in healers’ medical knowledge with a consequent reduction in harmful or even fatal outcomes;
- enhancement of inter-personal skills on the part of Western-trained doctors by acknowledging the cultural context of their patients;
- freedom of choice for health care consumers with safe options being offered in both sectors;

- improvement in the general quality of health care.

Thus, the cooperation strategy could have a number of benefits provided that some essential requirements were adhered to. Amongst these is the necessity for each sector to acknowledge its own limitations. In addition, both need to accept each other as equals and work as partners in a two-way system of referrals with the mutual goal of improving the quality of patient care. Through official cooperation between the two health care sectors patients would have better access to health care, while standards of care would be raised.

The government costs for treating unsuccessfully handled cases would arguably decline, and certain problems not easily dealt with by the modern sector (e.g. mental health disorders) could be referred to the traditional sector.

By increasing their knowledge and competence, traditional healers would be better able to protect their market share – with both sectors facing a healthy competition.

Enhanced communication between the two sectors could help to bridge the existing cultural gap and make biomedicine more relevant and effective.

In addition, traditional medicine could become a source for new drugs or perhaps a cheaper starting point for the synthesis of known drugs.

## **7.5 THE POTENTIAL DIFFICULTIES REGARDING OFFICIAL RECOGNITION AND STATUTORY REGULATION**

A new approach to the traditional health care sector must be adopted with clear reason and after due consideration of likely obstacles and opposing arguments. Two problem areas would be:

- (1) How can the various categories of healers best be accommodated in the proposed statutory regulation? For example, is it feasible to establish a professional board for each category?

(2) Is it possible to create a single traditional healers' association?

The type of association seen as most efficient is a national/central organisation with local branches. However, experience has shown that only more localised bodies have managed to develop. Traditional doctor Philip Kubukeli, President of the Western Cape Traditional Doctors, Herbalists and Spiritual Healers Association points out that there are likely to be difficulties in bringing all healers together into one organisation; a better solution might be to allow each of the approximately 200 existing associations to continue their existence and functions (*SAMJ* 1998:1057).

A further phenomenon associated with healers' organisations is that they usually consist of herbalists who tend to be more inclined to modernise traditional practice, often incorporate ideas emanating from modern pharmacology, and frequently support training that adopts some of the characteristics of medical schools, such as issuing certificates, diplomas, membership cards and even titles. Chavunduka (1986:263) found a similar trend in other African countries attributed to a number of factors. Firstly, herbalism is more easily taught, examined and controlled (Bourdillon 1989:31). Secondly, it is ideologically furthest away from anything that might be construed as witchcraft or sorcery. Lastly, herbalists have often been singled out by university departments of pharmacology, pharmacognosy and chemistry seeking their collaboration and local expertise. And they are frequently also favoured by pharmaceutical companies in search of "green medicine's wonder drugs" (Chavunduka in Last and Chavunduka 1986:264).

The most basic concern, however, arises from the extent and very nature of traditional medical knowledge with its strong religious, magical and spiritual aspects which may militate against any formal structuring in the way professionalisation might require. How can such knowledge be taught and assessed? How does it yield to objective examination and standardised tests of competence and efficiency? How does one set up proficiency criteria in these instances? The most notable examples here are faith healing and healing by medicines revealed through spirit possession or dreams. Likewise, many traditional healing practices cannot be scientifically evaluated or proven by Western scientific methods.

Thus, one of the fundamental problems facing those in favour of accommodating traditional medicine is the impossibility of reconciling modern scientific medicine with the moral, spiritual, magical and other supernatural principles, the very foundations on which this medical system is built, including its aetiological beliefs as well as the role played by magic, ritual, divination and ancestral spirits.

In conclusion, all the above obstacles and difficulties need careful consideration. In addition, it has to be established that traditional healers are indeed interested in the legal regulation of their activities. While the notion of official recognition, legal status and collaboration with the modern medical sector may seem attractive for most practitioners, they also involve adaptation to certain standards of modern medicine as well as restriction of practice to certain stipulated areas which might not be acceptable to all.

## **7.6 CONCLUSION**

A traditional health care sector exists, and is still widely used by the majority of the country's black population. It has not been replaced by modern scientific medicine, and will arguably continue to exist as an essential component of African traditional culture.

Traditional healers have a significant but so far largely unrecognised role to play in improving the health of South Africans. They represent an untapped health manpower resource which has enormous potential to treat many prevalent diseases and to educate people in all aspects of preventable disorders.

The present standing of the traditional sector in the national health care system is unsatisfactory. Traditional medicine is at best "informal", at worst – if strict legislation applies – illegal, and to a large extent unregulated. In order to facilitate official recognition and accommodation of traditional medicine in the official health care delivery system it is argued here that the traditional sector should be professionalised and regulated by statute.

This strategy requires commitment from all parties involved, starting with favourable government policy and appropriate changes in health care legislation.

From modern medicine it requires respect and tolerance with regard to the very foundations on which traditional medicine is based, and from traditional healers, the will to professionalise their activities is needed.

Traditional healers themselves should have the power, through their council and associations, to train, certify and license their practitioners and control traditional practices. An enforceable code of ethics is necessary to maintain the honour, good name and dignity of the profession.

Official recognition and statutory regulation are regarded as non-negotiable requirements for cooperation with the modern medical sector and mutual referral between the two health care sectors with ensuing benefits for all, including the following:

- The contribution to health care made by the traditional sector would be officially recognised.
- Health care coverage would be increased, with alleviation of the excess demand on Western medical services through mobilisation of local health care resources.
- An improved exchange of knowledge between the two medical sectors would mean that each side could specialise in those illnesses which it is best equipped to treat.

Health care, in general, would become more holistic and of higher quality.

Only in this way can traditional healers guarantee that members of their profession practise their activities in a safe and competent manner, and can traditional medicine be preserved as a cultural heritage that complies with human rights standards and is worthy of protection.

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- South African Medicines and Medical Devices Regulatory Authority Act 132 of 1998
- 2000      Chiropractors, Homeopaths and Allied Health Service Professions Second Amendment Act, 2000
- Pharmacy Amendment Act No 1 of 2000
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- Application of Health Standards in Traditional Circumcision Act 2001 (EC)
- 2002      Basic Conditions of Employment Amendment Act No 11 of 2002

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- 1948      Universal Declaration of Human Rights
- 1950      European Convention for the Protection of Human Rights and Fundamental Freedoms
- 1961      European Social Charter
- 1966      International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- 1981      African Charter on Human and Peoples' Rights

- 1989 International Labour Organisation's Convention Concerning Indigenous and Tribal Peoples in Independent Countries (Convention 169 of 1989)
- United Nations Convention on the Rights of the Child
- Convention on Indigenous and Tribal Peoples No 107 of 1989
- 1990 African Charter on the Rights and Welfare of the Child
- 1992 UN Declaration on the Rights of Persons belonging to National or Ethnic, Religious or Linguistic Minorities

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**NIGERIA**

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