

Department of Health and traditional health practitioners collaboration in the Western Cape

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The Department of Health in the Western Cape signed a Memorandum of Understanding (MOU) with the Western Cape *Inyangi Forum* recently. This represents a major milestone in relations between these two sectors in health care provision. In South Africa there is the Traditional Health Practitioners Interim Council Act of 2007 that recognized for the first time the involvement of traditional health practitioners (THPs) in health care. The signing of the MOU and the development of the Act came after many decades of a conflictual relationship between the two sectors. That potential for conflict is not yet resolved, however, because many of the underlying issues remain unattended.

History of the THP Interim Council Act and the MOU in the Western Cape

In 2006 a Presidential Task Team on African Traditional Medicine (ATM) was appointed. After consultations with stakeholders, the Draft Policy on African Traditional Medicine for South Africa was gazetted for comments. It was the work of this task team that informed the THP Interim Council Act of 2007. Whilst this draft policy was focusing on ATM, it incorporated many of the issues concerned with THP's practice. This can be gleaned from its definition of ATM:

“... defines ATM as a body of knowledge that has been developed over thousands of years which is associated with the examination, diagnosis, therapy, treatment, prevention of, or promotion and rehabilitation of the physical, mental, spiritual or social wellbeing of humans and animals (1).”

It is this definition of the practice that permeates the Act of 2007. In other words, the draft policy provided a basis for defining the scope of practice for THPs. It also gave an estimation of the number of THPs in the country:

“In addition, the health care services rendered by approximately 200 000 THPs makes it the biggest health service industry in the country (1).”

The ‘big debate’ continues on how to institutionalize and regulate ATM and, by implication, work done by THPs. A number of academic institutions are involved in research that seeks to validate claims made by THPs on traditional medicines. Speaking at a recent workshop on ATM, one researcher reminded the audience that:

“The THPs need to separate themselves from their medicines if they are to be made available to the general public, i.e. it must be subjected to research for efficacy evidence (2).”

It was on the basis of all of the above that since 2006 the department has been asking THPs to form an umbrella body in order to facilitate interactions. *Western Cape Inyangi Forum* was established in 2013 and it approached the department for formal engagements. Throughout these years the understanding between the parties was that a relationship can only be based on what can be done locally – put differently, there is a need to respect national processes that might take time. It is this broader context that makes this MOU significant – both sides being prepared to put aside their differences for the benefit of the patient.

Wellbeing of the patient as common interest

There are many role-players in health care provision worldwide. What is often neglected in health care discourses is the agency of patients in health care provision. In South Africa it is acknowledged that many patients consult THPs first for all sorts of reasons. The draft policy on ATM captures this in the following manner:

“Such a resource plays a vital role, as it is often the first resource of many people. Although health facilities are present, the services and advice given by indigenous practitioners are valued because they are given in terms that patients can understand and in the context of cultural values and practices that are shared by both patients and healers alike (1).”

The parties in the MOU identified the wellbeing of the patient as the common interest. Turning this principle into practice, they agreed to the following formulation:

“... both Parties acknowledge that patients are to remain in one stream of health care at a time; that being either traditional health provided by THP or mainstream health services provided by the Department (3).”

By framing the problem in this manner, this agreement opens the way for both parties to work systematically towards tackling the more difficult problems. More importantly, though, this approach constitutes a break with the conventional notion of ‘consulting’ other stakeholders. It seeks to give meaning to working with THPs. One complaint that is often raised by THPs is that they should not just be seen as only good for ‘singing and dancing’ in community events run by health departments.

Basing the collaboration on common interest also helps in avoiding obstacles such as ‘care/cure’ binaries where divisions are supposed to be clear. This will open up spaces for those who want to continue learning in health care provision. It encourages both sides to allow practitioners to take ‘radical’ steps as once described in nursing circles:

“Some go further and reject the care/cure division altogether. The more we learn about health, the more we are realizing that it depends on many factors, emotional, physical, environmental and so on. Who can say with certainty why one person recovers from a disease and another does not (4)?”

Forum members involved in this agreement have demonstrated a keen interest in health promotion and prevention drives. After some attended a training workshop on the dangers of tobacco products, they requested the department to provide this training to all the forum local chapters. This request was made despite the fact that snuff is widely believed to be part of the ‘calling’. This is an example of how this relationship has opened a space for individual THPs to shift their attitude towards certain practices.

The above example also shows dynamism within traditional health practice. Operating in the 21st century is different from what THPs did 100 years ago. They are keen on understanding the world of mainstream health care for the benefit of their patients. Referral is a word used very often in THP circles because they realize that help is available in other sectors of health care. Urbanisation has brought about different health problems to those faced by THPs years ago – diseases of lifestyle kill more people now. Even though there is agreement on referrals from THPs to health services, the parties have not agreed on referrals from health services to THPs. There is no clear way of doing the latter because there is no evidence base for it.

Making it work

The idea of the MOU came out of a session where the two parties held a joint celebration of *ATM Day* in August 2014. On the day, a space was created for learning about each other – the department explained its Healthcare 2030 vision and the THPs gave a sense of their daily practice and experiences. One of the issues that came up was the challenge of working with mainstream health services at local levels. In the absence of a policy guiding interactions with district health managers, relations at that level tend to be ‘reactive’, i.e. how to solve *this* problem. This policy vacuum can perpetuate stereotypes and prejudice. The MOU seeks to close this gap by moving towards formal engagements even at district level.

The Forum has agreed to provide a database of its members and this will be done per district. The idea here being that each local/district chapter of the Forum will be introduced formally to health district directors. This will hopefully allow interactions to be decentralized to districts. Provision has been made in the MOU for training to be conducted at local level, this will make it cost-effective, thus giving this activity a bigger reach. The Forum was also asked to identify ‘health calendar’ days that are more relevant to them for joint activities. The celebration of *ATM Day* has been incorporated into the provincial health calendar for 2015/16. Ultimately, the parties are moving towards sharing platforms on health promotion and prevention drives.

Another first from the MOU is the agreement by THPs to assist the department in health messaging. This entails the entire process from development to field testing of messages to ensure resonance with audiences shared by the two parties. This will constitute a shift from ‘stakeholders’ echoing what the department wants audiences to hear – departmental posters in THP consulting rooms will reinforce what is conveyed in the one-on-one in those consulting rooms. These consulting rooms constitute spaces that afford health messages a far wider reach as explained below:

“... it is used by a large part of the world’s population, who consider it more affordable and more in line with the patient’s ideology (1).”

Forging a way forward

Provision is made in the agreement for quarterly meetings between the parties. These meetings will be chaired by the Chief Director: Health Programmes or a designated person. The department will be responsible for all meeting logistics and secretariat duties. Forum members have undertaken to use the office of the Forum’s chairperson for communicating with the department. In turn, the department will relay all communication and new developments from national structures to THPs via the Forum.

The parties also agreed to invite representatives from local government whenever there is an issue that requires their inputs. The possibility of the Forum getting representation in district health councils is being explored. By keeping the relationship simple and practical, both parties are looking for a way of making collaboration work at local level whilst the big issues remain unresolved.

Currently the signing of the MOU has unleashed a lot of energy from both sides – THPs are travelling to meetings at their own expense. The challenge is keeping this energy going for the benefit of the patients.

References:

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